BOARD OF DIRECTORS OPEN

BOARD OF DIRECTORS OPEN

14 March 2024

09:30 GMT Europe/London

Conference Room, Field House, BRI

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AGENDA - 14.3.24

REFERENCES

Only PDFs are attached

Bo.3.24.0 - Open board agenda 14.3.24 v4.pdf

BOARD OF DIRECTORS MEETING IN PUBLIC AGENDA

Date:	Thursday, 14 March 2024	**Time:**	09:30 – 14:00
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair

- 09:35 - 10:00 – SPaRC Team - Bo.3.24.3 - Ramadan Allies
- 11:40 – 12:10 - Kez Hayat, Head of Equality, Diversity & Inclusion – Bo.3.24.16 – EDI Update
- 12:15 – 12:30 - Sara Hollins, Director of Midwifery and Annesha Archyangelio, Chief Nurse for Specialised Commissioning, NHS England – Bo.3.24.20 - Maternity and Neonatal Services Update
- 13:40-13:55 – Sharon Milner, Charity Director & Michael Quinlan, Deputy Director of Finance – Bo.3.24.23 – Charity Independence

Observers: Helen Wilson, Staff Governor

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.3.24.1	Apologies for Absence • Sughra Nazir, Non-Executive Director • Mohammed Hussain, Non-Executive Director	Chair	For information	Verbal
Bo.3.24.2	Declarations of Interest	Chair	For information	Bo.3.24.2
Bo.3.24.3	SPaRC Team – Ramadan Allies	Chief Nurse	For information	Bo.3.24.3
10:00 Section 2: Business from Previous Board Meeting				
Bo.3.24.4	Minutes of the meeting held on 18 January 2024	Chair	For approval	Bo.3.24.4
Bo.3.24.5	Matters arising	Chair	For information	Verbal
10:05 Section 3: Business Reports				
Bo.3.24.6	Report from the Chair	Chair	For information	Bo.3.24.6
Bo.3.24.7	Report from the Chief Executive	Chief Executive	For information	Bo.3.24.7

10:25 Section 4a: Delivery of the Trust's Corporate Strategy				
Bo.3.24.8	Board Assurance Framework and High-Level Risks	Associate Director of Corporate Governance/Board Secretary	For assurance & approval	Bo.3.24.8

10:40 Section 4b: Finance and Performance				
Bo.3.24.9	Report from the Chair of the Finance and Performance Academy – January & February 2024	Chair of the Finance and Performance Academy	For assurance	Bo.3.24.9
Bo.3.24.10	Operational and Financial Plan 2024/25	Director of Finance/Chief Operating Officer	For information	Presentation
Bo.3.24.11	Capital Programme 2024/25	Director of Finance	For information	Bo.3.24.11

Supporting reports:				
Bo.3.24.12	Integrated Dashboard	Chief Executive	For assurance	Bo.3.24.12
Bo.3.24.13	Finance report	Director of Finance	For assurance	Bo.3.24.13
Bo.3.24.14	Performance report	Chief Operating Officer	For assurance	Bo.3.24.14

BREAK 11:20 – 11:30

11:30 Section 4c: People				
Bo.3.24.15	Report from the Chair of the People Academy – January & February 2024	Chair of the People Academy	For assurance	Bo.3.24.15
Bo.3.24.16	EDI Strategy annual update / Equality, Diversity & Inclusion update (WRES, WDES)	Interim Director of HR	For assurance	Presentation
Bo.3.24.17	Staff survey results	Interim Director of HR	For assurance	Presentation
Bo.3.24.18	Looking after our people	Interim Director of HR	For information	Verbal

12:05 Section 4d: Quality and Patient Safety				
Bo.3.24.19	Report from the Chair of the Quality and Patient Safety Academy – January & February 2024	Chair of the Quality and Patient Safety Academy	For assurance	Bo.3.24.19
Bo.3.24.20	Maternity and Neonatal Services Update	Chief Nurse	For assurance	Bo.3.24.20

BREAK 12:30 – 13:30

13:30 Section 4e: Audit & Assurance				
Bo.3.24.21	Report from the Chair of the Audit Committee – February 2024	Chair of the Audit Committee	For assurance	Bo.3.24.21
Bo.3.24.22	Report from the Chair of the Charitable Funds Committee – March 2024	Chair of the Charitable Funds Committee	For assurance	Bo.3.24.22

13:40 Section 5: Governance				
Bo.3.24.23	Bradford Hospitals Charity – Case for Independence	Chief Operating Officer	For approval	Bo.3.24.23
Bo.3.24.24	Fit and Proper Person Test	Interim Director of HR / Board Secretary	For information	Bo.3.24.24

13:55 Section 6: Board Meeting Outcomes				
Bo.3.24.25	Any other business	Chair	For information	Verbal
Bo.3.24.26	Issues to refer to Board Committees/Academies or elsewhere	Chair	For approval	Verbal
Bo.3.24.27	Review of meeting	Chair	For information	Verbal
Bo.3.24.28	Date and time of next meeting: • 9 May 2024	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 14 March 2024

Annex 1: For Information				
Bo.3.24.29	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.3.24.29

Annex 2: For Information: reports received by Board Committees/Academies				
Bo.3.24.30	Guardian of Safe Working Hours quarterly report	Chief Medical Officer	For information	Bo.3.24.30
Bo.3.24.31	Workforce Report	Interim Director of HR	For information	Bo.3.24.31
Bo.3.24.32	Freedom to Speak Up quarterly report	Chief Nurse	For information	Bo.3.24.32
Bo.3.24.33	Violence Prevention & Reduction Standard	Chief Operating Officer	For information	Bo.3.24.33
Bo.3.24.34	Bradford Hospitals Charity Annual Report and Accounts 2022/23	Director of Finance	For information	Bo.3.24.34

Annex 3: For Information: Board Committee/Academy Governance				
Bo.3.24.35	Confirmed Academy minutes: • Quality & Patient Safety Academy –29 November 2023, 13 December 2023 & 31 January 2024 • People Academy – 29 November 2023 & 31 January 2024 • Finance & Performance Academy –29 November 2023 & 31 January 2024	Chairs of Academies	For information	Bo.3.24.35
Bo.3.24.36	Confirmed Audit Committee minutes – 21 November 2023	Chair of the Audit Committee	For information	Bo.3.24.36
Bo.3.24.37	Confirmed Charitable Funds Committee minutes – 7 November 2023	Chair of the Charitable Funds Committee	For information	Bo.3.24.37

BO.3.24.1 - APOLOGIES FOR ABSENCE

BO.3.24.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.3.24.2 - Declarations of Interest.pdf

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21,2021/	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/	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/	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/	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
Bryan Machin	Non-Executive Director	04/02/2020	2019/20	Outside Employment		Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01/09/2023	2023/24	Outside Employment		Zero hours contract as a Senior Project Manager	Community Ventures Ltd	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
Faeem Lal	Director of Human Resources	20/04/2023	2023/24	Gifts		Invited to the HPMA Awards and dinner by Beachcrofts as their guest. This is a professional NHS People awards, this is not uncommon and Beachcroft are not an exclusive provider of legal services to the Trust, there are a number of other firms that are also used. Attendance at the awards has been approved by the CEO.	DAC Beachcroft Solictors	160
Faeem Lal	Director of Human Resources	14/06/2023	2023/24	Gifts		Invite to attend the HPMA Awards as a guest of Mills and Reeve. Invitation declined as previously received invite to same event from another supplier.	Mills & Reeve LLP	160
Faeem Lal	Director of Human Resources	14/06/2023	2023/24	Gifts		Invitation to attend the HPMA Awards as their guest. Invitation declined as previously received invite to same event from another supplier.	Hempsons Solicitors	160
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/	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	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/	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/	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Netwwork national	0
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/	Loyalty Interests		Son is now an employee of Yorkshire Ambulance Services.	Bradford Teaching Hospitals NHS Foundation Trust	0
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
Julie Lawreniuk	Non-Executive Director	11/03/2021	2020/21,2021/	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20,2020/	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	2022/23,2023/	Outside Employment		Board member and chair of system finance and performance committee	Bradford District and Craven Partnership	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	01/11/2021	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 Walker	Non-Executive Director	01/07/2022	2022/23,2023/	Outside Employment		Deputy Chair, People Committee	Bradford District and Craven Health Care Partnership	0
Laura Parsons	Associate Director of Corporate Governance/Bo	04/05/2023	2023/24	Nil Declaration				0
Matthew Horner	Director Of Finance	12/07/2017	2017/18,2018/	Outside Employment		Board member of north of England commercial procurement collaborative	Board member of north of England commercial procurement	0
Matthew Horner	Director Of Finance	12/07/2017	2017/18,2018/	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/	Outside Employment		Director of Pet Food Manufacturer (Family Business)	E&S Feeds	0
Matthew Horner	Director Of Finance	01/04/2018	2018/19,2019/	Outside Employment		Board Member of Audit Yorkshire (Consortium)	Audity Yorkshire	0
Matthew Horner	Director Of Finance	03/01/2021	2020/21,2021/	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 Serv	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	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/	Outside Employment		Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/	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	Medical Director	10/10/2018	2018/19,2019/	Clinical Private Practice		Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/	Clinical Private Practice		Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	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	16/05/2023	2023/24	Hospitality		Eid Milan Event - Invited and attending as part of BTHFT Charity representative	Yorkshire Cricket Club (Hilcrest)	25
Sarah Jones	Chair	01/10/2020	2020/21, 2021/	Outside Employment		Chair of Realise Education & Training	Chair of Realise Education & Training	0
Sarah Jones	Chair	04/03/2024	2023/24	Loyalty Interests		Brother MD of the Cheshire & Merseyside Cancer Alliance	Cheshire & Merseyside Cancer Alliance	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Outside Employment		Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	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
Zafir Ali	Non-Executive Director	01/11/2016	2016/17,2017/	Outside Employment		Various roles including: Deputy Head of Internal Audit – Department of Health & Social Care Head of Internal audit for the NHS Counter Fraud Authority Head of Internal audit for the NHS Health Research Authority	Government Internal Audit Agency	0

BO.3.24.3 - SPARC TEAM - RAMADAN ALLIES

REFERENCES

Only PDFs are attached

Bo.3.24.3 - SPaRC team - Ramadan Allies project (presentation).pdf

RAMADAN ALLIES PROJECT
SPaRC Team

HSJ Award Winner

"STAFF WELLBEING INITIATIVE OF THE YEAR 2023"

Spiritual, Pastoral and Religious Care

RAMADAN

What?

Why?

When?

Where?

How?

Bradford Teaching Hospitals
NHS Foundation Trust

WHAT IS RAMADAN? HOW DOES IT AFFECT THE WORKPLACE?

- One of the 5 pillars in Islam
- 9th month of the Islamic calendar
- Muslims fast from dawn until sunset for 29/30 days.

An increase in:

- Use of prayer facilities at work
- Requests for flexibility in working hours/shifts.
- Increased requests for annual leave.
- Ramadan related queries from managers

WHY DO SOMETHING?

- Employees are increasingly looking to employers to embody values that matter to them (20% Muslim staff at the Trust)
- Helpful to have guidance for consistency across the Trust (reduces pressure on individual managers to balance needs of the service alongside religious needs of staff)
- Improves staff recruitment, retention and wellbeing (reduces complaints)

WHAT WOULD HELP MUSLIM STAFF?

- 69% Flexible shift patterns
- 60% Team members understanding what Ramadan means to them
- 58% Annual leave for the final days of Ramadan
- 46% Reduced hours

If Muslims feel their employers are supportive during Ramadan, they are twice as likely to stay for 5 years or more

(Muslim Engagement and Development 2021)

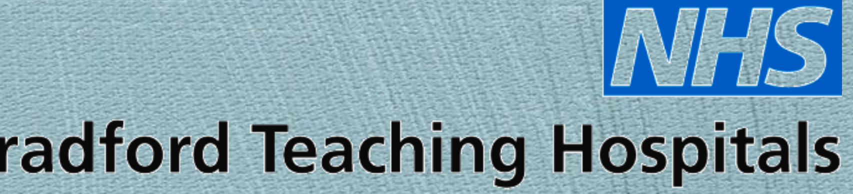
HOW CAN WE HELP?

THE VISION

To make BTHFT “A Ramadan Friendly Employer”

Fasting
At BTHFT’s
Supportive
Trust

To create “The Ramadan Experience @ BTHFT”



THE RAMADAN ALLIES PROJECT

AS A RAMADAN ALLY …

I pledge:

- to be committed to positive action to create the "Ramadan Experience"
- to create a Ramadan inclusive ethos in the workplace
- to take a pro-active approach around Ramadan dialogue
- to champion the right for all to bring themselves to work fully and unconditionally
- to create a culture of acceptance and support

Bradford Teaching Hospitals
NHS Foundation Trust

COLLABORATION

OD
- Support through Thrive (improved staff wellbeing)
- People's Promise Exemplar Site (staff retention/experience)

HR
- Information and advice on the Trusts Flexible Working Policy

COMMUNITY INVOLVEMEMT
- Re-launch visitors prayer room (community representative)
- Donations of prayer mats and beads for Prop bags

A RAMADAN FRIENDLY EMPLOYER

THE RAMADAN EXPERIENCE @ BTHFT

COMMS/SOCIAL MEDIA
- Globals, screensavers
- Ramadan countdown calendar
- Let's Talk
- Mel's Vlog, Karen's filming
- Twitter (200k)
- T&A, Asian Newspapers
- Radio interviews

EDI POLICIES
- Equality Act 2010 (Protected Characteristics)
- Peoples Charter/BTHT values

CHARITIES
- Funding for the project
- 100 Club for Fasting Friday (provide food to open fast)

PPE HUB
- Storage & distribution of Fast Packs and Prop Packs across all Trust sites

Bradford Teaching Hospitals
NHS Foundation Trust

RAMADAN PACKS

Managers PROP pack

Staff FAST pack

Bradford Teaching Hospitals
NHS Foundation Trust

FACTS & STATS - RESULTS

- 1000 Fast packs
- 130 Prop packs
- 131 wards and departments
- 120 Ramadan Allies
- Over 200k (207,66) twitter views
- 98% staff engagement
- Article published in NHS England publication as “Good practice”
- Finalists for 5 awards (including 2 HSJ, Nursing Times)
- Winners of 1 HSJ, Act as One, Brilliant Bradford Awards

Bradford Teaching Hospitals
NHS Foundation Trust

FEEDBACK & POSITIVE OUTCOMES

I have worked in Education for 15 years and have never had the privilege of having a designated area just for prayers. We now have a lovely area behind the lecture theatre to pray in. It really is nice knowing the support that is out there **Staff**

Absolutely love this concept. As a manager it has enabled me to have a greater awareness of Ramadan. Super idea that has grown due to its simple concept **Manager**

Thank you all for organising such a fantastic Ramadan at the Trust! This gesture of Ramadan packs has gone down very well with colleagues here. It practically demonstrated inclusivity and recognition of religious beliefs. Thank you so much! **External**

This has helped open up several conversations with staff that I would normally never have had **Manager**

The support is just incredible thank you **Staff**

A big thank you for your support with Ramadan this year. Especially the Ramadan packs and educating so many staff on how they can make it easier to support Muslim colleagues whist at work **Staff**

Fantastic initiative can be tried at Barnsley Hospital **External**

Bradford Teaching Hospitals
NHS Foundation Trust

SHARING GOOD PRACTICE

Associate Director of Quality – Patient Experience
(University Hospital Coventry & Warwickshire NHS Trust)

General Manager (Westward Care Ltd Headingley Hall Care Home & Apartments, Leeds)

Telegraph & Argus
(local newspaper)

Nursing Standards
(Magazine)

Office Manager
(Alstrom Syndrome UK)

Webinar British Islamic
(Medical Association)

Asian Standard
(Newspaper)

Teams with Manchester
(EDI Department)

Business Support Manager
(London Ambulance Service NHS Trust)

Equality & Involvement Manager
(South WY Partnership NHS FT)

Consultant in Public Health
(Blackpool Council)

Community Radio

BHT Early Education and Training
(Registered Charity)

Chief Executive Officer
(Leeds Hospital Charity)

Race & Inclusion Engagement Partner
(Manchester NHS)

RAMADAN ROADSHOW

MEET HR

Share information about the Trust's Flexible Working Policy

DISTRIBUTE PROP BAGS

Demo of how to use the bags

MEET RAMADAN PROJECT AMBASSADORS

Share good practice with those that have implemented good practice in their ward/department

RECRUIT RAMADAN ALLIES

Sign up
Take the pledge
Receive Ramadan Allies badge

DISTRIBUTE INFORMATION

Ramadan Factsheet and timetable

Details of Fast Packs

Details of the Bradford Hospitals Charity

THE RAMADAN EXPERIENCE @ BTHFT

Bradford Teaching Hospitals
NHS Foundation Trust

Bradford Teaching Hospitals
NHS Foundation Trust

REFLECT & CONNECT CELEBRATION

Bradford Teaching Hospitals
NHS Foundation Trust

RAMANDAN ALLIES AWARD CEREMONY

Bradford Teaching Hospitals
NHS Foundation Trust

THANK YOU FOR SUPPORTING OUR PROJECT

BO.3.23.4 - MINUTES OF THE MEETING HELD ON 18 JANUARY 2024

REFERENCES

Only PDFs are attached

Bo.3.24.4 - Unconfirmed Minutes of the meeting held on 18 Jan 2024.pdf

BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday 18 January 2023	**Time:**	09:30-12:35
Venue:	Conference Room, Field House, BRI	**Chair:**	Helen Hirst, Interim Chair
Present:	**Non-Executive Directors:** - Helen Hirst (HH) - Julie Lawreniuk (JL) - Barrie Senior (BS) - Karen Walker (KW) - 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) - Matthew Horner, Director of Finance (MH)		
In Attendance:	- Dr Paul Rice, Chief Digital and Information Officer (PR) - Faeem Lal, Interim Director of Human Resources (FL) - John Bolton, Deputy Chief Medical Officer (JB) - Laura Parsons, Associate Director of Corporate Governance & Board Secretary (LP) - Sara Hollins, Director of Midwifery (SH) for item Bo.1.24.9 only - Katie Shepherd, Corporate Governance Manager - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- David Wilmshurst, Governor, BTHFT - Elenor Nossiter, Interim Senior Communications Lead, BTHFT - Sarah Smith, Communications Manager, BTHFT - Mark Silver, Communications Officer, BTHFT - Three members of the public -		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.1.24.1	**Apologies for Absence** Apologies were received as follows: - Altaf Sadique, Non-Executive Director - Sughra Nazir, Non-Executive Director - Jon Prashar, Non-Executive Director - Mohammed Hussain (authorised absence), Non-Executive Director - Ray Smith, Chief Medical Officer	
Bo.1.24.2	**Declarations of Interest**	**Associate Director of**

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No.	Agenda Item	Action
	No declarations of interest were noted. The published declarations of interest did not include those of the Non-Executive Directors. This would be rectified, and an updated version published.	**Corporate Governance / Board Secretary Bo24001**
Section 2: Business From Previous Board Meeting		
Bo.1.24.3	**Minutes of the Meeting held on 16 November 2023** The minutes of the meeting held on 16 November 2023 were approved as a true and accurate record subject to adding two formal actions as referenced in the body of the minutes: **Bo.11.23.7 – Corporate Strategy:** *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.*	**Chief Operating Officer Bo23016** **Director of Strategy and Transformation Bo23017**
Bo.1.24.4	**Matters Arising** The actions from the log were reviewed and the outcomes agreed have been recorded within the action log.	
Section 3: Business Reports		
Bo.1.24.5	**Report from the Interim Chair** HH introduced the report and highlighted the following key points: • Two new NED appointments were approved by the Council of Governors on 23 October 2023, and it was hoped they all necessary checks would be complete by the end of January to allow them to start in post as full members of the Board by 1 February 2024. • The substantive Chair appointment process was progressing well with the shortlisting to take place at the Governors NRC on 19 January, followed by interviews on 2 February. • It was the final meeting of two outgoing NEDs, Jon Prashar and Barrie Senior, both having served two terms of three years. HH thanked them for their services and support to the organisation. • The next Council of Governors election process will launch on 9 February 2024. *(Post meeting note: On review, due to the upcoming local authority elections the current governor election schedule will run into the pre-election period for the local authority elections. Therefore, the governor election process will be moved forward and formally commence on 7 May 2024 to ensure there is no conflict with the local authority elections.)*	

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	• The first Quality Improvement Group (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 was largely positive, and MP would update further in her CEO report. JL referred to the emotive presentation from neonatal colleagues at the last closed meeting and recognised the need to understand how they would be informed of the QIG updates, and what further support the Board can provide. The Board noted the report.	
Bo.1.24.6	**Report from the Chief Executive** MP highlighted the following key points from the report: • The previously mentioned QIG had been constituted by NHS England as a direct response to allegations made by the former Chairman. There had been a very robust analysis of procedures to assess the efficacy and safety of the neonatal unit with involvement from clinical staff on the unit. There was another meeting of the QIG on 26t January and verbal feedback indicates the QIG is sufficiently assured of the safety of care on the unit. MP recognised that this has been a difficult time for patients and families as well as staff within the unit. • Industrial action had taken place in December and January, which is traditionally one of the most challenging times for the NHS. MP paid tribute to all the clinical teams providing excellent care throughout that period to enable patients to remain safe and well cared for. There were impacts on elective patients who had their procedures cancelled to enable a safe focus on urgent and emergency care, and these patients were being kept under consistent review given their extended waiting times. Despite the challenges of industrial action, A&E performance remained consistently strong. • The establishment of the surgical day-case unit at St Luke's Hospital was continuing, as was the work on developing the new endoscopy unit. • The initial staff survey results had been received but this was currently under embargo. The results would be shared in due course. • Three new Executives had been appointed to the vacant Executive Director positions. It was hoped they would be in post from 1 April pending completion of the Fit and Proper Person and pre-employment requirements. The successful candidates would also be announced once all checks were complete.	

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	JL referred to the financial position of the local authority referenced in the report, and the impact of local authority beds on the Trust's performance. She queried whether there would be an opportunity to contribute to the consultation, and MP confirmed this. MP also referred to discussions at the latest Bradford District and Craven Health and Care Partnership Board meeting which focused heavily on this issue, and the request made by the local authority to the Treasury for emergency funding which was pending an outcome. There was also consideration of opportunities presented given the scenario in the health sector as a result of the financial pressures expected in 2024/25. MP recognised there were difficult decisions to be made for all sectors. This would need to be considered as part of the next executive discussion on the high-level risk register to ensure that the current risk is reflective of the current context. PR shared an update in relation to partnerships, regarding the awarding of £4.86m to the University of Bradford's Centre for Digital Innovations in Health and Social Care to develop and evaluate innovative health technology. HH sought an update on the preparations for the latest planning round. MP advised that the process was being undertaken by the Trust and then would be replicated at place and West Yorkshire level. There was a 'closing the gap' programme board in place to address how to inform decisions around investment at place level. MH confirmed that at a Trust level, work was ongoing with finance, operational and workforce teams to triangulate plans, with an executive team session planned on 29th January to 'opportunity scan'. This had been the most challenging year financially since 2018/19 resulting in a significant change in the level of scrutiny and controls in place to manage the run rate. SA advised that from an operational perspective, capacity was being considered within Clinical Service Units to assess the deliverability of planning assumptions. The Board noted the report.	
Section 4a: Delivery of the Trust's Corporate Strategy		
Bo.1.24.7	**Board Assurance Framework (BAF) and High-Level Risks** LP introduced the report which detailed changes to the BAF and high-level risk register. In relation to the BAF, LP highlighted the following changes: • 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. This risk is currently scored at 20 and is aligned to all strategic objectives.	

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With regard to the high-level risk register, the following changes were shared:

There were two risks which had reached their target mitigation date (3810 – haematology services; and 3468 – staff now following correct EPR processes), both of which would be extended.
There had been one new risk added to the high-level risk register (3896 – histopathology) but it was 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.
There were two risks which had increased in score which would be reconsidered at the Executive Team meeting prior to any changes being made to their scores (3530 – fire risk due to extension leads; and 3788 – roof leaks in Heaton House).
One risk had closed as the Trust's gas and electricity has been bought at a capped rate for 2024/25 and 2025/26 (3800 – cost of gas and power increasing).
There had been three changes in risk score, detailed as follows:

Risk 3732 in relation to nursing and midwifery staffing levels had reduced from 20 to 16 due to successful recruitment.
Risk 3823 relating to mortuary storage facilities had reduced from 16 to 12 as procedures were now in place to manage this.
Risk 3748 in relation to haemodialysis demand had increased from 16 to 20 due to ongoing issues with capacity within the service.

It had been proposed to reduce one risk in score from 16 to 12 (3881 – pharmacy vacancies) due to successful recruitment, but the Executive Team had requested that this remain at 16 until further improvement is seen in the medicines reconciliation rate.

MP referred to the longstanding risk regarding the age and condition of the aseptic pharmacy unit, advising that the interim solution in place will soon be operationalised, and confirmation has been received this week that £4.5m capital funding has been secured for the aseptic unit relocation. LB queried whether there was a time frame for this to be completed, and MP advised that it was hoped that once funding is received in 2024/25 it would be an in-year build.
HH referred to the extension to risk 3810, recognising that this had already been on the risk register for a significant length of time. JB clarified that whilst the risk remains on the high-level risk register, progress has been made in terms of appointing to posts within the haematology service and therefore the service has been strengthened. The Trust was working collaboratively with Airedale NHS FT, and this was taking longer than expected hence the
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	continuing risk, rather than the risk being reflective of the resilience of the current service. HH requested that at the next Executive Review this risk is nuanced to better reflect the current position. The Board was 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 approved the addition of risk 6 (board leadership and governance) to the BAF.	**Associate Director of Corporate Governance / Board Secretary Bo24002**
Section 4b: Quality and Patient Safety		
Bo.1.24.8	**Report from the Chair of the Quality and Patient Safety Academy (QPSA) – November and December 2023** LB provided an overview of the report highlighting the following items: • The escalation to the ICB Chief Nurse and in turn the North East and Yorkshire Chief Midwife of the significant number of women waiting on planned inductions for labour whereby one case of harm had occurred resulting in the unfortunate death of a baby. • The discussion at Academy on Health Inequalities and how best to engage our diverse workforce in considering action plans and strategies in relation to health inequalities. • The trust managing to maintain high levels of performance during December despite the Junior Doctors industrial action. • Academy support for t the addition of a new CLIP metric to the quality dashboard from next year. • Whilst SHMI data was higher than expected the Academy noted the issues with coding and received assurance that all deaths in the Trust within the period had been scrutinised with no safety concerns found. In regard to the strep B research (one of the causes of the increase in women waiting for inductions); JL questioned whether a risk assessment had been carried out prior to participation. KD advised that this was a national research project, and that it was a known risk that undiagnosed strep B in mothers could result in stillbirth, so this risk was balanced against the risk of delaying planned inductions. The national research continued and would be evaluated in April 2024. She also advised that all hospitals in the region had a significant backlog of delayed inductions due to multiple factors. KD also confirmed that the stillbirth in November had been escalated very quickly (both internally via the Executive huddle and more widely via the ICB), and the clinical teams had worked to increase the number of inductions and considered how to describe the processes to women attending the Maternity Assessment Clinic.	

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	MP advised of a letter received on 28 November from NHS England which was a statement of information on health inequalities. The letter gave much more detailed information on what should be monitored and reported on to satisfy organisations that they are tackling heath inequalities in a meaningful and measurable way. In terms of A&E performance, MP recognised that the Trust was regularly one of the top achievers, both regionally and nationally, and that there had been a number of measures put in place within the department to aid this, including the implementation of the same day emergency care (SDEC) unit and GP streaming at the front door. Whilst the industrial action had created challenges, there were also benefits in utilising more senior decision makers in A&E and this had demonstrated that decisions made on admittance tend to result in fewer admittances and much smoother patient flow. HH put on record her thanks to the teams for working hard to maintain high levels of performance. PR referred to the SHMI data and noted the latency between the Trust supplying data for the report and this being reflected. The data supply issue had now been rectified and it was expected that the March report would feature the correct data. KD updated the Board that as of this week, the Trust had changed its risk management system from Datix to InPhase, the latter of which was more intuitive and allowed for a thematic review of complaints. This had highlighted a repetitive theme of lack of palliative care input for those patients who had sadly died. The team was reviewing this further to identify opportunities to improve. KD also highlighted the reference to the safeguarding annual reports which showed an increase demand on services, not only in terms of workload but also in the level of scrutiny following the report into the death of Star Hobson. The Board was assured by the report.	
Bo.1.24.9	**Maternity and Neonatal Services Update** The Board noted that all papers within this section had been received by the QPSA and the Board was assured by the update provided above by the Chair of the Academy. It was also noted that the Neonatal Medical and Nursing action plans had been approved by the People Academy in November, and the Board confirmed their further approval of the action plans. SH provided some further highlights as follows: • The LMNS assurance visit was positive, and despite having taken place on a challenging day for the department, the feedback was that staff were engaged and committed, and could articulate challenges and actions taken to respond to these.	

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	• The aforementioned pressures in delayed inductions had been managed, and there had been another slight increase in induction backlog but this was replicated across the region therefore the Trust was not an outlier in comparison to neighbouring Trusts. The challenges in November and the sad death of a baby meant that the system has improved to address backlogs in a more robust way. The daily assurance meetings continued despite a reduction in pressures to ensure oversight. HH recognised that the neonatal unit staff have been subject to rigorous external feedback which has been difficult at times, but she thanked them for their attitude in responding to this with a focus on improvement. SH and KD noted that this was JP's final meeting of the Board and thanked him for his work as the maternity safety champion . There would be a gap following his departure and HH confirmed she would discuss this with other NEDs to see who may be interested in taking up this position, recognising that this may be a holding position for now until the new substantive Chair is in post. **Maternity Incentive Scheme (MIS)** SH advised that the annual MIS submission was due on 1s February 2024, and despite the challenges year on year as the level of scrutiny expands, the Trust will declare full compliance as in previous years. The papers shared with the Board provided a breakdown of each standard and available evidence if requested to share this by the MIS. The summary for the Trust had been shared with the Accountable Officers for the ICB and ICS, both of which confirmed they were assured by the content. SH highlighted the following points against several safety actions: • The Trust has met all standards in all cases in relation to safety action one, with the exception of one baby who was a surveillance case only. In this case, the surveillance information was not completed within four weeks of death due to technology issues. Having discussed this with NHS Resolution, it is anticipated that the mitigation will be accepted in this case. • The Board formally recorded approval of the Neonatal Medical and Neonatal paper and action plans which had also been approved at the November People Academy. • The Board formally approved the 1:1 care in labour risk / assessment action plan required to achieve compliance with safety action five. KW confirmed that safety action four came to People Academy at the end of November, as at that point there was non-compliance with staffing. SH confirmed that whilst the maternity unit does not always meet the British Association of Perinatal Medicine (BAPM) standards	**Interim Chair Bo24003**

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	for staffing, the related action plan shows progress towards working towards this, and the stipulation of the safety action is in relation to progress made. Therefore, the Trust was able to declare overall compliance with this action. KW confirmed that the People academy was assured of the progress being made. MP confirmed that Beverly Geary, Chief Nurse of the ICS, had also reported satisfaction with the Trust's assessment of compliance. LB recognised that a regular issue raised at QPSA is 1:1 care and a lack of clarity on this as there is limited feedback. SH advised that the maternity survey does highlight that women feel they are left alone at a vulnerable time, and the action plan will focus on actions as a service to improve this, but there are wider factors to consider such as women often feeling they need 1:1 care at times when this is not clinically required. HH referred to the case in relation to safety action one whereby surveillance information was not completed within the required time frame. Whilst she acknowledged that this was an isolated incident and not an ongoing safety concern, she queried if there was any learning from it. SH advised that the system is very robust, and she was confident that such an incident would not be repeated due to additional arrangements put in place to ensure continuous monitoring of surveillance information. The Board was assured by the update and approved the MIS compliance submission which would be signed off and submitted by the CEO on 1 February 2024 on behalf of the Board.	
Bo.1.24.10	**Proposal to establish a Maternity and Neonatal Task and Finish Group** KD referred to the paper which sought approval from the Board to form a task and finish group, with the purpose of identifying new ways of managing and presenting the large quantity of maternity and neonatal information that is mandated for submission to various forums. HH recognised that there is also a national review of the mandated reporting requirements to ensure these are appropriate. The Board approved the establishment of the task and finish group and the draft terms of reference.	
Section 4c: People		
Bo.1.24.11	**Report from the Chair of the People Academy – November 2023** KW introduced the report. The following key items from the report were highlighted. • The Academy review of the MIS safety action four in detail.	

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	• With regard to the risks reviewed the Academy noted in particular the good progress in reducing midwifery and nursing staffing vacancies. • The reductions in the levels of staff turnover and staff absence rates. Of particular note was the stretch target set for absence of 5.5% by the end of March. • The long-term workforce plan had been developed. • A detailed update was received on The Outstanding Pharmacy Services (OPS). Whilst there had been much positive progress, which was pleasing to hear, 55% of the pharmacy staff were not engaged in workstreams and so focus is now on how best to reach this cohort of staff. • Recent campaigns for the St Luke's Hospital day case unit and in general nursing and midwifery had attracted a total of1100 candidates registering their interest and with 59 new staff appointments. KW shared that the Academy was experiencing challenges currently. She was the only NED in attendance recently and also was responsible for Chairing the meeting – this inevitably contributed to the meetings running over the scheduled time. However other attendees along with the Executives present did a great job of challenging information provided. Board was assured by the report.	
Bo.1.24.12	**Equality and Diversity Council Update** MP presented the report detailing discussions at the Equality and Diversity Council meeting held on 15 December 2023 highlighting: • The Trust had received two national awards in recognition of work the Trust is doing to address EDI – a Nursing Times Workforce Award in the category of 'Best Employer for Diversity & Inclusion' and a HSJ Workforce Wellbeing Award for the SPaRC team in recognition of their innovative work on the Ramadan Allies project. • RESIN membership continues to increase, from 173 members in October to 224 in December, many of whom are new overseas recruits to the Trust. • 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. • Ali-Jan Haider provided EDC members with a detailed update report on "Root out Racism" and shared some of the highlights in the meeting. He 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	

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	- change throughout the organisation and become anti-racism champions. - 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. - Kez Hayat, Head of EDI would be preparing a paper for an upcoming Executive Team Meeting 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. There was a specific need to ensure all senior managers have an EDI objective as part of their appraisal by end of March 2024. SA highlighted the 'Pause for Peace' initiative led by the SPaRC team each Tuesday, recognising that the Trust was one of the very few, if not the first, organisations who have publicly invited staff to have open and difficult conversations about world events such as the ongoing Israel / Palestine conflict. LB commended this and the importance of recognising the difficulties for clinicians in managing faith needs alongside clinical needs. The Board was assured by the update.	
Section 4d: Finance and Performance		
Bo.1.24.13	**Report from the Chair of the Finance and Performance Academy – November 2023** JL introduced the report and highlighted the following key points: - There continues to be a risk to delivering the 2023/24 financial plan. The risk is, in the main, due to increased costs as a result of 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 an end of year break-even position. - The Trust's cash position is forecasted 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. - The Trust's A&E performance remains strong against local peers. - The plan for 2024/25 across the three 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 are required to achieve our ambition. 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.	

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No.	Agenda Item	Action
	The Board was assured by the report.	
Section 4e: Supporting Reports		
Bo.1.24.14	**Integrated Dashboard** MP reported that the Trust was performing very well in comparison with peers, and that the biggest concern at present is the development of financial plans for 2024/25 and beyond. However, there was a higher number of patients experiencing long lengths of stay, and work was ongoing at place level to define the optimal model of intermediate care. MP also highlighted that the number of colleagues from non-white British backgrounds employed by BTHFT had increased and now exceeds representation in terms of the proportion of the population. Concentration was now on accelerating representation at the most senior levels within the organisation with recognition that attention is needed on developing the pipeline of individuals into more senior posts. MP noted that there had been three recent executive appointments, none of which were from a minority ethnic background. There was a need to develop the talent pipeline to support greater diversity at bands 8 and above into deputy, then director, posts. The Board was assured by the dashboard.	
Bo.1.24.15	**Finance Report** MH provided an updated financial position since the November Academy meeting which had already been discussed under item Bo.1.23.13. The latest figures at the end of Month 9 suggested a slightly better than forecast position in terms of the predicted underlying run-rate. Overall, the Trust was still targeting a breakeven position at year-end against a revised£1.1m deficit plan, but there was a need to be mindful of the £10m system wide gap, which colleagues were reviewing together at system level to address. Internally, opportunities to address the underlying run rate are regularly reviewed with opportunity scanning ongoing. Work is also ongoing to identify ways to catch up on the activity lost through industrial action and in particular, to address the 65-week waiters. Financial escalation meetings are now in place with challenged clinical service units. The waste reduction workstreams also continue but are not seeing much output. There has been good progress on reduction in agency spend with HCA agency usage reduced to zero and a reduction on agency reliance in estates and facilities. The Maternity Incentive Scheme would also release £700k towards the waste reduction plan if deemed compliant. MH also highlighted the capital risks, with £40m remaining to spend in Quarter 4 and an escalated risk of deliverability of the capital	

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No.	Agenda Item	Action
	programme. At present, schemes were being moved and brought forward to ensure that the £40m is spent in-year. MH noted that at present, the finance teams were planning for 2024/25 and the opportunities available as an organisation given that all technical and non-recurrent adjustments have been deployed this year so will not be available next year. The executive team would need to consider whether there is capacity, capability, and resource to take forward some transformation/ change opportunities presented to them. JL referred to the balance sheets peer review being undertaken, recognising that this was a significant step change from previous system working, and a very open and transparent look at organisation finances. She welcomed the view of the incoming Director of Strategy and Transformation on how they can help to support an improvement programme and the workforce with some of the transformation work. SA quantified the impact from the December and January strikes – in those two months alone, 1464 outpatient procedures were cancelled, 51 cancer patients, 71 inpatients, and 96 day-cases. The operational team were undertaking an assessment of challenged areas and working closely within the remainder of financial year to work with the independent sector on ensuring longer wait patients are seen where possible. The Trust was also offering mutual aid to support other organisations who had some longer length waits. BAS referred to previous reports which showed a decrease in productivity against an increase in headcount and queried what opportunities for improvement were being identified to address this. SA referred to improvements undertaken in service areas, such as endoscopy, to reduce reliance on insourcing and outsourcing, including consultant posts being filled and lists now being delivered internally which will quickly reduce the cost being spent to a much more sustainable model. CSUs were also looking at forward planning for vacancies. MP advised that the use of GIRFT was being embraced to help inform decision making, with all business case proposals for additional consultants to reference comparison with GIRFT guidance. JB referred to the requirement for service areas to consider current workforce and describe why they need additional headcount when funding requests for expansion of workforce are made. BAS recognised that staff needed to understand the serious financial risks, and MH agreed that the executives needed to agree how to change this mindset. There was an upcoming executive time out on 29 January to focus on this. KW highlighted that innovative practices and the 'embedding kindness' programme may also have impacted on productivity levels, as the focus on patient experience means some procedures and	

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No.	Agenda Item	Action
	conversations now take longer than previously. She echoed the need for staff to understand the financial position but identified that this could be done differently and in a more positive manner, such as encouraging staff to make suggestions and contributions on opportunities for waste reduction. The Board was assured by the report.	
Bo.1.24.16	**Performance Report** SA referred to the latest performance report, noting the aspiration to be in the top quartile for all measures. For those areas where performance was already within the top quartile, the aspiration was to achieve top decile performance which would support the Trust's ambition to deliver operational excellence and outstanding services. As mentioned previously, UEC performance remained steady, and the Trust was consistently ranked as one of the best performers in the country. SA noted this was due to a number of factors including front door streaming and the development of SDEC. The ambulance handover position was also strong and improving, with HALOs in place within the emergency department to speed up the handover process and release ambulances rapidly. With regards to the winter plan, SA confirmed that the opening of wards and beds is continuing as planned and it was anticipated that this would improve performance metrics such as the SSNAP data, given the opening of ward 9 which resulted in additional beds for stroke patients. SA commented on the learning as a result of the industrial action, which had demonstrated that consultant presence at the front door of A&E did enable a faster turnaround of patients. This learning would help inform next year's winter response. There were a number of organisations operating at OPEL 4, but the operational response to pressures within the Trust had meant that BTHFT was not in that position. In terms of the RTT standard, the Trust was currently not complaint at 66.59% but there was a focus on prioritising the order of patients to ensure that clinically urgent patients were seen first. There were no patients waiting beyond 78 weeks, and the Trust was on target to have zero patients waiting beyond 65 weeks by the end of March 2024. The Trust was also in a relatively good position in relation to 52 week waits. There would be a focus in 2024/25 on maximising productivity in house and reducing reliance on insourcing and outsourcing. In relation to diagnostics and cancer standards, the two week wait, and faster diagnosis standard positions were strong. The 62-day backlog was on plan to be at no more than 43 patients by the end of March. The biggest challenge for diagnostics was in histopathology, and there was a programme in place to improve this pathway.	

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No.	Agenda Item	Action
	Diagnostic waiting times remained challenging, but the Community Diagnostic Centre was now largely completed with a formal handover expected shortly, which would improve diagnostic, cancer and RTT pathways. KW congratulated the finance and operational teams on the clarity of presentations and reports that are shared through the Finance and Performance Academy, which regularly provide detail from operational, tactical and strategic perspectives. BAS commented that the expanded stroke bed capacity was welcome, and asked whether there would be an action plan with set time frames to achieve stroke aspirations. SA advised that there was a strong focus on this, and that the overall aim was to achieve an 'A' rating from SSNAP. A more immediate ambition was to achieve and consistently maintain a 'B' rating, and then assess the investments needed to achieve an 'A' against other priorities. A further update would be brought to the Board in 6 months' time detailing the progress made and improvements seen as a result of the opening of ward 9. The Board was assured by the report.	**Chief Medical Officer Bo24004**
Section 4f: Audit & Assurance		
Bo.1.24.17	**Report from the Chair of the Audit Committee – November 2023** BAS introduced the report which was taken as read. There were no further comments from the Board.	
Section 5: Governance		
Bo.1.24.18	**Distributed Leadership Model – Director of Nursing and Quality** KD advised that the Director of Quality and Nursing for Bradford District and Craven had formally retired on the 31 March 2023. This had provided an opportunity to review both the existing and future arrangements. The three provider Chief Nurses and the Director of Nursing and Quality reviewed the possibility of a distributed leadership model shared between the three provider Chief Nurses and this has been in place since 1 April 2023. As part of the agreement to trial the arrangements for a one-year period, a 6 monthly review and evaluation was presented to Partnership Leadership Executive (PLE) where colleagues were supportive of continuing the arrangement. The Board noted the proposal approved at PLE and endorsed the current arrangements for the Chief Nurse to continue with the distributed leadership model.	
Bo.1.24.19	**Constitution Amendments**	

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No.	Agenda Item	Action
	MP advised that following the retirement of John Holden, Director of Strategy and Integration/Deputy CEO, 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 was requested that either the Chief People and Purpose Officer or the Director of Strategy and Transformation is appointed as a voting Executive. The Board agreed that the Director of Strategy and Transformation should be appointed as a voting Executive. The Constitution would be amended in line with the Board's decision and the proposed amendments would be presented to the Council of Governors for approval on 6 February 2024.	
Bo.1.24.20	**Academy Work Plans** The Academy work plans were noted and approved.	
Section 6: Board Meeting Outcomes		
Bo.1.24.21	**Any Other Business** No other business was discussed.	
Bo.1.24.22	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no additional issues to refer to the Committees/Academies or elsewhere.	
Bo.1.24.23	**Review of Meeting** It was agreed to continue to include the finance report, performance report and integrated dashboard report as separate items on the agenda. LP would ensure that future Board meeting agendas replicated this.	**Associate Director of Corporate Governance / Board Secretary Bo24005**
Bo.1.24.24	**Date and Time of Next Meeting** 14 March 2024 – 09:30am	

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ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 18 January 2024

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo23016	Bo.11.23.7	**Corporate Strategy:** 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.	Chief Operating Officer	March 2024	Update circulated via e-mail. Action complete.
Bo24001	Bo.1.24.2	**Declarations of Interest:** The published declarations of interest did not include those of the Non-Executive Directors. This would be rectified, and an updated version published.	Associate Director of Corporate Governance / Board Secretary	March 2024	The register of interests was updated to include all Board members. Action complete.
Bo24002	Bo.1.24.7	**Board Assurance Framework (BAF) and High-Level Risks:** As risk 3810 has been on the risk register for a significant length of time; HH requested that at the next Executive Review this risk is nuanced to better reflect the current position.	Associate Director of Corporate Governance / Board Secretary	March 2024	ETM will review and confirm revised narrative at their meeting scheduled for 19 February. Action complete.
Bo24003	Bo.1.24.9	**Maternity and Neonatal Services Update:** HH confirmed she would discuss the maternity safety champion role with other NEDs to see who may be interested in taking up this position following Jon Prashar's departure.	Interim Chair	March 2024	Zafir Ali appointed as NED Maternity Champion. Action complete.
Bo24005	Bo.1.24.23	**Review of Meeting:** It was agreed to continue to have the finance report, performance report and integrated dashboard report as separate items on the agenda. LP would ensure that future Board meeting agendas replicated this.	Associate Director of Corporate Governance and Board Secretary	March 2024	Action complete.
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	May 2024	Added to Board Development planner – date to be confirmed. It was agreed to keep this open on the log until a date is confirmed.

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Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	May 2024	Update to be presented to QPSA in April 2024, followed by an update to the Board in May 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	May 2024	Item to be discussed at People Academy on 24.4.24.
Bo24004	Bo.1.24.16	**Performance Report:** A further stroke update would be brought to the Board in 6 month's detailing progress made, and improvements seen as a result of opening the ward 9 beds.	Chief Medical Officer	July 2024	
Bo230017	Bo.11.23.7	**Corporate Strategy:** JL requested that a key be added to the document, and it was confirmed that this would be included in future updates.	Director of Strategy and Transformation	November 2024	

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BO.3.23.5 - MATTERS ARISING

BO.3.24.6 - REPORT FROM THE CHAIR

REFERENCES

Only PDFs are attached

Bo.3.24.6 - Report from the Chair.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.6

Report from the Chair

Presented by	Sarah Jones, Chair	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Sarah Jones, Chair	
Purpose of the paper	To provide an update on activity and engagement involving the Council of Governors and Membership since the previous report provided to the Board (from the Interim Chair) in January 2024	
Key control	N/A	
Action required	For Information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Introduction

I would first like to introduce myself as your new Chair. I am looking forward to working with the Council of Governors, the Board, our staff and our diverse communities so that we may continue to work to deliver the best healthcare and services possible for our patients.

I would also like to formally acknowledge our thanks to the Interim Chair, Helen Hirst for the work she has done during the period following the resignation of the former Chair. I am sure you will join me in wishing Helen well for the future.

1. Council of Governors meeting held 6 February 2024

The Council last met on 6 February 2024. The agenda and papers from the meeting are available here. The minutes from the meeting will be presented for approval at the next meeting on 25 April 2024, however a summary of key items considered on 6 February are included below.

- Report on the discussion that took place at the Governor and NED pre-meeting held earlier in the day focussed primarily on the areas covered at the Board Academies (Finance & Performance, Quality & Patient Safety and, People.)
- CEO Report covering key activity since the last report on our Patients, People, Partners and Place.
- Operational Planning and the significant challenges ahead for our Trust and our partners within the wider system.
- The 'Membership Plan update' including progress against recruitment targets for our Keighley membership constituency and, for young people across our district aged between 16 and 20yrs.
- The Council discussed the Governors' 'annual effectiveness/skills & knowledge audit' and noted that this would be superseded by the development work with Governors undertaken by ANHH Consulting. The outcomes and actions from the two development sessions held in January would be brought back to the April meeting for review and approval.
- Governors Nominations & Remuneration Committee (NRC) report providing a summary of the activities of the NRC since the last meeting of the Council. The Council also noted that two seats on the NRC were due to fall vacant. Nominations received for these vacancies will be approved at the next Council meeting in April.

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.6

- Constitution amendment which was approved by the Council to appoint the new Director of Strategy and Transformation as a voting member of the Board of Directors. *The revised Constitution is now available on our website here.*

Summary of one of the key items considered by the Council at the closed meeting.

The Council approved my appointment as BTHFT Chair, the remuneration for the role and the associated terms and conditions in line with the Council's statutory duties and responsibilities.

The Board is asked to note that a report on the appointment process will be included in the Trust's Annual Report 2023/24.

2. Elections to the Council of Governors

The Board was previously advised that our next governor elections process would launch on Friday 9 February 2024. On review, the interim Chair, Helen Hirst, determined that due to the upcoming local authority elections in May, this would mean that the governor elections schedule would coincide with the pre-election period for those local authority elections. Therefore, the BTHFT governor elections process has been re-scheduled and will now formally commence on 7 May 2024 to ensure there is no conflict.

As a reminder, nominations will be sought for the following seats on the Council.

- 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 do 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 including the revised election schedule.

Executive led sessions for Governors

- Operational Planning: Further to the Council meeting on 6 February, this session is intended to provide our Council members with the opportunity to discuss and comment on the Trusts proposals in advance of submission to the ICB with our Chief Operating Officer, Sajid Azeb and our Director of Finance, Matthew Horner. The Council is aware that in this era of partnership working a joint plan will be submitted to NHS England. The session is scheduled for Monday 11 March.

- Freedom to Speak Up: A session has been scheduled to take place on Tuesday 19 March (re-scheduled from November 2023). This is in response to questions raised by Governors, prompted by the Lucy Letby case. Our Chief Nurse, Karen Dawber and members of her team will be providing a briefing to governors on Freedom to Speak Up and the themes and clinical areas that have to date emerged.

Invitations to Trust Operational activities extended to Governors

We recognise that Governors are volunteers however, where appropriate invitations continue to be extended to Governors, where their schedules permit, to provide opportunities to add to their experience

and knowledge of our Trust which might support them in their understanding of the Trust and the delivery of their duties. Governors have over the last few months been invited to:

- Attend the 'CSU (Clinical Service Unit) to Academy event' on 8 March where the following CSU's (Musculoskeletal (MSK) and Therapies; Theatres, Critical Care and Day Case and, Women's) have an opportunity to present their learning and improvement work, their plans for continuous improvement and, reflect on how this impacts on quality, people, performance, and finance.
- Attend the Outstanding Theatres celebratory event on 9 January to celebrate the Theatres improvement journey over the last two years and hear about future plans.
- Participation within the shortlisting panels for the Team of the Month awards.

Performance Briefing for Governors

Following discussions between the Interim Chair, Helen Hirst and the Lead Governor, Mark Chambers a new style performance briefing has been developed to support more frequent communications between the Board and Governors on key areas, for example performance and industrial action. The briefings follow on from those received by the Non-Executive Directors from the CEO, Mel Pickup. The information provided tends to be focused on the areas where all Trusts come under scrutiny. The briefings appear to be well received by Governors.

3. 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.

A new staff governor bulletin has also recently been developed in consultation with all four staff governors, Raquel Licas, Ruth Wood, Farzana Khan and, Helen Wilson for internal circulation via global email. The first bulletin was circulated in December 2023 and provided staff with the key highlights from the November 2023 Council of Governors meeting. The second is due to be circulated shortly and will report on the key outcomes from the February 2024 Council of Governors meeting.

4. 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.

Recommendation

The Board is asked to note this report.

BO.3.24.7 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

Bo.3.24.7 - Report from the Chief Executive.pdf

Bo.3.24.7 - Appendix 1 - 2024 02 06 QIG Update letter BTH Final.pdf

Bo.3.24.7 - Appendix 2 - PRN01107 4HS and 76% letter NEY 250124.pdf

Bo.3.24.7 - Appendix 3 - PRN01161_Letter re Multi-factor authentication_February 2024.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.7

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 January 2024.	
Key control	N/A	
Action required	To note	
Previously discussed at/ informed by	N/A	
Previously approved at:	Committee/Group	Date

Situation

1. Patients

Quality Improvement Group Bradford Teaching Hospitals- Neonatal Key Line of Enquiry

On the 26th January 2024 I attended the BTHFT Quality Improvement Group (QIG) made up of representatives of the NHSE regional office, WY ICB clinical leads, Specialised Commissioning, and the Care Quality Commission (CQC). The QIG process was instigated by or regulators NHSE, in response to the serious allegations made by the former chair upon his resignation from the trust relating to our neonatal services and concerns about leadership within the trust.

Over a number of months now the QIG has been reviewing evidence,(Such as Trust Board papers, Quality and Patient Safety Academy papers and our investigatory processes in relation to the Serious Incidents our undertakings in respect of the, duty of candour and learnings and actions taken in response to those, the appropriateness and timeliness of those actions. They have been meeting staff and there have over that same period been formal inspections of our neonatal and maternity services respectively. You will hear more about the findings of the QIG review and the inspections of clinical services later in the meeting from our Chief Nurse and Chief Midwife, in their routine report to the Board. I am however delighted to report that as you will note from the letter included in this report at appendix 1, that on the matters relating to the care of babies in our neonatal unit, the reporting and learning from incidents, the Board governance and transparency of this, that they have received significant assurance and have closed this line of enquiry. This is welcome news not just for the families of Bradford who rely on those services and whose confidence in them may have been affected by what they read in national and local press, but also for our clinical teams who are passionate and proud of the services they deliver and continue to strive to improve the safety, effectiveness and user experiences of their unit over a number of years, and as you will hear in particularly in the inspection reports, their success in so doing.

The letter and the findings on which it is based finally gives external validation that the neonatal service is safe and high quality and clearly chronicles that the Board and the Patient Quality and Safety academy were fully sighted throughout on all matters subsequently raised as concern.
I'd like to thank the Clinical teams on the neonatal unit for their professionalism and cooperation throughout this difficult period, something which was also comment upon by the QIG team.

- **Operational Update**

Industrial Action

As at the end of February 24 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
BMA JD	3-9 January 2024	144 hours
BMA JD	24-28 February 2024	113 hours

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

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

- Outpatients Routine 701 cancelled 15% of total booked
- Outpatients Cancer 255 cancelled 45% of total booked
- Inpatients (excluding colonoscopy's) 25 cancelled 61% of total booked

- Daycases 42 cancelled 48% of total booked.

It is likely that further periods of JD IA will occur and we believe that the BMA is currently out to ballot for continued JD strike action.

Our clinical and operational teams have continued to prioritise clinically urgent patients given the significant non-elective demand expected during this period of the industrial action.

Planning Guidance 2024/25

In the absence of formal planning guidance we are developing our operational, finance and workforce plans based on the information already available to us and conversations with the West Yorkshire locality team at NHSE. As a system we are working to an agreed set of principles aligned to improving performance and achieving financial balance. We are committing to meet the expectations set for Urgent & Emergency Care (ECS at 77% and ambulance turnaround <30 mins), Cancer Waiting Times (FDS at 77% and 62 Day FT at 70%), and Referral to Treatment (no 65 week waits by September 2024) whilst also increasing activity and improving diagnostic waiting times. This has been indicated in the returns made at the end of February and will be finalised in the return due at the end of March, before which further triangulation between Finance, Workforce and Operational plans will be undertaken to ensure emerging information from national and regional colleagues has been incorporated. 2024/25 will be a very difficult year, which will likely impact on the priorities we set ourselves and the decisions we make. Achieving these 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.

- **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 (AECU).

The AECU has resulted in a reduced admission rate which is alleviating some pressure on beds across the Trust. Unfortunately, winter demand and delays for patients requiring intermediate care beds or packages of care has meant occupancy has increased to very high levels. As a result, some patients do continue to have an extended length of stay in the Emergency Department (ED) whilst awaiting a bed. 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 continue to support 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. Ongoing IA is likely to result in some patients remaining over 65 weeks on our RTT incomplete waiting list at year end. This is a position recognised nationally and the expectation is now for clearance by September 2024 which we are confident we will meet. Elective activity will increase in 2024/25 with the opening of the SLH Day Case Unit and diagnostic activity will also increase, in part due to the opening of the Community Diagnostic Centre (CDC). The CDC is an excellent facility at Eccleshill and the project with SRO support provided by our COO/Dep CEO. The official opening event took place on the 27/02/2024 and received local and regional coverage.

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 for diagnosis and are working to reduce treatment wait times into Q4 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.

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

The development of SLH DCU is progressing, however the target for handover has now shifted to the end of May 2024 as opposed to mid-April 2024. This is due to contractor delays, and we continue to work with the Darwin Group to try and ensure no further slippage of practical completion date. 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. Planning

permission for the enabling works and the final scheme have been submitted and we anticipate a decision by the end of March 2024.

2. People

- **NHS Staff Survey 2023**

The NHS Staff Survey was undertaken between Wednesday 20th September 2023 and Friday 24th November 2023. The results are embargoed at the time of writing this update however the embargo will be lifted on 7 March 2024. The staff survey is a measure of how we are performing as an employer from the perspective of our staff and provides us with an understanding of where we can learn and improve. The staff survey is planned for discussion on the Trust Board agenda however it is important to highlight that we have had a significantly improved results from the previous years survey which at the time was a significant improvement. The staff survey improvements have come off the back of a difficult period of time for the NHS and our Trust in particular and during a period of prolonged industrial action. The overall response rate for the survey was 43% which is an increase of 6% on the 2022 staff survey.

- **Financial Wellbeing**

We launched a new option for colleagues who work bank shifts to access their pay more quickly on 29th of February 2024. Flexible workforce colleagues launched the new offer at the BRI concourse with a stall between 10am and 3pm on Thursday, 29 February offering colleagues the opportunity to find out more about this instant pay option, run by Wagestream, which is available to all bank staff.

The new system means that once a bank shift has been worked and finalised for payment, colleagues can access 50% of their pay for the shift, providing greater flexibility to access pay early. Whilst there is a small charge for the service it offers our staff further flexibility on pay.

- **Equality Delivery System Engagement**

At the end of February, we held two important engagements events as part of our annual Equality Delivery System review. We held an event for staff on 29th January and an event for the voluntary and community section of 1st February. Both events provided a great opportunity to showcase the excellent work we are doing as a Trust to advance equality, diversity & inclusion and to gather feedback on area's where we can make improvements. As a Trust we achieved an EDS rating of achieving (indicating we are doing what is required, but there is still some scope for improvement). Outcomes of the EDS review will be published on the Trust website.

- **Race Equality Week and RESIN**

The theme for this year's Race Equality Week, which took place 5th – 11th February 2024 was: '#Listen, Act and Change,' and the Trust's Race Equality Staff Inclusion Network (RESIN) ran an event to raise the profile of race equality on Tuesday 13th February on the main concourse to coincide with

celebrations for the Chinese New Year. The event was well received, and the network signed up a further 74 members as a result.

Colleagues from across our partnership were also encouraged attend a wide range of events and webinars, including the “creating change” series, where Kez Hayat, Head of Equality, Diversity & Inclusion at BTHFT was invited as a guest speaker to talk about his own career journey and experiences of making changes in the workplace to tackle racism and inequality.

We also saw the launch of the second stage of the Root out Racism movement, which aims to drive an anti-racist culture change, where staff are confident to challenge unconscious and conscious bias, creating a system where institutional racism that perpetuates inequality, favouritism and unfair outcomes is seen as and dealt with as any other serious incident.

- **Celebrating LGBT+ History Month (February 2024)**
-

At the end of January, the LGBT+ staff equality network published an article in Let’s Talk to showcase some of the excellent work the network is doing across the Trust and at place level. This was also an opportunity to generate support for the LGBT+ History Month celebrations. The LGBT+ staff equality network, along with colleagues from the EDI team came together on 19th February on the main concourse at BRI to raise the profile of LGBT+ equality, sharing information about the network and freebies with staff. They also arranged a ‘trolley dash’ taking refreshments and information about staff equality networks and how staff can support the LGBT+ services users by joining the Rainbow Badge scheme.

3. Place

- **National context and policy development**

Arrangements for delegation and joint exercise of statutory functions

NHS England has published guidance for NHS bodies to help support new collaborative working arrangements that are possible between NHS organisations and local government following implementation of the Health and Care Act 2022. This updated guidance supersedes that previously issued in September 2022. Locally we will continue to use our Bradford District and Craven Health and Care Partnership Board - as a committee of the NHS West Yorkshire ICB - to strengthen the way we work together linking through to our strategic partnership agreement. In addition, we will work at scale across West Yorkshire, including involving the West Yorkshire Combined Authority, where policies can be developed and are suited to a regional level.

Advanced Pharmacy First service launched

On 31 January 2024, a new Pharmacy First advanced service was launched, with over 10,000 pharmacies registered nationally to provide support to local communities. The new Pharmacy First Service will enable community pharmacists to complete episodes of care for patients without the need for the patient to visit their general practice. This, alongside expansions to the pharmacy blood pressure checking and contraception services, is designed to reduce pressure felt by GP practices by

providing quicker and more convenient care, including the supply of appropriate medicines for minor illness. Information for patients is being shared as part of national, regional and local communications campaign. An easy to follow guide is also available on the gov.uk website.

Measles, mumps and rubella

The United Kingdom Health Security Agency (UKHSA) has declared a national incident following Measles outbreaks in London and West Midlands, as well as increasing numbers of cases across the Country. Most of the cases have been in children under the age of 10 years with many outbreaks linked to nurseries and schools. They have done this because unless urgent action is taken, we are likely to see the measles virus spreading in areas with low MMR vaccine uptake. UKHSA will coordinate the investigation and response to the rise in measles cases to reduce spread of infection. The NHS have launched a national campaign for missed MMR vaccines – GPs sent letters to parents of all unvaccinated 6-11yrs olds, inviting them to book a vaccine. The current national situation is directly linked to the low levels of MMR vaccination in our District. The measles catch up campaign started in November and the immunisation teams have already identified areas of likely low coverage.

Health Secretary announces new women's health priorities for 2024

Speaking at a women's health summit in January 2024, the Rt. Hon Victoria Atkins MP, Secretary of State for Health and Social Care outlined the new women's health priorities for 2024. This builds on the work carried out to date on the Women's Health Strategy which was launched in July 2022. The Secretary of State's update included an ambition to rollout women's health hubs in every local health area.

We are planning for our first women's health hub for Bradford District and Craven. Our model of delivery will see us using our existing wellbeing hubs and health sites to accommodate services you would traditionally find in a women's health hub, giving a connection to each of the localities we serve. We are supporting and coordinating work at place focusing on screening (cervical, STI) and contraception (LARC, emergency contraception, TOP). Additional interventions, including mental health support or signposting will be considered as part of the approach. We are developing a bank of online video resources aimed at providing women with helpful information about various women specific health issues, such as menopause, produced in a number of community languages. We will also working closely with VCSE partners to provide grants that support community-based services for women.

Disposable vapes banned to protect children's health

Following a national consultation on smoking and vaping, the Government has announced that disposable vapes will be banned. Vaping alternatives - such as nicotine pouches - will also be outlawed for children who are increasingly turning to these highly addictive substitutes. The ban forms part of a range of measures being introduced to help achieve a smokefree vision. Smoking remains the single biggest cause of preventable illness and disease in the UK. Locally we have continued our efforts, through public health, to implement our tobacco free vision recognising the significant health

impacts smoking has on people's health and our wider health and care system. Locally anyone looking to quit can contact Bradford Stop Smoking Service at StopSmokingService@bradford.gov.uk or call 01274 437700. People in Craven can contact the Living Well Smokefree service for North Yorkshire by using an online form or calling 0300 131 2131.

National review into mental health inpatient services

The Healthcare Services Safety Investigations Body (HSSIB) has published its terms of reference in a bid to help improve patient, staff and community safety. HSSIB and its predecessor, the Healthcare Safety Investigation Branch (HSIB), has worked since June 2023 to determine the scope of the investigation and have been reviewing relevant evidence.

The aims of the investigation include:
- learning from inpatient mental health deaths
- improving patient safety
- helping to provide safe care during transition from children and young people to adults in mental health services
- creating conditions for staff to deliver safe and therapeutic care

HSSIB will engage with patients, families and carers, as well as local and national healthcare organisations, as part of its review. As an ICB and as a place-based partnership we will closely monitor the review, contribute if asked to and learn from the findings and recommendations once the review is completed.

- **West Yorkshire Health and Care Partnership activity and implications for Bradford District and Craven place partnership**

West Yorkshire ICB operating model review

We are continuing to provide support for ICB staff following the recent review and publication of the revised operating model staffing structures. This includes individual support and a focus on organisational development (OD) work, to focus on new ways of working, continued wellbeing offers, practical skills and coaching to prepare staff participating in selection or being made redundant. The outcomes of the operating model review will impact on the work we do at place as we will be working with a reduced staffing base. We are working with partners to understand what this means for operational delivery of our place-based partnership functions.

Response to the BRAP Report 'Too hot to handle'

'Too hot to handle' is a report that has been published by national charity BRAP, that looks into health service's efforts to tackling racial discrimination. The report argues there is a culture of avoidance, defensiveness, and minimization of racism within NHS trusts. Our West Yorkshire Health and Care Partnership has responded with an open letter recognising the findings of the report and showing how we are already demonstrating that so many elements of the report's recommendations are already being actioned locally. In Bradford District and Craven we are well underway with planning for the

second stage of the Root Out Racism movement, taking the lead for West Yorkshire in re-energising the movement at place.

Thank you letter in response to seasonal pressures

A letter of thanks was issued by the NHS West Yorkshire ICB in recognition of the work of all colleagues across all sectors in response to seasonal pressures. This year has seen a number of issues coming together to create an additional level of challenge to our health and care system. The letter, issued both on behalf of the ICB and the West Yorkshire Health and Care Partnership Board, acknowledges the work that colleagues have carried out during one of the busiest periods ever for health and care services.

People's experiences of end of life care in West Yorkshire

NHS West Yorkshire Integrated Care Board (WY ICB) approached Healthwatch in West Yorkshire after committing to developing an end of life care vision to ensure residents of West Yorkshire receive the support they need and can die in a place of their choice, with consideration given to what and who matters to them. NHS West Yorkshire Integrated Care Board (WY ICB) commissioned Healthwatch in West Yorkshire to gather the views and experiences of people living in each of the five places who receive end of life care (or have a loved one who does), in relation to the six ambitions set out in the national Ambitions for Palliative and End of Life Care framework. The findings from this project have now been published. Further work will take place through Healthwatch Bradford and District to ensure we capture the views of our culturally and ethnically diverse communities.

Changes to medical certification of death

Following campaigning by local communities, MPs, and partners within the ICS including local clinicians as well as others from around the country, the government has published draft regulations to take effect from April 2024 as part of the Death Certification Reforms. This will facilitate faster release of bodies for burial following death, which is important for our communities in enabling religious observance, and will improve the experience of bereaved people. We continue to engage with local communities and stakeholders to help people understand how this will affect them and their planning for funerals and burials. There is work ongoing to ensure we have established effective pathways that local clinicians can follow to ensure we follow both the legal process and help people sensitively during a particularly emotional time.

Find out how you really are

With the new rugby league season now starting and the cricket season preparing for launch in spring, the NHS in West Yorkshire is working with local clubs to encourage supporters to 'Find out how you really are.' The new initiative encourages people to take steps to understand and reduce their risk of developing diabetes or experiencing a heart attack or stroke. It's estimated that approximately 300,000 people across the region are unaware that they have high blood pressure. Persistent high blood pressure can increase the risk of several serious and potentially life-threatening health conditions,

including stroke. Locally we have developed a number of initiatives - including Bradford Beating Diabetes, Bradford Healthy Hearts and Bradford Breathe Better - with the learning from these helping inform campaigns and programmes such as this one.

- **Bradford District & Craven Partnership progress and issues to note**

Latest update from closing the gap programme: meeting our financial challenge

Our closing the gap programme has been set up to help us - across our Bradford District and Craven Health and Care Partnership - take a collective approach to the incredibly challenging financial situation affecting all of our individual organisations. We are involving all sectors of our partnership in an open and transparent way to close the gap we currently have between the budget available and our current expected spending across all sectors.

Our latest update (opens in Microsoft Word) describes the current financial position for Bradford District and Craven, with an anticipated deficit of between £80-£90m across our combined NHS budget in place. This is in addition to wider, financial pressures on our key partners. You can read more on the progress we've made in setting up partnership and governance structures to oversee the closing the gap programme.

Bradford Council's finance position

The consultation for Bradford Council's budget proposals has closed. At the time of writing this report the findings from the consultation and the decisions made as a result had not been published taken place. We did however submit a response on behalf of our wider partnership, with a specific focus on some of the impacts on health and care, outlining our thoughts on the budget proposal. In our response we recognised the complexities and interdependencies of decisions facing all of us across all sectors across our partnership and very much want to work together to find solutions that mitigate impacts as much as possible within the resources available to us.

Racism causes poor mental health and prevents people accessing support

Experiencing racism increases a person's chances of having poor mental health but also makes it harder for them to get the right support, according to a new report from Centre for Mental Health. The report, Pursing racial justice in mental health report, is based on research in Bradford District and Craven on the ways in which voluntary and community organisations locally support people with their mental health. It finds that racism not only causes poor mental health in the first place, it also stops people getting into services, and it impedes their recovery. Research shows that racism, in its many manifestations, can cause psychological trauma, anxiety and depression. But it also stops people from getting help when they need it.

Following the findings of the Centre for Mental Health's report and recommendations, a multi-agency project team - representing stakeholders from Bradford Council, NHS, VCSE, people with lived experience and the Bradford District and Craven Health and Care Partnership's Reducing Inequalities

Alliance - was brought together to establish a specialist service to meet the needs of ethnically and culturally diverse communities.

I'd like to acknowledge the work that's taken place that included having challenging and uncomfortable conversations that demonstrate and reaffirm our commitment to tackling racism and any other inequalities head on.

Healthy Minds Summit

Over 200 people joined us at this co-produced event which took place at the end of January to come together and share ideas and experiences that will drive the work of our refreshed Healthy Minds strategy. The Healthy Minds strategy drives the work of the Healthy Healthy Minds priority area, with the aim of achieving better lives and improving support we offer to people with mental health, substance use needs, learning disabilities or are neurodiverse so that people can live happy, healthy at home. As well as launching our refreshed Healthy Minds strategy, we also formally launched our revamped Healthy Minds website (www.healthyminds.services). I'd like to say thank you to event hosts Madeyah Khan and Matthew Riley, who shared their lived experience and expertly guided the day.

Root Out Racism

During Race Equality Week (5-11 February) we reaffirmed our commitment to the Root Out Racism movement. To do this we have prioritised:

- the maternity journey and experiences of black and south Asian women
- mental health support in the community for ethnically and culturally diverse communities
- supporting young people into employment from ethnically and culturally diverse communities
- addressing educational inequality in minoritised communities.

Action that is being taken as part of these priorities includes mandatory training and development for staff across all sectors, clear representation of ethnically diverse staff across organisations in the district, listening and engaging with ethnically diverse communities and sharing their stories and lived experience of racism.

Minister praises 'heartening' progress of Bradford District's Family Hubs

Health Minister Andrea Leadsom, MP and Parliamentary Under Secretary of State, said Bradford District's Family Hubs and Start for Life programme has made 'heartening' progress, at her visit to Farcliffe Family Hub, Bradford, on 2 February.

I'd like to say a thank you to the colleagues from our partnership who were involved in the ministerial visit, showcasing the amazing work we do with our partners to support families across the Bradford District through the Family Hubs and Start for Life programme. Colleagues can access information dedicated to professionals and practitioners on the FYI website. You can also sign up for the monthly Family Hubs and Start for Life newsletter – with information for families and professionals it's a valuable resource for keeping up to date with services and news across the Bradford District.

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Bradford District and Craven case study in 'Keep it local for better health' report

A new national report, 'Keep it local for better health: How Integrated Care Systems can unlock the power of community', has been launched by Locality, a national membership network for community organisations. Keep it Local for Better Health describes an approach for integrated care systems (ICSs) to achieve their priorities by unlocking the power of communities through six Keep it Local principles. The 'Keep it local for better health' report includes a case study (see page 23) on our community partnerships in Bradford District and Craven. Carlton Smith, Chief Executive for Bradford Trident and Clare Dinsdale Head of Community Partnerships and Localities Development for our place-based partnership presented at the launch of report.

Covid inquiry team visits Bradford

With thanks to the Bradford Care Association, the views of the independent care sector were shared with members of the Covid inquiry team. This was part of the Covid Inquiry's Every Story Matters activity that is encouraging people to share their experiences of the pandemic and how it affected them. During February the Covid Inquiry team was keen to hear more about the experiences of people working in social care locally. In addition, they held two drop in events at Forster Square Retail Park for wider members of the public to share their own stories. People are still being encouraged to share their story https://covid19.public-inquiry.uk/every-story-matters/

Congratulations Professor Abbas

I'd like to congratulate Dr Sohail Abbas on his appointment as Honorary Professor at the University of Bradford within the Faculty of Life Sciences. Dr Sohail Abbas is the Director – Population Health and Inequalities, Bradford District and Craven Health and Care Partnership and Deputy Medical Director - NHS West Yorkshire Integrated Care Board.

4. Partners

- **WYAAT Committee in Common (CiC) meeting, 30th January 2024**

I attended the WYAAT CiC meeting on 20th January 2024, where we discussed the financial position, and approved the WYAAT Strategy and 2024/25 Plan. We had a strategy focused session on pharmacy aseptics and NSO, and received the programme executive and collaborative reports. We also discussed the upcoming WYAAT conference: Innovation through collaboration.

- **WYAAT Programme Executive, 6th February 2024**

I attended the WYAAT Programme Executive on 5th February 2024 where we considered the commercial model for imaging network maturity, reviewed the CiC actions including workforce priorities, the April meeting plan and discussed external invites, and looked at the system financial recovery lessons learned. We also discussed key themes for the upcoming WYAAT all executive event.

- **WYAAT All Executive Meeting, 5th March 2024**

Myself and other Executives joined the WYAAT All Executive meeting on 5th March 2024 where we had a detailed discussion on the financial position and operating context, and then undertook three separate sessions on opportunity identification, framework for assessment and implementation, and delivery leadership.

- **West Yorkshire Partnership Board Meeting, 5th March 2024**

I joined the West Yorkshire Partnership Board meeting in public in Leeds City Centre on 5th March 2024, at which we received the Fair Work Charter and agreed to issue a call for action for the adoption of this, received an update on progress made to date with the WY Creative Health System, and supported the proposal that the West Yorkshire Health and Care Partnership becomes the first "Keep it Local" Integrated Care System in the country. We also noted the collective action taken to understand and address AMR as a system to date; the challenges faced and support the recommended actions proposed. In relation to climate change, we acknowledged the strategic requirements for addressing climate change as a Partnership and agreed to formally incorporate environmental (and social) sustainability considerations into all future WY Partnership board papers.

5. National Reports

Implementation of first phase of Martha's Rule

Martha's rule is something we are keen to be part of. We were heavily involved with some of the background work to this, namely the 'worries and concerns' pilot which has gone on over the past year. There was one trust represented in each region, and we were it for our region. There was concern that the right to a 'second opinion' would generate more work, but that has not been borne out in practice. It has been well-received by patients, staff and families. We meet the requirements of a first wave Trust (24/7 critical care outreach provision) and would be keen to be part of it. There are no details yet on the expression of interest process. There is money attached, but again no detail on that.

The report can be access here: https://www.england.nhs.uk/long-read/implementation-of-first-phase-of-marthas-rule/

Review of Midwifery Education and Training and Newly Qualified Experience: Thematic Analysis HASKE report

The findings into this report into the experiences of Newly qualified midwives will be incorporated into the midwifery preceptorship plans and the nursing and midwifery recruitment and retention plan.

The report can be access here: https://www.england.nhs.uk/publication/review-of-midwifery-education-and-training-and-newly-qualified-experience-thematic-analysis/

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Safe Learning Environment Charter Launch Letter

The letter can be access here: https://www.england.nhs.uk/long-read/safe-learning-environment-charter/

Urgent & Emergency Care (UEC) Recovery Plan

The letter issued by NHSE colleagues on 25 January 2024 outlines the need for continued focus on the ambition to improve to at least 76% performance against the Emergency Care Standard this year with further improvements planned for next year. In addition there is an ask to ensure delivery of the ambulance response times for category 2 incidents to 30 minutes on average over 2023/24. In specific there is a requirement that all provides achieve the 76% during March and there is an ask to ensure that the following initiatives are fully implemented:

- Streaming and redirection
- Rapid Assessment & Treatment
- Maximising the use of UTCs
- Improving ambulance handovers
- Reduce time in department

At BTHFT we have all suggested initiatives in place and currently compliant with the 76% ambition. We continue to input into the daily ICB performance meetings and have been asked to share the good work undertaken at BTHFT at both the regional and national workshops.

The report can be access at appendix 1.

Leadership Competency Framework for Board Members

A new leadership competency framework has now been launched for leaders in the NHS and will apply to all board members across the Trust. The framework was a recommendation of the Kark review in 2019, it sits alongside the Fit and Proper Persons Test for board members. The framework has 6 domains that that require board members to have specific skills, knowledge and behaviours to undertake a board role. The competency framework will be part of the annual appraisal and will require board members to demonstrate proficiency against the framework.

The framework can be accessed here: https://www.england.nhs.uk/publication/nhs-leadership-competency-framework/

Multi-factor Authentication Letter

User Access
End user devices with VPN (Virtual Private Network) are secured with the addition of user and device security certificates, this is the default configuration of the VPN remote access system. Remote access by other methods such as VDI (Virtual Desktop Infrastructure) is be secured with MFA (Multifactor Authentication) using SMS (Secure Messaging System) or an Authentication app. This is fully implemented.

Supplier Access Suppliers are being transitioned from legacy RDP (Remote Desktop Protocol) access via HSCN (Health & Social Care Network) to a Privileged Remote Access using MFA. This project is over 50% complete and will be complete by the July deadline. The letter can be accessed at appendix 2.
Recommendation
The Board is asked to note this report.

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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	
☒	☒	☒	

Julie Clennell
Joint Regional Chief Nurse (Interim)
North East and Yorkshire
NHS England

Email: julieclennell@nhs.net

Helen Hirst
Interim Chair
Bradford Teaching Hospital NHS FT

Sent by email

6 February 2024

Dear Helen

Quality Improvement Group – Bradford Teaching Hospital NHS FT

I'm writing to update you on the discussion at the Bradford Teaching Hospital NHS FT Quality Improvement Group held on 26 January 2024.

In respect of the concerns raised in relation to the timeliness of the conclusion of three serious incidents in the Trusts neonatal service alongside the implementation of lessons learned the Quality Improvement Group has received several sources of assurance in relation to clinical quality governance and safety within the service. This includes a detailed presentation and associated evidence from the Clinical Director of the Neonatal Service, the reports from an ICB led Ockenden Assurance Visit and joint NHSE/ICB Commissioner Assurance Visit to the Neonatal Unit as well as a report from a detailed desk top review of the management of the three serious incidents. The Quality Improvement Group has therefore concluded that there is a comprehensive body of assurance in support of the issues under consideration and this key line of enquiry is therefore closed.

The Quality Improvement Group noted the updates provided in relation to the action plan developed in response to a range of recommendations in respect of leadership and governance considerations. The group is supportive of the plan to postpone the planned Well Led Review to a later date in Q4 to enable appointments to the Chair, as well as Executive and Non-Executive appointments to be progressed.

It is recognised that Trust colleagues require the time and opportunity to progress several of the action areas in relation to governance and leadership. In response it was agreed that the Quality Improvement Group scheduled for February 2024 will be rescheduled to March 2024 and will focus on progress made in terms of the leadership and governance priorities.

I would like to take this opportunity to thank you and colleagues throughout the Trust for the significant work undertaken to support this quality assurance and improvement process, and for their open and helpful cooperation with the scheduled reviews.

If you would like to discuss this in any further detail, please don't hesitate to get in touch.

Yours sincerely

Julie Clennell
Joint Regional Chief Nurse (Interim)
NHS England
North East and Yorkshire

Copy to:
Professor Mel Pickup, Chief Executive Officer, Bradford Teaching Hospital NHS FT
Richard Barker, Regional Director, 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

To: Chief Executive Officers - all
Integrated Care Boards
All Acute NHS Trusts and
all Type 3 Providers (NHS and
Private Providers)
Chief Executives - all NHS Provider
Trusts
Ambulance Services: Chief
Executives

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

25 January 2024

cc.
- Chief Operating Officers
- Medical Directors / Chief Medical Officers
- Chief Nurses / Chief Nursing Officers
- Clinical Directors (Emergency Department)

Dear colleague,

Thank you for your ongoing work to support front line teams and deliver high quality urgent and emergency care for patients. We are very aware that the winter period has been particularly pressurised and exacerbated by several rounds of industrial action; and would like to thank you and your teams for their outstanding leadership throughout.

We are now almost halfway through delivering the two-Year Urgent and Emergency Care Recovery Plan, published in January 2023, and centred around two key deliverables for 2023/2024.

- Patients being seen more quickly in Emergency Departments (EDs): with the ambition to improve to 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

Significant progress has already been made, with four-hour performance better in every month this year compared to the same month last year; and category two ambulance response times in December significantly improved in comparison to last year.

However, there is more to do to ensure that the NHS delivers on these key public commitments by March 2024, and that plans to achieve these standards are implemented in full, as set out in the operational planning reset which took place in November 2023.

The **UEC Recovery Plan** establishes a programme of transformative improvement across the entire urgent and emergency care pathway and this work should continue at pace. In addition, and in the immediate term, it is also essential that every ED operates as effectively as possible to achieve planned performance levels this year, even with the current constraints many are experiencing.

Given this, we are writing today to ask that as a priority, Trusts review their own internal systems and processes to support their ED teams, ensuring that the initiatives described at Appendix A are in place.

We are aware that the best performing trusts and systems follow these approaches routinely and are sharing as a reminder of the (evidenced) ways in which consistent application delivers results. They are also the areas that we will place a particular focus on, in terms of our oversight and support offers, which will include:

- **Access and instructions to optimise Getting it Right First Time (GIRFT) UEC data**, supporting identification of opportunities at system level related to the five initiatives set out above. These resources can be accessed through the Summary Emergency Department Indicator Table (SEDIT). If you have not already registered to the OKTA/Insight platform, please register at https://apps.model.nhs.uk/register. Once registered, login to your account using this link https://apps.model.nhs.uk/products. Scroll down to the bottom of the "Insight" home page and then press the button to "*request access*" to the SEDIT. Alternatively, please try this link SEDIT: Launch - Tableau Server (england.nhs.uk) which is bespoke for SEDIT access.

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- **National Workshops (multiple locations).** NHS England national and regional teams will be running a series of workshops to expand on the five initiatives, including case studies supporting rapid implementation. Attendance is for an executive sponsor and a representative of the UEC pathway delivery triumvirate (operations, medicine, nursing). The sessions will also provide space for providers to discuss their plans, constraints and support needed, whilst learning from one another. A summary of the events are set out at Appendix B below.

- **Virtual drop-in sessions.** NHS England will facilitate support and connection between colleagues as challenges are worked on together. This will include access to subject matter experts.

- **Improvement support pack.** The support pack at Appendix C includes resources and materials to assist with delivery of the initiatives outlined in this letter. A series of UEC improvement guides have also been designed for providers and systems to consider embedding as good practice to reduce handover delays. Resources include key principles for ED leaders to help create a positive culture and enable change.

In addition to the national support offer above, and building on the success of our "four plus one" collaborative approach this winter, the **North East & Yorkshire Regional team** will:

1. Maintain a performance focus on delivery of 4 hour and Cat 2 trajectories for March, using weekly oversight to rapidly identify exceptions and agree recovery actions with systems and providers.

2. Work with ICBs and providers through the NEY UEC Collaborative to prioritise and deliver the Emergency Department initiatives set out above.

3. Work with ICBs and providers to identify variation, share good practice and ensure robust information is available, aligned with national improvement offers.

We will be separately writing to each ICB, setting out the key financial and performance trajectories that were agreed through the H2 planning process. Colleagues are reminded that providers with a Type 1 Emergency Department who can achieve better performance in the second half of the year are still able to access a share of a £150 million capital fund in 2024/25 to be used for local improvement projects.
We would like to thank you in advance for your ongoing support and will be in touch in due course, with regard to next steps for your system and organisations.

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We hope this provides a clear way forward for the remainder of 2023/24, however should you have any further questions on the details included in this letter, or any of the individual components, please contact your NHS England Regional Performance and Improvement Director in the first instance.

We look forward to working with you closely in the coming weeks.

Yours sincerely,

Sarah-Jane Marsh
National Director of iUEC
and Deputy Chief Operating Officer
NHS England

Richard Barker
Regional Director
– North East and Yorkshire
NHS England

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Appendix A: Five Priority ED Improvement Initiatives:

1. **Streaming and redirection:** A competently trained member of clinical staff should perform an initial assessment within 15 minutes of a patients arrival and be able to stream and redirect appropriate patients to an alternative service in line with the CQC Patient First framework. This is a tool providing practical solutions for all ED leaders to support good, efficient, and safe patient care. Planning for discharge from hospital services also should start at the point of initial assessment in ED.

2. **Rapid assessment and treatment (RAT)**: RAT is the most intensive form of initial assessment and incorporates both streaming and triage. A competently trained member of clinical staff should perform a rapid assessment within 60 minutes of a patients arrival to ED to reduce delay and support immediate referral where appropriate, and / or the initiation of required diagnostics and first line treatment. Where a specialty opinion is required, this must be available in a timely way.

3. **Maximising the use of Urgent Treatment Centres (UTCs**): All UTCs should be compliant with UTC standards and principles and where possible co-located with EDs and open for 24 hours a day. UTCs that are not co-located should be open for a minimum of 12 hours per day 7 days a week.

4. **Improving ambulance handovers:** EDs should ensure prompt assessment by a trained clinician as part of the ambulance handover process and perform regular care rounds which include fit to sit assessments. There should be adequate seated and cubicle capacity to meet the needs of patients, and executive oversight of the ambulance handover position must be in place, with timely escalation and associated actions to resolve delays. There is now clear evidence that timely handover is a whole hospital leadership issue and it must be approached as such. Planning to safely reduce avoidable conveyance: aims to support ambulance services, systems, and commissioners to safely reduce the number of patients conveyed to EDs. Leaders should familiarise themselves with the objectives and deliverables set out in the guidance and test where there is potential to go further.

5. **Reducing time in department:** We know that having too many patients in an ED is a serious risk to patient safety. Again, regular executive and senior clinical lead oversight is imperative so that all patients approaching the maximum waiting times are highlighted for escalation. It is also crucial that Same Day Emergency Care (SDEC), acute frailty services and other ambulatory capacity is not used for bedded care otherwise it is not possible to maintain flow. Use of ambulatory facilities also enhances the opportunity to discharge patients either to their usual place of residence or to a specialty bed.

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Appendix B: ED Improvement Workshops in February 2024 (further details to follow)

1. Title: **ED Improvement Workshop**

2. What is it?

- Four events will be hosted, focussing on ED performance improvement.
- Events have been grouped by NHS region.
- Please attend the event for your region.
- If you are unable to attend on the preferred date, please consider attending one of the other sessions.

3. Dates, Times, and Venues:

A. For colleagues based in the **Midlands**:

- **Date: 20th February** from 0900-1700.
- **Venue TBC**

B. For colleagues based in **London and East of England:**

- **Date: 27th February** from 0900-1700:
- **Venue:** Mary Ward House (27th), 5-7 Tavistock Place, London, WC1H 9SN

C. For colleagues based in the **South East and South West:**

- **Date: 28th February** from 0900-1700.
- **Venue:** Ambassador Bloomsbury, 12 Upper Woburn Place, Bloomsbury, London, C1H 0HX

D. For colleagues based in the **North East and Yorkshire and North West:**

- **Date: 29th February** from 0900-1700.
- **Venue:** Metropolitan Hotel, King Street, Leeds, Yorkshire, LS1 2HQ

4. Registration:

A **link to register** will be provided, along with the agenda and event details in our follow-up communications. The registration link includes venue, location, timings, dietary and access requests.

5. Who should attend?

- NHS Providers: one executive sponsor and one member of the UEC Pathway triumvirate.
- ICB's: Ideally the accountable individual/s for delivery of the 4 Hour Standard.
- Regional UEC leads
- ECIST regional and national leads
- GIRFT leads
- National UEC leads

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Appendix C: Improvement Tool / Resources

Intervention area	Metric Focus	Tools or products in existence that will directly help a trust to focus on what to do to improve in this area in 4-6 weeks. *"How" not "why".*
Streaming & Redirection & Initial Assessment	Time to initial assessment % patients streamed 100% 4HS Type 3	• Maturity Index – streaming Maturity Index – redirection How to do a missed opportunity audit • ECIST Emergency department crowding and patient delays improvement guide • Effective Streaming presentation Case studies from Highest Performing on HHO delays • Case studies - Streaming and redirection
Senior Decision Maker & RAT (stationary and roving)	Seen within 60 minutes Time in Department admitted Time in Department non-admitted	• Case studies from Highest Performing on HHO delays. • Case studies - seen within 60 minutes interventions. • Pre-hospital Navigation and Access – Improvement Guide • ECIST criteria to admit audit tool and podcast • ECIST Emergency department crowding and patient delays improvement guide
Maximising the use of UTCs	>% patients attending Type 3 <% patients attending Type 1	• Maturity Indices: collocated UTC or equivalent (link below) Case studies from UTC programme • Co-located ECIST emergency department crowding and patient delays improvement guide
Improving Ambulance Handovers & Direct Access	>% ambulance handover 15 mins <% ambulance handover 30 mins	• Maturity Index - Ambulance Receiving Area AtED audit Futures resource on Direct Access & SPoA Pre-hospital • Navigation and Access, Fit to Sit – Improvement Guide Case studies from Highest Performing on HHO delays • Case studies - Ambulance receiving models
Reducing Time in Department - 12 hours & IPS & Escalation	<time in department for non admitted <time in department for admitted	• Maturity Index - operational comms and escalation • Maturity Index - Site management • Case studies from Highest Performing on HHO delays • Case studies - Operations, Leadership and Escalation • RCEM Best practise guide Nov 21-ECIST emergency department crowding and delays improvement guide

If you would like access to any of the documents described above, please contact us at england.universalsupportoffer@nhs.net

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Classification: Official

To:
- All NHS trusts:
  - chief executive officers
  - chief information officers
  - chairs
- ICB:
  - chief executive officers
  - chief information officers
  - chairs
- Arm's length bodies
  - chairs

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

29 February 2024

Dear colleagues,

Multi-factor authentication

Ensuring good cyber security is essential to safeguarding health and care services; our Cyber Security Strategy for Health and Social Care looks to build a more cyber secure heath and care service for the future. In an increasingly digitised service, organisational leaders are accountable for managing their own organisational cyber risk, to protect valuable data and build patient and service user trust in our systems.

Multi-factor authentication (MFA) is widely recognised as one of the most effective ways to protect data and accounts from unauthorised access, preventing 99.9% of account compromise attacks.

When enabled, MFA requires users accessing systems to present proof of at least two factors from:

- something they know (such as a password)
- something they have (such as a device)
- something they are (biometrics, like a fingerprint or iris scan)

This extra layer of security means our systems are far less likely to be attacked, and our data and ability to continue to provide patient care is much more secure. Its use in the NHS will help protect patient data and organisations' capability to deliver patient care.

Publication reference: PRN01161

Key dates

We are writing to remind you of the key dates for the implementation of MFA as a critical cyber security measure:

- Thursday 29 February 2024: interim 2023-24 Data Security and Protection Toolkit submissions, which should include your progress towards implementation on all systems
- Sunday 30 June 2024: final Data Security and Protection Toolkit submissions, which should include your confirmation of full implementation on all systems
- Sunday 30 June 2024: NHSmail enable MFA for all NHSmail user accounts

These dates are in line with our recently published MFA Policy for the NHS, which will ensure that MFA is used on digital systems throughout the health sector, with particular requirements on accounts that are remotely accessible or have privileged access to systems.

What you need to do

The actions described below were published as part of the enforcement intent for the national MFA policy. For the avoidance of doubt, we are asking: chief information officers to ensure these actions are completed; chief executive officers to support them; and boards to assure themselves that actions are taken and monitored.

By **29 February 2024**, organisations are expected to provide the National Chief Information Security Officer [CISO] (using their interim submission of the 2023-24 Data Security and Protection Toolkit) with **either**:

- confirmation of full compliance with the MFA policy
- confirmation that plans are in place to achieve full compliance by June 2024, and a summary of the plans

By **30 June 2024**, organisations are expected to provide the National CISO (using their final submission of the 2023-24 Data Security and Protection Toolkit) with **both**:

- confirmation of full compliance with the MFA policy, with MFA implemented on all relevant systems
- details of exceptions, as required by the policy

The Department of Health and Social Care expects to use its enforcement powers under the Network and Information Systems (NIS) Regulations where insufficient assurance is provided at the second checkpoint.

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Further support

If you would like a briefing or conversation with national teams about this advice and the importance of MFA and the risks it mitigates, please do contact us at england.cyber@nhs.net.

Yours sincerely,

Phil Huggins	**John Quinn**
National Chief Information Security Officer	Chief Information Officer
Department of Health and Social Care	NHS England

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BO.3.24.8 - BOARD ASSURANCE FRAMEWORK AND HIGH LEVEL RISKS

REFERENCES

Only PDFs are attached

- Bo.3.24.8 - BAF & HLRR (cover).pdf
- Bo.3.24.8 - Appendix 1 - BAF Feburary 2024.pdf
- Bo.3.24.8 - Appendix 2 - HLRR February 2024.pdf
- Bo.3.24.8 - Appendix 3 - Risk on a Page Report.pdf
- Bo.3.24.8 - Appendix 4 - Target Mitigation.pdf
- Bo.3.24.8 - Appendix 5 - Risk Management Strategy DRAFT February 2024.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.8

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 – 19 February 2024, Quality and Patient Safety Academy, People Academy Finance and Performance Academy – 28 February 2024. High Level Risk Register: ETM – 22 January 2024 and 19 February 2024 Academies – Quality and Patient Safety Academy, People Academy, and Finance and Performance Academy – 31 January 2024 and 28 February 2024.	
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:
- There were no changes to the risk scores.
- A full review of the BAF will be undertaken during March/April 2024 in preparation for presentation to ETM on 15th April 2024, Academies on 24th April 2024 and Board on 9th May 2024.

The BAF was reviewed and updated by the lead executives, and was reviewed and agreed by the Executive Team on 19 February 2024. The Quality and Patient Safety Academy, People Academy and Finance and Performance Academy reviewed the BAF risks within their remit on 28 February 2024.

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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 22 January and 19 February 2024, 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 on 31 January 2024 and 28 February 2024.

The HLRR, showing all high level risks rated 15+ for February 2024, 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 January and February 2024, 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:
January/February 2024:						
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

ETM agreed that it would be appropriate for this risk to be closed down and a new risk to be developed to reflect the current context, given that this risk was first raised in 2019. The risk has since been reviewed and has been kept open as it is still relevant. The target mitigation date has been extended to 30 June 2024.

The second risk is ref. 3309 relating to histopathology, which is new to the HLRR (February 2024) due to an increase in score. The current target mitigation date is 30 December 2022. ETM noted that the mitigation date would be reviewed and updated as soon as possible.

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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 January, ETM noted that there were a number of risks relating to paediatrics and therefore agreed that there should be a focus on risk at the next Children's Executive to CSU meeting. Therefore this risk was not accepted onto the HLRR pending a more in depth discussion with the CSU.

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Academy:
January 2024:					
3474	**16**	**8**	There is a risk of harm to children referred to paediatric service as new patients, from a delay in initial diagnosis and initiation of appropriate investigation and therapy.	Sajid Azeb, Chief Operating Officer	Finance and Performance, Quality & Patient Safety Academy

In February, one new risk was accepted:

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Academy:
February 2024:					
3309	**16**	**4**	There is a risk of harm to patients and the organisation from delays in processing histopathology samples, with potential of having an impact on delayed diagnosis and treatment pathways The BTHFT histopathology department process a high volume of histopathology samples with a high proportion of complex specialist work.	Smith, Dr Ray	Quality and Patient Safety Academy

Risks which have been removed/closed

ETM has agreed the closure of two risks since the last report:

Risk ID:	Score before closure:	Risk Description:	Lead Director:	Reason for closure:
January 2024				
3788	**20**	There have been a number of roof leaks in Heaton House. This has been flagged with Estates but as yet no remedial work has been carried out. We have been advised the work will be quite significant and unlikely to be on the capital expenditure priority list. Numerous buckets to catch the drips cause an ongoing trip hazard. There is also concern with water seeping into electrics, risk of collapse and	Matthew Horner, Director of Finance	There is already a 20-rated risk on backlog maintenance and a standalone risk on roofs generally is being developed which will pick up Heaton House and Daisy Bank.

		damp/mould/fungus which could affect the health of staff working in the immediate area. It is possible that a member of staff could be harmed leading to time or work and potential permanent impact to their health.		
3767	**16**	Working alone without using a lone worker device	Karen Dawber, Chief Nurse	20/12/23 Local risk now resolved, staff group training and use of devices in place following procurement and delivery of the new devices

<u>Risks which have changed in score</u>

ETM agreed four changes in risk score:

Risk ID:	Current Score:	Previous Score:	Target Score:	Risk Description:	Lead Director:	Reason for change in score:	Academy:
January 2024:							
3530	**12**	**16**	**6**	The HR team in Heaton House is dependent on the use of extension leads to accommodate the team. When we were relocated to Heaton House it transpired that the trunking was insufficient/located in the wrong place to accommodate the number of workstations allocated. It was reviewed by Estates at the time and no solution was found other than the use of extension leads which were supplied. A number of staff in the HR department would be unable to do their job if we asked them to disconnect extension leads with immediate effect.	Matthew Horner, Director of Finance	Reduction in likelihood score from 4 to 3, based on the likelihood of a fire occurring.	People Academy

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3711	12	16	4	Paediatric Inherited Metabolic Disorder - Y&H Dietetic Service Capacity	Karen Dawber, Chief Nurse	Further prioritisation plan has been put in place to support the team to clear the backlog of highest priority patients (where no dietetic input could lead to harm) and ensure those patients most at risk of harm have ongoing care. This plan will limit input to those patients who are less likely to need complex dietetic input or where harm is less likely. However long-term harm could still occur as these patients do need routine and ongoing dietetic support. In addition - to support the team to take annual leave, one of the band 7 general paediatric team leads will be supporting the team for 2/3 days / week - her caseload is being backfilled by overtime in the paediatric team & a bank paediatric dietitian.	People Academy/ Quality and Patient Safety Academy
February 2024:							
3877	12	16	12	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.	Sajid Azeb	Consequence reduced from Major (4) to Moderate (3). Although we still have the potential for IA related cancellation the COVID impact is now much reduced. In addition good work has been undertaken in reducing the backlogs of the long wait patients and the Trust no longer has any 104 week waits or 78 week waits. There are a small number of 65+ week patients all of whom are subjected to the recommended reviews of the waiting list at the appropriate timescales.	Finance and Performance, Quality and Patient Safety Academy
3896	12	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. The most significant harm is for those women awaiting a cancer diagnosis causing a delay in their cancer pathway also resulting in delays	Ray Smith	Risk reduced in scored as this relates specifically to gynaecology, where the generic histopathology risk (3309) is relevant to several specialities (and therefore potentially impacting a greater number of patients), meaning that the consequence would be higher.	Quality and Patient Safety Academy

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				in KPIs, public confidence and the reputation of BTHFT.			

It was agreed at the Finance and Performance Academy that the target score for risk 3877 (operational pressures) should be lowered as the reduction in score from 16 to 12 meant that it was currently rated at its target score.

A discussion took place at the Quality and Patient Safety Academy in relation to risk 3896 (gynaecology histopathology) and it was agreed that a reassessment of the score be undertaken as it was felt that it should remain at 16. If following the reassessment it is deemed to be rated 16, it would not be included in future reports to Executives or Academies, as it would be managed locally and as part of risk 3309.

It was proposed that risk 3885, which related to lack of 24/7 operational supervision, management oversight and inadequate resilience within the security service, be reduced from a score of 15 to 9, however the Executive Team did not accept the reduction pending all vacancies being filled and new staff being in post.

Risks beyond their review date

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

Risk ID:	Score:	Risk Description:	Lead Director:	Review Date:
3696	16	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit.	Saj Azeb, Chief Operating Officer	31/12/2023
3877	16	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.	Saj Azeb, Chief Operating Officer	31/12/2023
3881	16	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.	Saj Azeb, Chief Operating Officer	29/12/2023
3469	16	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.	Karen Dawber, Chief Nurse	30/01/2024
3732	16	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.	Karen Dawber, Chief Nurse	31/01/2024
3850	15	Pharmacy accommodation	Sajid Azeb, Chief Operating Officer	31/01/2024

Since the report 3877 was reviewed and reduced in score from 16 to 12 (reported to ETM in February 2024).

The new risk to the HLRR (3309) referred to above is also beyond its review date. This will be amended as soon as possible.

ETM noted that there were no significant changes to note in relation to the risks, and the review dates would be updated as soon as possible.

Ongoing risks

ETM discussed potential risks and impacts on patient experience as a result of high demand in A&E, despite good performance being achieved in comparison to other Trusts. It was agreed that this would be considered further and either be included with an existing risk or a new risk would be developed if required.

It was also noted that risk 3810 (haematology) will be updated risk to reflect the current position and the progress made since the risk was first raised.

ETM also noted the discussion that took place at the People Academy meeting in January regarding the closure of the lone worker devices risk (3767) and whether a new risk assessment was required due to a need to clarify the process for responding to alerts from the devices. The current position will be assessed and a risk will be raised if required.

Risk Management Strategy

Minor amendments are proposed to the Risk Management Strategy to reflect the change from Clinical Business Units (CBUs) to Clinical Service Units (CSUs) and the removal of the former Planned and Unplanned Care groups and associated meetings. The updated Strategy is attached at Appendix 5 and was presented to the Audit Committee on 21 February 2024.

The Board is asked to review and approve the proposed amendments to the Risk Management Strategy.

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
- review and approve the revised Risk Management Strategy.

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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):

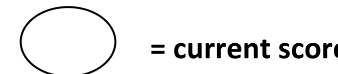
Relevance to other Board of Director's Committee:	
Audit Committee	Other (please state)
▪	Academies

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, industrial action over winter unlikely from consultants however the pay offer has been recently rejected (January 2024). 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 / Risk	Score	Trend	Target	Owner	Update
	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 **Assuring Academy: People** **Risk appetite: Seek** - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)					**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.
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 **Assuring Academy: Quality & Patient Safety** **Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward					**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 **Assuring Academy: N/A - Board** **Risk appetite: Seek -** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)					**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	Health Inequalities Statement published by NHSE requires a Trust response as part of/alongside the Annual Report. Service & Business Development and Performance working on developing response. Work is progressing against the action plan.
	Risk relevant to all strategic objectives **Assuring Academy: N/A - Board** **Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward					**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	⟺	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 February 2023 – February 2024**	**Initial Score (CxL): 4x3=12**
Date added: 1 April 2022 **Date of last review:** 14 February 2024		**Current Score (CxL): 4x3=12**
Lead Director: Karen Dawber, Chief Nurse / Ray Smith, Chief Medical Officer		**Target Score (CxL): 4x2=8**

Movement in score February 2023 – February 2024

25
20
15
10
5
0
February
April
June
August
October
December
February
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**
• 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).	**Positive:** • Patient Experience Annual Report 2021/22 (inc. complaints, compliments, PALS, FFT) • Patient Experience 6 monthly update – January 2024 • Patient Experience Group Update – latest January 2024 • Monthly Maternity Services Update – latest as at December 2023 • CLIP Report – latest as at Q2 23/24 • SI Report – latest as at January 2024 • Quality Dashboard – latest as at December 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 Q2 23/24 • SI Report – latest as at January 2024 • Quality Dashboard – latest as at December 2023	**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.	• 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	• Waiting list analysis work and actions to address findings • Operational plans to manage industrial action • Dashboard to be updated.	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	**Movement in score February 2023 – February 2024** 25, 20, 15, 10, 5, 0 February, April, June, August, October, December, February Current Score Target Score	**Initial Score (CxL): 4x4=16**
Date added: 1 April 2022 **Date of last review:** 14 February 2024		**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**	
• 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.	**Internal** **Positive:** • Estates & Facilities Quarterly Service Report – latest Q2 2023/24 • IPC Quarterly Report – latest January 2024 • IPC Board Assurance Framework – latest report as at January 2024 • 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 – Significant assurance (April 2023) ➢ Infection Prevention and Control; Bloodstream infections – High assurance (August 2023) ➢ Cleaning Standards – Significant assurance (November 2023) ➢ Premises Assurance Model -High assurance (November 2023) ➢ Laundry and Linen Services – Significant assurance (February 2024) • 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) ➢ COSHH – Limited assurance (November 2023)	**Gaps in control** • Some areas are not suitable for airborne infections • Lack of negative pressure isolation rooms • No formal lead allocated for anti-microbial stewardship (AMS) **Gaps in assurance** N/A	**Action** • Manage patient flow according to side room specifications • Daily review of potential patients for de-isolation. • A business case is being prepared for another anti-microbial clinical pharmacist	**Timescale** Ongoing Ongoing. Work on ward 1 is nearing completion. Ongoing. Current position: A risk assessment and gap analysis would be undertaken to support the development of the business case.
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: 15 February 2024

Lead Director: Director of Finance

Movement in score February 2023 – February 2024

Initial Score (CxL): 5x4=20

Current Score (CxL): 5x4=20

Target Score (CxL): 4x2=8

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

- 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 CSUs, with meetings chaired by Deputy Ops Directors and supported by Service Area Triumvirate.

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

Internal

Positive:

- Extended Monthly Finance Report to F&P Academy, latest as at December 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 December 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 December 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)

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 (Aug 2023)
  - 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 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 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 4 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 4 2023/24

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

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 February 2023 – February 2024	
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Chart: y-axis 0, 5, 10, 15, 20, 25; x-axis February, April, June, August, October, December, February; legend: Current Score, Target Score	**Initial Score (CxL): 5x4 = 20**
Date added: 1 April 2022 **Date of last review:** 15 February 2024		**Current Score (CxL): 5x4 = 20**
Lead Director: Director of Finance		**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
• 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 December 2023 • Monthly F&P Academy Dashboard, latest as at December 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 (Aug 2023) ➢ 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 4 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 4 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.

	Movement in score February 2023 – February 2024	
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Current Score: 16 (February, April, June, August, October, December, February); Target Score: 8 (February, April, June, August, October, December, February). Y-axis: 0, 5, 10, 15, 20, 25	**Initial Score (CxL): 4x4 = 16**
Date added: 1 April 2022 **Date of last review:** 15 February 2024		**Current Score (CxL): 4x4 = 16**
Lead Director: Director of Finance		**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
• 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.	**Internal** **Positive:** • Monthly Finance Report , latest as at December 2023 • Monthly F&P Academy Dashboard, latest as at December 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 December 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 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.	**Action** Closely monitor delivery of the Programme and ensure the full value of the programme is delivered	**Timescale** 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 February 2023 – February 2024**	**Initial Score (CxL): 4x4 = 16**
Date added: 1 April 2022 **Date of last review:** 1 February 2024		**Current Score (CxL): 4x3 = 12**
Lead Director: Chief Operating Officer		**Target Score (CxL): 3x3 = 9**

Chart: Movement in score February 2023 – February 2024

Y axis: 0, 5, 10, 15, 20, 25

X axis: February, April, June, August, October, December, February

Legend: 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
• 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)	**Internal** **Positive:** • Act as One Updates to F&P Academy – latest November 2023 • Partnerships Dashboard – latest as at November 2023 • WYAAT ICS Programme Updates – latest January 2024 – e.g. WYVAS second arterial centre • Exec to CSU scorecard / rating • Outstanding Theatres Programme update to Quality Academy – latest January 2024 • Outstanding Pharmacy Programme update to People Academy – November 2023 • Cancer Performance Improvement Plan to F&P Academy – latest January 2024 • RTT Improvement Plan to F&P Academy – latest November 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 – latest Jan 2024 • 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, latest March 2023) • SSNAP (Stroke Audit Programme) – Dec 23 Overall 'C' Rating. • 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) ➢ Ambulance Handovers – Significant assurance (January 2024) • Human Tissue Act assessment **Negative:** • GIRFT Reports • Joint venture – loss of UKAS accreditation	**Gaps in control** • 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 • Fragile services e.g. Stroke, Haematology, NVIR, VIR, Histopathology • Financial challenges for 2023/24 resulting in less resources to develop and transform services	**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. • Locum agency / international search for suitable VIR candidates. • WYH Cancer Alliance / NSO steering group input to deliver recommended sector model. NSO North Sector Group – 5 sessions held and target operating model developed. • Work with COO / MD counterparts at AGH to develop service resilience plans at place. The Acute Provider Collaborative to establish a formal working relationship. • 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. • 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. • Work with CHFT to review clinical model for plastic surgery across Bradford CHT footprint.	**Timescale** Financial model to be agreed. Ongoing Ongoing Ongoing Ongoing Ongoing 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: 1 February 2024

Lead Director: Chief Operating Officer

Movement in score February 2023 – February 2024

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 January 2024
- Performance Report – monthly, latest as at January 2024
- Cancer Performance Improvement Plan to F&P Academy – latest January 2024
- RTT Improvement Plan to F&P Academy – latest November 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 Green = improving **Black = no change** Red = deteriorating **Performance as at Dec 2023**	• Emergency Care Standard • 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

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) – Dec 23 - Overall 'C' Rating.
- 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	Timescale
Gaps in control	**Action**	
• 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: 20 February 2024

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

Movement in score February 2023 – February 2024

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 December 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 - September 2023
- Nursing & Midwifery Staffing Review – November 2023
- Nursing & Midwifery Staffing Data Publication – January 2024
- Nurse Staffing Board Assurance Framework - latest September 2023
- Workforce planning submission – People Academy March 2023

Negative:
- People Dashboard: staff sickness rates and turnover rates – latest as at December 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	Action	Timescale
Gaps in control		
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)

Date added: 1 April 2022

Date of last review: 20 February 2024

Lead Director: Director of HR

Movement in score February 2023 – February 2024

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

Initial Score (CxL): 3x4 = 12

Current Score (CxL): 3x3= 9

Target Score (CxL): 2x3 = 6

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

- 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

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

Internal

Positive:

- People Dashboard and Workforce Report – as at December 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 – December 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 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
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)

- **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)

Date added: 1 April 2022

Date of last review: 20 February 2024

Lead Director: Director of HR

Movement in score February 2023 – February 2024

Initial Score (CxL): 3x3 = 9

Current Score (CxL): 3x3=9

Target Score (CxL): 3x2=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
• 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)	**Positive:** • People Dashboard: BAME overall workforce – latest as at September 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 September 2023 • Report to Board: disciplinary processes – latest as at 31 December 2023	**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	•In development •To continue to roll out the equality impact assessment guidance and proforma	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	**Movement in score February 2023 – February 2024**	**Initial Score (CxL): 4x4=16**
Date added: 1 April 2022 **Date of last review:** 14 February 2024		**Current Score (CxL): 3x3=9**
Lead Director: Chief Medical Officer / Chief Nurse		**Target Score (CxL): 3x2=6**

Chart: Movement in score February 2023 – February 2024 (y-axis 0–25; x-axis February, April, June, August, October, December, February)

	February	April	June	August	October	December	February
Current Score	12	12	12	9	9	9	9
Target Score	6	6	6	6	6	6	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 Q2 23/24 (People Academy – Nov 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 / Actions to address gaps in controls or assurance

Gaps in control	Action	Timescale
Numbers of junior doctors on rotas	Lobby Deanery to increase trainee numbers.	Ongoing
	Development of Hospital at Night project.	December 2023 Phase 1 – Clinical Support Workers – advert out.
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: 4.2

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: 14 February 2024

Lead Director: Chief Medical Officer

Movement in score February 2023 – February 2024

Initial Score (CxL): 3x3=9

Current Score (CxL): 3x2=6

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) – 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 – Action	Actions to address gaps – Timescale
• 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.	**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 control** • Promotion of research activity and raise awareness that research is a core business for Trust. • How research is promoted and managed within CSUs as Core Business.	• Trust Research Strategy and associated action plan. • CSUs' research activity to be part of the formal Trust Performance Framework	Strategy approved September 2022; implementation started 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. • Promotion of ward entrance	Delayed; originally scheduled to be June 2022 but anticipating that achieved by March 2024. 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	**Movement in score February 2023 – February 2024**	**Initial Score (CxL): 5x3=15**
Date added: 1 April 2022 **Date of last review:** 14 February 2024	25 20 15 10 5 0 February April June August October December February Current Score Target Score	**Current Score (CxL): 4x3=12**
Lead Director: Chief Medical Officer		**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 November 2023.
- Serious Incident Report – latest as at January 2024.
- CLIP (Complaints, Litigation, Incidents, Patient Experience) report – quarterly – latest report Dec 2023 (covering Q2 23/24).
- Tracking of actions from safety events overseen by Patient Safety Group.
- Ward / department quality accreditation programme.
- Quality Account – progress on priority areas – Quality Academy (Sept 2023)
- Medical Examiner has scrutinised 100% of deaths since October 2021.
- Learning from Deaths – latest report January 2024.
- 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 (November 2023)
- 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)

Date added: 1 April 2022

Date of last review: 29 January 2024

Lead Director: Chief Executive

Movement in score February 2023 – February 2024

Initial Score (CxL): 3x3 = 9

Current Score (CxL): 3x3 = 9

Target Score (CxL): 3x2 = 6

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

- 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

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

Internal

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
- Updates to Board on BTHFT input to WYHCP developments
- There is a Health Inequalities workstream in place at BTHFT providing regular reports to the Equality & Diversity Council.

Negative:

N/A

Independent

Positive:

- WYAAT & WYHCP programme update reports and position summary to every Board of Directors meeting demonstrate BTHFT input

Negative:

N/A

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

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 (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.

Actions to address gaps in controls or assurance

Action	Timescale
• Revise existing Partnerships Dashboard to capture activity/progress in a more meaningful/accessible way	• Revised Partnerships dashboard has been developed (May 2022) and is now submitted to each Board with updated entries to provide relevant and timely information
• 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 • Since May 2023 Health Inequalities is reported at the "Learning and Improvement" sessions of the Quality & Patient Safety Academy

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: 29 January 2024

Lead Director: Chief Executive

Movement in score February 2023 – February 2024

Y-axis: 0, 5, 10, 15, 20, 25
X-axis: February, April, June, August, October, December, February
Legend: Current Score; Target Score

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 2024/25 planning 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

Positive:
- Partnerships Dashboard has consistently shown "green/amber" rating 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
- Updates to Board on BTHFT input to BD&C HCP developments

Negative:

N/A

Independent

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 in control	Action	Timescale
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
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.	Ongoing – Board dashboard includes Reducing Inequalities update Since May 2023 Health Inequalities is reported at the "Learning and Improvement" session of the Quality & Patient Safety Academy

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.

	Movement in score February 2023 – February 2024	
Risk Appetite: **Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	25 20 15 10 5 0 December February Current Score Target Score	**Initial Score (CxL): 5x4 = 20**
Date added: 6 December 2023 **Date of last review:** 16 February 2024		**Current Score (CxL): 5x4 = 20**
Lead Director: Chief Executive		**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	
• 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	**Internal** **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	**Independent** **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 – Significant assurance (February 2024) **Negative:** N/A	**Gaps in control** • 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	**Action** • 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	**Timescale** March 2024 12-18 months – June 2025 TBC February 2024 March 2024 Complete Complete
			Gaps in assurance • External Well Led Review to be undertaken	• Review to be commissioned	Q1 24/25
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 (as at 13.02.2024)

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)
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
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
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.	Nov 2023: Fire Safety scheme continues to progress, maternity building 80% complete, autronica system / phase 1 one progressing on the main BRI site. Cost in for Daisy Bank roof - £500k+	31/03/2025	20	(5) Catastrophic	(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. [illegible]	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
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 - 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
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

3810	14/10/2022	Smith, Dr Ray	Green, Jen	Risk Assessment	People, Quality & Patient Safety Academy	Highlighting the service risk for Haematology, o Risk to Acute consultant Rota and timely inpatient reviews o Risk to Outpatient delivery and the increase to wait times for Urgent / routine / cancer and the specialised Haemophilia patients o Service delivery for the whole Haemophilia service , surgical and outpatient work o Service delivery for complexity of haematology patients o In 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 o Cover for out of hours on call for the regional haemophilia network o Leeds are the agreed point of contact and can support with severe, surgery, high risk and acquired haemophilia patients o High risk patients to be transfer to Leeds. o Acquired haemophilia , to be transferred to Leeds o Sharing of protocols , triaging protocols of what patients they can support and not o Mild issues, Leeds can give guidance – consultant to consultant (Meadows – CNS can communicate to Leeds) o Contact can be made to duty haemophilia consultant o Severe patients to have 6 monthly review at Leeds o Pregnant patients transferred to Leeds if Dr Pollard unavailable o Leeds to get back about elective patients – in first instance, call from consultant to consultant to find out urgency and sensible triage o Leeds want consultant to consultant communication/discussion, not comfortable with CNS queries o In reach to the paediatric service o Sarah 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 o Leeds to write clear rules on what they can and cannot do o Transfer of new outpatient complex patients They cannot support: o On-site support o Milder Haemophilia Inpatient care o Outpatient review of the routine and new patients currently in our system o Very elective patients, these would have to be delayed o Any 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
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 owrkload Dec/Jan AED/Ward collaboration commenced with start date Nov 23 Score remains unchanged. 04/01/2024 no change to December 23 position.	31/03/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3309	26/11/2018	Smith, Dr Ray	Maleki, Nima	Risk Assessment	Quality & Patient Safety Academy	There is a risk of harm to patients and the organisation from delays in processing histopathology samples, with potential of having an impact on delayed diagnosis and treatment pathways The BTHFT histopathology department process a high volume of histopathology samples with a high proportion of complex specialist work. The team has 3 vacancies. 2 vacancies are currently filled by locum staff. 1 locum is a sub specialist 1 locum is a generalist	30/11/2023	12	(4) Major	(3) May recur occasionally	4	(4) Major	(1) Cannot believe that this will ever happen again	• 2 locums are in place • Some work is outsourced (as and when required) • Additional sessions are covered by existing substantive staff	25.1.24 ETM have advised that consequence score should be 4x4=16 as could potentially impact greater number of patients.	30/12/2022	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	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
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	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

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.	01/05/2024	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.	09/02/2024 - all existing controls continue as per previous updates are in place. In addition Corporate Access Team (CAT) is working on targeted validation of patients with ticking clock. CAT has started validation of Non-RTT new referrals and Non-RTT patients with no orders in place (DQ Process failures) using the OP PTL.	30/06/2024	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
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	International recruitment has commenced and a number of IR midwives have started. The current vacancy against the safe staffing establishment is 11.48 WTE. This continues to be our priority recruitment figure. To achieve the funded establishment to enable MCoC as default position for all women, the current vacancy is 37.9 WTE. Daily staffing challenges persist but there has been a positive response to 'super surge' TNR rates during the last few months, which remain in place until review in the New Year. Improved offer of twilight shifts in key areas such as MAC, are having a small but positive impact. 10 of the NQM commenced their induction/supernumerary period in October and we expect that this will improve the staffing position towards the end of December when they are counted in the numbers. The remaining NQM will join us in stages between now and spring time. The first of our International Midwives arrived in November and is currently at the OSCE assessment centre in York. We are awaiting further update on a further 5 International Midwives who have offers of employment at BTHFT. Clover team is currently under review, but it is likely that 3 midwives will remain in the intrapartum areas. 4/05/23 Birth rate plus tabletop exercise undertaken in March 2023. Midwifery establishment requirement has reduced slightly due to drop in birth rate. Full Birth rate plus acuity tool has Trust approval to be commissioned for Autumn 2023, as tabletop does not account for any changes to the acuity of service users. Based on the recalculated figures: Vacancy safe staffing -9.84 WTE Vacancy MCoC -28.28 WTE Super surge rate ceased on 01/04/23 and TNR is now paid at surge rate across the whole of the organization. This has resulted in a slight reduction in the uptake of TNR shifts, which will be monitored and escalated if it impacts on safe staffing. All recruitment and retention plans continue, including pastoral support, international recruitment and appointment of newly qualified midwives. Acorn team recommenced intrapartum on calls 01/04/23. Clover team are still under established but all based in the community providing enhanced antenatal and postnatal care. No new MCoC teams are in the pipeline until safe staffing levels are achieved and maintained. 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
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
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

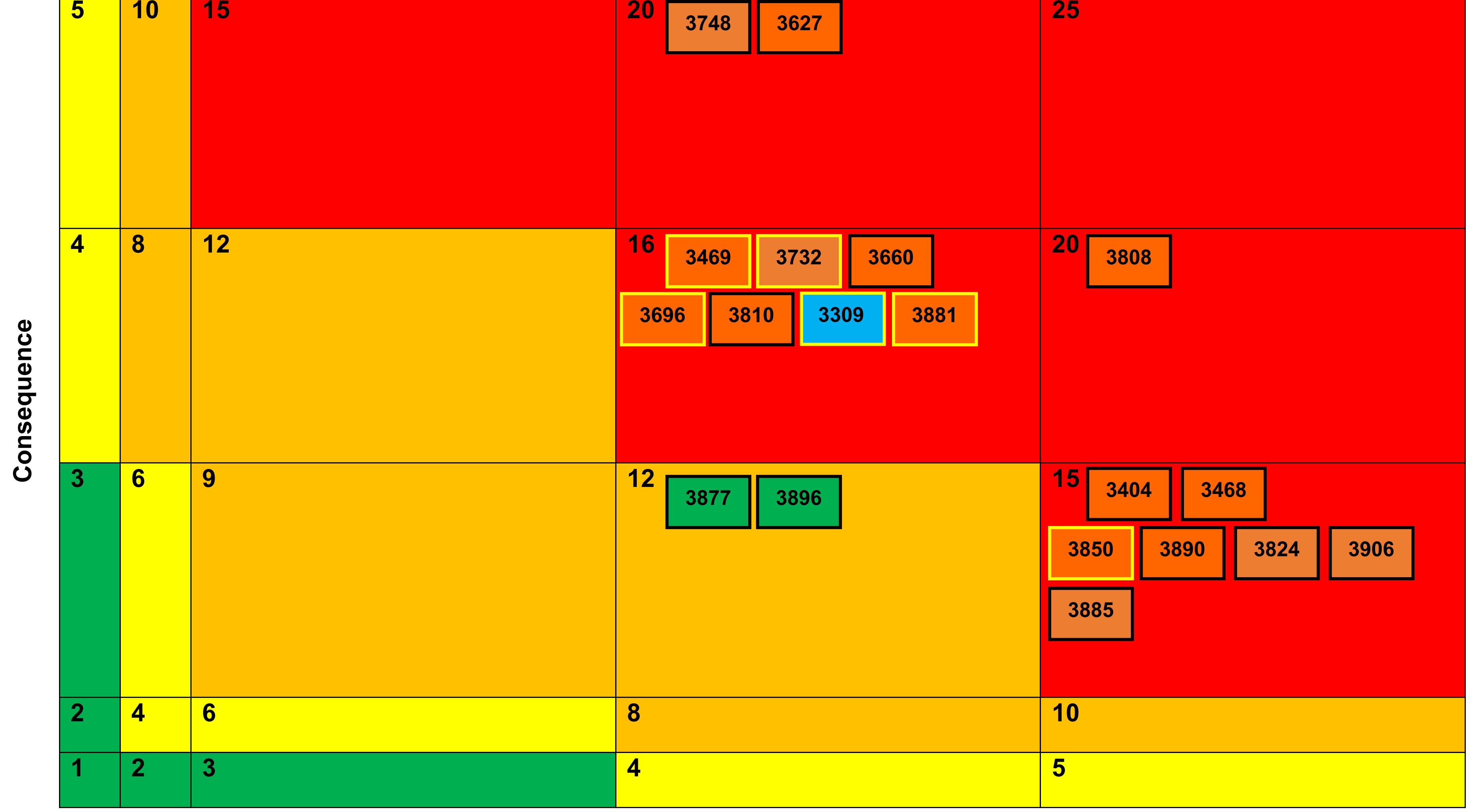
High Level Risks Report on a Page – February 2024

Total High Level Risks	17*
Aligned to F&PA	4
Aligned to QPSA	14
Aligned to PA	9
Aligned to Board	1

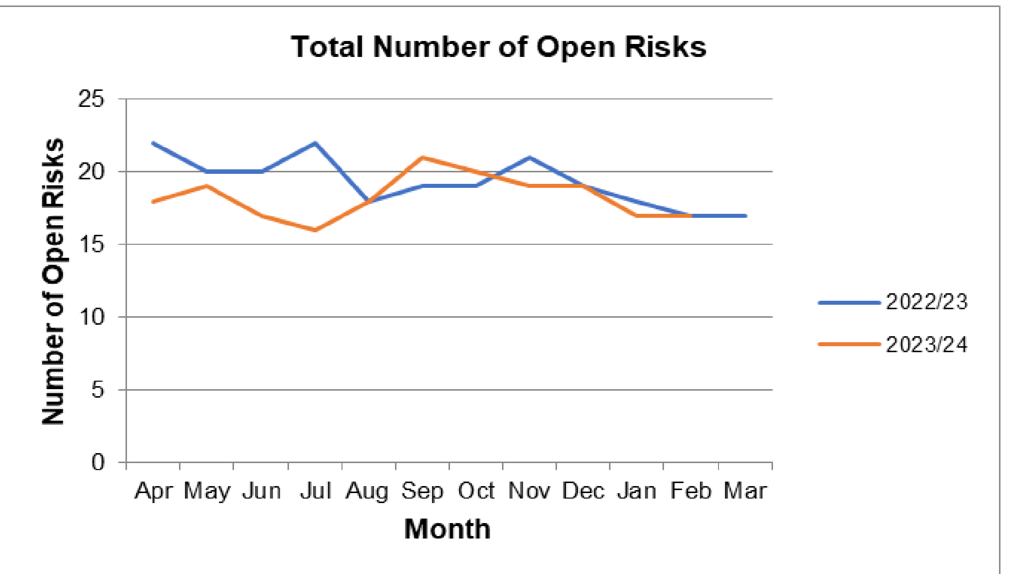
*Note some risks are aligned to more than one Academy

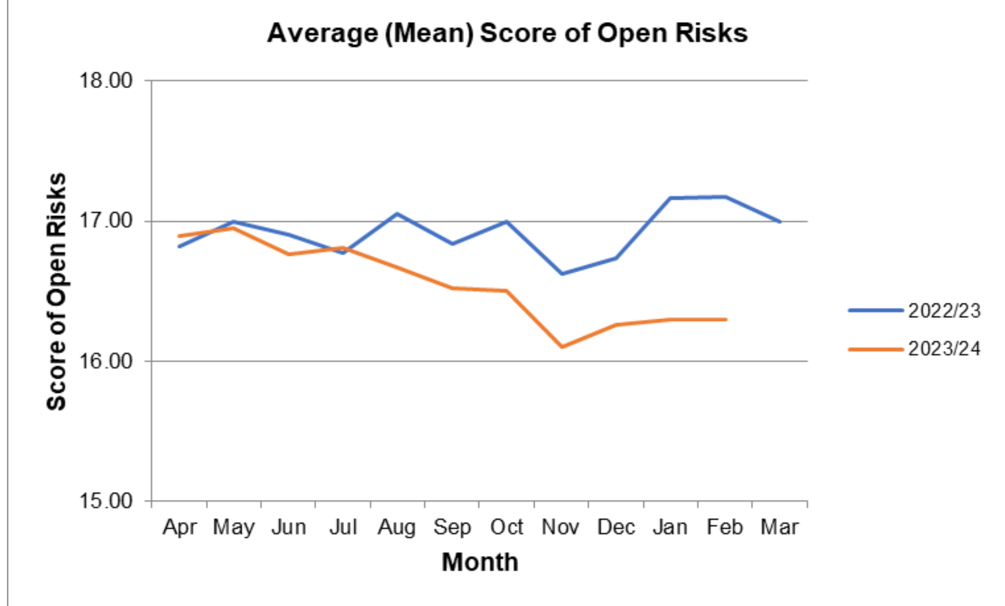
Movement of Risks	
New	1
Marked for closure	0
Risk score increased	0
Risk score static	16
Risk score decreased	2

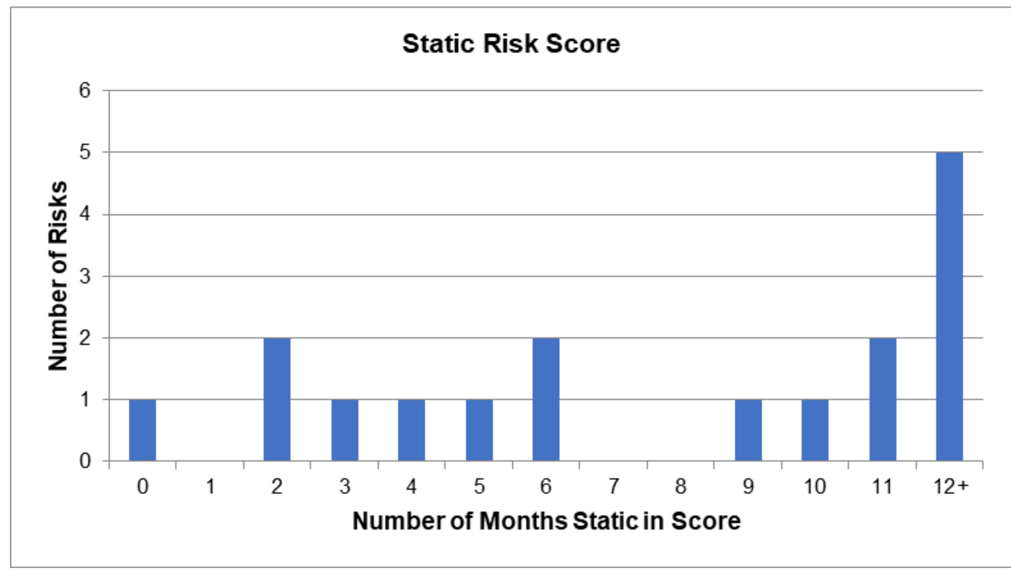
Risk Overview



Key: New | Closed | Increase | Decrease | Static | Past Review Date







Changes to Target Mitigation Date of Current High Level Risks-February 2024

ID	Date of entry	Academy	Current Score - February 2024	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	30/06/2024				
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									
3732	20/01/2022	PA & QPSA	20	10	02/01/2023	31/03/2023	31/05/2023	31/10/2023	31/03/2024										
3469	11/10/2019	QPSA	16	8	31/12/2019	30/09/2021	29/07/2022	29/07/2023	30/04/2024										
3309	26/11/2018	QPSA	16	4	30/04/2019	31/12/2019	30/04/2020	30/12/2022											
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												
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	30/03/2024														
3881	27/07/2023	PA & QPSA	16	8	30/08/2024														
3890	30/08/2023	QPSA	15	5	31/08/2024														
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

Risk Management Strategy

DRAFT

Author:	Associate Director of Corporate Governance/Board Secretary Associate Director of Quality
Version:	DRAFT
Approved by:	Board of Directors
Date:	
Review date:	

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1. Statement of intent

This document describes the Trust's Risk Management Strategy. The Trust is committed to establishing an organisational philosophy that ensures risk management is aligned to strategic objectives, clinical strategy, business plans and operational management systems.

We recognise that the specific function of risk management is to identify and manage risks that threaten our ability to meet our strategic objectives. We are clear, therefore, that understanding and responding to risk, both clinical and non-clinical, is vital to provide a safe, effective and efficient healthcare environment whilst ensuring quality care and the safety of patients.

We will identify risk as either an opportunity or a threat, or a combination of both, and will assess the significance of a risk as a combination of probability and consequences of the occurrence.

All of our staff have a responsibility for identifying and minimising risk. This will be achieved within a progressive, honest and open, just culture where risks, mistakes and untoward incidents are identified quickly and acted upon in a positive way.

2. Principles

In order to effectively deliver this risk management strategy there will be:

- An articulated and demonstrated Board and Senior Management commitment to risk management.
- A clearly articulated organisational risk appetite described and approved on at least an annual basis by the Board of Directors.
- An effective Quality Governance Framework to ensure the strategy remains effective in the application of risk management.
- Employee participation, consultation and accountability in risk management processes.
- Effective systems to ensure that risks identified from major projects are incorporated into operational risk assessment and mitigation strategies.
- Application of this strategy across the organisation, including clinical and corporate departments.
- Effective mechanisms for incidents to be immediately reported categorised by their potential impact and consequences and investigated to determine system failures in an open and fair manner.
- System design with a focus on the reduction of the likelihood of human error occurring.
- Formal and effective mechanisms to measure the effectiveness of risk management strategies and infection control strategies, plans and processes against NHS standards and regulations.
- Preventative risk management processes applied to the management of facilities, amenities and equipment.
- Risk Management principles and processes applied to contract management especially when acquiring, expanding or outsourcing services.
- Safe systems of work and practice in place for the protection and safety of patients, visitors and staff.
- Plans for emergency preparedness, emergency response, business continuity and contingency.

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3. Purpose

Our risk management strategy is designed to strengthen our ability to achieve our strategic objectives and business targets thus ensuring the continuation of the safe and effective delivery of our services. It will do this by supporting our strategic and operational decision making and planning, helping us to comply with legal and regulatory requirements, improving our governance and controls and ensuring a just culture where people feel encouraged to take responsibility for minimising any negative effects of risk on our services and support improvements to the safety of the services.

The risk management strategy will directly influence and support the:

- Development and maintenance of risk registers for all major projects, service improvement activities, and departments within the Trust demonstrating effective management of risk.
- Implementation of a risk escalation framework.
- Development and implementation of a Board Assurance Framework.
- Training for managers to enable them to identify, assess and manage risk as part of normal everyday management responsibilities.
- Effective use of the Trust's governance system and structures.
- Implementation of systems and processes to ensure that risk assessments are undertaken systematically in all clinical and corporate departments, and the effectiveness of controls is monitored.
- Development of actions plans at corporate and service level.
- Development and implementation of Trust policies to strengthen the systems of control.
- Use of information from risk assessments, incidents, complaints, audit, claims, implementation of external recommendations and other relevant external sources to improve safety and support organisational learning.
- Use of internal and external audit findings and assessments to provide assurance on the effectiveness of controls to minimise risk.
- Highest possible standards of risk management supporting external validation, for example the Care Quality Commission's standards of quality and safety.

4. Approaches to identifying risk

The Trust will take both proactive and reactive approaches to identifying and understanding risk.

4.1 Proactive approaches to identifying risk

The Trust will take a number of steps to proactively identify risk by:

- Ensuring an effective Safety Alert System (see the Central Alert System (CAS) Policy).
- Ensuring a robust approach to clinical audit and the identification of risk (see the Clinical Audit Policy including National Confidential Enquiries).
- Ensuring efficient Emergency Planning and Business Continuity Planning (see the Emergency Preparedness, Resilience and Response Policy and the Incident Response Plan incorporating Mass Casualty Arrangements).
- Horizon scanning, identifying, evaluating and managing changes in the risk environment for instance through the review of:
    - Legislation

- Government White Papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- Department of Health and Social Care publications
- Local demographics
- Stakeholder views
- National targets/ standards

4.2 Reactive approaches to risk management

The Trust has a range of sources of information about areas of actual and emergent risk within the organisation. These include:

- Near-miss and Incident reporting process.
- Complaints and Patient Advice and Liaison Service (PALS) contacts.
- Claims management.
- Inquest management and learning from Prevention Of Future Deaths (Regulation 28).
- National Clinical Audits.
- Implementing recommendations from national inquiries, internal/external reviews/recommendations etc.
- The outcome of Health Safety Investigation Branch (HSIB) reports.
- Implementing legislative changes to those resulting from changes in national policy.
- Using information about services published by our regulators and commissioners.

5. Risk assessment, management and monitoring

The formal proactive method of identifying operational risks within the Trust is through the use of risk assessments. A template has been developed to support staff to undertake risk assessments (Appendix 1).

All types of risk identified are graded using a common grading matrix, which measures the risks in terms of both consequence and likelihood.

Table 1- Risk Evaluation							
Table 3 – Impact / Severity	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Minor	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5
Risk = Table 2 - Likelihood x Table 3 - Impact			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Table 2 – Likelihood / Probability				

Table 2- A guide to determining likelihood				
1	Rare	Less than 20%	Once every two years or more	Rare / Low
2	Unlikely	20% to 39%	Once a year	Unlikely / Low to Medium
3	Possible	40% to 59%	Once a Month	Possible / Medium
4	Likely	60% to 79%	Once a Week	Likely / Medium to High
5	Almost Certain	80% or more	Once a Day or more	Almost Certain / High

Table 3- A guide to determining impact			
1	Negligible	No / Minor Injury / Minimal loss / No time off work	Low
2	Minor	Minor Injury / Some loss / 7 or Less days off / Some Damage	Low to Medium
3	Moderate	Injury / 7 or more days off / Damage / Loss / RIDDOR Incident	Medium
4	Major	Long term injury / irreversible injury / serious damage or loss / RIDDOR Incident	Medium to High
5	Catastrophic	One or more fatalities / irreversible injury / substantial damage or loss / RIDDOR Incident	High

Operational risks are managed and reviewed within specialties, CSUs, and corporate departments. The risk owner will be required to identify:

- **Risk title**
- **Assuring Academy or Board** (if the current score is 15 or over)
- **Description** (risks should be described as follows: **IF (cause)**….**THEN (event)**….**RESULTING IN (effect)**….) For example – **IF** we are unable to release clinical staff for mandatory training due to staffing levels, **THEN** staff will not receive compulsory training in relation to resuscitation or blood safety, **RESULTING IN** an increased safety risk to patients.
- **Existing control measures** (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?)
- **Risk lead**
- **Lead Director** (if the current score is 15 or over)
- **Initial risk score** (the risk score at the time the risk assessment is undertaken)
- **Current risk score** (the risk score at the time of each review of the risk. It will be the same as the initial risk score at the time the risk is entered on to the risk register, but should change at each review provided mitigations have been acted upon)
- **Actions required** (actions to reduce the risk to an acceptable level, target date for implementation and action plan lead)
- **Residual risk score** (the risk score once all mitigation has been actioned and adequate control measures are in place)
- **Date of review**

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6. Operational risk escalation framework

The Trust manages operational risks at Board, Academy, Executive, corporate department, CSU and specialty level. Risks are escalated and de-escalated though these different levels depending on the **current** risk score. The risk escalation framework is set out in Figure 1 below:

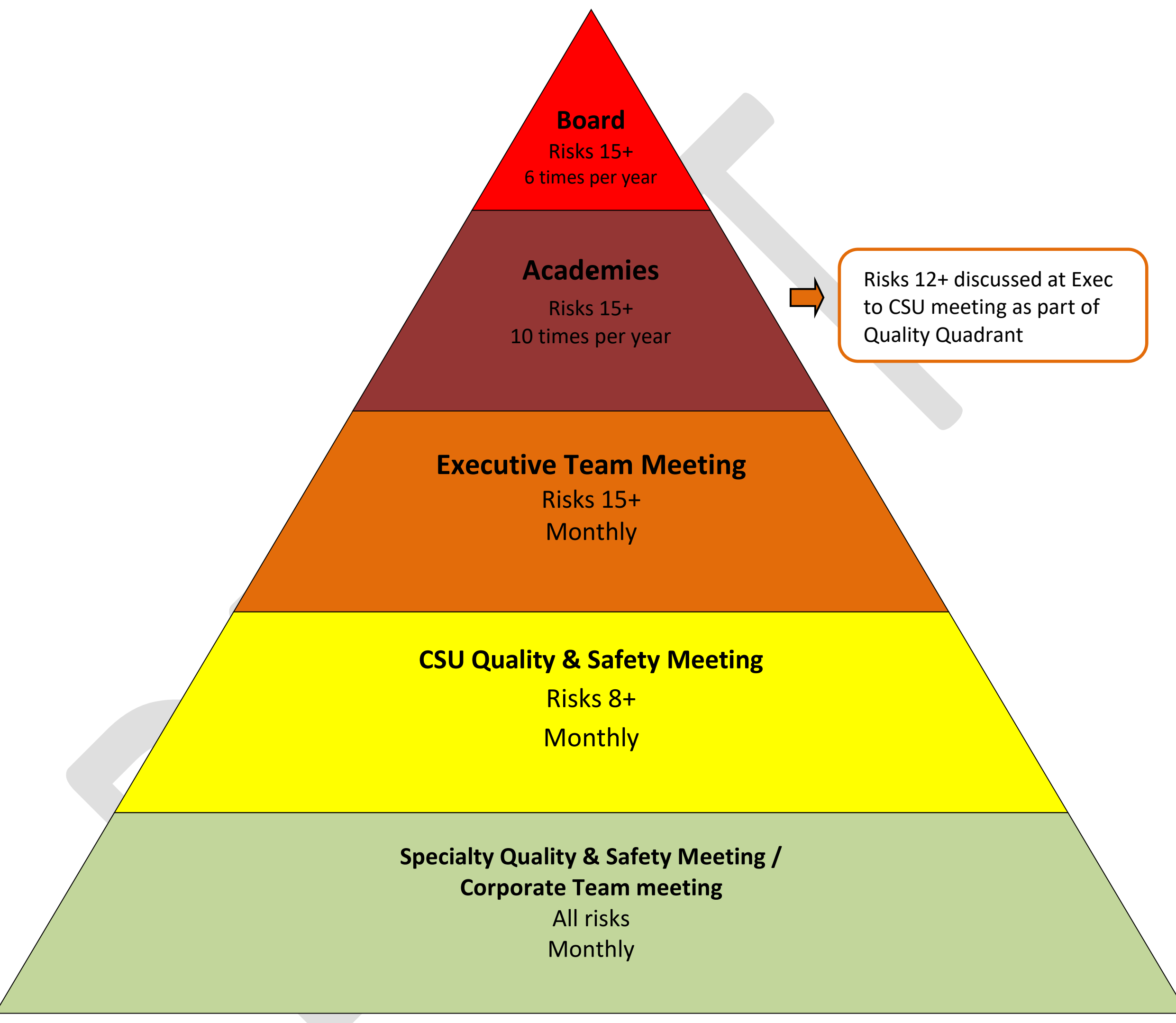

Figure 1. Operational risk escalation framework

Any risks with a current score of 15 or above are reported to the Trust Executive Team for discussion. If the Executive Team agree that the risk is scored at 15 or above, it is included on the High Level Risk Register.

The High Level Risk Register is a dynamic document which is constantly changing as actions are taken addressing high risk issues for the organisation. New risks are added as they are identified.

The High Level Risk Register is fully reviewed every month at the Executive Team Meeting alongside a summary of the key changes and progress against mitigating actions. High Level Risks are assigned to one or more of the three academies or the Board (as appropriate), who will have oversight of the actions being taken to mitigate the risks. At each meeting (10 times per year) the Academies review, challenge and assess the High Level Risks within their remit. The purpose of these reviews is to provide assurance to the Board that all relevant risks are appropriately recognised and that all appropriate actions are being taken on appropriate timescales where risks are not appropriately controlled.

The Board reviews, challenges and assesses the full High Level Risk Register (risks graded as 15 and above) at each meeting (6 times per year). The Board also receives details of the discussions held at the Executive Team Meeting via the risk report, and at the Academies via the Chairs' reports.

Risks scoring 12 and above are reported as part of the CSU to Executive meetings, to provide the Executive team with an overview of risks which have the potential to become high level risks.

7. Strategic risk and assurance: the Board Assurance Framework

The purpose of the Board Assurance Framework (BAF) is to assure the Board that the Trust is mitigating the identified significant risks to the delivery of its strategic objectives (strategic risks) adequately and that there are no significant gaps in assurance. The BAF identifies the:

- Strategic objectives
- Risk appetite in relation to the objectives
- Risks to achieving those objectives (strategic risks)
- Initial risk score
- Current risk score
- Target risk score (consistent with risk appetite)
- Movement in risk score
- Controls and assurances
- Gaps in controls and assurances
- Actions to address gaps
- Lead director
- Related risks on risk register

The BAF provides a high level overview of the Trust's position against the risks to achieving the Trust's strategic objectives.

The Executive Directors initially identify the strategic risks, which are recorded on the BAF, for agreement by the Board. The Board may also identify further strategic risks as appropriate. The BAF is reviewed, challenged and assessed by the Executive Team and Board six times per year. The Academies also review, challenge and assess the strategic risks within their remit six times per year, to provide assurance to the Board that the strategic risks are being managed appropriately and that any gaps in controls or assurance are being addressed within appropriate timescales.

On an annual basis, the Board reviews the description of the risks contained within the BAF and considers whether any amendments, closures or new risks are required.

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8. Risk taking, risk appetite and risk tolerance

8.1 Risk taking

Bradford Teaching Hospitals NHS Foundation Trust acknowledges that in delivering health improvements and in embracing positive advantages risks may need to be taken. The Trust recognises that it cannot create a risk free environment, but rather one in which risk is considered as an integral part of everything it does and is appropriately identified and controlled.

8.2 Risk appetite

Risk appetite is 'the amount and type of risk that an organisation is prepared to pursue, retain or take[1]' in pursuit of its strategic objectives. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

On an annual basis the Board of Directors will publish its risk appetite statement as a separate document. The risk appetite statement will be generated from a formal discussion and will focus on key categories of applied the delivery of the strategic objectives and the application of a risk appetite matrix (see Appendix 2).

8.3 Risk tolerance

Risk tolerance is the acceptable level of variation relative to achievement of an individual objective. It is the amount of risk to which a programme or an activity is prepared to be exposed to or that its resources allow it to be exposed to, before actions become necessary.

The Trust has set its tolerance threshold for acceptable risk at moderate; i.e. a **current** risk score of 1-6. This threshold is set in expectation of what risks are likely to be actually realised and the resources needed to realistically control them (See Figure 2 below).

Risks scoring 1-6 are monitored and evaluated on an on-going basis to confirm or reassess that rating. All risks above this threshold are actively managed and mitigating actions taken to bring the risks back to within tolerance.

All risks graded at 15 or above are routinely considered by the Executive Team and reported to Board Academies and the Board of Directors.

Risk Matrix					
Severity	*Likelihood*				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	Score:5	Score:10	Score:15	Score:20	Score:25
4 Major	Score:4	Score:8	Score:12	Score:16	Score:20
3 Moderate	Score:3	Score:6	Score:9	Score:12	Score:15
2 Minor	Score:2	Score:4	Score:6	Score:8	Score:10
1 Negligable	Score:1	Score:2	Score:3	Score:4	Score:5

Figure 2. The 'line of risk tolerance'

[1] ISO 31000

9. Individual roles and responsibilities supporting the delivery of this strategy

9.1 Board of Directors

- Commitment, through approval of the Risk Management Strategy, to maintaining a sound system of internal control.
- Assessment and approval of any necessary risk management developments.
- Identification and allocation of any resources required to implement risk management initiatives.
- 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.)

9.2 Academies

- Review, challenge and assess the identification and management of risks within their remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

9.3 Audit Committee

- Review, challenge and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including this Risk Management Strategy, and provide assurance to the Board in that respect.

9.4 Executive Team Meeting

- Review of risks on the High Level Risk Register, to ensure that risks are appropriately described, scored, and mitigated. Accept new risks onto the High Level Risk Register and approve the de-escalation of risks, where appropriate.
- Review of risks scoring 12 and above at Executive to CSU meetings.
- Review the BAF to ensure that risks are appropriately described, scored, and mitigated, and that gaps in controls and/or assurances are being appropriately addressed.

9.5 Chief Executive

- Overall responsibility for ensuring that the Trust has in place the required systems and processes that support risk management across the organisation and that these systems and processes are approved and monitored by the Board of Directors.

9.6 Executive Directors

- Each Executive Director will ensure that all risks on the High Level Risk Register and BAF for which they are identified as executive lead, are appropriately described, scored, mitigated, monitored and reviewed.

9.7 Associate Director of Corporate Governance

- Is responsible for organising the Board of Director's work plan making provision for the discussion of all new risks entered on to the High Level Risk Register and for ensuring that the BAF is maintained and reported to the Executive Team, Academies and Board.

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9.8 Associate Director of Quality

- Is responsible for ensuring that incident and risk management reporting processes are embedded within the organisation and that CSUs and corporate department risk registers are subject to regular review and updated to reflect key risks.

9.9 CSU Triumvirate Leadership Teams/Directors of Corporate Departments will ensure through their line management structures that:

- There is active implementation of the Risk Management process within their teams.
- Annual clinical and/or non clinical risk assessments are undertaken and local level risk registers are maintained.
- Specific policies and procedures are implemented.
- Ensure attendance of staff at appropriate risk management training sessions.
- Raise risk awareness on risk management issues as required.
- Seek advice on risk management issues as required.
- Notify their Quality and Patient Safety Facilitator of identified risks.

9.10 Quality & Patient Safety Facilitators

- Provide support to CSU Triumvirate Leadership teams to ensure that risks are identified, recorded, managed and monitored appropriately.

9.11 All staff are responsible for

- Having a general awareness of risk at all times.
- Notifying line managers of any identified risks.
- Complying with the Trust's incident reporting procedure.
- Attending risk management training.

10. Training

Contributing to risk management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all grades of clinical and non-clinical staff.

Risk management training is part of the mandatory training for all clinical staff.

The following training and education will be provided to support the implementation of the governance and risk management strategy.

10.1 Board of Directors

The commitment and engagement of the Board of Directors within the organisation is paramount in creating a foundation for the implementation of this strategy and embedding the key principles throughout the Trust. To support this priority, updates and awareness training programmes will be provided at least annually from both internal and external experts. For executive and non-executive directors, this will form part of the on-going Board development programme.

10.2 All Staff

Risk management awareness and the incident reporting procedure is a structured part of the Trust's induction programme for new staff. This is also included in the induction programme for all medical staff. In addition there will be:

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- Regular risk management updates for staff which can be linked to specific clinical risk or health and safety training programmes, including raising awareness of policies, i.e. Health and Safety Policy, Infection Control and Incident Reporting Procedure.
- Training for Line Managers in in the implementation of the Strategy and to support the devolvement of the Risk Management process. This will include risk assessment and grading, and safety event investigation and the discharge of our professional and legal obligations in relation to the Duty of Candour.

11. Monitoring and assurance

Compliance with the Risk Management Strategy will be monitored through a bi-annual report to the Audit Committee.

The report will be prepared jointly by the Associate Directors of Quality and Corporate Governance, it will monitor as a minimum:

- The key individuals for risk management are discharging their responsibilities in line with the Strategy through attendance at key risk management meetings and there is evidence of activity through the minutes of those meetings.
- The Executive Team, Academies, and Board have discharged their responsibilities in line with the relevant Terms of Reference.
- How all risks are assessed using a standard template and Trust-wide grading matrix.
- How risk is managed locally through a review of compliance with the Trust-wide risk management process.

Where deficiencies are identified, an action will be developed and monitored through the Executive Team.

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Appendix 1: Risk assessment

Risk title:				
Summarise from the description below:				
Risk description:	CAUSE	EVENT	EFFECT	**Risk location:**
Include any relevant background information to provide context of why the risk is being assessed:	***IF……..****we are unable to release clinical staff for mandatory training due to staffing levels*	***THEN……..****staff will not receive compulsory training in relation to resuscitation or blood safety*	***RESULTING IN……..****an increased safety risk to patients*	

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
1.				
2.				
3.				
4.				
Insert more lines as required…				

Current/Initial Risk Score

(Current/initial risk score assessed at the time the risk assessment is undertaken)

Consequence		Likelihood		Total score
	X		=	

Rationale – include narrative

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.		
2.		

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3.		
Insert more lines as required…		

Residual Risk Score (This is the risk score once all mitigation has been actioned and adequate control measures are in place)

Consequence		Likelihood		Total score
	X		=	
Rationale – include narrative				

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

Risk Assessment Owners	
Risk Assessment Lead: For example, Ward manager/Matron/CSU lead/Speciality Lead.	
Risk Assessment created by:	
Date:	

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Appendix 2: Risk Appetite Matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

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BO.3.24.9 - REPORT FROM THE CHAIR OF THE FINANCE AND PERFORMANCE ACADEMY ? JAN & FEB 2024

REFERENCES

Only PDFs are attached

Bo.3.24.9 - Report from the Chair of the Finance and Performance Academy - 31 January 2024.pdf

Bo.3.24.9 - Report from the Chair of the Finance and Performance Academy - 28 February 2024.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo3.24.9

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 31st January 2024

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. As at month 9 the Trust is £1.1m in deficit but is forecasting a full year break- even position. This position masks the underlying financial deficit that is being carried into 2024/25. **Financial Plan** - The Academy discussed the significant underlying financial position; the actions being taken to minimise this risk and the significant deficit being carried into next financial year. At this stage in the planning process there is more than £40m of risk that will need to be managed to deliver a break-even plan. The Executive team have had a time out to discuss how we manage this risk and a good discussion took place in the Academy about how we might best address this deficit and over what period financial recovery could take place.
Advise:
Cancer and Diagnostic Improvement Plan – The Academy was updated on key cancer performance indicators, national and cancer alliance targets for 24/25 and plans to improve cancer performance. We had a great presentation on the HISTO programme that will focus on improving and transforming services in histopathology. Progress on the HISTO programme will be monitored through further updates on the Cancer and Diagnostic Improvement Plan. **Performance Highlight Report** – The Academy received and reviewed the monthly comprehensive report. Our performance remains strong in comparison with our West Yorkshire (WY) peers. The Academy noted the great performance in Urgent Care recognising that it was still below the 95% standard (79.1%) and how we were being asked to share our practices at national level to help other Trusts. Referral to treatment performance continues to be impacted by industrial action and performance decreased in December to 64.6% but remains within the upper quartile compared to other Acute Trusts. **WYATT/ICS Programme Quarterly –** The Academy agreed that to avoid duplication these updates would no longer be shared at our meetings but continue to be shared through the updates that are already presented to Board. **Capital Update –** We have spent £20m of the £58m capital budget but are forecasting to spend the full budget by the end of the financial year.
Assure:

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo3.24.9

EPRR Governance Proposal – the Academy agreed that they will receive an update on EPRR progress against core standards three times a year in addition to signing of the final report annually. This will be added into the Academy work plan.

High Level Risks Relevant to the Academy - The Academy raised one risk at the end of the meeting which may need to be included on the risk register, this was about local authority cuts and the impact on our long stays and resulting performance targets.

Challenge in the meeting was good and there was good participation across the range of attendees in the meeting, due to the high number of papers in the finance section of the agenda we needed to take a number of items as read in order to prioritise the areas we felt we needed a discussion.

Report completed by:

Julie Lawreniuk
Academy Chair and Non-Executive Director
February 7th, 2023

Meeting Title	Board of Directors		
Date	14.3.24	Agenda item	Bo.3.24.9

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 28th February 2024

Key escalation and discussion points from the meeting
Alert:
Financial Plan Update - At this stage in the planning process there is £54.6m of financial risk in 2024/25, a waste reduction target of £25.3m has been agreed that will leave a residual deficit of £29.3m. Work is ongoing to agree plans to deliver the £25.3m waste reduction plan. There will need to be a balance in decision making between finance and performance in addressing this challenge. **Intermediate Care** – The Urgent Care Improvement presentation included an update on the impact that the challenges in the local authority are having on our admitted pathway. The Trust is working closely with our health and social care partners to reduce delays and mitigate the impact of the financial pressures.
Advise:
Monthly Finance Report – There continues to be a risk to delivering the 2023/24 financial plans but the Trust is forecasting a full year break- even position. This position masks the underlying financial deficit that is being carried into 2024/25. **Urgent and Emergency Care Improvement Plan –** We are currently ranked 3rd best in region and 7th best nationally in delivery of the Urgent Care Target. The Academy noted the continued work ongoing to sustain/improve this performance further. **Performance Highlight Report** – The Academy received and reviewed the monthly comprehensive performance report. Our performance remains strong in comparison with our West Yorkshire (WY) peers but continues to be impacted by industrial action. The new Community Diagnostic Centre is now open and is supporting a new sustainable service offer resulting in improvements in our diagnostic performance. The new Day Case Unit once opened next year will further improve our performance against targets. The Academy noted their continued appreciation of the evaluation and understanding of our data and performance reports. **Health Inequalities and Waiting List Analysis –** The Academy received a verbal update on the work continuing to reduce health equalities, this is focusing on three main areas, access, patient experience and outcomes. A further written report detailing progress will be shared with the Academy later in the year. **Capital Update –** We have spent £26m of the £57m forecast spend against the capital plan. Although there is a risk given the amount still to be spent, the team are confident that the plan will be delivered.

Meeting Title	Board of Directors		
Date	14.3.24	Agenda item	Bo.3.24.9

Assure:
High Level Risks Relevant to the Academy - The Academy were assured that all relevant risks had been identified, reported to the academy and were being appropriately managed. **Internal Audit Plan** – The process for pulling together the internal audit plan was shared with the Academy, and they were asked to flag anything they felt needed including within the plan. 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
March 6th, 2024

BO.3.24.10 - OPERATIONAL AND FINANCIAL PLAN 2024/25

REFERENCES

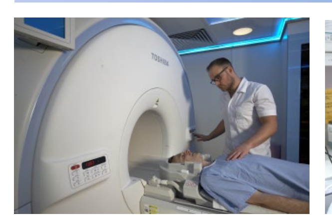
Only PDFs are attached

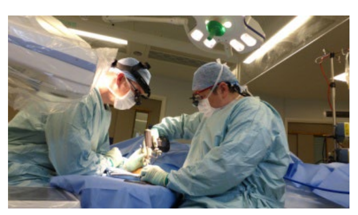
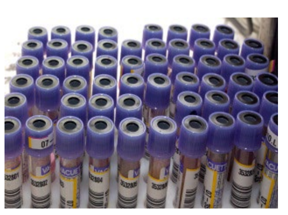
Bo.3.24.10 - Operational and Financial Plan 2024-25.pdf

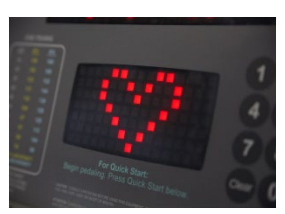
2024/25 Draft Operational & Financial Plan

Board of Directors

14 March 2024





Workforce Planning
Faeem Lal, Interim HR Director

Planning Assumptions

- Reductions in temporary staffing across the year (substantive staff growth tracked against temporary staffing reduction)
- Some growth due to developments:
- Assumption of no further Industrial Action in 2024/25
- In addition there are a number of KPIs to consider as part of the workforce plan. The table below outlines our assumed delivery across 2024/25 against our targets.

KPI	Trust Target	2024/25 Plan
Turnover	11%	9.75%
Sickness Absence	6%	5.2%

Key Headlines

	March 2024 Baseline (WTE)	Planned March 2025 (WTE)	Difference from baseline to March 2025 plan (WTE)
Substantive	6313.26	6559.43	+246.17 (3.89%)
Bank	685.30	600.78	-84.52 (-12.33%)
Agency	114.23	35.47	-78.76 (-68.94%)
Total	7112.79	7195.68	+82.89 (1.16%)

- Maintaining current staffing levels in some areas.
- Continued reduction in agency to bank usage has created significant savings.
- Recruitment plans will deliver temporary staffing reductions, e.g. Facilities.
- Retention initiative from start of the employment lifecycle to reduce employee attrition rates

Funded Projects in Plan

Bradford Teaching Hospitals
NHS Foundation Trust

- St Lukes Day Case Unit (May 2024

Roles (WTE)	WTE in Plan	Appointed 2023/24	Appoint 2024/25
Theatre	41.19	31.77	9.42
Anaesthetics	3	0	3
Estates & Facilities	6.65	0	6.65
Pharmacy	5	1	4
Radiology	2	0	2
Surgeons	3	0	3
Total	60.84	32.77	28.07

- Diagnostic Centre

Roles (WTE)	WTE in Plan	Appointed 2023/24	Appoint 2024/25
Radiology	52.2	34.2	18
Cardio-Respiratory	19.3	16.8	2.5
Pathology	6	4	2
Women's Service	1	0	1
Endoscopy	0.5	0	0.5
Total	79	55	24

Supply Bridge

Accounts for the overall changes to recruitment are based on:

- no planned International Recruitment Campaigns
- vacancies will be filled through domestic recruitment (supported via links with University of Bradford, University of Bolton and local innovative initiatives, e.g. At One Entry Level Recruitment; and
- an aspiration of increased apprenticeship offers at 7%.

Priorities for Delivery

- Understand and reduce reliance on temporary staffing usage for substantive vacancies.
- Understand and reduce other drivers in temporary staffing usages, e.g. sickness absence.
- Continued investment to focus on recruitment innovation including:
  - Develop fair and inclusive communications, policies and procedures through an EDI lens;
  - Volunteer to Career roles;
  - At One Entry Level recruitment initiative;
  - Recruiting Refugee talent;
  - increased usage of apprenticeships.
- Understand the Trust implications of the Long Term Workforce plan regarding the apprenticeship ambition over the next 7 years, specifically in clinical roles..
- Maximise use of advertising platforms and social media including TikTok and LinkedIn.
- Retention initiatives focusing on:
  - People Promise (we are a cohort 1 exemplar site);
  - Flexible working;
  - Career Development - we have piloted talent management conversations, and continue to develop our Leadership Pathways, recognising all our colleagues as leaders. Our Leadership Conference in June 2023 was attended by over 500 staff, and we are currently developing the 2024 Conference;
  - Retire and Return initiative;
  - New starter candidate experience/onboarding;
  - Health & Wellbeing Initiatives;
  - Stay conversations are being trialled in 5 areas to understand what makes our colleagues stay, what makes them consider leaving, and how we can address these issues with local retention strategies.

Current Risks

- Recruitment challenge – not achieving recruitment levels in areas with a high turnover or increased use of bank/agency
- Ability to deliver a recruitment plan where the focus is on domestic recruitment as opposed to international
- Unable to recruit to hard to filled vacancies, e.g. ODPs
- Skills deficit, e.g. Renal, Cancer nurses and midwifery leading an increase in super numerary.
- Advertising campaigns e.g. social media, not reaching prospective workforce.
- Plans do not account for additional temporary staff usage required if industrial action continues in 2024/25.

Activity & Performance
Saj Azeb, Chief Operating Office

Activity and Performance Plans

Headlines

- No formal guidance issued; in place we used 2023/24 priorities, content of the return templates, and NHSE locality team insight to inform plans
- Activity plans will likely inform elective recovery fund (ERF), which would work like payment by results
- Targets: no 65-week RTT waits by September; 77% FDS and 70% 62-day cancer; 77% ECS performance and 92% bed occupancy
- Potentially the ICS has a 95% DM01 target

Key Assumptions

- Waste reduction programme has no negative impact on current levels of activity and performance (or CSU plans supported by already approved business cases)
- Capital programmes complete on time (particularly SLH DCU)
- Services sustain or improve in line with the plans they have described (which were triangulated with quality, finance and workforce plans)
- Improvements aligned to delivering operational excellence and GIRFT further faster can be realised

Activity and Waiting Times

The Ask:

- Increase outpatient first and outpatient with procedure (OPPROC) activity
- Increase day case and elective ordinary activity
- Reduce outpatient follow up, supported by increased use of PIFU
- Clear 65-week RTT waits before September and reduce 52-week RTT wait

Our Response:

- Delivering operational excellence and GIRFT further faster to support outpatient and inpatient transformation/ improvement
- **Improved activity compared to 2023/24**: Outpatient first +2%; OPPROC +10%; day cases +7%; elective ordinary +22%; outpatient follow ups -3%
- **ERF related activity will be at 107.5%** of 2019/20 baseline
- PIFU increases to 5% of outpatient activity to meet target;
- 52-week waits reduce to no more than 426; **65-week target met in August**

Urgent & Emergency Care

The Ask:

- ECS at 77% for type 1 & 3 attendances
- Bed occupancy at 92% and bed base as per winter levels
- Supported by use of SDEC and improving discharge metrics

Our Response:

- **ECS target of 77%** will be met (or exceeded)
- Impact of IMC issues included in bed modelling
- SDEC and NEL spells included based on post AECU data

Any gaps:

- **Bed occupancy at 93.5%** average and >95% in winter
- 21-day length of stay and daily percentage occupancy with no criteria to reside higher than historic best due to IMC impact

Cancer and Diagnostics

The Ask:

- 77% Faster Diagnosis Standard to be met against expected +5% demand
- 70% 62-day cancer treatment performance against CWT12 and with reduced backlog (c.57 but to be confirmed)
- 95% (to be confirmed) DM01 diagnostic waiting times target

Our Response:

- **Full compliance with cancer targets** (with a stretch to exceed these)
- +5% expected increase in cancer demand
- +2% growth in diagnostic demand plus additional activity from CDC or other recovery plans; therefore +5% activity compared to 2023/24 and +14% compared to 2019/20 baselines

Any gaps:

- Diagnostic activity plans are modelled to achieve a minimum of **85% DM01** performance for each modality (but not 95% as per the potential ICS target)

Financial Plan
Matthew Horner
Director of Finance

1. Summary of Draft Plan 2024/25

Bridge - 2023/24 Forecast Outturn to 2024/25 Draft Plan

Item	£m
23/24 Forecast	0.0
NR measures 23/24	(23.6)
FYE WRP & developments	(2.3)
FYE nurse recruitment	(5.4)
NHS funding changes	4.4
Cost Inflation 24/25	(18.4)
Growth / pressures 24/25	(3.5)
SLH DCU / CDC / Endosc.	(5.6)
Net Deficit before WRP	54.6

Axis: £m — 0.0, (10.0), (20.0), (30.0), (40.0), (50.0), (60.0)

2. Key Headlines

- Tues 12 March - Draft plan to be submitted to ICB (formal NHSE submission 21 Mar)
- Deficit before Waste Reduction Programme (WRP) = £54.6m
- WRP target = £26.3m (4.5%)
- Net deficit plan = £28.3m (but need to save £26.3m to "achieve" this level of deficit)
- Realistic assessment of inflation in excess of NHS nationally published assumptions:
  - Utilities = £3.7m, Drugs uplift to 5% = £1.6m, Non-pay uplift to 4% = £3.4m
- Pay inflation assumption reduced from 2.7% to 2.1% as per national guidance
- NHS contract income growth confirmed at 0.6% = £3m (previously planned for 1% @ £5m)
- NHS income inflation uplift 1.9%, less Tariff Efficiency -1.1%, less Convergence Adjustment -0.97% = 0.17% *funding reduction (-£0.8m)*
- Probable requirement for interest bearing cash support for day to day spending
- Have to maintain balance between money, performance and quality

	Income £m	Expenditure £m	Net I&E £m
Plan before WRP	580.1	-634.7	-54.6
WRP target (4.5%)	0.2	26.0	26.3
Net Plan	**580.4**	**-608.7**	**-28.3**

3. Submitted WRP Plan (Draft)

Row Labels	Recurrent £m	Non-Recurrent £m	Total £m
Pay	11.9	3.7	**15.5**
Non-Pay	8.0	2.5	**10.5**
Income	0.2		**0.2**
Grand Total	**20.1**	**6.2**	**26.2**

Status	Low Risk £m	Medium Risk £m	High Risk £m	Total £m
Fully Developed	1.7	0.2	1.8	**3.7**
Plans in Progress	1.9	5.8	5.2	**12.8**
Opportunity	0.3	1.3	2.0	**3.6**
Unidentified			6.2	**6.2**
Grand Total	**3.9**	**7.3**	**15.1**	**26.2**

- WR plan development ongoing - modelling of premium cost opportunities and workstreams approved by ETM
- Phasing and categorisation of WRP target is indicative - modelled by Finance Dept
- NHSE template stipulates maximum 25% of plans may be “unidentified” at draft stage - £6.2m unidentified in BTHFT submission
- Only £3.7m of plans classed as “fully developed”
- Majority of plans rated high or medium risk
- Scrutiny on credibility of WRP delivery is to be expected

4. WRP – Revised Approach 2024/25

- Corporate project management structure based on the successful “Outstanding Services” model to be introduced to oversee the delivery of the WRP / Financial Recovery Plan
- Director of Strategy will lead the process via a Waste Reduction Programme Board (WRPB) - TBC
- WRPB to comprise Executive Directors, Workstream Leads and relevant support from PMO and Exec Deputies
- Each CSU to be allocated an Executive lead to support their WRP delivery
- A number of cross cutting workstreams will identify opportunities across all CSUs and will assist the CSUs with implementation
- Workstreams to be led by senior managers from all disciplines, Workstreams may be allocated nominal WRP targets to be achieved by the CSUs they support
- Workstream leads to be accountable to Programme Board for delivery of their objectives
- CSUs / corporate departments remain accountable for delivery against their allocated WRP targets – the hard financial benefits can only be realised in the spending departments
- CSUs to be represented in and engage with all relevant workstreams to take advantage of all opportunities
- CSUs expected to supplement workstream activities via development of local initiatives informed by expert knowledge of opportunities within their own services
- CSUs are accountable to the Executive Team for delivery against all of their financial targets
- CSU datapacks highlighting opportunities for WRP will be issued to inform plans and discussions with Executive sponsors (packs to be issued incrementally as and when items of analysis are completed)

5. WRP – Matrix Structure

Finance & Performance Academy

↑

Executive Team Meeting

↑

Waste Reduction Programme Board

↑

			Workstream Lead 1	Workstream Lead 2	Workstream Lead 3	Workstream Lead 4	Workstream Lead 5	Workstream Lead 6	Workstream Lead 7	Workstream Lead 8	Workstream Lead 9	Workstream Lead 10	Workstream Lead 11	Workstream Lead 12	Workstream Lead 13	Workstream Lead 14	Service Area Snr Team
Executive Lead for CSU	Department	WR Target £000s	GIRFT Implementation	Elective Recovery	Nurse Rostering	Junior Doctor Bank	Consultant Workforce	Medicines Management	CDS / Clinical Coding DQ	Financial Controls	Core Service Reviews	Quality & Service Improvement	Digital	Workforce Improvement	Estates & Facilities	Corporate Benchmarking	Service Specific WRP
Exec 1	CSU 1	£2,315															
Exec 2	CSU 2	£2,537															
Exec 3	CSU 3	£4,190															
Exec 4	CSUs 4 - 10	£12,433															
Exec 5	Estates & Facilities	£1,935															
Exec 6	Corporate Services	£2,891															
CEO	Trust Total	£26,301	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

→ **EXECUTIVE MANAGEMENT TEAM**

£26,301

6. Key Messages

- Scale of the Challenge (9.4% of turnover)
- Assurance that we know ‘why we are where we are’ (eg Key Deficit Drivers)
- Need to submit a Plausible/ realistic but very stretching plan (demonstrate we are really testing ourselves)
- Demonstrate we have a robust recovery plan, that reflects the seriousness of the challenge we face
- Demonstrate that we can deliver in a controlled & safe way & remain in control of own destiny
  - Sustainability & Stability v Slash & Burn
- Very likely we will be in deficit – As such we will be in ‘Financial Recovery’ – understanding the implications
  - Expect that we will attract external scrutiny
  - Have we done everything we can?
  - We will need to adopt the ‘Deficit protocol’ and accept the implications
    - Eg External approvals required
- Consideration given to resetting our ‘risk appetite’ regarding the money
  - Assess our position (the balance between Quality, Performance & Money)
- What unpalatable options must we/ are we willing to consider
- Establish robust quality impact assessment process
- Consider our position and implications as a place and system partner
- Place, WYAAT, System opportunities & ROI
- Service sustainability, duplication across Place & System (opportunities & risks)

7. Next Steps

- Embed the updated governance arrangements - New ‘Outstanding Programme’
  - Transfer Waste Reduction Group in new Programme
  - Understand resourcing implications (ie facilitation of Waste Reduction Programme Board – eg PMO)
- Communicate the position to whole organisation that we are in ‘Financial recovery’
  - Including Launch event
- Consider and impact assess the unpalatable options (demonstrating we have tested everything)
- Discuss whether additional resource/ external support is required
- Agree the immediate ‘Run Rate Improvement’ options for Q1 – ETM process underway
- Establish a robust, clear, deliverable (but stretching) recovery plan
- Establish a strengthened financial reporting and delivery framework (commensurate with the scale of the challenge that we face) – For example - Weekly cycle of meetings
- Establishing/ recalibrating the key non-financial productivity KPI’s triangulating performance and waste reduction – with improvement trajectories to support financial recovery
- Translate Place, System, Provider Collaborative opportunities
- Ongoing input into Place ‘Closing the Gap’ Work
- Proposed that detail is discussed in a dedicated Board Session on the Operational Plan

BO.3.24.11 - CAPITAL PROGRAMME 2024/25

REFERENCES

Only PDFs are attached

Bo.3.24.11 - Capital Programme 2024-25 (cover).pdf

Bo.3.24.11 - Capital Programme 2024-25.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.11

Capital Programme 2024/25

Presented by	Matthew Horner, Director of Finance	
Author	Michael Quinlan, Deputy Director of Finance	
Lead Director	Matthew Horner, Director of Finance	
Purpose of the paper	Approve 2024/25 Capital Programme and note indicative position for future years.	
Key control	Yes	
Action required	For information	
Previously discussed at/ informed by	Capital Strategy Group – February 2024	
Previously approved at:	**Meeting**	**Date**
	Capital Strategy Group	February 2024
	Capital Operational Group	February 2024

Key Options, Issues and Risks

The Board of Directors is asked to note the current status of the capital programme for 2024/25 that will be included in the operating plan submission to NHS England. This report builds on the capital programme update paper presented to the Finance and Performance Academy, Executive Directors, Capital Strategy Group and Capital Operational Group throughout the year.

The purpose of this paper is to inform the Board of Directors of the proposed indicative plan for 2024/25 with further detail for the subsequent 2 years, recognising that allocations have not been formally notified for any year.

Since the 2023/24 capital programme is still ongoing the Board of Directors are asked to delegate the approval of the final capital programme to the Finance and Performance Academy.

Analysis

The Programme is divided into the normal areas for investment with the standard indicative values allocated to Equipment replacement, Backlog Maintenance and Digital replacement. Adjustments have been made where spend has been brought forward into 2023/24 (eg Digital) and may still need to be made if additional slippage occurs in March 2024.

Within each area a prioritisation process is underway to ensure the highest risk areas are addressed within the allocations. The final lists will be agreed through Capital Operations and Capital Strategy Group. There remains a value retained in contingency, which will not be finalised until the final slippage number is understood. Once understood, an agreed amount of the contingency can be released for investment with risk based decisions taken on what is targeted for investment. There are a number of priorities arising out of the needs from the estate, the need for replacement of clinical and nursing equipment, investments to improve information systems and the needs of the service reconfiguration programme to support the deliver of services.

The capital programme developed remains tight and it has been challenging to develop a programme that promotes sufficient mitigation of service delivery risk within the Trust overall capital budget availability and liquidity headroom.

Recommendation

The Board of Directors are asked to delegate the approval of the 2024/25 capital programme to the Finance and Performance Academy.

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.11

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	☐	☒

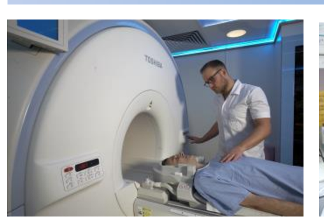
Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose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

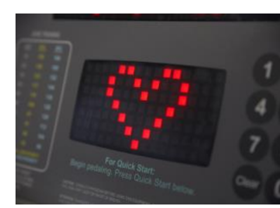
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Charitable Funds Committee
☐	☐	☒	☐

Capital Programme 2024/25

Matthew Horner
Director of Finance

Open Board of Directors, 14 March 2024





Background

- Current funding available for the 2024/25 capital programme is £42.1m (as at March 2024).

	ICS Allocation	Cash Generated	Difference
	£m	£m	£m
ICS Capital Allocation	23.6	12.8	(10.8)
PDC Funding	17.2	17.2	0.0
Total Capital	**40.8**	**30.0**	**(10.8)**
IFRS 16 (Leases)	1.3	1.3	0.0
Total	**42.1**	**31.3**	**(10.8)**

- To fund the ICS Capital Allocation the Trust will need to use £10.8m of its own internal cash (Appendix 1) as the allocation is higher than the level of cash generated by the Trust.

- Outstanding Maternity Services (£4.9m), St Luke Hospital Day Case Unit (£3.0m) and Endoscopy Transformation Programme (£15.1m) are material 24/25 capital schemes (£23.0m) with risks to deliverability. See Appendix 2 for indicative three-year capital plan.

Background

- It is likely again to be challenging to deliver the exact level of spend in the year to match available resources, however this will be managed as closely as possible.
- The current position for 2024/25 suggests little flexibility for new schemes, with particular risks to critical infrastructure risks and replacement of medical equipment.
- Planning work is underway to review the Capital Programme and determine priorities for subsequent years
- Capital planning/prioritisation and scheme “value engineering” continue to be crucial in securing maximum value for money from constrained resources.

Key Risks

- **Deliverability** - delivering capital schemes within approved budgets and timescales is a challenge and puts at risk service resilience and performance of the Trust.

- **Slippages** – the Trust is currently forecasting £5.1m slippage (appendix 3) into 24/25. Should further slippages occur this will impact on budget set for 24/25.

- **Financial Sustainability** – should the Trust report a deficit and or not deliver the waste reduction programme this will limit cash available to invest in capital schemes. The Trust may be required to reduce its capital programme.

Appendix 1
Internal CDEL

- Trusts internal CDEL (cash available) for 24/25 capital investment is £12.8m.

	£m
Depreciation (24/25)	15.9
Loan Repayments	(3.1)
23/24 Surplus / (Deficit)	0
Internal CDEL	**12.8**
ICS Capital Allocation	(23.6)
Internal Cash Reserves	**(10.8)**

- The above calculations assumes the Trust delivers a breakeven position during 2023/24. Surplus or (Deficit) will Increase or (Decrease) cash available for 24/25 capital.

Appendix 2
Three Years Capital Programme

Bradford Teaching Hospitals
NHS Foundation Trust

	2024/25	2025/26	2026/27	Total
	Budget £m	**Budget £m**	**Budget £m**	**Budget £m**
Operational Capital				
Medical Equipment	3,000	3,000	3,000	9,000
Estates and Facilities	4,400	4,400	4,400	13,200
Digital	500	800	800	2,100
Total Non Capital Strategy Capital	**7,900**	**8,200**	**8,200**	**24,300**
Capital Strategy				
Estates Capital Strategy				
Outstanding Maternity Services	4,900	7,000	0	11,900
Research and Development Main Entrance	682	0	0	682
Hand Surgery	315	0	0	315
St Lukes Hospital Day Case Unit	2,572	0	0	2,572
Endoscopy Transformation Project	0	8,603	0	8,603
Total Estates Capital Strategy	**8,469**	**15,603**	**0**	**24,072**
Medical Equipment Capital Strategy				
Gamma Camera Turnkey	688	0	0	688
Total Medical Equipment Capital Strategy	**688**	**0**	**0**	**688**
Digital Capital Strategy				
TIF Theatres and Anaesthesia	1,972	0	0	1,972
Total Medical Equipment Capital Strategy	**1,972**	**0**	**0**	**1,972**
Contingency	5,453	(275)	15,328	20,506
Total Capital Strategy	**16,582**	**15,328**	**15,328**	**47,238**
Total Operational Capital	**24,482**	**23,528**	**23,528**	**71,538**

Appendix 2
Three Years Capital Programme

Bradford Teaching Hospitals NHS Foundation Trust

	2024/25	2025/26	2026/27	Total
	Budget £m	Budget £m	Budget £m	Budget £m
Non Operational Capital				
Public Dividend Capital				
Eccleshill Community Diagnostics Centre	190	0	0	190
Endoscopy Transformation Project	15,055	0	0	15,055
Yorkshire Imaging Collaboration	6	0	0	6
Digital Diagnostics	601	0	0	601
Total Public Dividend Capital	**15,852**	**0**	**0**	**15,852**
Targeted Investment Fund				
St Lukes Hospital Day Case Unit	384	0	0	384
Total Targeted Investment Fund	**384**	**0**	**0**	**384**
Total Non Operational Capital	**16,236**	**0**	**0**	**16,236**
Total Capital Budget	**40,718**	**23,528**	**23,528**	**87,774**

	2024/25	2025/26	2026/27	Total
Internal and External Investments	Budget £m	Budget £m	Budget £m	Budget £m
Significant Capital Investment Schemes				
Endoscopy Transformation Project	15,055	8,603	0	23,658
Outstanding Maternity Services	4,900	7,000	0	11,900
St Lukes Hospital Day Case Unit	2,956	0	0	2,956
Total	**22,911**	**15,603**	**0**	**38,514**

Appendix 3
Forecast Slippage

	£000
Research and Development Main Entrance	682
St Luke Hospital Day Case Unit	2,572
Gamma Camera Turnkey	688
Theatres and Anaesthesia Digital Systems	800
Hand Surgery Unit	315
Total	**5,057**

- Forecast Slippage is based on Month 10 actual position and forecast outturn. Slippage value could change before 31 March 2024.

- Additional slippages will need to be top sliced from 24/25 capital programme

Thank you

BO.3.24.12 - INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.3.24.12 - Integrated Dashboard (cover).pdf

Bo.3.24.12 - Integrated Board Dashboard - January 24.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.12

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 assurance	
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	14 March 2024	Agenda item	Bo.3.24.12

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:	
Care Quality Commission Fundamental Standard:	
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

31st January 2023

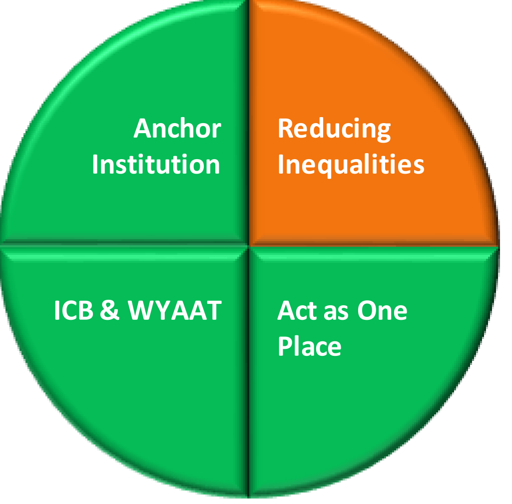
Integrated Dashboard
31st January 2024

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

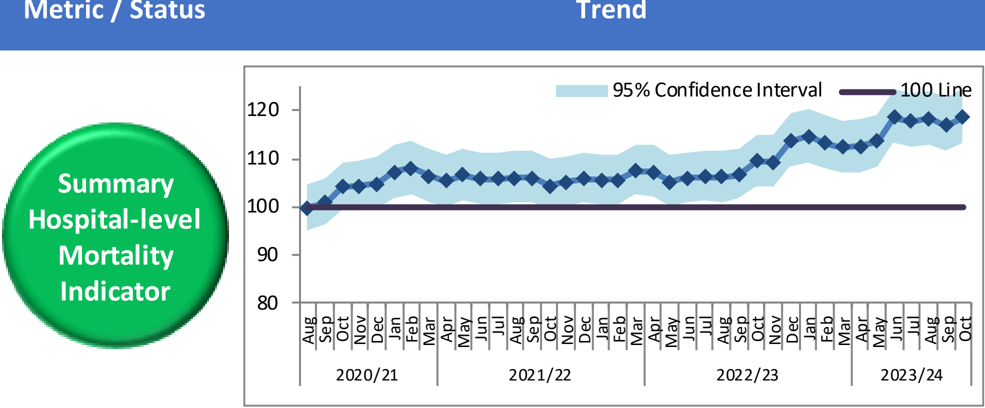


To be a continually learning organisation and recognised as leaders in research, education and innovation

To provide outstanding care for patients
Clinical Effectiveness

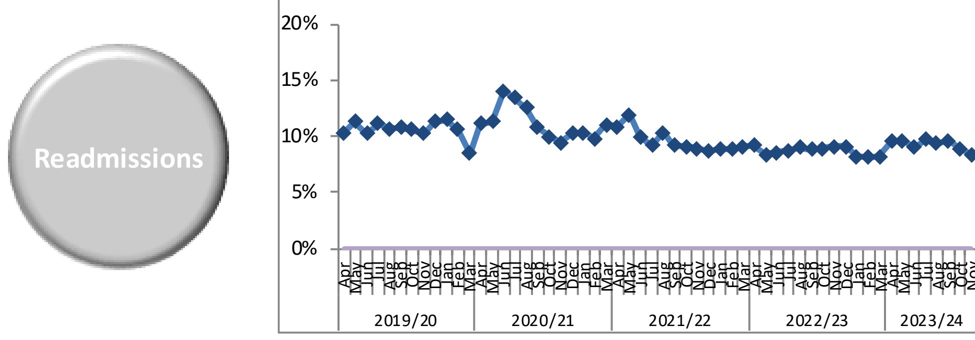
Metric / Status	Trend	Challenges and Successes	Benchmarks

Summary Hospital-level Mortality Indicator

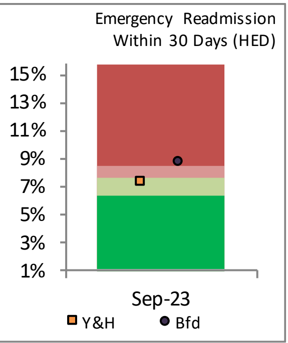


The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England and is evaluated over all diagnosis 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 (12-mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (January 2024) : **118.67** – High (>95%). There is ongoing work with the Learning from Deaths team and Clinical Coding to explore issues with the depth of coding that are possibly affecting the SHMI value.

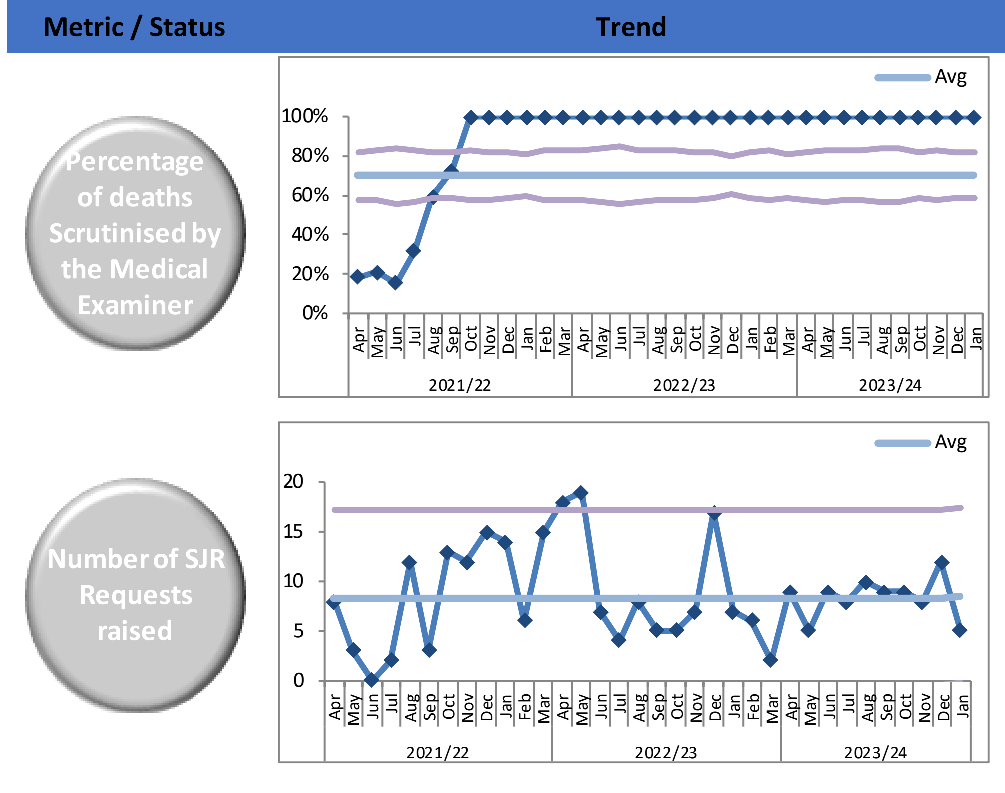
Readmissions



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).

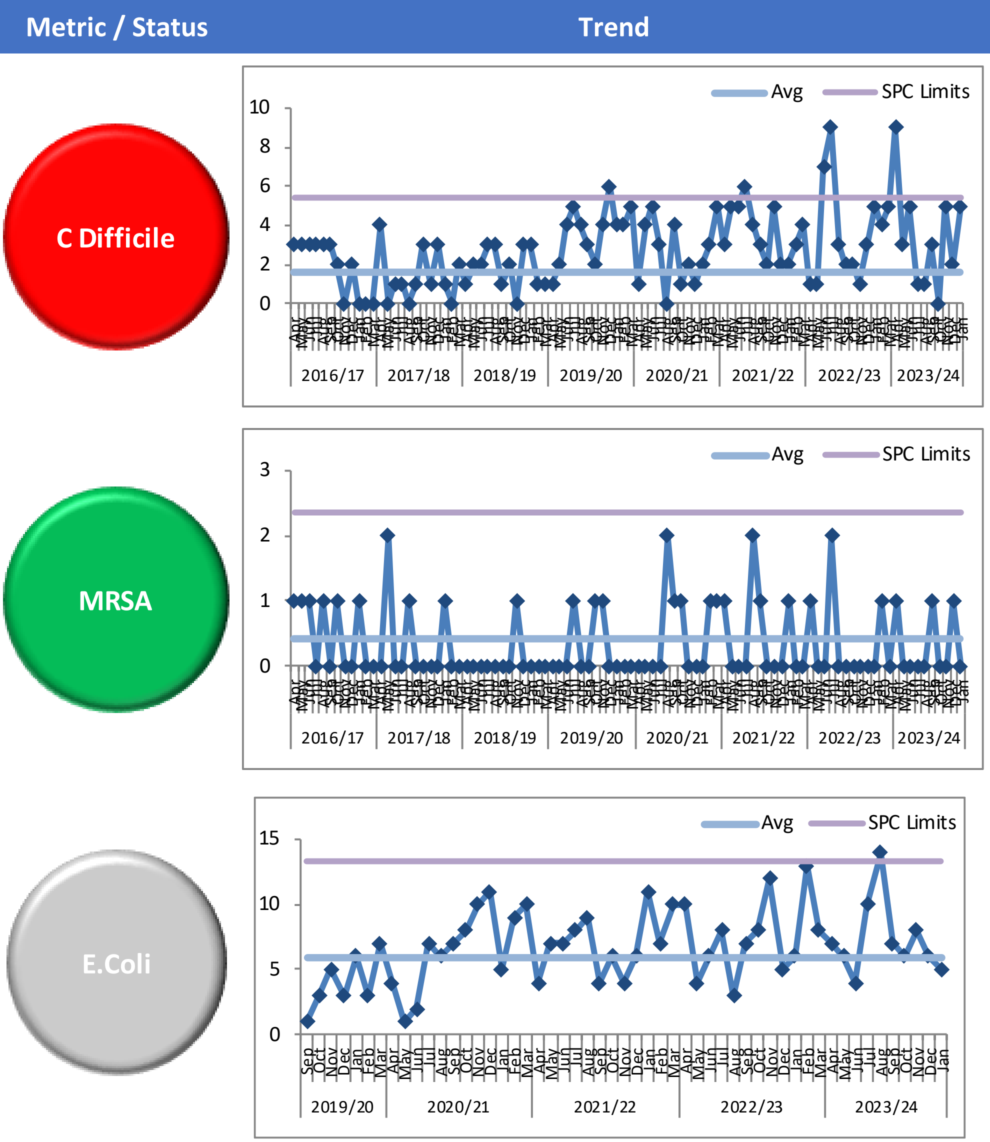


To provide outstanding care for patients
Learning from Deaths

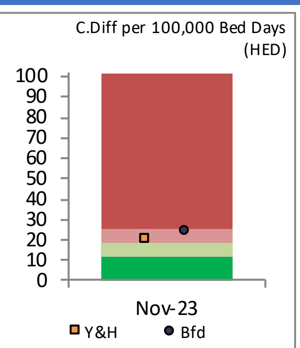
Metric / Status	Trend	Challenges and Successes	Benchmarks
Percentage of deaths Scrutinised by the Medical Examiner Number of SJR Requests raised		We continue to meet 100% scrutiny for all hospital deaths. We have engaged with all of the GP practices in our remit (55 out of 55 GP sites). **January 2024** There were 133 in-patient deaths with three SJRs requested via the Medical Examiner's office. There were six SJRs were completed by reviewers with five scoring between Adequate to Excellent overall care and one scoring 2 or below, which will be discussed at the Mortality oversight meeting for further review and identify learning. One referral concerned a death in the community, rather than at BTHFT. There are 11 outstanding SJR requests awaiting completion for September to December 2023. Reasons for the SJR's requests raised in November 2023 include: Deaths where learning will inform provider's Quality Improvement Work: n=1 Deaths of those with severe mental health illnesses: n=1 Deaths of those in the community: n=1	

To provide outstanding care for patients
Patient Safety

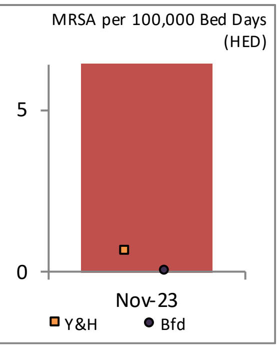
Metric / Status	Trend	Challenges and Successes	Benchmarks

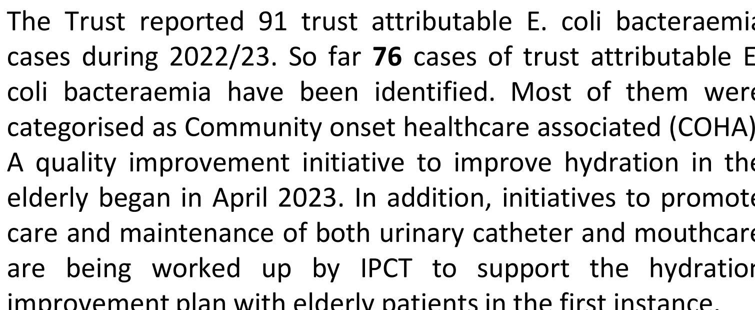


The Trust reported 43 cases of C. diff infection during 2022/23. So far **34** trust attributable cases have been identified. There were 9 trust attributable cases in the April 2023. There was no evidence of an outbreak or transmission between patients. Antibiotic usage was considered the most common 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 2023 and September 2023 and January 2024. 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.

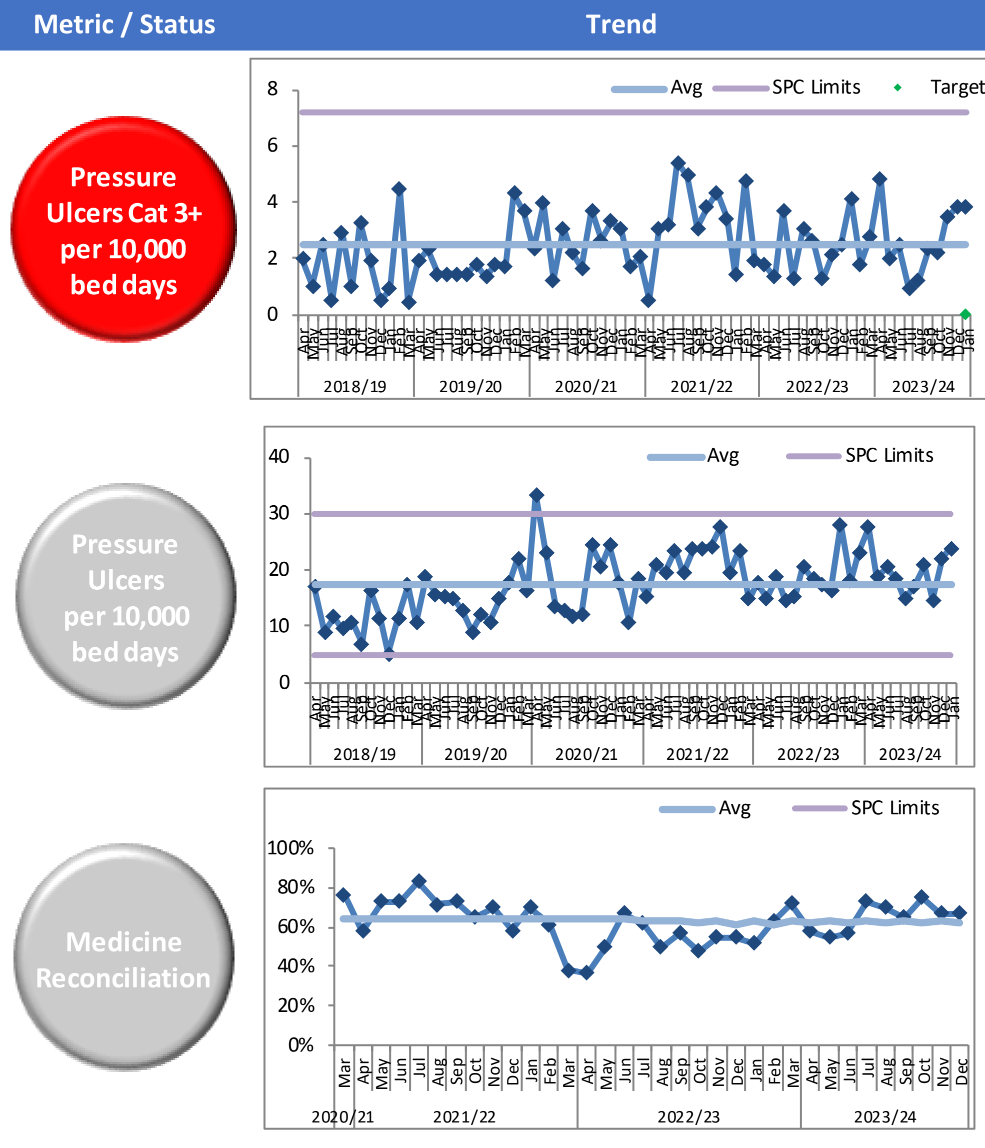




The Trust reported 91 trust attributable E. coli bacteraemia cases during 2022/23. So far **76** cases of trust attributable E. coli bacteraemia have been identified. Most of them were categorised as Community onset healthcare associated (COHA). A quality improvement initiative to improve hydration in 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

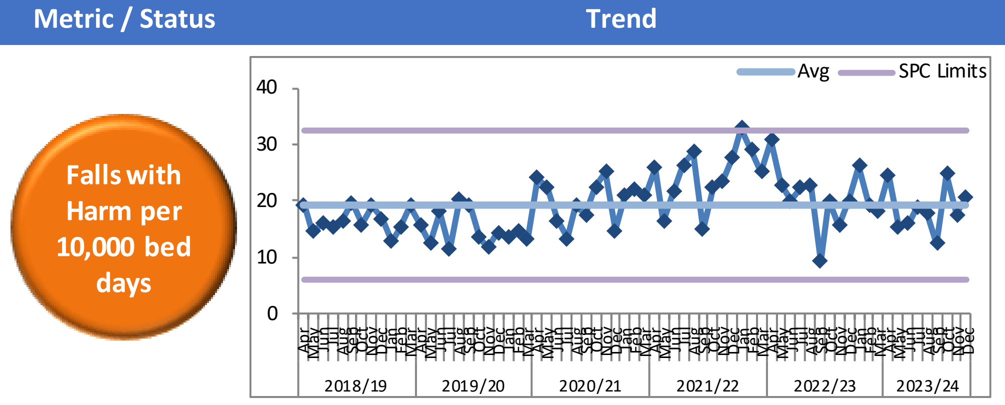


Pressure ulcer incidents increased over the past 2 months. Increased demand, increased patient frailty and deconditioning and staffing pressures may have been contributory factors. A patient safety incident response plan (PSIRP) for pressure ulcers has been developed following the introduction of PSIRF. If a pressure ulcer incident occurs a review of care takes place which should consider what went well, what did not go to plan and what could be done differently. Patients and their families should be involved in the review. CSUs will be invited to attend the pressure ulcer improvement group to discuss their challenges, learning and improvement plans. The pressure ulcer group will monitor trends and themes and support trust-wide learning. 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. The tissue viability team are testing out protected time to undertake practice development and training with ward teams assigned to them. Two tissue viability conferences are planned for 2024 (June & October). The theme for June is patient safety.

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** | **Challenges and Successes** | **Benchmarks**



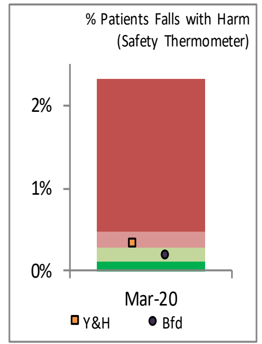
Falls are being reviewed by the Lead for falls Improvement. A new process has started, in line with PSIRF, to meet learning and assurance needs for individuals and the wider organisation. CSU teams will be asked to attend the Falls Improvement group to present all falls and their themes for learning and improvement. They will discuss how they are implementing the actions or QI work they have identified.

The new process involves –

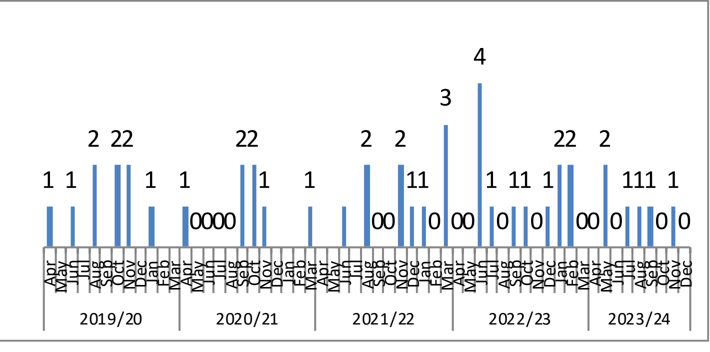
- Medical review (if suspected harm, within 30 minutes of the patient falling)
- Completion of DATIX
- Completion of the hot debrief form by Registered Nurse(on the same shift as the fall happened)
- Fall reviewed by falls lead – this is to give recommendations for the after action review.
- If a fall 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

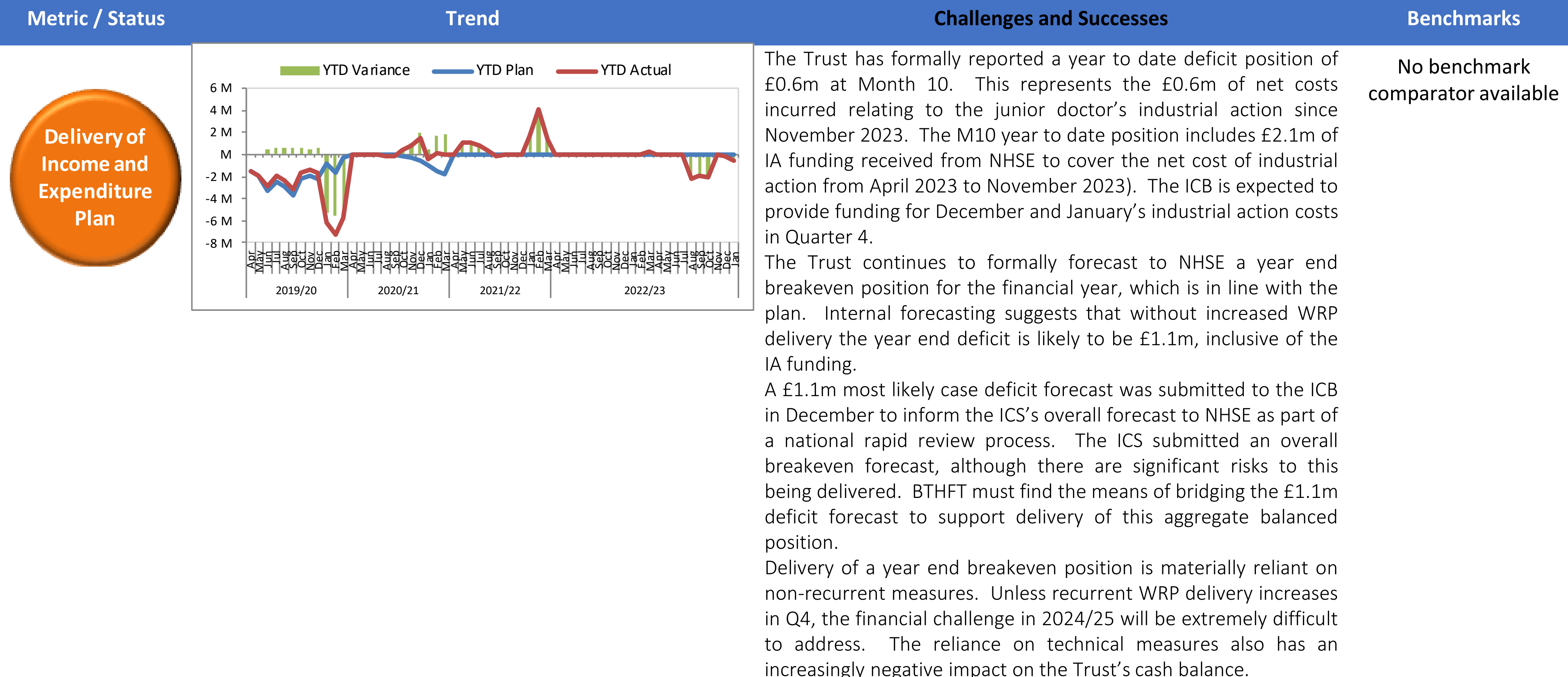
Metric / Status	Trend	Challenges and Successes	Benchmarks

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 January.

HIE cases are monitored, reviewed and referred to MNSI for independent investigation subject to criteria.

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 £0.6m at Month 10. This represents the £0.6m of net costs incurred relating to the junior doctor's industrial action since November 2023. The M10 year to date position includes £2.1m of IA funding received from NHSE to cover the net cost of industrial action from April 2023 to November 2023). The ICB is expected to provide funding for December and January's industrial action costs in Quarter 4.

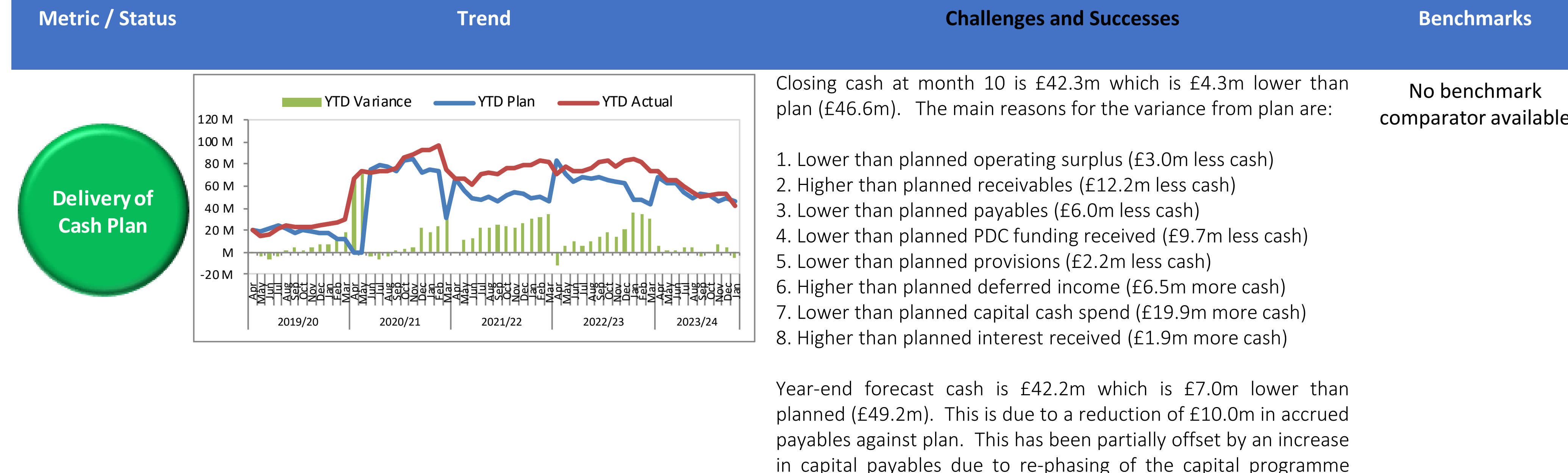
The Trust continues to formally forecast to NHSE a year end breakeven position for the financial year, which is in line with the plan. Internal forecasting suggests that without increased WRP delivery the year end deficit is likely to be £1.1m, inclusive of the IA funding.

A £1.1m most likely case deficit forecast was submitted to the ICB in December 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 a year end breakeven position is materially reliant on non-recurrent measures. Unless recurrent WRP delivery increases in Q4, the financial challenge in 2024/25 will be extremely difficult to address. The reliance on technical measures also has an increasingly negative impact on the Trust's cash balance.

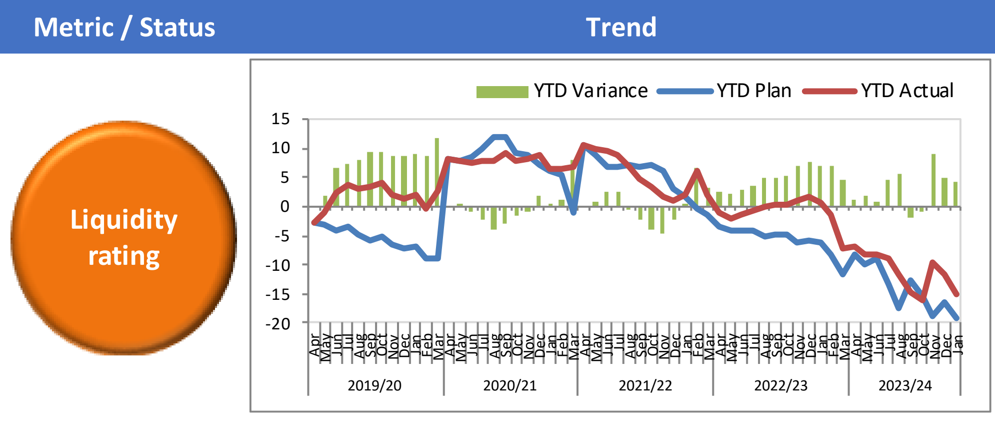
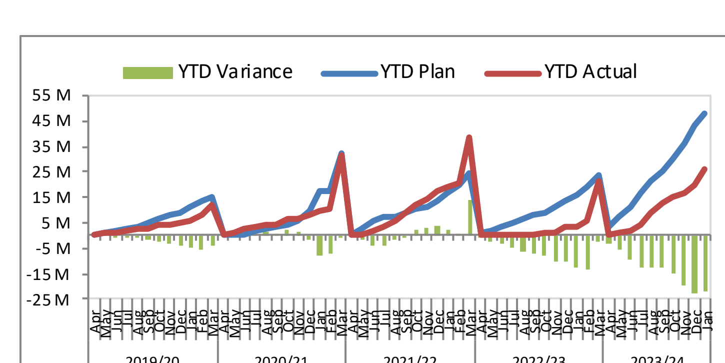
No benchmark comparator available

To deliver our key performance targets and financial plan
Finance



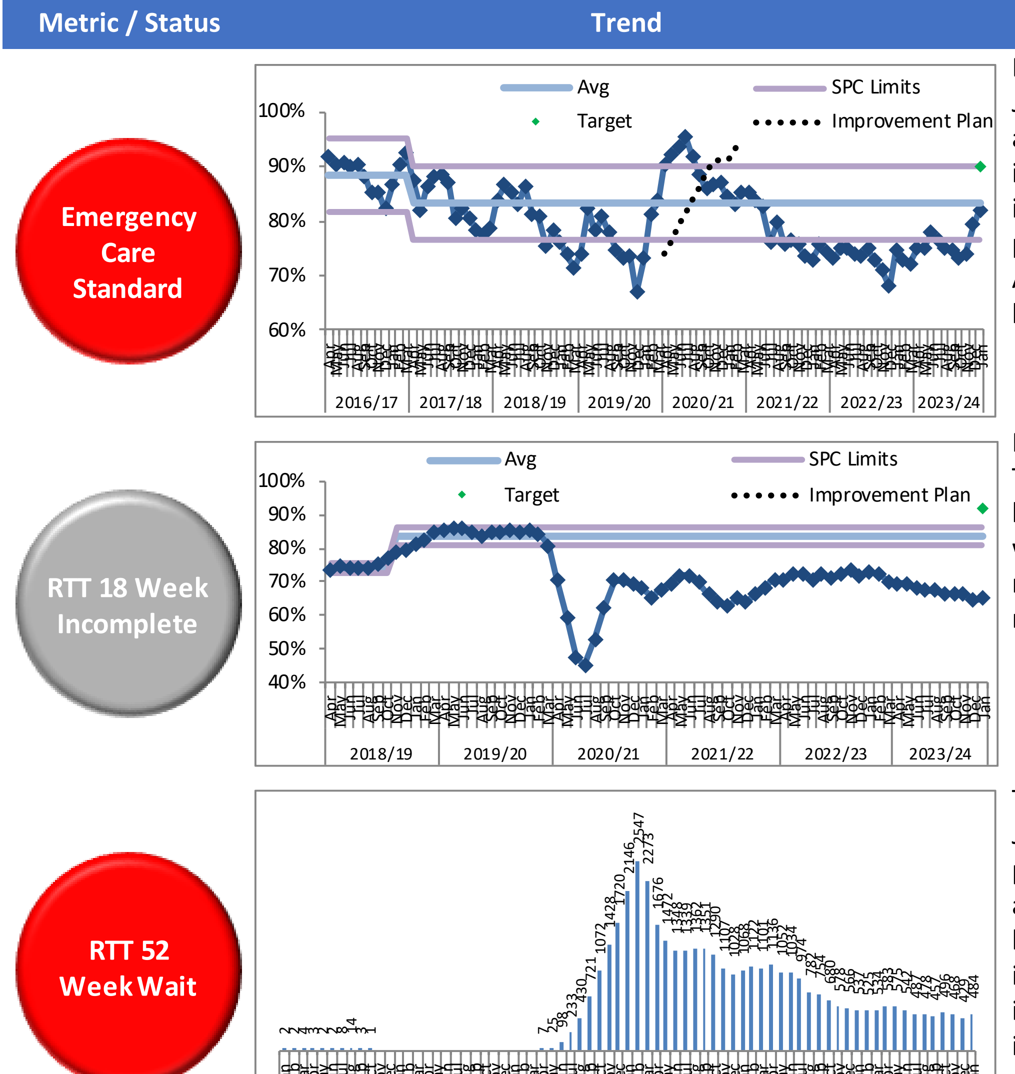
Metric / Status	Trend	Challenges and Successes	Benchmarks
Delivery of Cash Plan		Closing cash at month 10 is £42.3m which is £4.3m lower than plan (£46.6m). The main reasons for the variance from plan are: 1. Lower than planned operating surplus (£3.0m less cash) 2. Higher than planned receivables (£12.2m less cash) 3. Lower than planned payables (£6.0m less cash) 4. Lower than planned PDC funding received (£9.7m less cash) 5. Lower than planned provisions (£2.2m less cash) 6. Higher than planned deferred income (£6.5m more cash) 7. Lower than planned capital cash spend (£19.9m more cash) 8. Higher than planned interest received (£1.9m more cash) Year-end forecast cash is £42.2m which is £7.0m 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

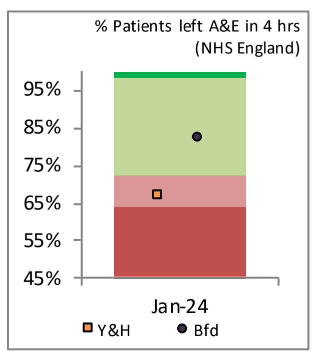
Metric / Status	Trend	Challenges and Successes	Benchmarks
Liquidity rating		Liquidity represents the number of days the Trust could meet its operating costs from its liquid resources (current assets less stocks and current liabilities). Year to date liquidity is negative 14.9 days which is 4.3 days higher than plan (negative 19.2 days). Liquidity is higher than plan due to capital spend being less £23.2m lower than plan and current receivables being higher than plan by £11.9m. Liquidity is rated as red due to the year-end forecast of negative 18.1 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.	No benchmark comparator available
Delivery of Capital Plan		Total capital departmental expenditure limit ("CDEL") for 2023/24 is £57.9m. The Trust is forecasting to spend its full CDEL allocation by 31 March 2024. At month 10 the Trust reported a year-to-date underspend of £20.3m. This is due to delays in the delivery of internally funded Estates (£3.5m), equipment (£2.0m) and strategy (£5.3m) schemes. PDC funded schemes are behind plan by £10.9m due to delays to the Eccleshill Community Diagnostic Centre and St Lukes Day Case Unit. The slippage reported on the schemes identified will be recovered by the end of the year. Capital expenditure is amber rated as 55% of the programme needs to be delivered in the remaining 2 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

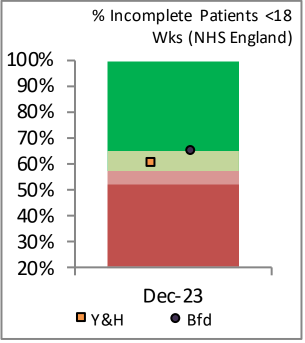
Metric / Status	Trend	Challenges and Successes	Benchmarks



Emergency Care Standard (ECS) performance was at 81.98% for January 2024, which remains above peer and national average and into the top decile of all Acute Trusts. 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. The new Ambulatory Emergency Care Unit (AECU) has helped reduce breaches, avoid admissions and reduce time spent in ED.



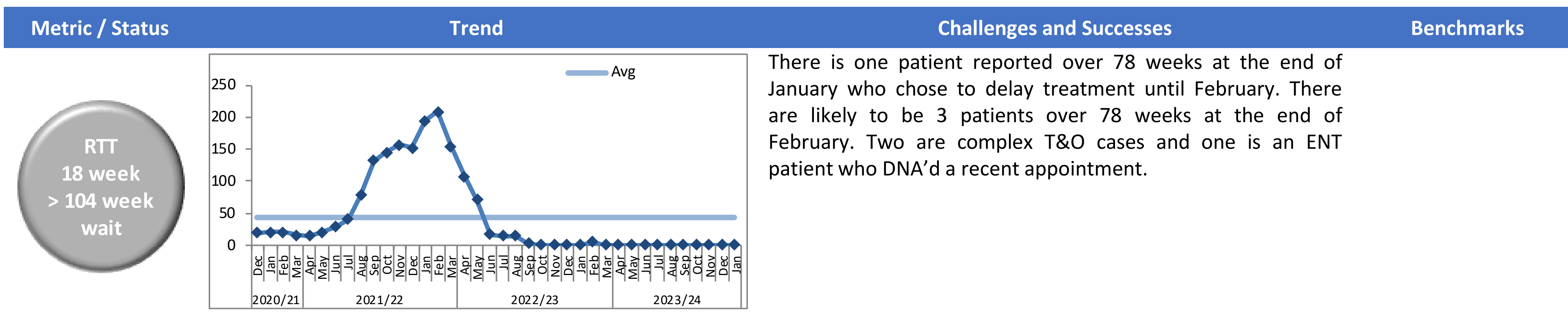
RTT performance continues above peer and national average. Theatre activity is higher than during the pandemic but slightly below 2019-20 baselines. Theatre productivity is reviewed weekly and improvement actions are being progressed to reduce delays and increase throughput. A theatre recovery meeting with Executive oversight is in place to support this.



The Trust had 484 incomplete 52 week waits at the end of January 2024. 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 less than 500 which would be well inside the IA adjusted ERF target.

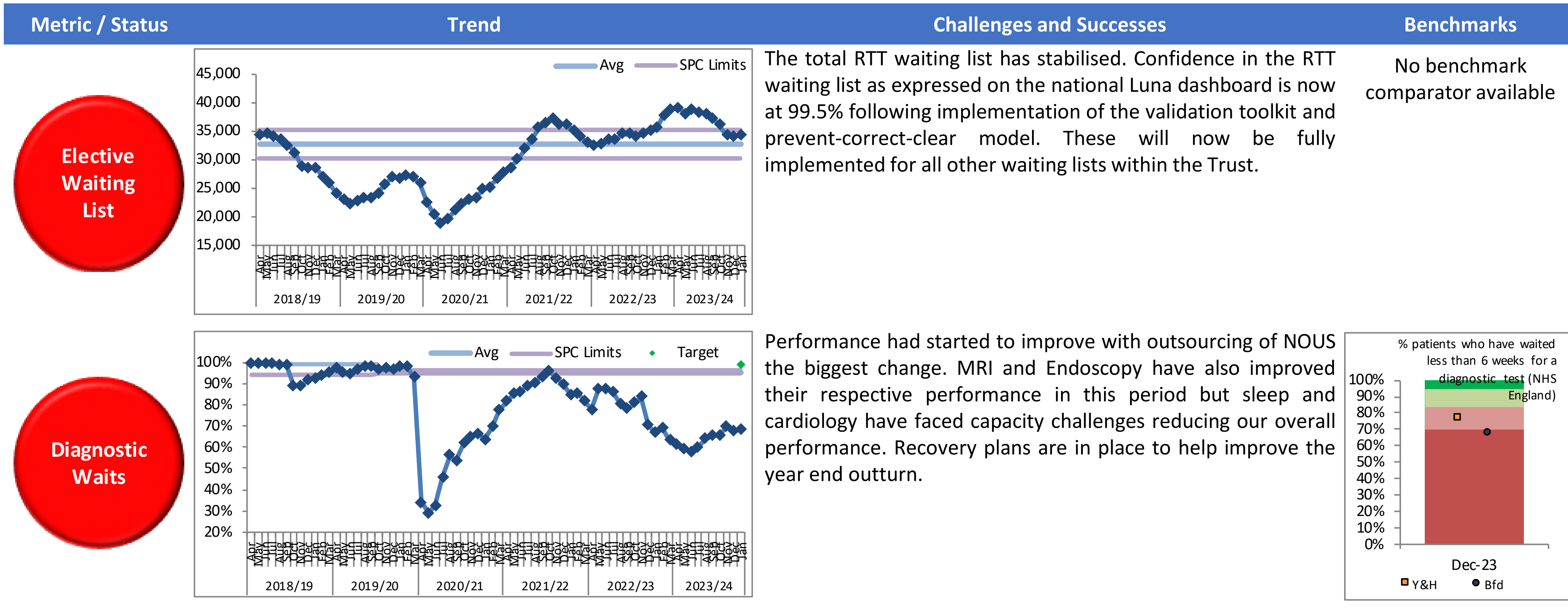
No benchmark comparator available

To deliver our key performance targets and financial plan
Performance



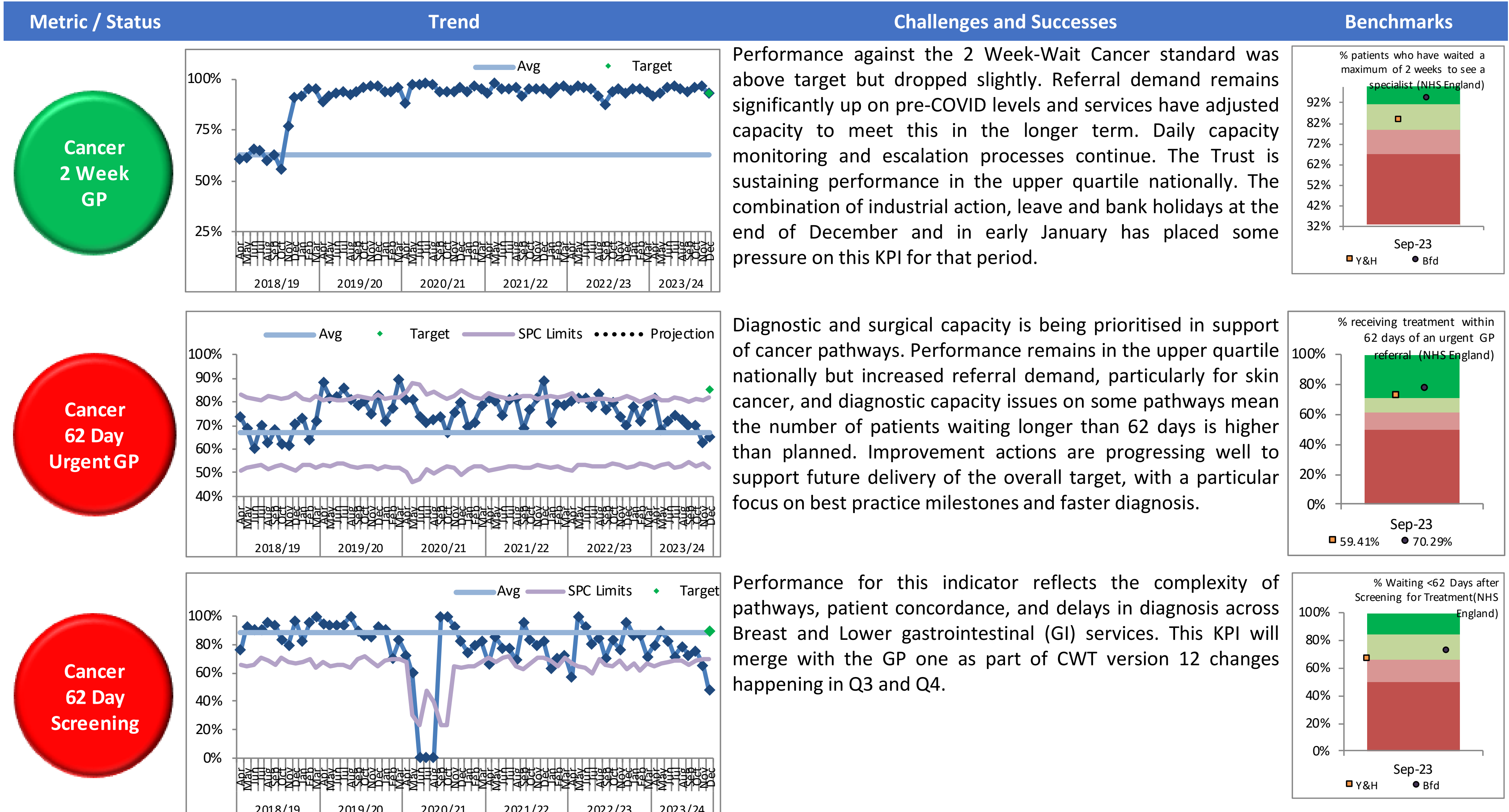
There is one patient reported over 78 weeks at the end of January who chose to delay treatment until February. There are likely to be 3 patients over 78 weeks at the end of February. Two are complex T&O cases and one is an ENT patient who DNA'd a recent appointment.

To deliver our key performance targets and financial plan
Performance

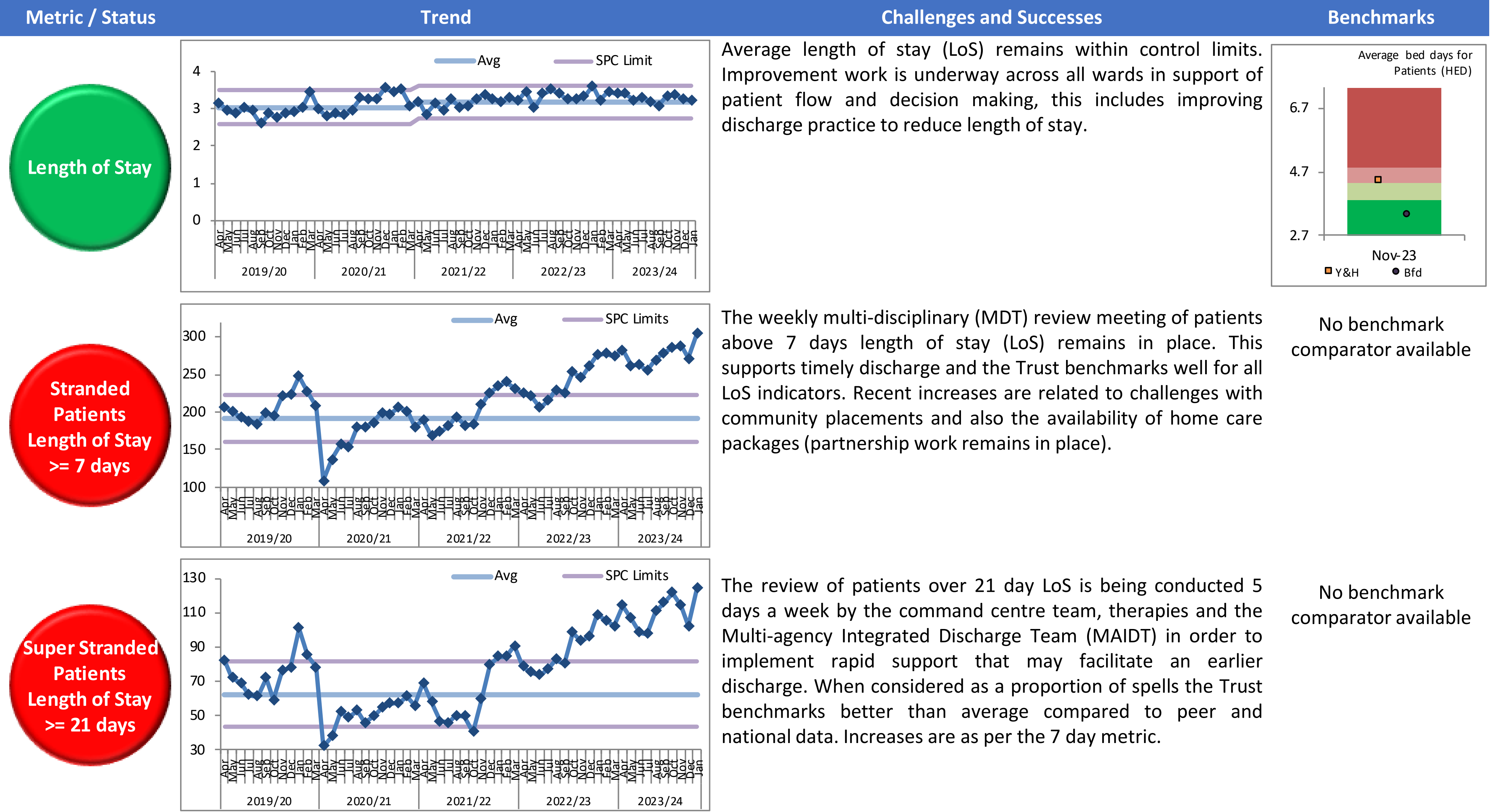


Metric / Status	Trend	Challenges and Successes	Benchmarks
Elective Waiting List		The total RTT waiting list has stabilised. Confidence in the RTT waiting list as expressed on the national Luna dashboard is now at 99.5% following implementation of the validation toolkit and prevent-correct-clear model. These will now be fully implemented for all other waiting lists within the Trust.	No benchmark comparator available
Diagnostic Waits		Performance had started to improve with outsourcing of NOUS the biggest change. MRI and Endoscopy have also improved their respective performance in this period but sleep and cardiology have faced capacity challenges reducing our overall performance. Recovery plans are in place to help improve the year end outturn.	

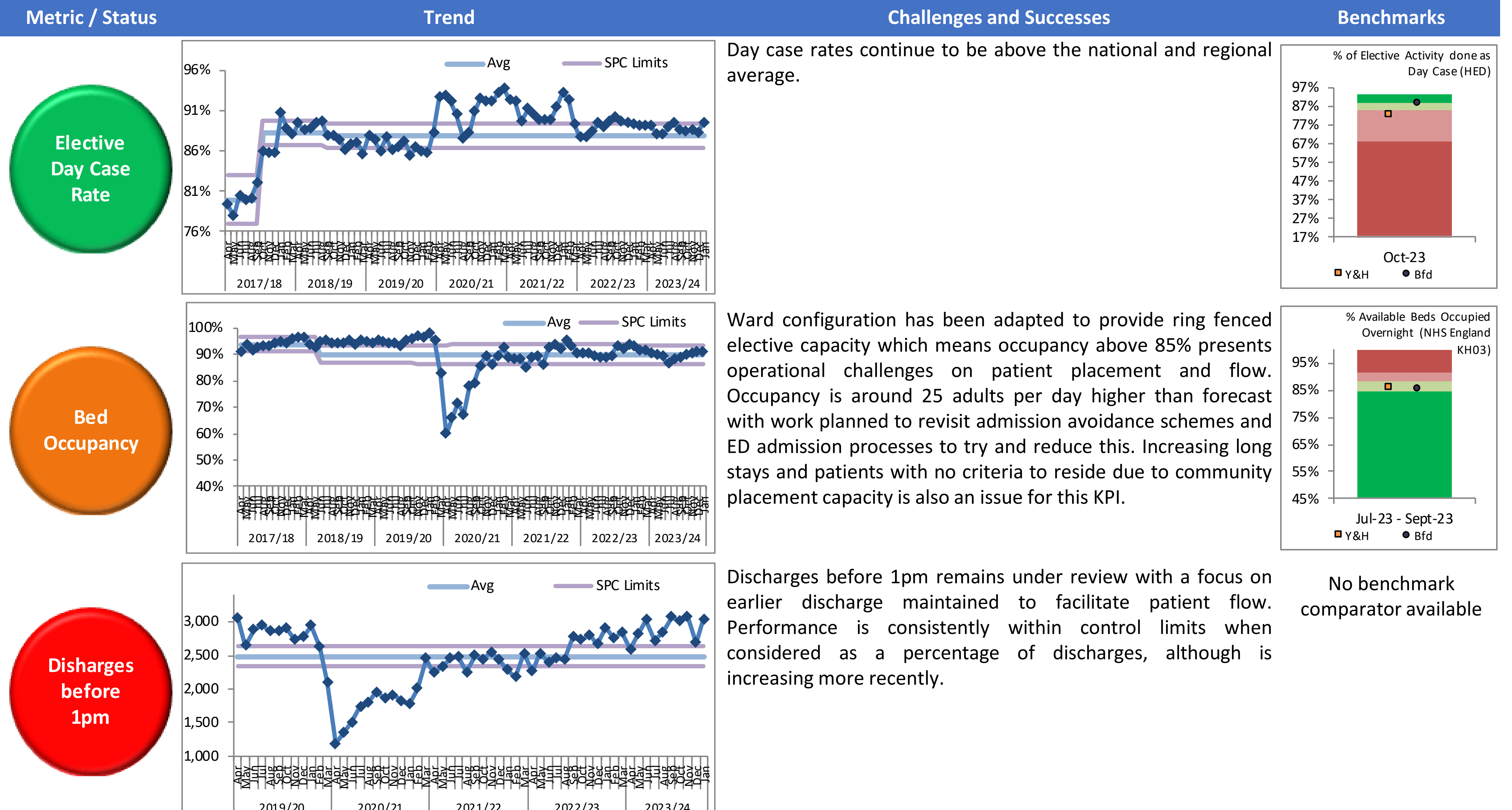
To deliver our key performance targets and financial plan
Performance



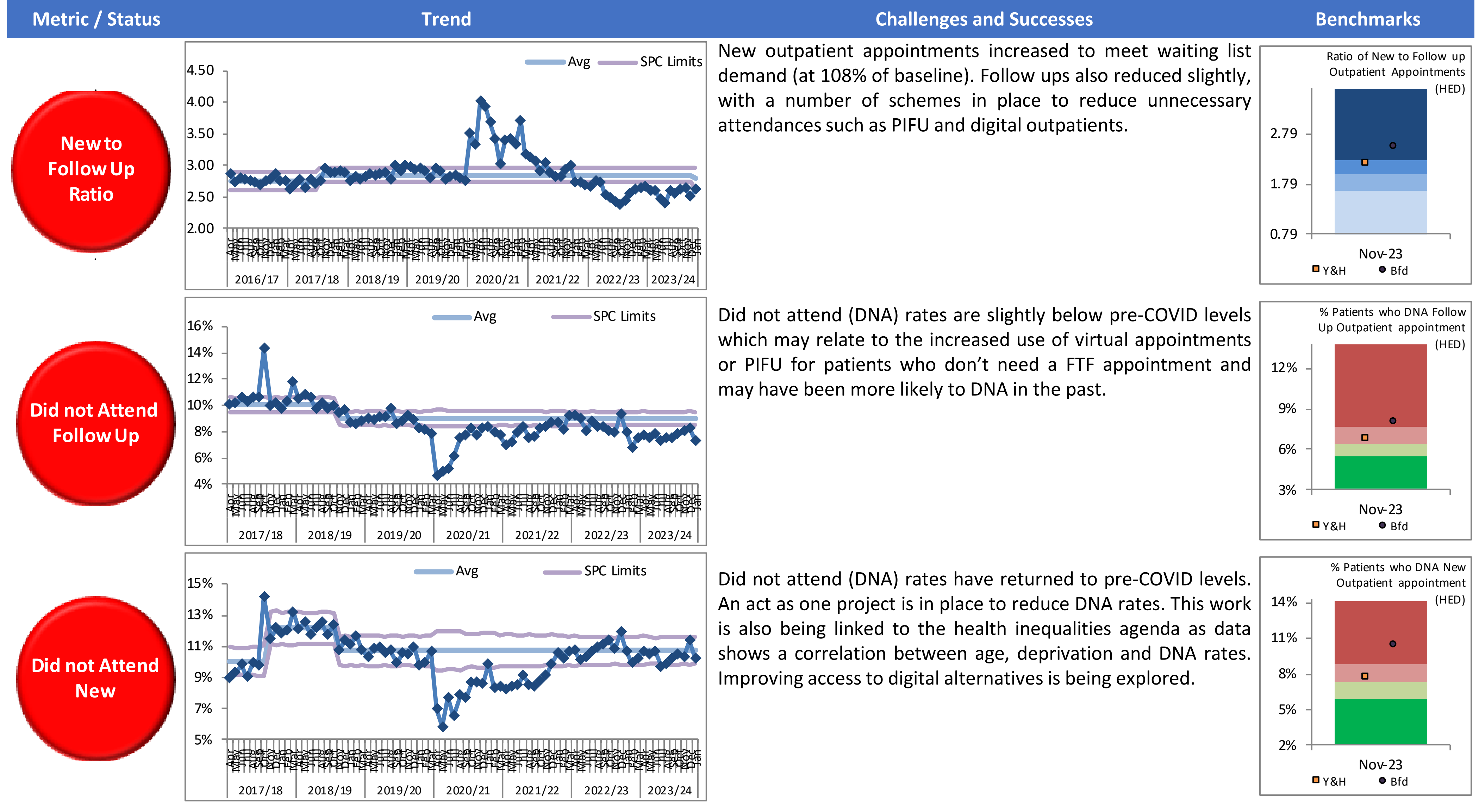
To deliver our key performance targets and financial plan
Productivity



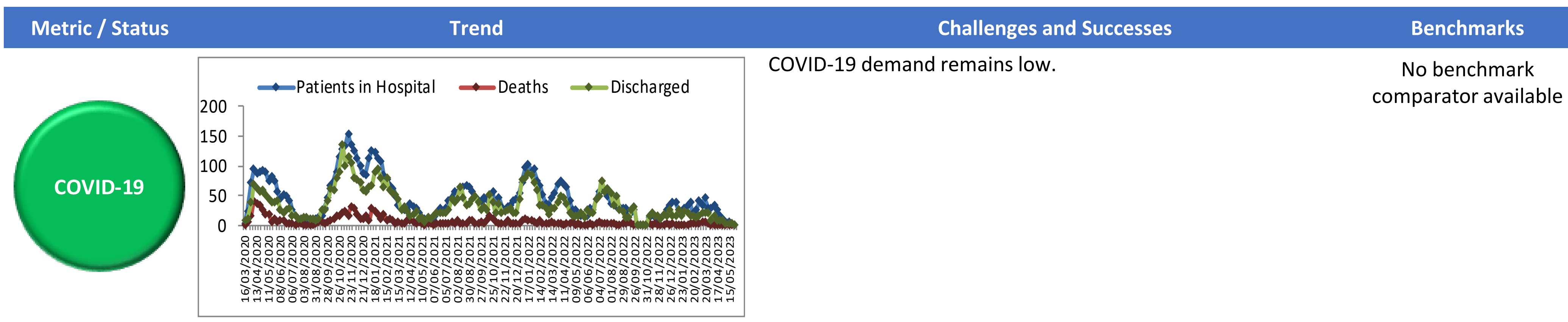
To deliver our key performance targets and financial plan
Productivity



To deliver our key performance targets and financial plan
Productivity



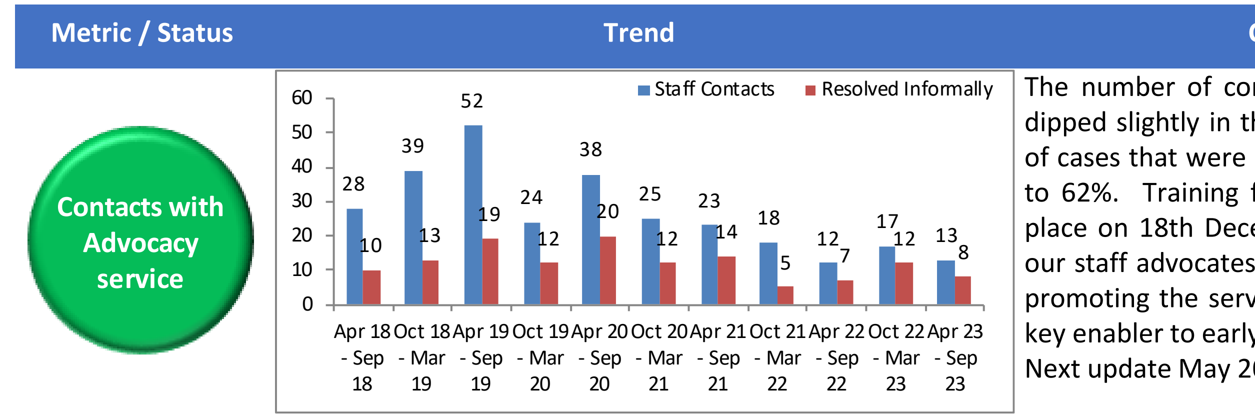
Covid-19



Metric / Status	Trend	Challenges and Successes	Benchmarks
COVID-19		COVID-19 demand remains low.	No benchmark comparator available

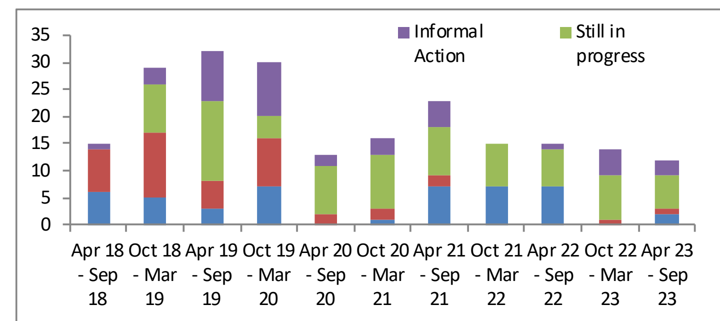
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks



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

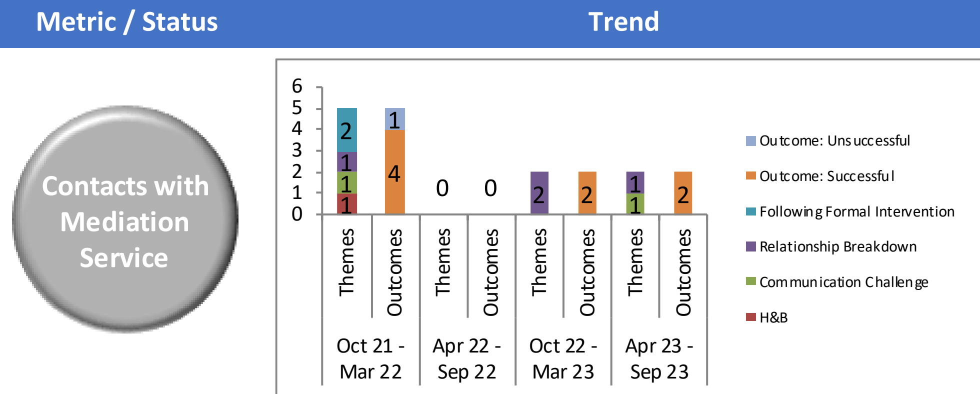
No benchmark comparator available



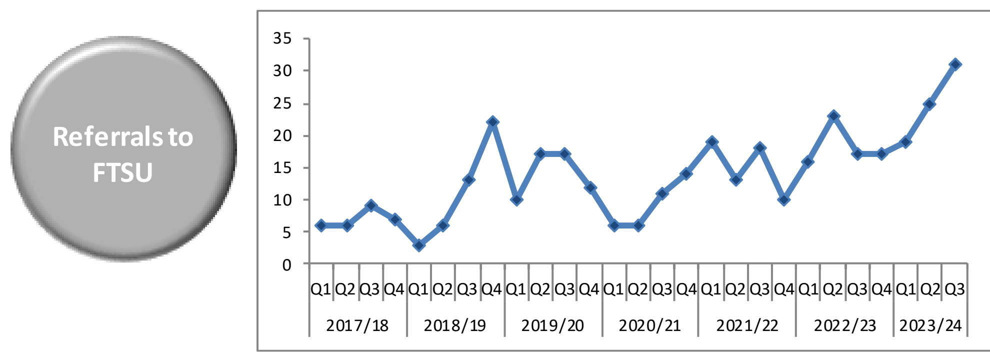
The number of formal cases has stayed fairly static since the last 6 month update. Of the 6 cases that were completed during the period 50% resulted in some form of “informal action” (e.g. recommendation for mediation). 17% (just 1 case) resulted in disciplinary action and 33% (2 cases) resulted in no 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

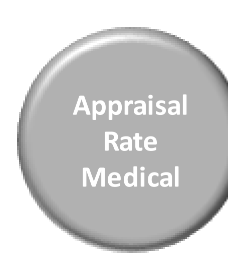
Metric / Status	Trend	Challenges and Successes	Benchmarks
Contacts with Mediation Service	 * (please see narrative)	2 referrals have resulted in mediation taking place over the last 6 months. Both cases resulted in some level of success, which is positive. 1 further case being pursued resulted in both 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	

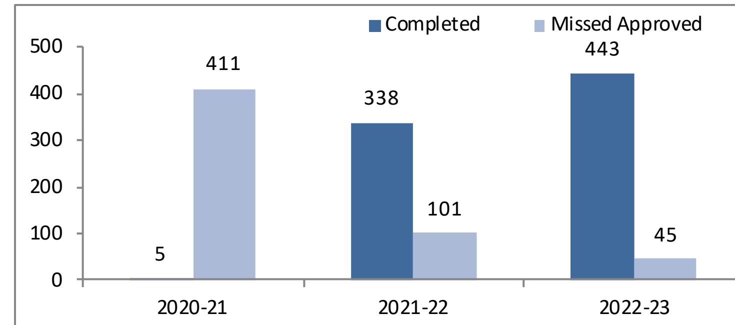
To be in the top 20% of employers
Engagement



In Q3 there were 31 concerns raised to the Freedom to Speak Up team. 12 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 31 concerns* raised, 5 concerns were raised due to patient safety, 14 concerns were raised due to inappropriate attitudes and behaviours, 5 for bullying and harassment and 9 for worker safety or wellbeing. (*- some concerns have more than one category). This quarter has seen the highest number of FTSU concerns raised to the FTSU team. There has been two HR investigations on the back of FTSU concerns being raised which have concluded this quarter.





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.

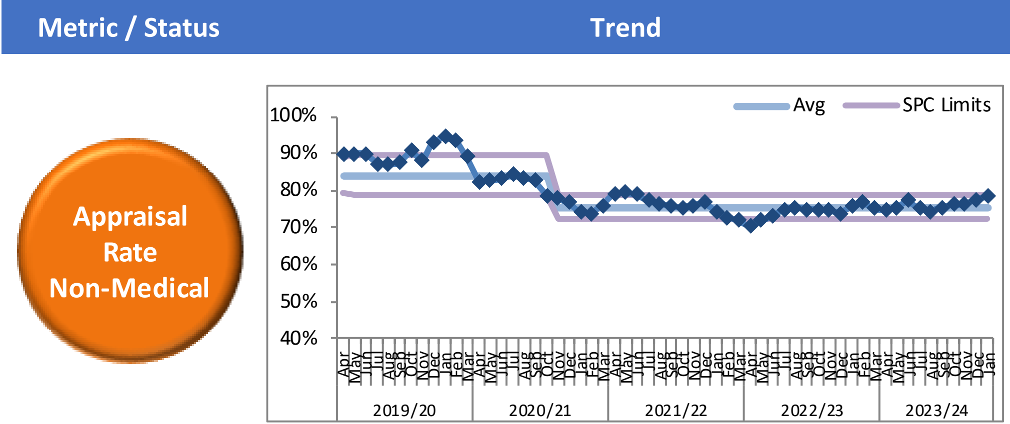
There were 2 Outcome Measure 3 appraisals (0.41%) (Unapproved Missed) for this period.

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.

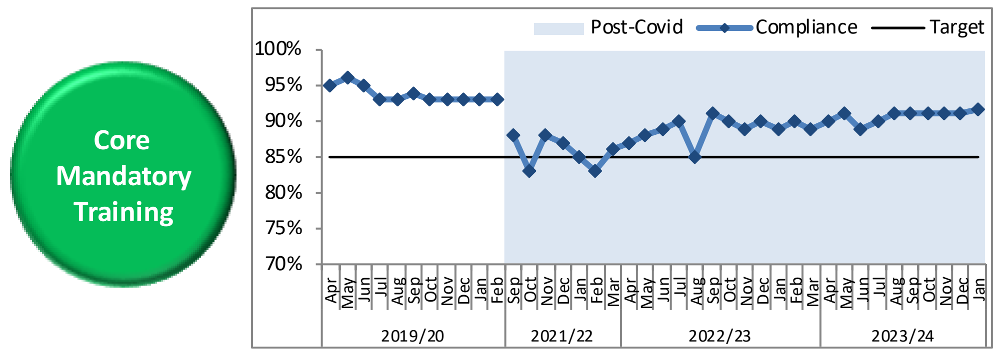
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks



The non-Medical appraisal rate for January 2024 has decreased from 79.07% in December to 78.25%. Increases were seen in Planned Services and Corporate Services with the largest increase in Corporate Services of 0.91%. Decreases were seen in all other areas.

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 subjects is 92%, an increase of 1% from last month.

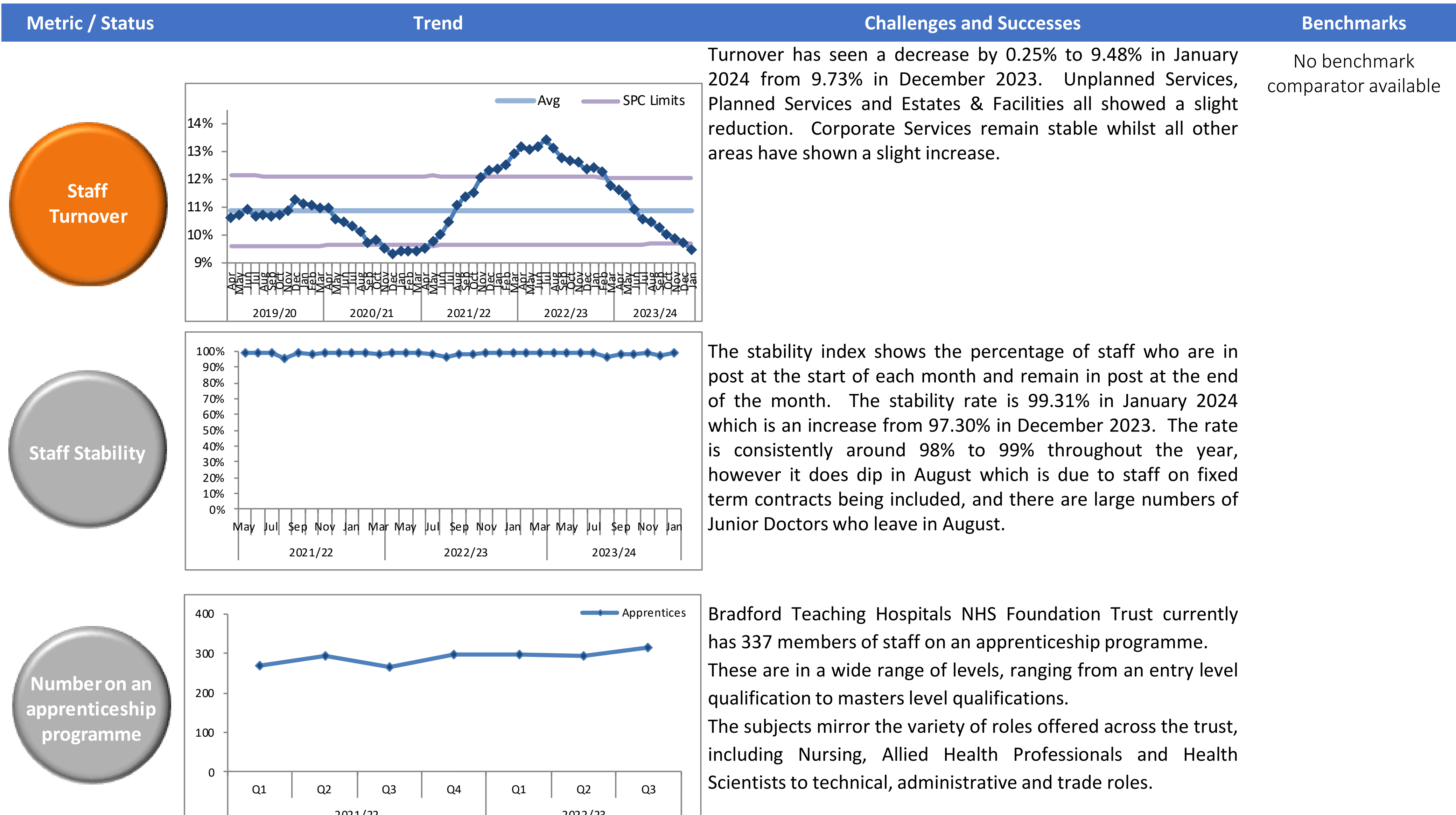
Preventing Radicalisation (Basic) compliance is 93%, an increase of 7% from last month. Safeguarding Adults Level 1 & 2 and Basic Prevent Awareness compliance have seen a 1% increase from last month.

Several subjects have maintained compliance from last month.

All of the broad service areas are achieving >85% compliance.

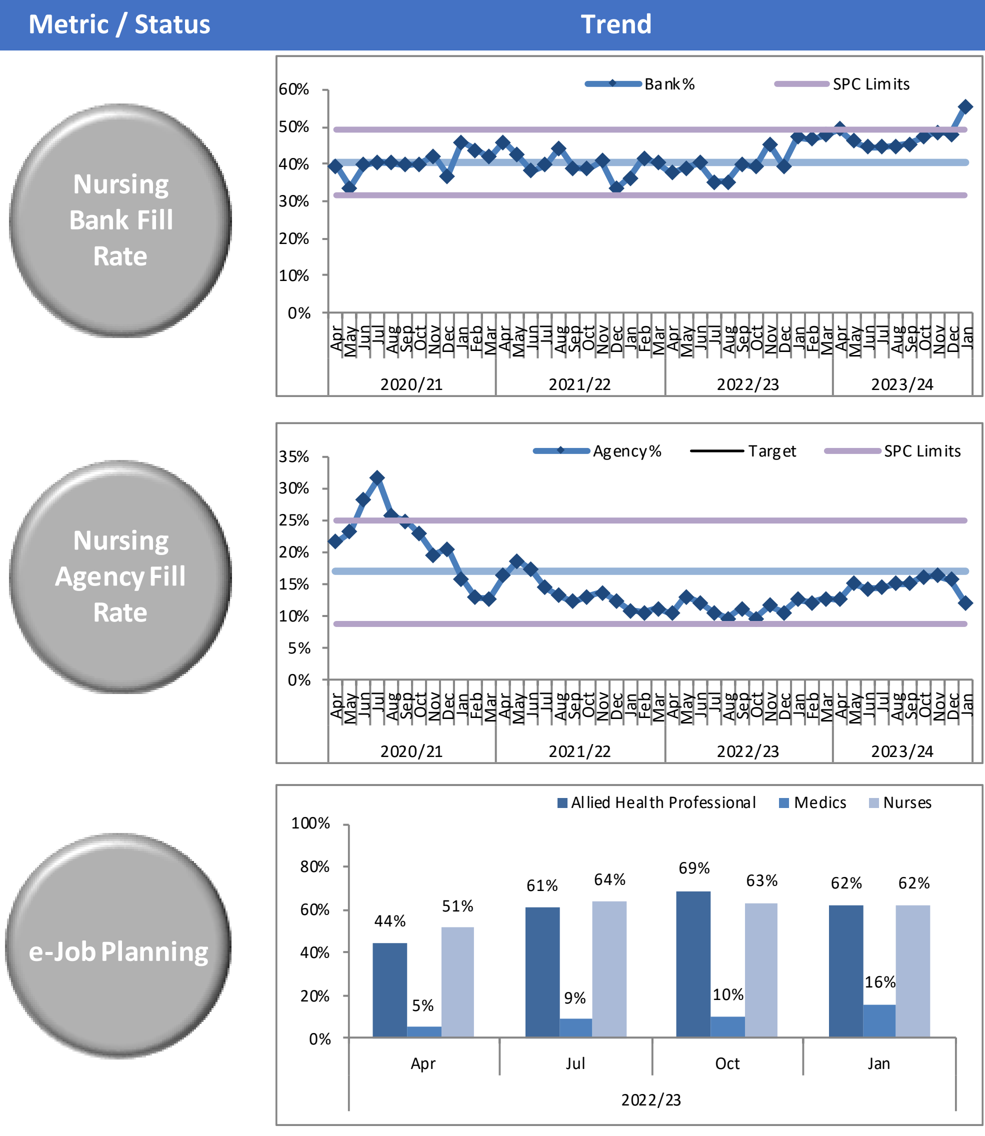
Targeted actions continue to promote overall compliance for all subjects, across all service areas.

To be in the top 20% of employers
Staffing



To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks

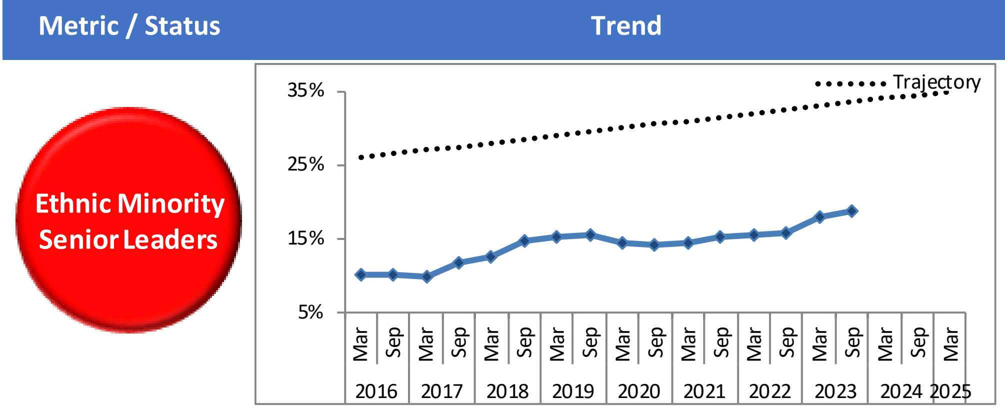
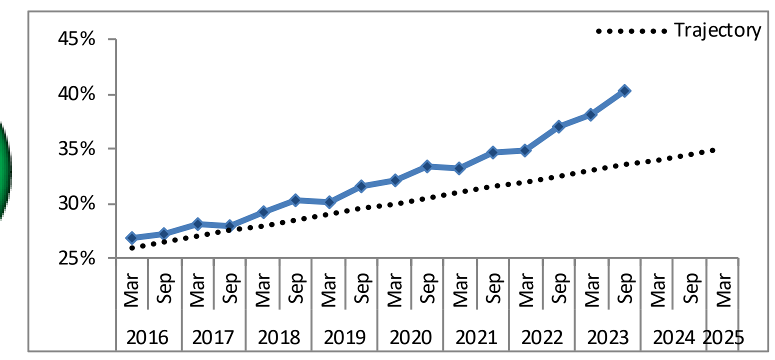


In January the total number of requests sent to bank was 12222 compared with Decembers requests of 11157 an increase of 1065 requests. This is split as 5221 requests for registered staff and 7001 requests for unregistered staff. Of those 12222 requests a total of 8198 were filled by bank staff which is 67.1% compared with 64.5% in December – a increase of 2.6%. 2890 are filled by registered and 5308 filled by unregistered staff. Out of the 5221 requests for registered staff, the filled shifts were 2890 (55.4%) and for the 7001 requests for unregistered staff the filled shifts were 5308 (75.8%). Compared with December, fill rates increased by 7.8% for registered and decreased by -.9% for unregistered. Out of the 2890 filled registered shifts, 487 were filled by registered Theatre staff.

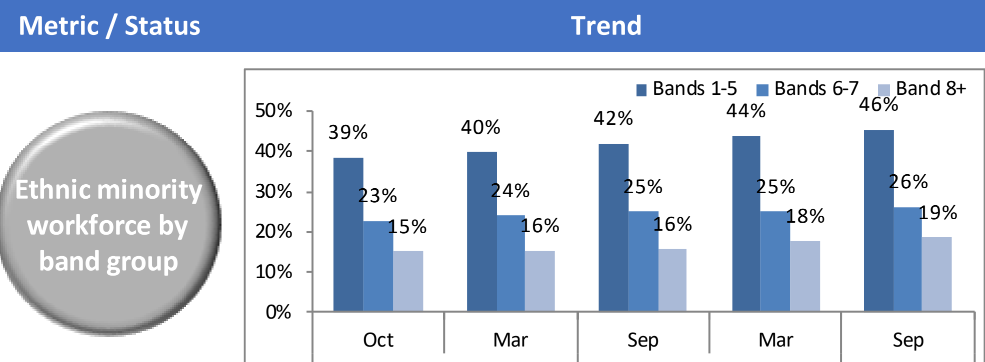
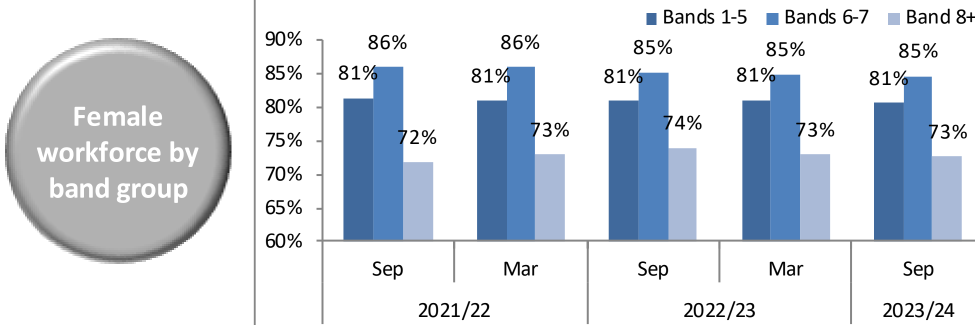
Agency staff filled 630 shifts in the month of January. This is split 630 registered and 0 unregistered staff. Out of the 630 filled registered shifts, 251 were filled with registered theatre staff. In January Agency fill rates decreased by -3.5% for registered staff. Agency rates for HCA's are 0 as these have not been in use since September

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 880 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 350 Medics, 350 AHPs and 180 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. Currently there are 97 Job plans signed off for Medics with 10 awaiting 1st Sign off, 40 awaiting the 2nd sign off and 180 in review. Despite the drop in job plans required (due to SAS Dr's being removed – please see below) 1st and 2nd Sign off job plans have increased.

To be in the top 20% of employers
Equality & Diversity

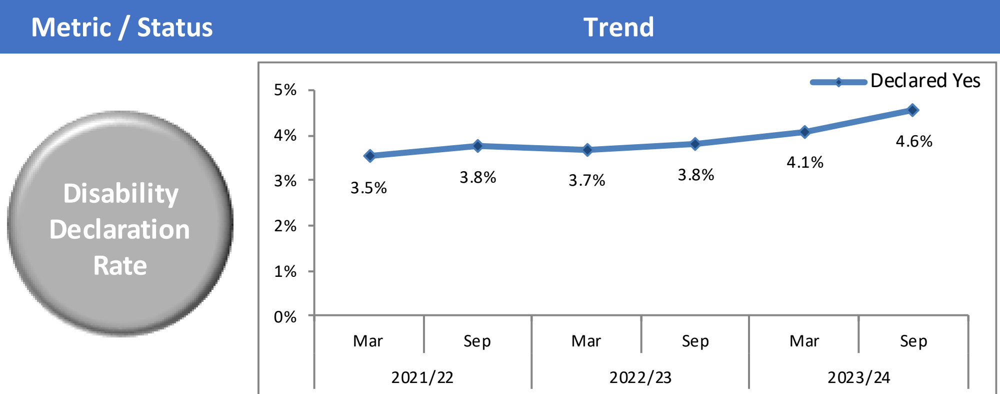
Metric / Status	Trend		Benchmarks
		A further slight increase in our Ethnic Minority representation at Senior Management levels over the last 6 months which has risen from 17.84% to 18.67%. At our current rate of trajectory, achieving our ambition to have a senior workforce reflective of the local population (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
		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
Ethnic minority workforce by band group		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	
Female workforce by band group		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

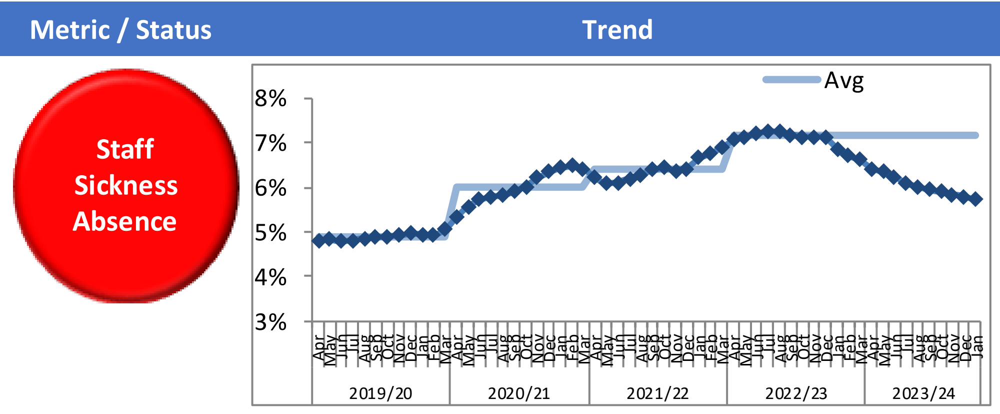
Metric / Status	Trend	Challenges and Successes	Benchmarks



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
Staff Sickness Absence		The rolling 12-month sickness absence rate at the end of January 2024 was 5.77% compared to 5.78% in December. Decreases were seen in Unplanned Services and Diagnostic & Corporate Services, Research remained stable and all other areas have seen a slight increase. The largest decrease seen in Unplanned Services. Monthly absence in January decreased to 6.20% from 6.46% in December. 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

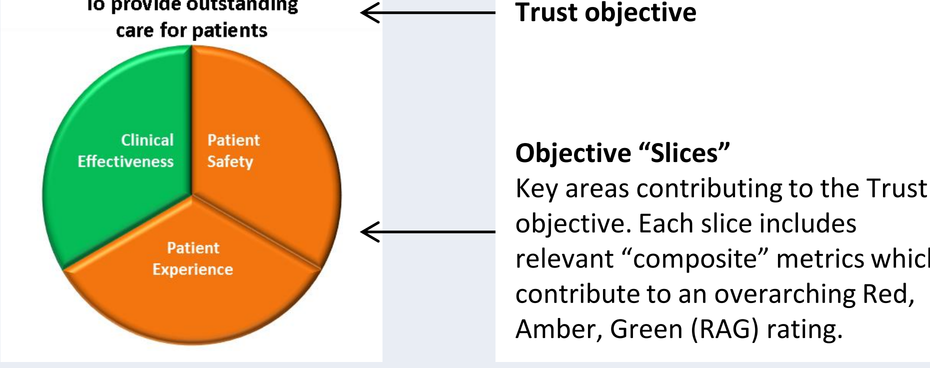
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals				
Partnership				
Reducing Inequalities	Working with partners to contribute to the overall reduction of health inequalities 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



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.3.24.13 - FINANCE REPORT

REFERENCES

Only PDFs are attached

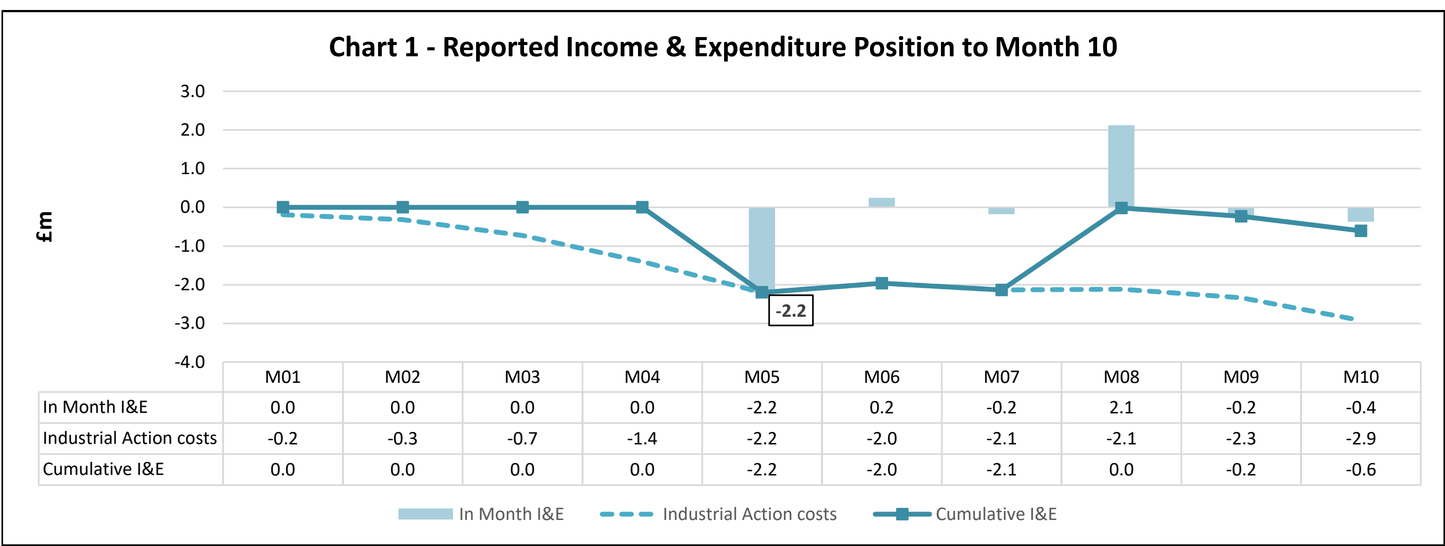
Bo.3.24.13 - Finance Report Month 10.pdf

FINANCIAL PERFORMANCE REPORT	MONTH 10

Meeting:	**Board of Directors**
Meeting Date:	**14 March 2024**
Agenda Item:	**Bo.3.24.13**

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	47.1	49.9	2.9	466.8	478.9	12.1	560.4	577.6	17.2
Pay	(30.4)	(29.8)	0.6	(300.1)	(298.6)	1.6	(361.1)	(362.9)	(1.8)
Non-Pay	(17.2)	(20.6)	(3.3)	(178.6)	(181.0)	(2.4)	(212.3)	(214.7)	(2.4)
WRP outstanding	0.5	(0.0)	(0.5)	11.9	0.1	(11.8)	13.0	(0.0)	(13.0)
Grand Total	**(0.0)**	**(0.4)**	**(0.4)**	**(0.0)**	**(0.6)**	**(0.6)**	**0.0**	**0.0**	**0.0**



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10
In Month I&E	0.0	0.0	0.0	0.0	-2.2	0.2	-0.2	2.1	-0.2	-0.4
Industrial Action costs	-0.2	-0.3	-0.7	-1.4	-2.2	-2.0	-2.1	-2.1	-2.3	-2.9
Cumulative I&E	0.0	0.0	0.0	0.0	-2.2	-2.0	-2.1	0.0	-0.2	-0.6

Commentary - Reported I&E Position

The Trust has formally reported a year to date deficit of £0.6m at Month 10. This marginal deficit reflects the costs of the December and January 2023 Industrial Action. NHSE is expected to provide funding in Quarter 4 via the ICB for the December and January industrial action costs.

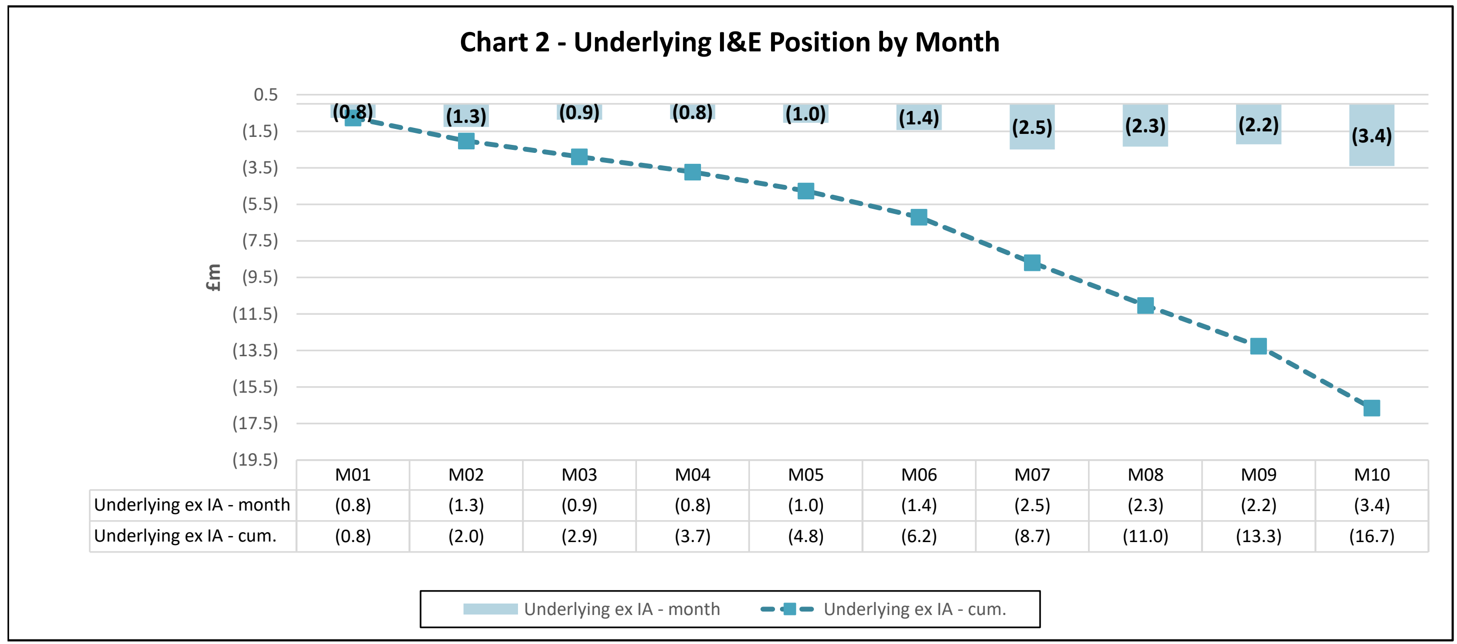
The Trust continues to formally forecast a year end breakeven position for the financial year to NHSE, which is in line with the plan.

The most likely forecast reported to the ICS remained a deficit of £1.1m. However, subsequent to external reporting for Month 10, additional non-recurrent income has been identified which suggests BTHFT may be able to achieve a breakeven position at year end.

This improvement in the internal forecast at Month 10 is not confirmed and there remain risks to achieving a breakeven position. The key risks to this forecast include the recovery of £1m of ICS funding for the Community Diagnostic Centre (CDC), recovery of full funding for IA costs incurred in Month 9 - 12 and the avoidance of any material deviations from the established underlying I&E run rate in Months 11 & 12.

These risks notwithstanding, breakeven is now considered to be the most likely outturn scenario, with the potential worst case scenario a deficit of £1.1m.

2. Underlying Income & Expenditure Position



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10
Underlying ex IA - month	(0.8)	(1.3)	(0.9)	(0.8)	(1.0)	(1.4)	(2.5)	(2.3)	(2.2)	(3.4)
Underlying ex IA - cum.	(0.8)	(2.0)	(2.9)	(3.7)	(4.8)	(6.2)	(8.7)	(11.0)	(13.3)	(16.7)

Commentary - Underlying I&E Position

Visibility of the underlying income and expenditure position, which excludes any non-recurrent income, 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 January in-month underlying position was a deficit of £3.4m, which is consistent with the deficit previously forecast for Month 10. The cumulative underlying deficit at Month 10 is £16.7m.

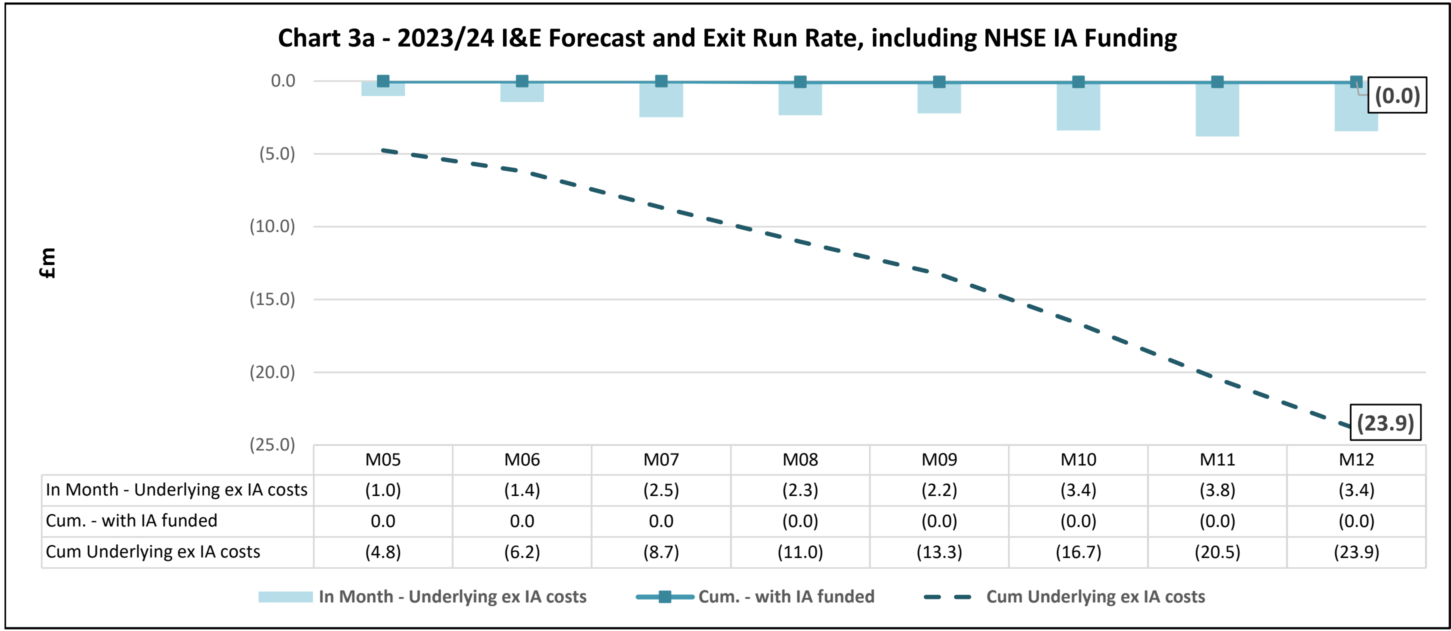
The reported YTD breakeven position could only be achieved by deploying £16.7m of non-recurrent income and non-recurrent flexibilities. The true average underlying run rate in the last 3 months (Months 8 - 10) is a monthly deficit of £2.6m per month - this is the difference between what the Trust is actually spending each month on a recurrent basis and the external funding it is receiving.

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 cost pressures have resulted in an underlying position which is £8.9m worse than planned at Month 10. The prospects for material recurrent improvements to the exit run rate in Quarter 4 are currently limited, with a resultant adverse impact on the outlook for 2024/25.

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)	(2.2)	(3.4)	(3.8)	(3.4)
Cum. - with IA funded	0.0	0.0	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Cum Underlying ex IA costs	(4.8)	(6.2)	(8.7)	(11.0)	(13.3)	(16.7)	(20.5)	(23.9)

Commentary - I&E Forecast

The current most likely scenario forecast is a year end breakeven position.

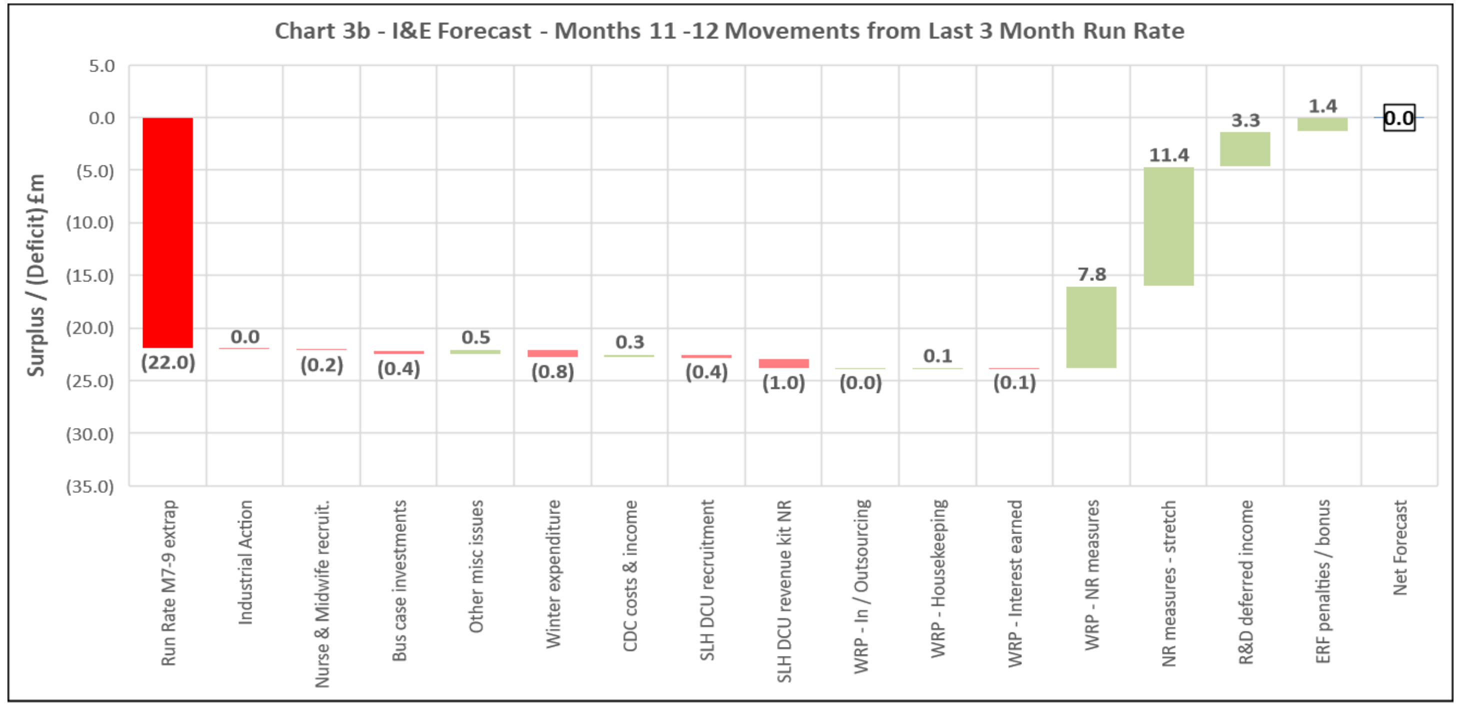
The underlying monthly run rate deficit, excluding IA costs, is forecast to deteriorate materially in the final months of the financial year to be in excess of £3m per month. This is a consequence of planned recruitment into vacancies, notably on internationally recruited nurses, approved investments coming on line, inflationary pressures and the increased costs which are always incurred in the winter months.

The forecast in month deficit in Months 11 & 12 is £3.4m - £3.8m, 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 11 & 12 include £0.5m per month of non-recurrent revenue expenditure for equipping the new SLH Daycase unit.

The total forecast underlying deficit for 2023/24 is projected to be £23.9m. A further £14.7m of non-recurrent income and flexibilities have been identified to supplement the £7.8m identified in the original financial plan (increase of £1.5m vs Month 9 forecast), providing a total of £23.9m of non-recurrent support to the I&E position in 2023/24, inclusive of £1.4m of additional ERF income notified in November.

It is projected that, without improved WRP delivery, the recurrent exit run rate heading into 2024/25 will be at least £2.2m per month. This equates to a £26m 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 £55m - this would potentially represent an unachievable financial challenge for the Trust to recover in a single year.**

3b. Forecast Income & Expenditure Position 2023/24 - Details



Commentary - I&E Forecast Details

Chart 3b explains how the current year end forecast breakeven position is derived, starting with the underlying YTD position at Month 10 and an extrapolation of the underlying Month 8 - 10 run rate into Months 11 - 12. This gives a base case forecast year end deficit of £22m.

Actual and forecast Industrial Action costs are netted off against an equal funding stream, meaning the IA now has zero impact on the forecast.

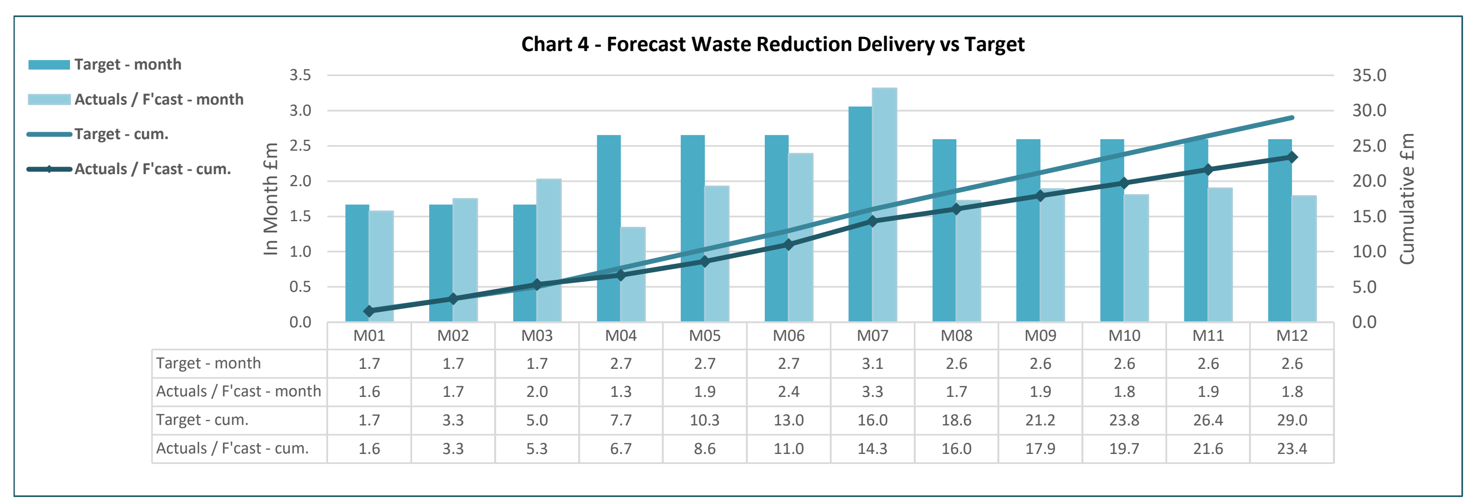
The chart then plots projected adverse deviations from this base case forecast in Months 11 - 12 resulting from planned investments, recruitment, winter pressures and other issues including estimates of inflationary pressures, together with projected run rate improvements resulting from WRP forecasts to generate a forecast deficit prior to mitigations of approximately £24m.

The Trust has been notified it can expect to receive £1.4m of non-recurrent ERF funding as a consequence of the national relaxation of targets to provide partial mitigation for Industrial Action restrictions on elective work.

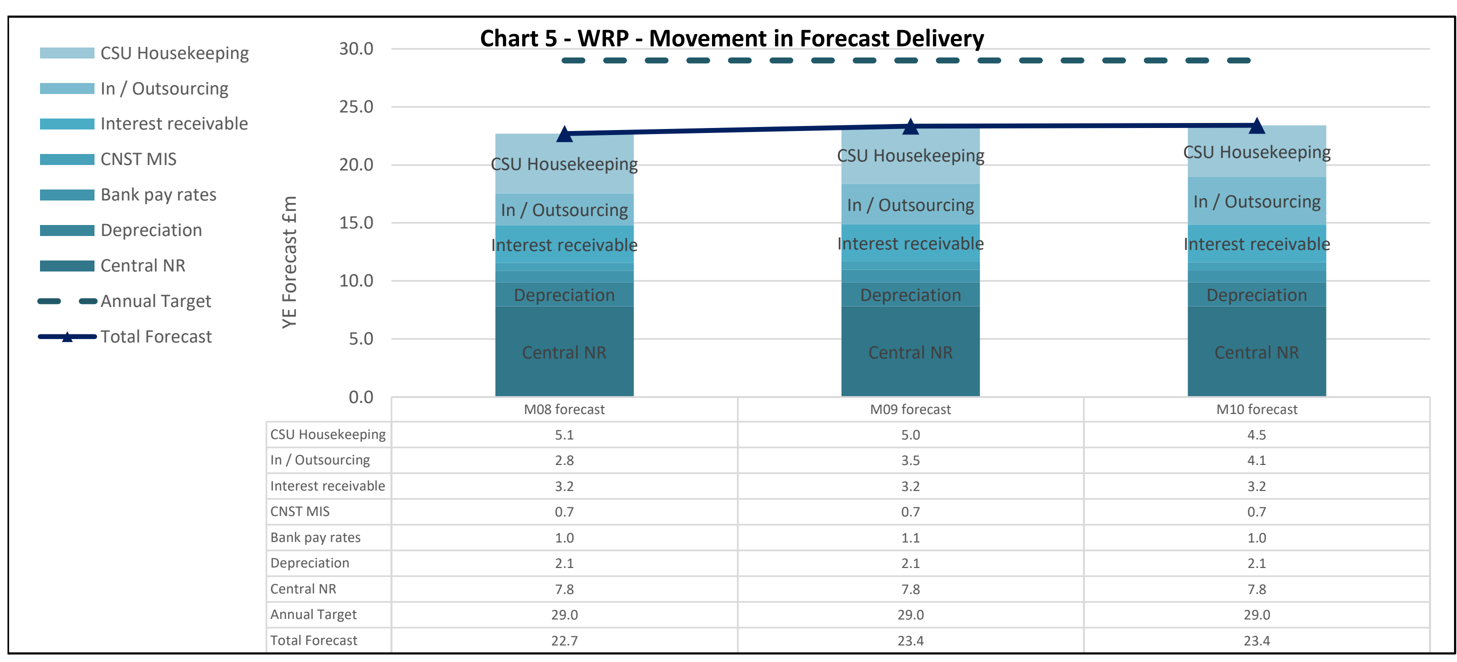
£22.5m of non-recurrent income and other measures are then factored in to arrive at the projected position after all currently identified mitigations, which is breakeven.

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	93	(32)	1,250	829	(421)	1,500	1,015	(485)
Centrally managed NR			0	7,824	7,824	0	7,824	7,824	0
CNST MIS	59	59	0	587	587	0	704	704	0
CSU Housekeeping	987	534	(454)	6,912	3,247	(3,665)	8,886	4,458	(4,428)
Depreciation	173	173	0	1,728	1,728	0	2,074	2,074	0
In / Outsourcing	1,169	680	(489)	4,674	2,730	(1,945)	7,012	4,089	(2,923)
Interest receivable	83	267	183	833	2,782	1,948	1,000	3,249	2,249
Total plans in Trackers	**2,596**	**1,804**	**(792)**	**23,808**	**19,726**	**(4,082)**	**29,000**	**23,412**	**(5,588)**



	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	1.9	2.4	3.3	1.7	1.9	1.8	1.9	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	8.6	11.0	14.3	16.0	17.9	19.7	21.6	23.4



	M08 forecast	M09 forecast	M10 forecast
CSU Housekeeping	5.1	5.0	4.5
In / Outsourcing	2.8	3.5	4.1
Interest receivable	3.2	3.2	3.2
CNST MIS	0.7	0.7	0.7
Bank pay rates	1.0	1.1	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	22.7	23.4	23.4

Commentary on Waste Reduction Programme progress 2023/24
At Month 10, the WRP for 2023/24 is projected to deliver £23.4m of efficiencies, which is £5.6m below plan. £12.1m of these savings are non-recurrent in nature, leaving a balance of £11.3m of true recurrent efficiencies forecast to be delivered in 2023/24. **Overall forecast WRP delivery has *remained static since Month 9, with gains in In/Outsourcing reductions offset by reduced delivery from CSU Housekeeping 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.** The latest CSU projections suggest a substantial amount of in / outsourcing will continue in Quarter 4, notably in Histopathology, Theatres, Breast Surgery and Plastic Surgery. This results in a forecast £2.9m 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 10 version of the CSUs' Housekeeping WR plans suggest up to £4.5m of efficiencies will be made in 23/24. This is £4.4m below the £8.9m targets allocated to the CSUs - this forecast has deteriorated by £0.5m since Month 9. 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 responses received to date have provided limited assurance that run rate improvements will be delivered. A revised WRP governance structure is being implemented for 2024/25 planning.

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**	**12,070**	**(7,032)**	**29,076**	**16,414**	**(12,662)**
Bank rates of pay	1,500	1,015	(485)	1,500	1,112	(388)
CNST MIS	704	704	0	704	704	0
CSU Housekeeping	8,886	3,014	(5,873)	11,849	4,854	(6,995)
In / Outsourcing	7,012	4,089	(2,923)	14,023	8,154	(5,869)
Interest receivable	1,000	3,249	2,249	1,000	1,590	590
Non-recurrent	**9,898**	**11,343**	**1,445**	**0**	**0**	**0**
Non-recurrent flexibility	7,824	7,824	0	0	0	0
CSU Housekeeping	0	1,445	1,445	0	0	0
Depreciation	2,074	2,074	0	0	0	0
Grand Total	**29,000**	**23,412**	**(5,588)**	**29,076**	**16,414**	**(12,662)**

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 £5.6m 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 Quarter 4, a £14.1m I&E planning gap related to undelivered 2023/24 WRP will be carried forward into 2024/25. ***The forecast for recurrent WRP delivery carried into 2024/25 has improved by £1.5m since Month 9, with the majority of the improvement related to Insourced theatre capacity.***

5. Agency Expenditure by Month (£000s)

Staff Groups	QTR 1	JUL-23	AUG-23	SEP-23	OCT-23	NOV-23	DEC-23	JAN-24	Total Agency Costs
Consultants	366	115	127	159	176	218	211	172	1,544
Other Med staff	28	24	22	10	1	4	0	(2)	87
Nurses & Midwives	705	274	275	113	274	239	181	155	2,216
Other clinical roles	335	152	160	135	174	174	142	148	1,419
HCAs	115	79	66	2	1	0	1	(1)	263
A&C / Managers	132	35	50	54	37	53	17	39	417
Estates & Facilities	718	262	308	227	199	202	163	132	2,211
Total Agency Costs	**2,398**	**941**	**1,008**	**701**	**862**	**890**	**715**	**643**	**8,158**
Total Pay Costs	**90,285**	**30,206**	**32,946**	**30,803**	**31,365**	**31,389**	**21,825**	**29,764**	**298,578**
Agency % of Total Pay	**2.7%**	**3.1%**	**3.1%**	**2.3%**	**2.7%**	**2.8%**	**3.3%**	**2.2%**	**2.7%**

Commentary on Agency Expenditure

YTD Agency costs at 2.7% of total pay costs remain well below the nationally mandated 3.7% ceiling. Forecast full year expenditure of £10m 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 once fully recruited.

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.

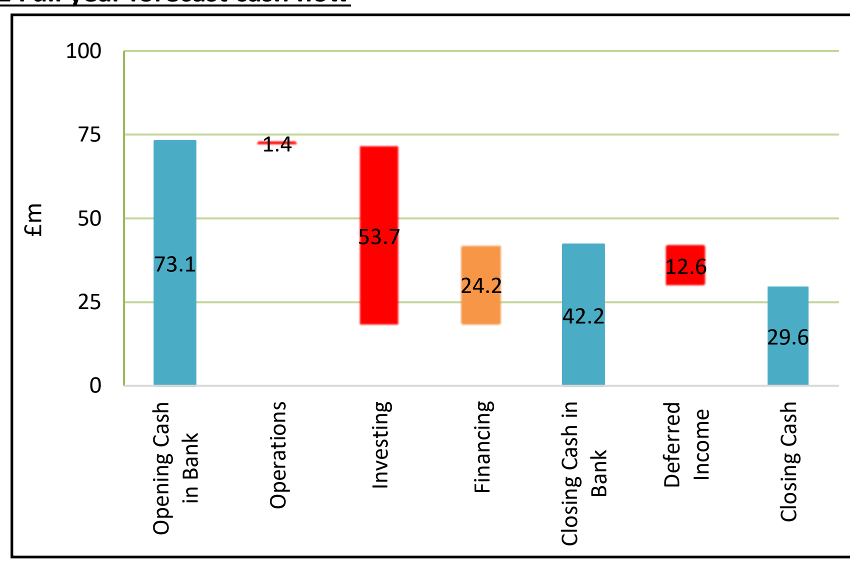
SECTION B - BALANCE SHEET, CASH & CAPITAL EXPENDITURE

B.1 Balance Sheet (forecast movement)

		31-Mar-23 £m	31-Mar-24 £m	Movement £m	Commentary
Non-Current Assets to increase by £43.6m	Capital Assets	217.1	260.2	43.1	The Trust is forecasting to spend £57.9m this financial year on capital. This includes £28.3m on operational capital and £29.5m on external funded schemes.
	Leases	10.9	11.7	0.8	
	Other Non Current Assets	2.5	2.2	(0.3)	
	Total Non Current Assets	**230.5**	**274.1**	**43.6**	
Current Assets to decrease by £43.5m	Inventories	9.7	9.7	0.0	The reduction in receivables this financial year relates to the Trust receiving £10.9m 2022/23 agenda for change non consolidated pay offer from NHSE.
	Receivables	27.1	14.5	(12.6)	
	Cash (see SoCF)	73.1	42.2	(30.9)	
	Total Current Assets	**109.9**	**66.4**	**(43.5)**	
Current Liabilities to decrease by £27.1m	Trade and other Payables	(84.3)	(57.2)	27.1	Reduction on trade and other payables (£27.1m) largely relates to the agenda for change non consolidated pay offer paid to staff and consultant study leave.
	Capital Payables	(9.3)	(9.5)	(0.2)	
	Loan	(4.5)	(4.9)	(0.4)	
	Provisions	(1.2)	(0.6)	0.6	
	Deferred Income	(11.7)	(11.7)	0.0	
	Total Current Liabilities	**(111.0)**	**(83.9)**	**27.1**	
Non-Current Liabilities to decrease by £6m	Loan	(23.1)	(20.4)	2.7	Loan repayments made for both the New Hospital Wing and Electronic Patient Records.
	Provisions	(7.2)	(5.4)	1.8	
	Deferred Income	(2.4)	(0.9)	1.5	
	Total Non Current Liabilities	**(32.7)**	**(26.7)**	**6.0**	
Taxpayers Equity to increase by £33.2m	Public Dividend Capital	154.8	188.4	33.6	The Trust is forecasting to receive £33.6m PDC this financial year from DHSC for capital investments. This includes £17.8m for SLH DCU and £8.7m for Endoscopy.
	Revaluation Reserves	51.8	40.1	(11.7)	
	Income and Expenditure	(9.9)	1.4	11.3	
	Total Taxpayers Equity	**196.7**	**229.9**	**33.2**	

See Appendix 1 for statement of financial position year to date plan v year to date actual.
See Appendix 2 for statement of financial position year to end of year plan v end of year actual.
See Appendix 3 for statement of financial position metrics.

B.2 Full year forecast cash flow



Commentary

The SoCF reflects the Trusts cash inflows and outflows.

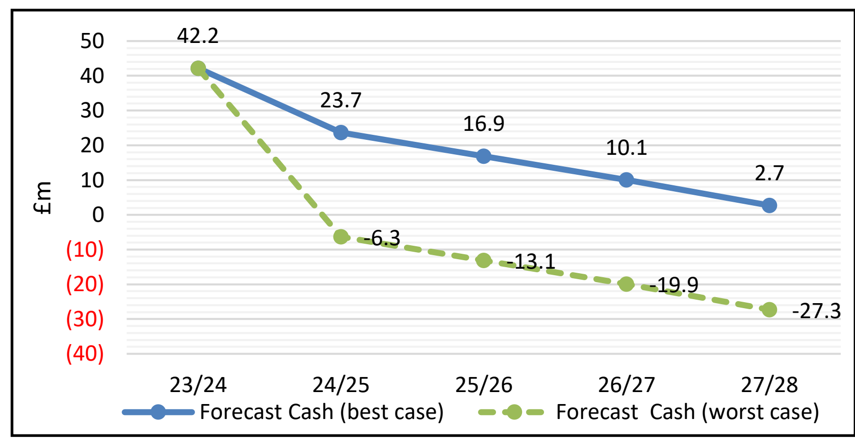
Operations - the Trust is forecasting £1.4m cash decrease from its operations (I&E) this financial year. This includes £1.6m operating surplus and £16.3m depreciation less £19.2m movement in working capital .

Investing - the Trust if forecasting £53.7m cash decrease from investing activities which includes £57.4m for capital investments. The Trust is also forecasting to receive £3.7m interest from investments.

Financing - the Trust is forecasting £24.2m cash increase from financing activities which includes £33.6m PDC and TIF less £3.1m loan repayments and £4.6m PDC dividend paid.

The Trust is forecasting to hold £42.2m cash at the end of the financial year. £12.6m will be for Research and Development leaving £29.6m for the Trust.

B.3 Five Year Cash Flow



Commentary

Cash is forecasted to fall £2.4m by the end of 2027/28 (including research and development funds). This assumes a break even I&E position and that the Trust spends its capital allocation in line with ICS capital budget allocation. It also assumes that the Trust will deliver the waste reduction programme of approx £30.0m per annum.

Should the Trust not deliver its waste reduction programme the worst case scenario highlights that cash could be negative by the end of March 2025.

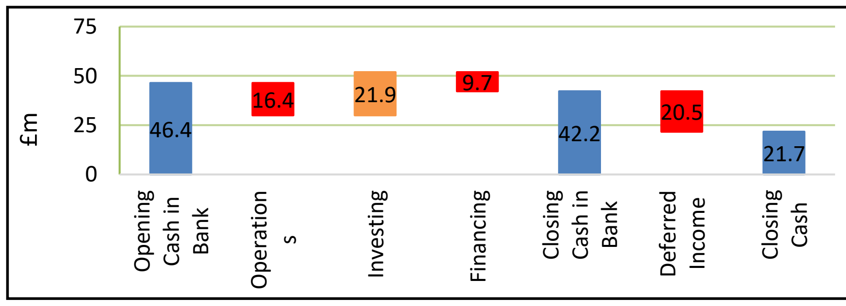
B.4 2023/24 Capital Programme

		Year to Date			End of Year			
		Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m	Slippage
Medical Equipment forecast to be overspent by £0.1m	Topslice	0.8	1.0	0.2	1.2	1.2	0.0	
	Diagnostics	0.5	0.3	(0.2)	0.5	0.5	0.0	
	Planned CSUs	0.6	0.3	(0.3)	0.6	0.7	0.1	
	Unplanned CSUs	0.5	0.2	(0.3)	0.5	0.3	(0.2)	
	Breast Screening	1.2	0.0	(1.2)	1.2	1.2	0.0	
	Other	1.0	0.7	(0.3)	0.4	0.6	0.2	
Digital forecast to be overspent by £3.3m	General	0.8	1.4	0.6	1.0	4.3	3.3	
	Other	0.4	0.0	(0.4)	0.3	0.3	0.0	
Estates forecast to be underspent by £2.2m	Rolling Backlog	3.8	0.6	(3.2)	4.0	2.2	(1.8)	
	Capitalised Salaries	0.3	0.0	(0.3)	0.4	0.0	(0.4)	
Capital Strategy forecast to be underspent by £0.9m	OMS Maternity	2.3	2.3	0.0	2.5	2.6	0.1	
	CT Scanner	2.1	0.7	(1.4)	2.9	2.9	0.0	
	SLH Day Case Unit (Equip)	0.5	0.2	(0.3)	2.6	2.6	0.0	
	TIF Theatres and Anaes	1.2	0.8	(0.4)	2.1	1.2	(0.9)	(0.9)
	Gamma Camera Turnkey	0.8	0.1	(0.7)	1.6	0.9	(0.7)	(0.7)
	Radiology Room 6	1.6	1.4	(0.2)	1.6	1.7	0.1	
	Wi-Fi Refresh and The Edge	1.5	1.8	0.3	1.5	1.8	0.3	0.3
	R&D Entrance	1.3	0.1	(1.2)	1.3	0.9	(0.4)	(0.4)
	Hand Surgery Unit	0.5	0.0	(0.5)	1.1	1.2	0.1	
	Single Isolation Rooms	1.1	1.1	0.0	1.1	1.6	0.5	
	Other	3.4	0.2	(3.2)	0.7	0.7	0.0	
PDC forecast to be overspent by £1.1m	Endoscopy Transformation	2.4	0.7	(1.7)	5.0	5.9	0.9	0.9
	Eccleshill CDC	4.7	1.5	(3.2)	4.5	4.5	0.0	
	Digital Diagnostics	0.7	0.0	(0.7)	1.1	1.1	0.0	
	Other	0.1	0.2	0.1	0.3	0.5	0.2	0.1
TIF forecast to be underspent by £2.6m	SLH Day Case Unit	15.7	10.3	(5.4)	17.8	15.2	(2.6)	(2.6)
Total		**49.8**	**25.9**	**(23.9)**	**57.8**	**56.6**	**(1.2)**	(3.3)

The Trust is forecasting to spend £30.73m during the remainder of the year which is 54.3 % of the total forecast.

Appendix 1 Balance Sheet and Cash Flow (YTD Plan v YTD Actual)

		Plan £m	Actual £m	Movement £m	Commentary
Non-Current Assets lower than plan by £18.2m	Capital Assets	249.3	231.6	(17.7)	YTD capital spend is lower than plan by £23.9m.
	Leases	10.5	9.7	(0.8)	
	Other Non Current Assets	2.5	2.8	0.3	
	Total Non Current Assets	**262.3**	**244.1**	**(18.2)**	
Current Assets higher than plan by £7.1m	Inventories	10.4	9.9	(0.5)	YTD receivables is higher than plan by £12.0m. Research and Development debtors is £3.8m higher than plan and NHS debtors is higher than plan £1.3m
	Receivables	17.0	29.0	12.0	
	Cash	46.6	42.2	(4.4)	
	Total Current Assets	**74.0**	**81.1**	**7.1**	
Current Liabilities higher than plan by £2.2m	Trade and other Payables	(70.9)	(65.0)	5.9	Trade and other payables is lower than plan as the Trust is reporting £1.7m reduction on health roster accruals. Current research and development deferred income is higher than plan by £8.0m.
	Capital Payables	(2.4)	(3.8)	(1.4)	
	Loan	(5.2)	(4.5)	0.7	
	Provisions	(1.2)	(0.6)	0.6	
	Deferred Income	(11.7)	(19.7)	(8.0)	
	Total Current Liabilities	**(91.4)**	**(93.6)**	**(2.2)**	
Non-Current Liabilities lower than plan by £3.1m	Loan	(19.2)	(19.3)	(0.1)	Non Current research and development deferred income is lower than plan by £1.6m
	Provisions	(7.2)	(5.6)	1.6	
	Deferred Income	(2.4)	(0.8)	1.6	
	Total Non Current Liabilities	**(28.8)**	**(25.7)**	**3.1**	
Taxpayers Equity lower than plan by £10.2m	Public Dividend Capital	174.5	164.9	(9.6)	Capital expenditure for externally funded schemes is currently behind plan by £10.9m which is why the Trust has not drawn down PDC as at month 10.
	Revaluation Reserves	51.8	40.3	(11.5)	
	Income and Expenditure	(10.2)	0.7	10.9	
	Total Taxpayers Equity	**216.1**	**205.9**	**(10.2)**	



Commentary

Year to date cash is currently less than plan by £4.4m.

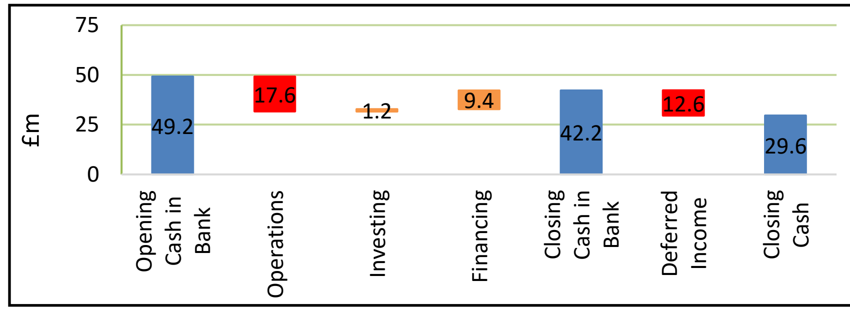
Operations - Material movements in working capital (debtors and creditors) mainly due to payments relating to agenda for change has led to the reduction from plan.

Investing - Capital programme is current behind plan which increases the cash balance by £21.9m.

Financing - Due to delays in the capital programme Trust has not drawn down £9.6m capital PDC funding.

Appendix 2 Balance Sheet and Cash Flow (End of Year Plan v Actual)

		Plan £m	Forecast £m	Movement £m	Commentary
Non-Current Assets higher than plan by £9.2m	Capital Assets	252.0	260.2	8.2	The Trust is forecasting to spend £8.8m on Endoscopy this financial year which wads not planned for. The Endoscopy scheme is fully funded.
	Leases	10.5	11.7	1.2	
	Other Non Current Assets	2.4	2.2	(0.2)	
	Total Non Current Assets	**264.9**	**274.1**	**9.2**	
Current Assets lower than plan by £7m	Inventories	9.7	9.7	0.0	
	Receivables	14.5	14.5	0.0	
	Cash	49.2	42.2	(7.0)	
	Total Current Assets	**73.4**	**66.4**	**(7.0)**	
Current Liabilities lower than plan by £5.7m	Trade and other Payables	(69.1)	(57.2)	11.9	Reduction on Trade and other payables largely relates to the agenda for change non consolidated pay offer paid to staff. Significant capital investment will be made during March 24 which will lead to an increase in capital payables.
	Capital Payables	(2.5)	(9.5)	(7.0)	
	Loan	(5.1)	(4.9)	0.2	
	Provisions	(1.2)	(0.6)	0.6	
	Deferred Income	(11.7)	(11.7)	0.0	
	Total Current Liabilities	**(89.6)**	**(83.9)**	**5.7**	
Non-Current Liabilities lower than plan by £1.5m	Loan	(18.6)	(20.4)	(1.8)	The Trust is expecting to enter into a new lease (IFRS 16) this financial year which was not planned for.
	Provisions	(7.2)	(5.4)	1.8	
	Deferred Income	(2.4)	(0.9)	1.5	
	Total Non Current Liabilities	**(28.2)**	**(26.7)**	**1.5**	
Taxpayers Equity higher than plan by £9.4m	Public Dividend Capital	179.0	188.4	9.4	The Trust is forecasting to receive £8.8m PDC for the Endoscopy programme.
	Revaluation Reserves	51.8	40.1	(11.7)	
	Income and Expenditure	(10.3)	1.4	11.7	
	Total Taxpayers Equity	**220.5**	**229.9**	**9.4**	



Commentary

End of year cash balance is expected to be £7.3m less than planned.

Operations - Unplanned material movements in working capital (£15.9m) is the main reasons for the reduction in operational cash.

Financing - The Trust did not plan for the Endoscopy Programme which will be funded by PDC (£8.8m). the Endoscopy Programme was awarded during 23/24.

Appendix 3 Receivables and Payables Performance

	target achieved	10% below target	more than 10% below target

BPPC % of Bills paid in target (Total)	Target	Current Month	Previous Month	Movement	Trend
- By number	**95.0%**	92.9%	93.3%	-0.4%	
- By Value	**95.0%**	94.0%	94.3%	-0.3%	
BPPC % of Bills paid in target (NHS)					
- By number	**95.0%**	88.9%	89.2%	-0.3%	
- By Value	**95.0%**	83.2%	83.4%	-0.2%	
BPPC % of Bills paid in target (Non NHS)					
- By number	**95.0%**	93.0%	93.4%	-0.4%	
- By Value	**95.0%**	94.8%	95.1%	-0.3%	
Creditor and Debtor Days (NHS and Non NHS)					
Creditor days	**171.0**	129.0	133.0	-4.0	
Debtor days	**17.1**	21.0	17.0	4.0	

BO.3.24.14 - PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

Bo.3.24.14 - Performance Report.pdf

Meeting Title	Open Board of Directors Meeting		
Date	14 March	Agenda item	Bo.3.24.14

PERFORMANCE REPORT – FOR THE PERIOD JANUARY 2024

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	F&P Academy – 28 February 2024	
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 January 2024.

Analysis

Ambulance Handovers:

- Attributable performance for handovers within 15 minutes was 72.42% in January 2024 which is an improvement from December. February performance is projected to reduce slightly to 69.49% due to increasing demand.
- The number of ambulances arriving daily at BTHFT has continued to increase by c.15% when compared to 22/23 volumes with a daily average of 113 in January '24 (vs. 101 in Jan '23). This is broadly in line with increases seen for other trusts across the region (c.19%) with increased patient acuity further impacting handover KPIs.
- Improvements in post-handover clear times, following the introduction of Hospital Ambulance Liaison Officer (HALO) in addition to the increase in bay capacity has mitigated some impact on handover performance with the Trust continuing to perform in the upper quartile for the region.
- Internally validated data indicates only 56% of handover clock stops match the time when a patient was physically allocated to an A&E trolley or cubicle – the Trust continues to work with YAS to identify opportunities to improve handover accuracy.
- The ED team and HALO are working to improve response plans to ensure that the quality of care and patient safety are maintained during peak periods.
- YAS direct access pathway to UCC and/or AECU for patients who are suitable is currently under review as the ED footprint has changed – this is to ensure an effective system and process is in place to minimise any preventable patient delays.
- The YAS Internal Review provided assurance that an effective system for ambulance handovers is in place. BTHFT carries a significant assurance opinion which reflects the robust systems and processes in place within the Foundation Trust.

Meeting Title	Open Board of Directors Meeting		
Date	14 March	Agenda item	Bo.3.24.14

Emergency Care Standard (ECS):

- ECS performance for Type 1 & 3 attendances was 81.98% for January 2024 and is currently forecast at 81.49% for February 2024. The position remains favourable against other Acute Trusts.
- Streaming to the AECU service went live in late November. Following initial assessment any patient streamed to the AECU is recorded as a type 5 attendance at which point the 4-hour clock is stopped. Streaming to the UCC and AECU have helped relieve pressure from ED and contribute to an improving ECS performance (81.98%), against a backdrop of increased attendance (c.16%) and higher acuity (c.16%) compared to January 2023.
- Performance data also shows that the AECU model continues to have the following impact:
    - Reduced average daily ECS breaches from 107 in October to 74 in January
    - Reduced average daily admissions from 98 in October to 81 in January
    - Improved LoS for discharged patients from 04:53 in October to 04:01 in January
- Whilst ECS continues to improve overall, patient admission times remain challenging with significant delays experienced. Decision to Admit (DTA) times have increased each month since September 2023 with some exceeding 12 hours. This is attributed to high bed occupancy in G&A adult beds (95.07%, Jan 24), especially non-elective patients (>98% occupancy) which is driven by winter pressures and issues within the social care sector.
- A UCC project group continues to meet bi-weekly looking at further opportunities to achieve ECS performance recovery, 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 124 in January 2024, and February 2024 is projected to be a daily average of 135.
- The number of patients that were awaiting packages of care continues to remain high due to the on-going external challenges with pathway 1 capacity. Weekly meetings are still taking place between acute providers and local authority to minimise the discharge delays with a focus on care package provision. Capacity remains challenged and is likely to continue through February 2024 placing more pressure on NEL adult bed occupancy, especially care of the elderly.
- Discharge to Assess is currently under review by the ICP at a system level and is expected to be facilitated by WYICB via the IMC workstream with CMBDC planning to pilot changes to their model at AGH mid-March. BTHFT are fully sighted on the implementation plan and will be inputting into the new model which aims for patients on pathway 1 to return home on the day they no longer meet the criteria to reside. The second phase of implementation will be focussed on issues with pathways 2 & 3. An implementation date is not confirmed at present therefore the benefits cannot be factored into our LLoS and discharge KPIs.
- A 'Criteria to Reside' meeting occurs twice weekly with multiple teams working closely to enable timely discharge of long length of stay (LLOS) patients. The Deputy Director of Nursing also conducts a weekly virtual review of 'Super Stranded Patients' with a LoS >21 days.

Meeting Title	Open Board of Directors Meeting		
Date	14 March	Agenda item	Bo.3.24.14

Inpatient and Outpatient Activity:

- Outpatient, Elective and Day Case activity increased in January 2024 despite 6 days of industrial action. Volumes are projected to decrease and remain below plan in February 2024 due to 5 days of industrial action and increased annual leave.
- Outpatient and elective transformation schemes are being brought together within the umbrella of GIRFT further faster. This is a clinically led approach to understanding opportunities presented by variation in data compared to peers.
- 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.
- The St Luke's Day Case Unit is progressing and will be operational during Q1 of 2024-25 allowing for an increase in overall activity and providing the opportunity for services to run high volume lists.

Referral to Treatment:

- Referral to Treatment (RTT) performance increased in January to 65.03% 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 was 1 patient reported over 78 weeks at the end of January, with 3 patients projected to breach 78 weeks at the end of February. Progress on reducing over 52 week waits is behind original plans but ahead of national expectations when adjusted for the impact of industrial action.
- Waiting list validation continues and patients are being involved via the use of SMS text messages. 56,315 patients have been contacted to date with 2,021 requesting discharge (3.6%).
- 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 should support further improvement in wait times by reviewing productivity, booking processes as well as demand & capacity with each CSU.

Diagnostic waiting times:

- DM01 performance for January was 68.11% which is a slight improvement on December performance. Some areas continue to be impacted by staffing resource and equipment gaps into February, which is hampering faster improvement. The overall position is expected to improve to over 70% in February as momentum grows.
- Non-obstetric ultrasound (NOUS) GP direct access requests continue to be transferred to Yorkshire Health Solutions with scanning at CDC getting under way and further improving the position from January onwards.
- MRI outsourcing of MSK patients continues to support performance but insufficient staffing for all 4 scanners and equipment problems continue to hinder improvement. The CDC going live in February will provide additional scanning capacity and begin to reduce growing waiting lists.
- Cardiology continues to face sustained challenges relating to referrals, equipment, and staffing. Insourcing commenced in January although not to expected levels. Work is ongoing to secure additional activity needed to clear the backlog. Longer term sustainability plans also in the final stages including resourcing additional space and equipment to support recovery.

Meeting Title	Open Board of Directors Meeting		
Date	14 March	Agenda item	Bo.3.24.14

Cancer Wait Times:

- Fast track referral demand remained high in December. Trust performance for two weeks wait (2WW) dropped slightly at 93.40% remaining above the 93% target and in the upper quartile nationally although performance in January is projected below target due to industrial action.
- The 28-day faster diagnosis standard (FDS) performance rose to 91.80% in December although this is expected to drop slightly in January it remains above target. There have been some issues with recording FDS within the required timescales which reduced December to a partial return. Work is underway to improve this and data capture since submission is in line with the performance shown.
- Improvement in the diagnostic phase is in part aligned to broader diagnostic capacity improvements described within the DM01 section but there is also specific work looking at one stop or straight to test opportunities, and a focus on histology turnaround improvements.
- 62 Day First Treatment performance remained below the target of 85% in December at 67.40%. Patients waiting beyond 62 days for treatment has increased across West Yorkshire and the cancer alliance is supporting system-wide improvement schemes.
- Improvement in the treatment phase includes review of MDT timings, capacity alignment with ICU and theatres, and specific work across the Urology pathway where this phase can be complex.
- Referral analysis by IMD aligned to the CORE20 approach for reducing health inequalities identified variation in demand that we are exploring alongside system partners as there are indications that patients from communities with poorer health outcomes are presenting later. Increasing earlier presentations from these communities will support reducing inequalities.

Other KPI of note:

- There were 3 breaches of the 28-day cancelled operation re-booking target in January as a result of industrial action.
- 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 this year.

Recommendation

The Board 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.

Meeting Title	Open Board of Directors Meeting		
Date	14 March	Agenda item	Bo.3.24.14

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 – JANUARY 2024

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	Jan-24	30	**184**	↑ (red)
3	Ambulance Handover 60+	Jan-24	10	**80**	↑ (red)
5	Emergency Care Standard	Jan-24	81.90%	**81.98%**	↑ (green)
7	Length of Stay ≥21days	Jan-24	101	**124**	↑ (red)
9.1	18 Week RTT Incomplete	Jan-24	72.92%	**65.03%**	→
9.2	52 Week RTT Incomplete	Jan-24	1.06%	**1.41%**	↑ (red)
10	Diagnostics Waiting Times	Jan-24	66.00%	**68.11%**	↑ (green)
11.1	Cancer 2 Week Wait	Dec-23	93.00%	**93.40%**	↓ (red)
11.2	Cancer 28 Day FDS	Dec-23	75.00%	**91.80%**	↑ (green)
11.3	Cancer 62 Day First Treatment	Dec-23	85.00%	**67.40%**	↑ (green)

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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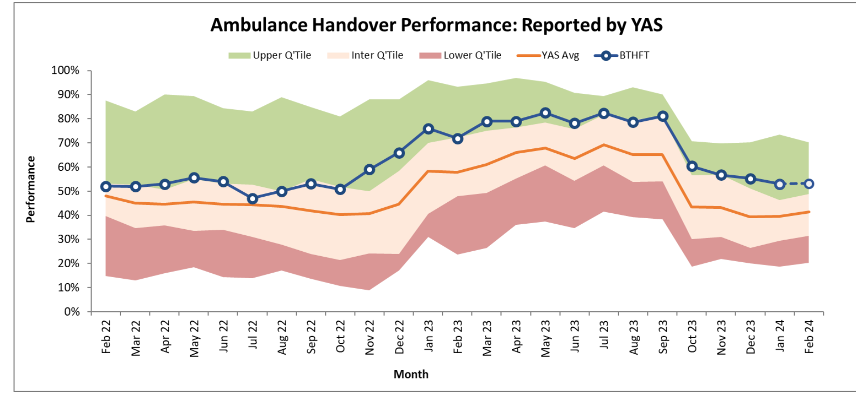
3. Emergency Ambulance Handover Performance

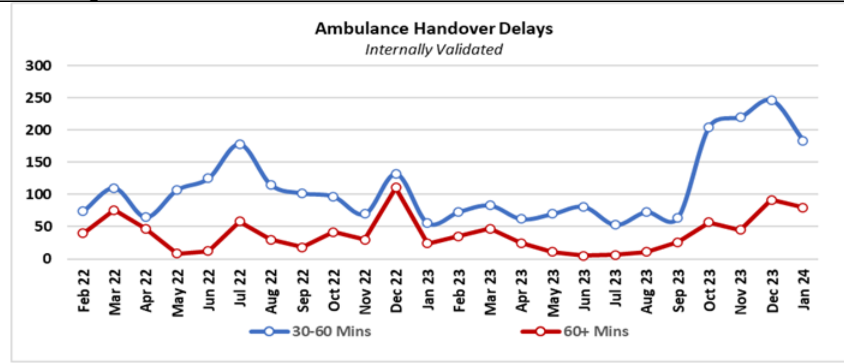
Figure 1 Ambulance Handovers – Yorkshire Comparison



Note: Changes in YAS clock reporting commenced in October.

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).

Figure 2 Ambulance Handovers – Attributable to BTHFT



The number of delayed handovers in January was 184 between 30 and 60 minutes and 80 over 60 minutes (this is the validated internal position which excludes resus, crew delays and patients transferred to other units).

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 1 hour.
- Estate works completed in September for the ambulance assessment area which increased bay capacity by 20%, has helped the Trust respond to recent increases in daily arrivals.
- Best practice SOP is under development and is expected to be finalised by March 1st, 2024, with Deputy General Manager (DGM), Specialty Leads, Matron, and HALO meeting weekly to ensure roles and responsibilities are clearly defined across a multi-disciplinary team including YAS co-ordinator, ICB liaison officer, HALO, Clinicians, Operational managers, and the Nursing team.
- Additional portering will be dedicated to the Ambulance Assessment Area (AAA) to support efficient and timely transfers. A monthly meeting with the portering/estates team is in place to address any internal challenges with AED, whilst also providing pastoral care for portering staff.
- A review of the current YAS handover SOP and action plan is under development following the YAS internal audit in November, to address the minor recommendation. The ED Clinical Lead must review procedures for when the Senior Nurse is unavailable to respond to 60-minute breaches. A review of current YAS handover SOP is underway to address this.
- DGM and HALO are revisiting the Ambulance Pre-Alert, Handover & Preparedness Supporting Framework to ensure that YAS crews are following best practice to improve YAS crews' consistency

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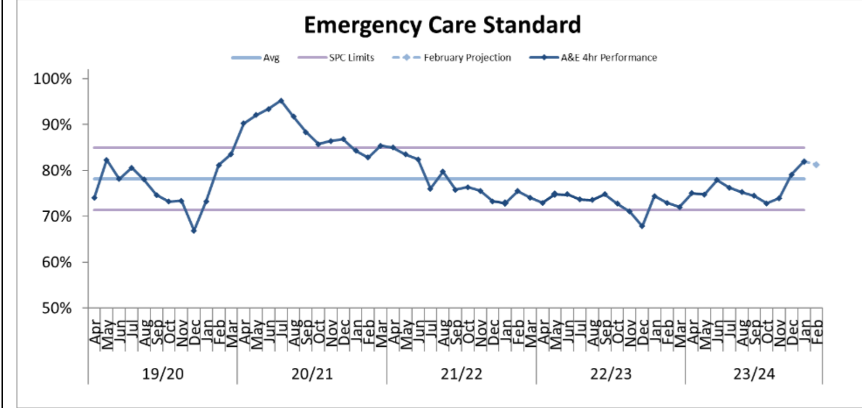
with the sign-out process and adherence to guidance regarding self-handovers of eligible patients during handovers.

- A daily validation exercise continues to remain in place to support timely remedial action due to differences in YAS reported data vs. BTHFT data. A one-day trial has now been proposed in February for ED and YAS to remove the use of the C2 screen during handover and utilise the YAS AMDT/e-signature as the only source of data (this will replicate the handover process followed by other local Trusts).

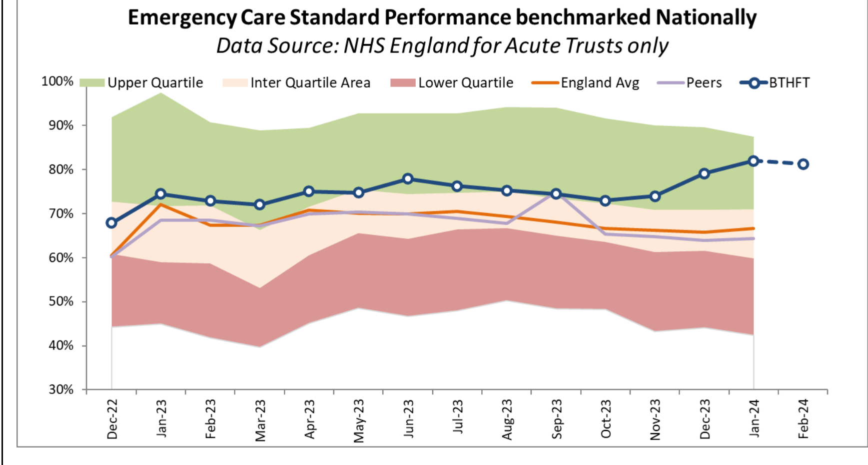
4. Emergency Care Standard (Type 1&3)

Figure 3 Monthly ECS Performance – BTHFT



BTHFT reported a position of 81.98% for the month of January 2024. February 2024 position is forecast to be 81.49%.

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.

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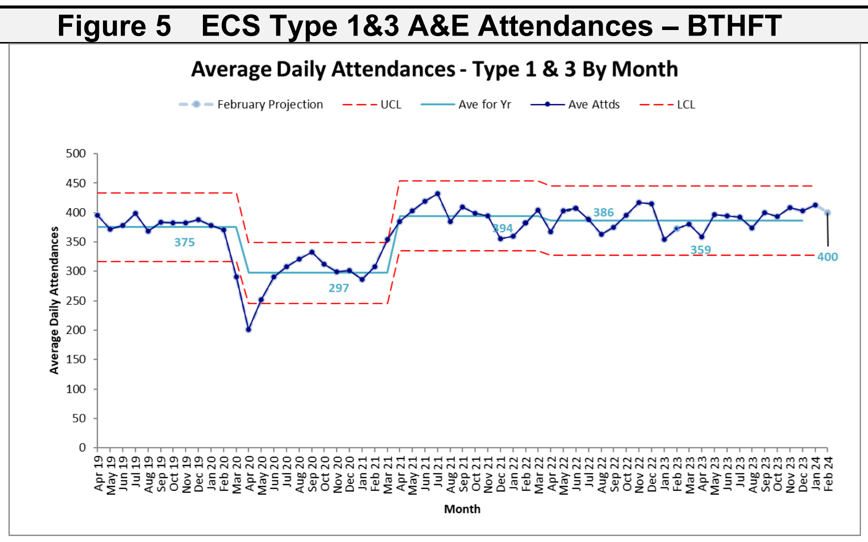
Figure 5 ECS Type 1&3 A&E Attendances – BTHFT



The Trust has continued to experience a high number of daily attendances during January 2024, with a daily average of 413, and projected at 400 for February.

5. Emergency Department Measures

Table 2 ECS KPI Performance – BTHFT

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Average Daily Attendances	381	359	396	394	392	373	400	393	408	403	413	404
Average Daily Breaches	106	89	100	87	93	92	102	107	106	84	74	77
ECS Performance	72.03%	75.08%	74.79%	77.91%	76.31%	75.30%	74.48%	72.84%	73.94%	79.14%	81.98%	80.98%
Arrival to Assess	00:25	00:22	00:22	00:22	00:21	00:22	00:22	00:24	00:26	00:23	00:22	00:22
Assess to Treat	02:09	01:41	01:47	01:42	01:44	01:40	01:47	01:47	01:58	02:10	02:15	01:41
Treatment Length	02:32	02:25	02:17	02:09	02:09	02:19	02:22	02:27	02:39	02:40	02:36	02:25
Total LOS - Discharged Patients	04:09	03:52	03:47	03:39	03:37	03:41	03:49	03:53	03:46	03:06	02:56	03:06
Total LOS	05:20	04:53	04:44	04:39	04:41	04:43	04:50	04:53	04:45	04:08	04:01	04:09

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.
- Updated triage training for nurses is due to commence in March 24 (with input led via experienced consultants), ensuring the patient pathway is correctly selected right first time, improving the patient experience and subsequently reduce conversion rates. Alongside this, a review of the triage process for streaming/streamers will run concurrently to ensure the correct pathway continues to be utilised.
- 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 January was 79% and total contracted activity delivered at 90%.
- Improvement to the AECU model is ongoing to enhance the service and patient experience. Learning from nurses has helped develop an improved understanding of the department and work is underway to prioritise the wellbeing of staff and patients through further nurse training and joint work with emergency/acute medics to support junior doctors.

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- A mixed model of medics and ED consultants was introduced in January to provide resilience and consistency in the AECU consultant rota which has led to improvements with speciality in-reach being available more frequently to support senior decision making.
- The ED nursing team are undertaking additional training to enable them to be deployed across the whole ED footprint (including AECU), which in turn will lead to a more resilient workforce model.
- A follow-up senior consultant led Rapid Assessment Triage (RAT) trial planned for December was unable to go ahead as planned due to industrial action and physical estate constraints. The trial is to commence in April 2024; ED demand is expected to be lower; streaming will have been embedded more effectively with the teams and staffing levels are expected to be closer to full capacity.

6. Hospital Admission Measures

Table 3 ED Admissions KPI Performance – BTHFT

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Conversion Rate*	23.83%	23.71%	24.01%	22.63%	24.26%	24.69%	24.18%	24.98%	23.01%	21.56%	19.57%	18.09%
Average Daily Admissions	91	85	95	89	95	92	97	98	94	87	81	73
DTA to Admit	05:21	04:42	04:17	03:38	03:20	04:03	04:02	04:21	05:06	05:22	06:37	04:42
Total LOS - Admitted Patients	09:00	08:11	07:44	07:03	06:42	07:15	07:31	07:38	08:01	07:33	08:23	08:29
% of Patients >12 Hours LoS	7.85%	5.41%	4.68%	3.79%	3.11%	5.43%	5.70%	5.87%	6.80%	5.52%	6.30%	6.67%

The observed reduction in admissions post AECU is mostly down to the re-classification of medical SDEC patients from admitted data to type 5 coding. However, there are examples where improvement has 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.
- 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, originally formed in July 2023 was relaunched in January 2024 and continues to focus on the daily operational running of the department and maintain 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 and is a single access point for coordinating information and ensuring a swift response to operational issues.
- Hub attendance has now been extended to include multi-disciplinary teams, supporting early interventions for patients with complex pathways (e.g. patients with mental health, learning disabilities, therapeutic requirements, safeguarding/social care needs etc). Bringing together teams provides a mechanism to identify complex requirements early and expediate safe and timely discharge.
- The ED team continues to attend the operational huddle twice a day, improving communication across the department and ward flow.

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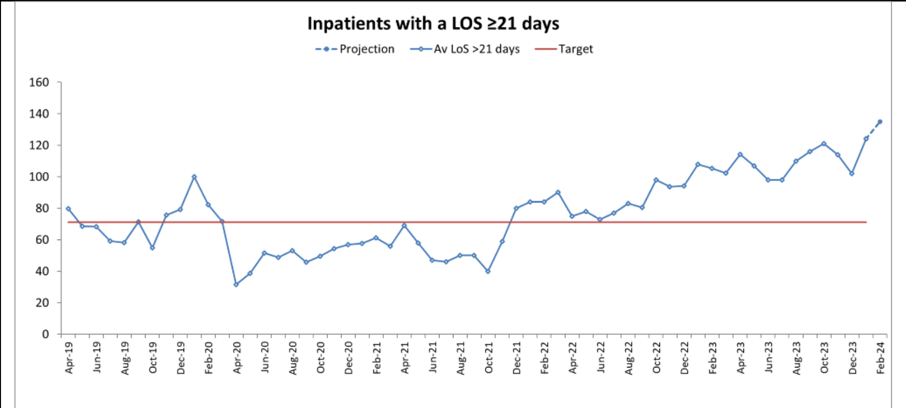
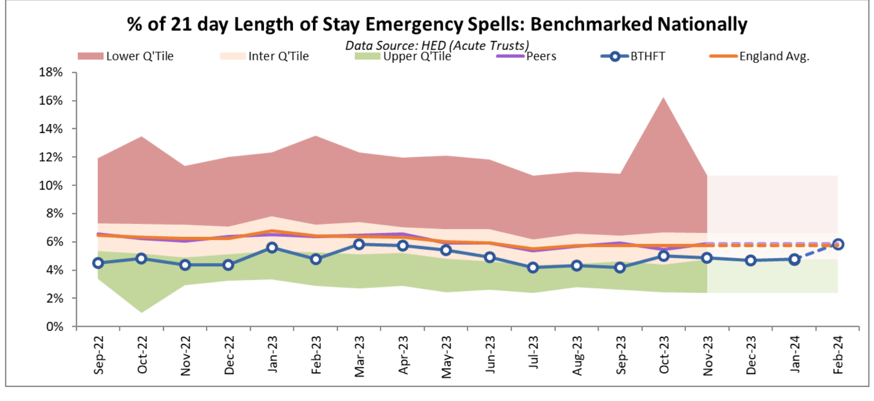
7. Inpatient Length of Stay (LOS) and Discharge KPI

Figure 6 Inpatient Length of Stay ≥21 days – BTHFT



The number of patients with a LOS over 21 days increased to an average of 124 patients per day in January 2024. February 2024 is projected at 135 patients per day.

Figure 7 Length of Stay– National Comparison



The percentage of patients with a LoS over 21 days was 5.87% in January.

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, with a 'discharge to assess' currently under review by the ICP at a system level. The availability of care packages and Intermediate Care (IMC) capacity will continue to present a challenge for discharge delays until resolved.

Table 4 Discharges on Discharge Ready Date (MFFD)

	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
# Total Adult G&A Discharges from Inpatient Wards	3653	3528	3680	3265	3225	3233	3007	3249	3120	2799
Of those Discharged, # with Discharge Ready Date	3457	3336	3521	3093	3038	3013	2819	3066	2954	2636
Of those Discharged, % with Discharge Ready Date	*95%*	*95%*	*96%*	*95%*	*94%*	*93%*	*94%*	*94%*	*95%*	*94%*
# discharged on or before MFFD date	2829	2696	2911	2525	2472	2475	2300	2465	2386	2062
% discharged on or before MFFD date	*82%*	*81%*	*83%*	*82%*	*81%*	*82%*	*82%*	*80%*	*81%*	*78%*
# discharged beyond MFFD date	628	640	610	568	566	538	519	601	568	574
% discharged beyond MFFD date	*18%*	*19%*	*17%*	*18%*	*19%*	*18%*	*18%*	*20%*	*19%*	*22%*
Avg stay beyond discharge ready (MFFD) date	3	3	3	4	3	4	5	4	4	4

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 95% 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 remains at ~4 days.

A patient's suitability for discharge is also expressed through their criteria to reside which is reported nationally each day. At present ~12% 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 pathway 1 capacity which we are working through with local authority partners.

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.
- 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.
- Following the relaunch of the patient flow hub in January 2024, multiple disciplinary teams are now in attendance at the daily huddle which identifies complex patients at the point of admission facilitating earlier intervention(s) to minimise discharge delay.

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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%	96%
Jan-24	110%	107%	105%
Feb-24	110%	113%	*99%*
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%	84%
Dec-23	110%	100%	86%
Jan-24	110%	102%	75%
Feb-24	110%	95%	*81%*
Mar-24	110%	99%	

Day case activity significantly increased in January, delivering marginally below plan whilst elective ordinary activity decreased. Total elective activity recorded an average of 1,088 spells per week and 219 spells per day, exceeding baseline of 1,015 spells per week in January 2020. Day case activity is projected to decrease in February whilst ordinary activity is expected to increase.

The number of patients per theatre list remains stable at 1.9, whilst capped 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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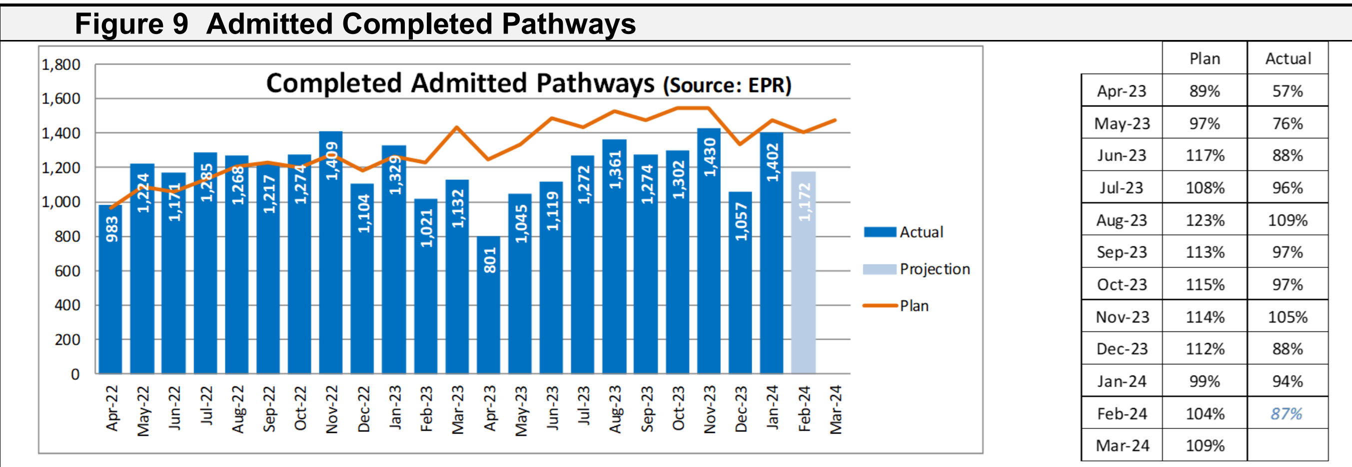
Figure 9 Admitted Completed Pathways



	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%	88%
Jan-24	99%	94%
Feb-24	104%	*87%*
Mar-24	109%	

The number of admitted clock stops increased in January in line with elective activity but remains behind plan. The number of completed admitted pathways is expected to decrease in February due to industrial action and increased annual leave.

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%	96%
Jan-24	105%	102%
Feb-24	110%	*110%*
Mar-24	99%	

Non-admitted clock stops increased in January in line with new and follow up activity. Clock stops in February are projected to deliver similarly to January, with an ongoing focus on validation.

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Figure 11 Outpatient Attendances

First Outpatient Attendances (Source: EPR)

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Actual	8,908	10,278	9,730	9,861	10,468	10,731	10,477	11,487	8,995	10,601	9,436	10,536	9,124	10,698	11,668	10,949	10,358	10,528	10,701	11,118	9,277	11,051		
Projection																							10,281	

Legend: Actual, Projection, Plan

	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%	106%
Jan-24	110%	112%	106%
Feb-24	110%	122%	*112%*
Mar-24	110%	121%	

Follow Up Outpatient Attendances (Source: EPR)

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Actual	23,501	27,722	26,604	24,952	26,576	26,533	25,856	29,067	23,878	28,670	25,785	29,034	24,364	28,477	29,416	26,974	27,356	27,667	28,885	29,989	23,931	29,304		
Projection																							27,324	

Legend: Actual, Projection, Plan

	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%	107%
Dec-23	85%	108%	96%
Jan-24	85%	103%	97%
Feb-24	85%	113%	*104%*
Mar-24	85%	101%	

First and follow up attendance activity increased in January despite 6 days of industrial action. 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.

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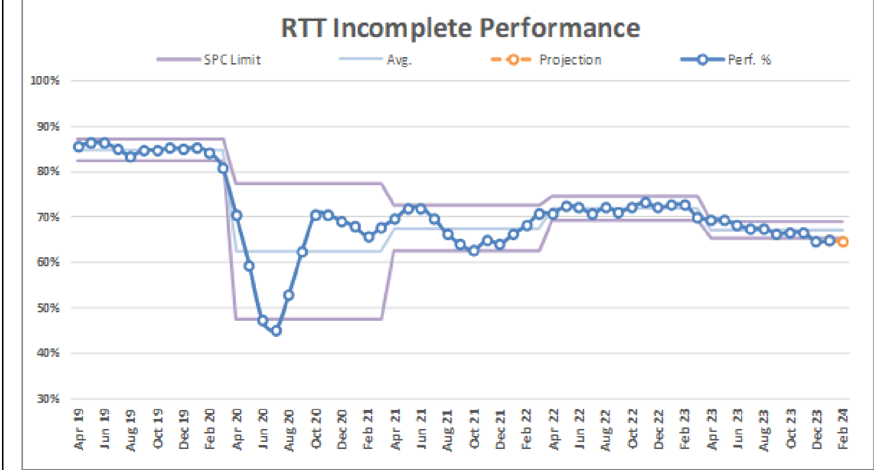
9. Referral to Treatment (RTT)

Figure 12 Monthly 18 Week RTT Incomplete Performance



The Trust's 18 Week RTT position for January 2024 is 65.03%. Performance is currently projected to decrease in February to 64.59%.

Figure 13 Monthly 18 Week RTT Incomplete Performance

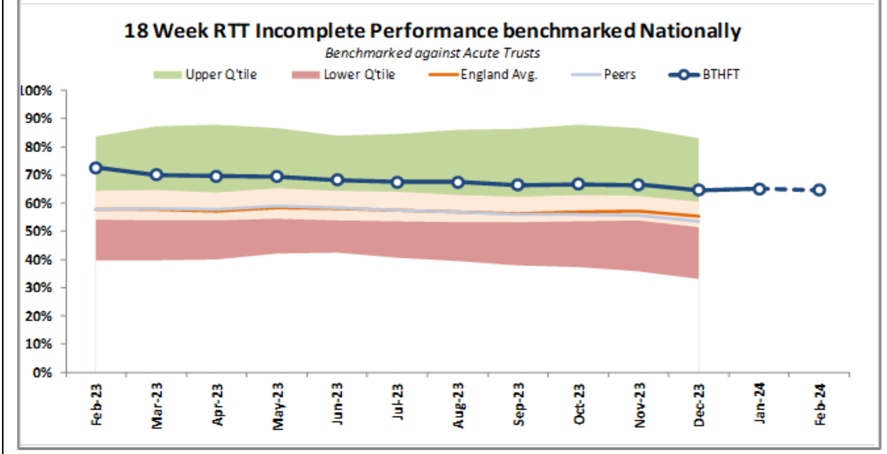
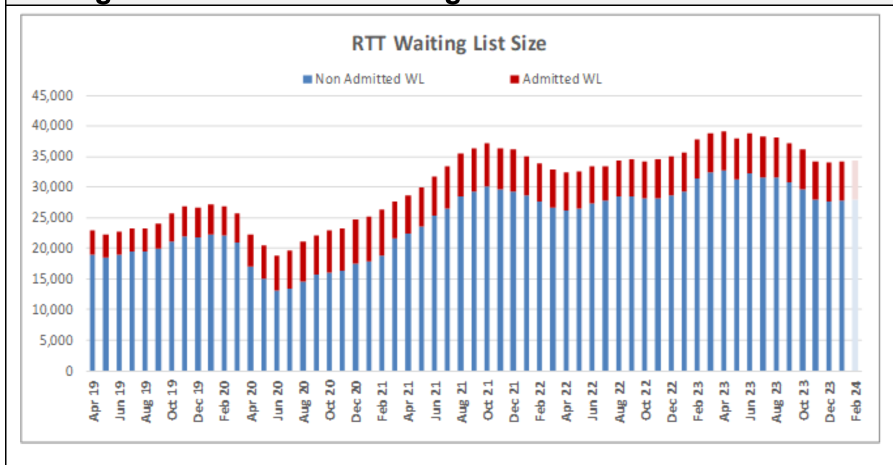


Figure 13 shows a national comparison of RTT Incomplete performance for acute Trusts with BTHFT significantly above the England and Peer average and remaining in the upper quartile.

Figure 14 RTT Total Waiting List



The overall waiting list marginally increased in January and is projected to remain stable in February.

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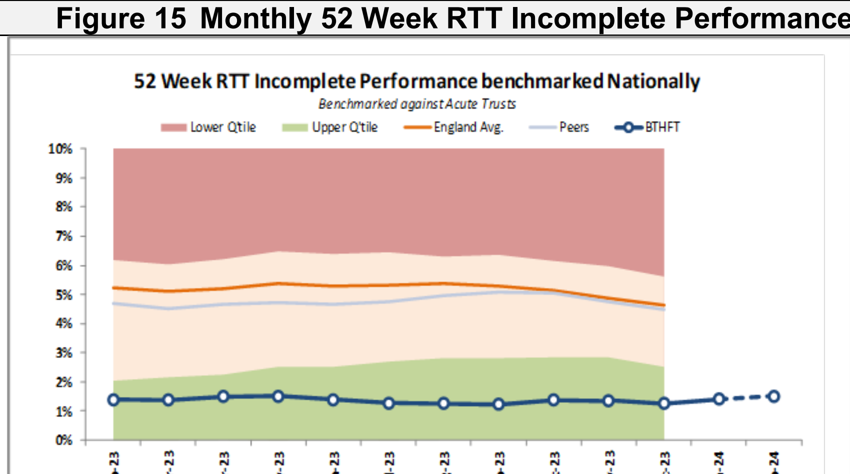
Figure 15 Monthly 52 Week RTT Incomplete Performance



52 Week RTT performance stands at 1.41% in January. 1 patient had a wait time of 78+ weeks at month end. Current projections indicate there will be 3 patients that will breach the 78+ week position by the end of February with focus now on the cohort of patients who risk breaching 65+ by year end.

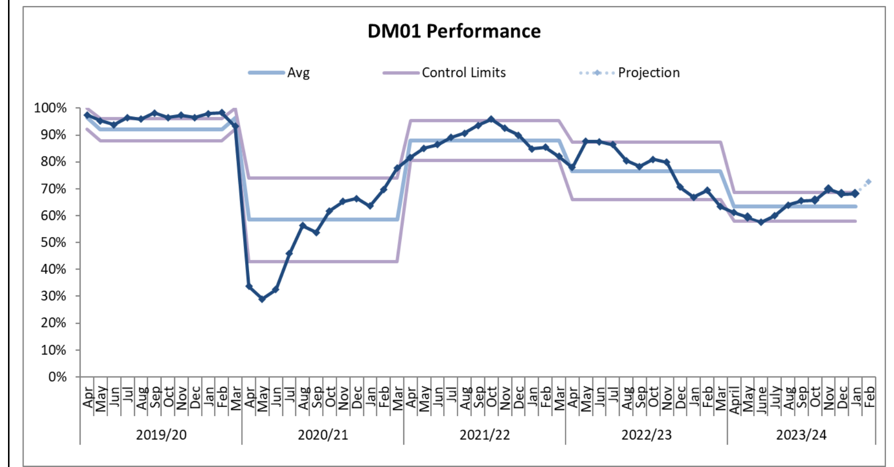
Activity and RTT Improvement:

- The GIRFT Further Faster program, which includes outpatient and inpatient opportunities, to improve patient experience and reduce waiting times, is currently being launched with clinical oversight.
- Patients are being routinely contacted via SMS as part of the waiting list management initiative aligned to the national validation toolkit recommendations. 56,315 patients have been contacted to date who meet the required criteria with 2,021 requesting discharge (3.6%).
- PIFU use decreased to 1.9% in January (-0.3% to December). The Trust has worked with Calderdale to update PIFU options on Cerner to support a consistent and streamlined process.
- A video to support elective admissions into the hospital will be shared with patients in Q4. 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.
- Text messages to patients to reduce DNA rates have not been as impactful as expected and the Trust will revert to standard reminders. The Trust will explore the use of a DNA predictor tool which will advise services of the patients most likely to DNA and where overbooking clinics could help utilise more slots. Increasing patient attendance will remain a priority with GIRFT and reducing health inequality programmes exploring what else can be done.
- Patients can reschedule appointments via DrDr with the impact on wait times being monitored. SeeMeSooner is also 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.
- Monthly recovery meetings started in January with all services in order to support performance improvements and provide early insight into deteriorating indicators. These meetings focus on reviewing booking processes, productivity, as well as demand and capacity modelling and should support a reduction in waiting times and long waiters over the next few months.

- Services are now validating non-RTT patients to work towards a cleansed position. Text based validation and PIFU will be extended to specific patients in the coming quarter as per service requests. Current focus is on patients over 12 months past their see by date.
- 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. Autotext will allow clinicians to select the right outcome from a drop down list for updates outside of clinics, in line with RTT pathway management.

10. Diagnostic Waiting Times

Figure 16 Monthly 6 Week DM01 Performance



January 2024 performance was 68.11% which is an improvement from December.

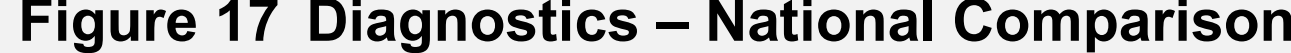


Figure 17 Diagnostics – National Comparison

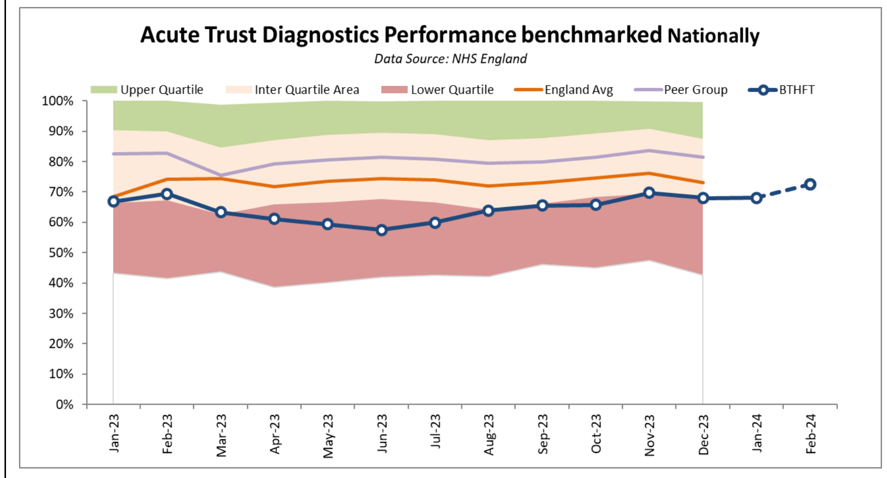


Figure 17 shows a national comparison of DM01 6-week diagnostic performance. Further work is being undertaken in this area and performance is expected to improve as the new Community Diagnostic Centre come on-line in February 2024.

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Table 4 DM01 6-week diagnostic standard by modality

Site	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	*Feb-24*
TRUST	69.4%	63.3%	61.2%	59.4%	57.5%	59.9%	63.9%	65.6%	65.8%	69.7%	68.0%	68.1%	*72.6%*
Audiology Assessments	95.7%	92.2%	88.1%	95.1%	85.1%	80.4%	79.3%	79.0%	75.5%	68.8%	67.1%	67.4%	*68.8%*
Cardiology - echocardiography	93.0%	76.2%	71.8%	86.4%	86.2%	90.2%	91.7%	83.8%	65.5%	57.4%	47.5%	35.6%	*44.7%*
Cardiology - electrophysiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
Colonoscopy	51.6%	70.1%	72.4%	76.0%	72.5%	71.6%	72.1%	66.3%	75.9%	73.6%	90.0%	81.8%	*80.6%*
Cystoscopy	96.1%	96.2%	97.2%	94.6%	72.5%	82.0%	100.0%	100.0%	100.0%	100.0%	97.5%	98.4%	*98.0%*
Flexi sigmoidoscopy	64.3%	70.2%	80.2%	70.4%	75.3%	84.2%	70.7%	74.6%	84.5%	80.0%	91.4%	85.3%	*86.0%*
Gastroscopy	55.6%	72.9%	73.4%	67.6%	77.3%	75.7%	71.5%	69.3%	77.0%	74.2%	84.9%	81.1%	*81.9%*
Computed Tomography	99.6%	94.3%	90.1%	95.9%	94.7%	97.4%	94.3%	94.3%	92.3%	99.7%	97.1%	98.5%	*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%	*100.0%*
Magnetic Resonance Imaging	78.8%	64.1%	73.6%	75.3%	76.0%	80.1%	71.3%	68.7%	67.8%	74.2%	64.6%	57.5%	*59.1%*
Non-obstetric ultrasound	52.6%	44.5%	38.8%	33.2%	33.1%	32.3%	38.9%	38.6%	42.4%	49.1%	58.7%	70.0%	*80.0%*
Neurophysiology - periph neuro	98.8%	100.0%	100.0%	100.0%	98.5%	100.0%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*100.0%*
Respiratory phys - sleep studies	99.0%	97.9%	92.6%	95.8%	97.1%	93.1%	88.2%	79.8%	67.8%	70.7%	61.2%	53.8%	*55.2%*
Urodynamics - pressures & flows	91.7%	85.1%	89.0%	80.7%	81.8%	91.1%	86.3%	76.0%	71.4%	64.3%	70.0%	59.3%	*60.0%*

Diagnostic Improvement:

- Strategic workforce planning supported by HR Business partners is ongoing 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.
- Operations & Clinical Pathway Delivery Group as sub-group of Endoscopy Programme Board are in place to oversee delivery of new operational model and successful application for JAG re-accreditation.
- Validation of full Endoscopy waiting list (diagnostic and surveillance) is ongoing with Transformation support to Endoscopy booking processes, implementation of SOPs and improved waiting list management.
- NOUS outsourcing is continuing to Yorkshire Health Solutions with a sustainability plan in place which includes insourcing to run alongside existing provision. The commencement of insourcing including additional staff can be seen to be positively impacting on performance from January 24. Obstetric admin has moved to the Gynae booking team which is having a positive impact, and work is ongoing to prepare for the new 24hr, and 72hr scanning targets.
- Medinet continue to provide insourced MRI capacity, which is reducing numbers of patients waiting for the longest time. As a result, the longest wait for patients will have dramatically decreased within the next few weeks.
- The CDC is expected to go live in February for MRI, CT & primary imaging. With greater community diagnostic provision being planned work is underway to develop a system-wide approach for access and the visibility of patient information.
- Insourcing to support recovery in echocardiography is underway although volume and capacity is lower than expected. Work is underway to provide the agreed level of support which will reduce backlogs as anticipated. Longer term plans are being explored to ensure sustained service resilience and meet demand going forward.
- Several Business Cases are underway to support specific staffing and delivery models for 2024/25 which will provide greater resilience and enable services and teams to meet changing and sustained demand.

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11. Cancer Standards

Table 5 Cancer Standards – Overview by Indicator – BTHFT

Measure	Target	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	*Jan-24*	*Feb-24*
14 day GP referral for all suspected cancers	93%	95.6%	94.1%	91.5%	93.4%	95.8%	96.8%	94.9%	94.0%	95.8%	96.4%	93.4%	*82.6%*	*93.0%*
14 day breast symptomatic referral	93%	96.9%	94.4%	97.3%	98.7%	93.5%	97.4%	94.5%	96.9%	93.5%	96.6%	90.7%	*77.4%*	*87.8%*
31 day first treatment	96%	92.5%	96.8%	94.7%	97.3%	93.6%	94.3%	97.3%	93.1%	92.6%	89.3%	90.5%	*89.6%*	*85.3%*
31 day subsequent drug treatment	98%	97.6%	97.3%	88.1%	93.4%	95.0%	96.9%	93.5%	98.3%	91.4%	83.9%	93.8%	*93.8%*	*90.5%*
31 day subsequent surgery treatment	94%	79.1%	86.5%	83.3%	89.1%	91.1%	95.0%	93.8%	90.7%	88.6%	84.8%	92.7%	*75.8%*	*90.9%*
62 day GP referral to treatment	85%	72.0%	78.7%	81.9%	67.0%	76.2%	74.6%	72.2%	70.3%	69.5%	62.5%	67.4%	*57.8%*	*67.6%*
62 day screening referral to treatment	90%	87.0%	71.4%	83.3%	84.2%	87.1%	71.4%	78.6%	28.1%	75.6%	65.3%	47.8%	*61.2%*	*66.7%*
62 day consultant upgrade to treatment		42.1%	27.3%	37.5%	70.6%	71.4%	100.0%	66.7%	66.7%	71.4%	71.7%	78.9%	*62.7%*	*77.8%*

Cancer Wait Time Improvement:

- Transition to Version 12 of the Cancer Wait Time standards is underway with reporting commencing from April 24. Internal tracking of patients in line with V12 began in January providing additional scrutiny of screening and upgrade patient volumes.
- The Non Site Specific (NSS) Service first draft business case is developed, with costings in progress to support sustainable commissioning arrangements for 2024/25.
- Joint working with primary care is underway to better understand high referral patterns with a focus on increasing earlier diagnosis for communities with low presentations and poorer outcomes.
- Locality and LMC are progressing agreement on GP's holding 2WW FT referrals (safety netting) where patients are going on holiday.
- Changes to appointment letters which provide more information about what patients should expect have been implemented. This will reduce DNA caused by patients wishing to change their appointment at the last minute.
- 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.
- Work completed to support the auto upload of Patient Centred Speciality Practice into EPR from Macmillan Care Plan overnight reducing manual process steps for specialty teams.
- Recruitment drive to support additional new staff in Cancer Lead Team to support CWT v12 delivery and Pathway Navigator role recruitment continues across tumour groups to support faster processes and patient pathways, alongside expanding Cancer Nurse Specialist roles as appropriate. The impact of existing roles has been positive improving patient access and experience.
- Best Practice Timed Pathway monitoring is being modelled across additional Tumour sites with medium term plans to develop a BPTP dashboard. This will inform service-level performance against patient pathway milestones which will also highlight challenges and shape plans for improved patient experience and outcomes.

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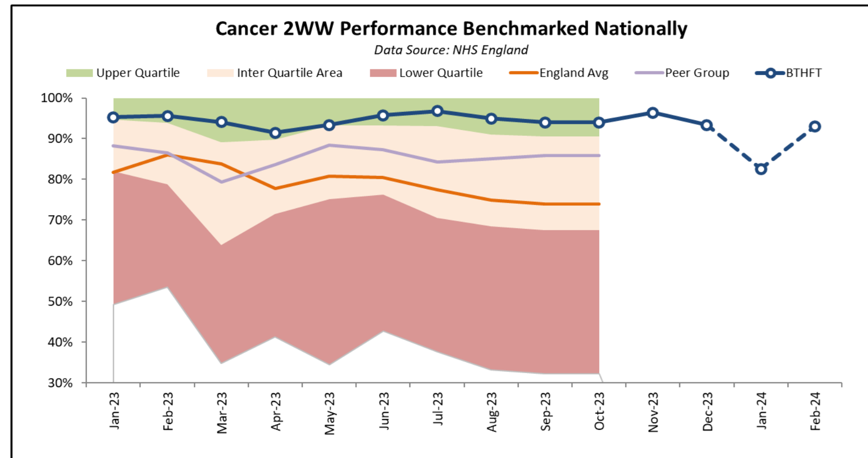
11.1. Cancer 2 Week Wait

Figure 18 2WW National Comparison – BTHFT



Performance in December 2023 places the Trust in the upper quartile, above peer group and England average however January performance is expected to drop significantly.

Table 6 2WW Performance by Tumour Group

Site	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	*Jan-24*	*Feb-24*
TRUST	**95.6%**	**94.1%**	**91.5%**	**93.4%**	**95.8%**	**96.8%**	**94.9%**	**94.0%**	**95.8%**	**96.4%**	**93.4%**	***82.57%***	***93.01%***
Breast	96.5%	96.3%	96.6%	99.5%	95.8%	96.8%	97.5%	97.8%	93.4%	97.0%	92.9%	*76.19%*	*82.46%*
Gynae	90.7%	96.6%	92.6%	93.5%	92.2%	94.5%	93.3%	78.2%	93.1%	94.9%	93.9%	*87.31%*	*93.94%*
Haematology	56.5%	75.0%	84.6%	88.2%	66.7%	100.0%	40.0%	90.5%	76.5%	84.6%	66.7%	*47.83%*	*83.33%*
Head & Neck	97.6%	94.5%	96.2%	93.7%	94.9%	98.3%	96.6%	91.3%	95.1%	96.3%	95.3%	*86.28%*	*89.32%*
Lower GI	90.0%	83.6%	69.3%	80.7%	93.6%	93.8%	86.9%	86.5%	92.1%	94.7%	93.3%	*80.37%*	*96.93%*
Lung	100.0%	100.0%	98.2%	100.0%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	*100.00%*	*97.73%*
Other	97.4%	96.8%	100.0%	85.7%	97.7%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	*100.00%*	*100.00%*
Skin	99.5%	98.3%	100.0%	97.3%	96.4%	97.0%	98.9%	99.5%	99.3%	97.9%	89.9%	*79.97%*	*95.44%*
Upper GI	97.0%	92.5%	92.4%	96.4%	99.2%	97.2%	95.7%	89.6%	93.2%	94.8%	95.7%	*89.47%*	*93.13%*
Urology	99.3%	97.4%	98.4%	100.0%	99.2%	99.2%	96.6%	98.5%	99.3%	97.7%	99.2%	*88.97%*	*98.36%*
NSS						100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	*100.00%*	*100.00%*

Demand remained high in early December due to sustained high referrals and national awareness campaigns. Staff leave, bank holidays and industrial action created capacity pressure with continuing industrial action hindering any recovery against this standard in January 24.

Performance is expected to return to an above target position in February, although Breast continue to see higher than expected referrals and will not recover as quickly as normal.

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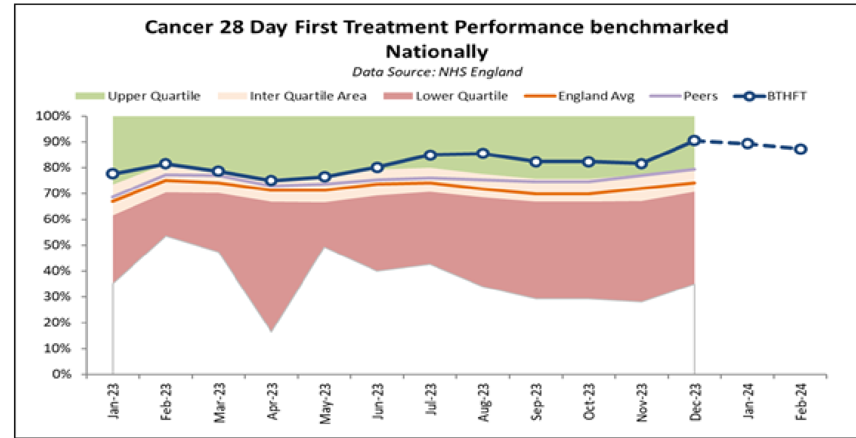
11.2. Cancer 28 Day Faster Diagnosis

Figure 19 28 Day National Comparison – BTHFT



Performance in December 2023 places the Trust in the upper quartile, remaining above peer group and England average.

Table 7 28 Day Faster Diagnosis Standard (FDS)

Site	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
TRUST	80.4%	76.8%	73.3%	75.1%	79.3%	84.2%	85.3%	81.5%	83.5%	81.8%	92.1%	89.21%	87.18%
Breast	101.8%	98.7%	96.1%	97.5%	98.4%	97.4%	97.6%	97.7%	96.6%	98.7%	97.9%	95.71%	95.45%
Gynae	70.1%	55.2%	61.5%	63.3%	65.7%	59.3%	67.5%	49.6%	64.7%	77.1%	86.9%	68.97%	61.29%
Haematology	23.8%	36.8%	50.0%	23.1%	27.3%	30.0%	20.0%	70.0%	33.3%	43.8%	50.0%	13.33%	47.62%
Head & Neck	73.3%	66.8%	77.6%	77.4%	74.3%	81.6%	91.3%	80.4%	86.5%	86.7%	93.5%	83.72%	83.74%
Lower GI	74.6%	74.2%	64.5%	63.0%	68.8%	80.2%	77.6%	71.9%	73.6%	71.6%	88.0%	90.78%	88.76%
Lung	85.2%	81.7%	86.5%	87.9%	87.2%	96.7%	76.7%	90.0%	83.3%	78.4%	84.2%	75.00%	54.55%
Other	84.0%	71.4%	65.0%	79.4%	61.1%	97.6%	33.3%	100.0%	100.0%	0.0%	66.7%		
Skin	85.5%	81.7%	74.6%	79.5%	88.5%	87.6%	89.0%	88.5%	86.7%	80.7%	93.9%	97.98%	97.25%
Upper GI	85.4%	80.0%	72.5%	62.2%	73.5%	79.1%	89.6%	76.7%	84.7%	90.8%	90.0%	92.19%	82.61%
Urology	69.6%	65.4%	65.1%	71.7%	71.8%	67.5%	80.5%	65.7%	81.3%	72.0%	80.0%	70.59%	84.62%
NSS						20.0%	57.1%	66.7%	50.0%	77.8%	90.0%	90.00%	100.00%

FDS performance has continued above target improving to 91.80% in December. Performance improved due to greater capacity, regularity of MDTs and improvements in referral booking processes particularly for lower GI, Gynae and Head & Neck.

Histology delays continue to impact on this phase of cancer pathways. Specific process improvements are being trialled within Skin and Gynae where the greatest scope for change exists. Work is underway to amend and develop job plans to ensure areas with the highest volumes of referrals are targeted whilst addressing the longest waiting patients. New prioritisation protocols are being closely monitored and any improvements measured to support longer term solutions and sustain improved performance. The number of patients waiting 'out of target' are monitored daily enabling flexing of consultant capacity where possible.

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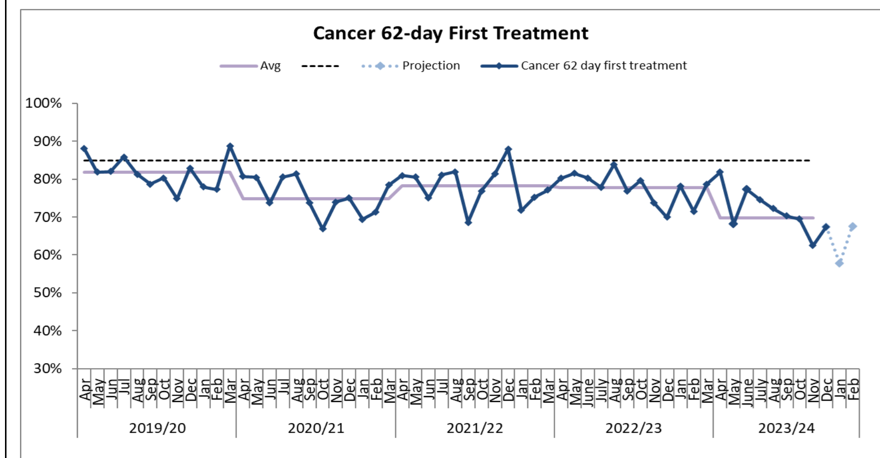
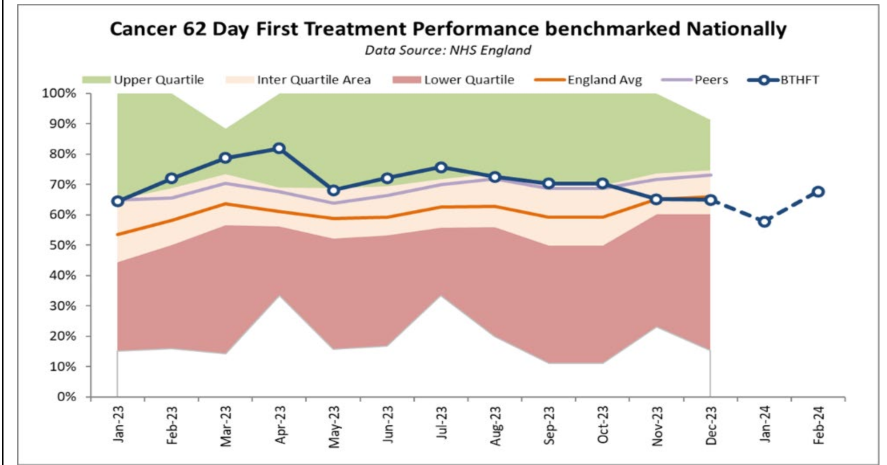
11.3. Cancer 62 Day First Treatment Performance

Figure 20 62 Day First Treatment Performance (Target 85%)



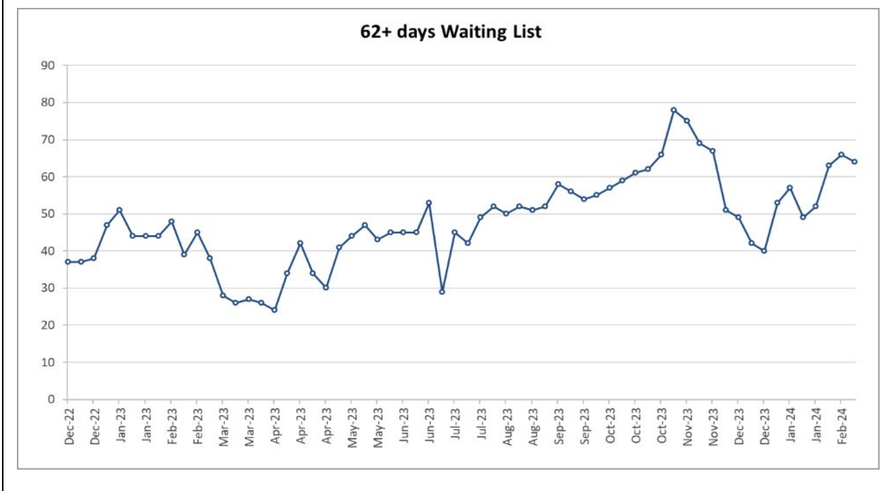
The 62 Day First Treatment in December 2023 was 67.40% which shows an improvement but is still below target.

Figure 21 62 Day First Treatment Performance – National Comparison



BTHFT performance for December 2023 improved slightly but remained in the interquartile above the England Average.

Figure 22 62 day or over waiting list size



The number of patients waiting over 62 days decreased in November and December but has since started to increase.

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Table 5 62 Day First Treatment Performance by Tumour Group

Site	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
TRUST	72.0%	78.7%	81.9%	68.1%	77.3%	74.6%	72.2%	70.3%	69.5%	62.5%	67.4%	57.8%	67.6%
Breast	94.1%	100.0%	92.3%	64.7%	100.0%	81.8%	83.3%	72.7%	73.3%	100.0%	91.7%	82.4%	91.7%
Gynae	50.0%	33.3%	40.0%	22.2%	100.0%	66.7%	63.6%	28.6%	57.1%	33.3%	40.0%	20.0%	60.0%
Haematology	25.0%	33.3%	100.0%	33.3%	60.0%	60.0%	50.0%	75.0%	100.0%	57.1%	40.0%	16.7%	75.0%
Head & Neck	71.4%	73.3%	85.7%	38.5%	60.0%	75.0%	50.0%	50.0%	33.3%	53.3%	36.4%	53.1%	64.7%
Lower GI	50.0%	66.7%	36.4%	45.0%	72.7%	70.6%	52.0%	57.1%	54.5%	54.5%	28.6%	83.3%	66.7%
Lung	16.7%	20.0%	50.0%	18.2%	16.7%	0.0%	0.0%	15.4%	0.0%	33.3%	61.5%	25.0%	62.5%
Other	100.0%	0.0%	0.0%	66.7%	0.0%	33.3%	0.0%	0.0%		66.7%			
Skin	100.0%	97.0%	100.0%	96.8%	93.8%	100.0%	91.4%	77.1%	81.3%	66.7%	75.0%	68.2%	75.0%
Upper GI	42.9%	66.7%	100.0%	0.0%	60.0%	0.0%	66.7%	0.0%	50.0%	50.0%	55.6%	0.0%	25.0%
Urology	64.2%	85.1%	81.4%	83.0%	73.4%	68.8%	69.7%	84.9%	81.4%	69.2%	86.4%	66.7%	59.1%

Treatment timeliness for cancer continues to be the focus with fast-track patients taking priority and early identification of capacity issues in place. The impact of diagnostic delays during Q3 and a loss of capacity due to leave and industrial action is resulting in some pressure during Q4 to date.

It is expected that the transition to the new V12 cancer standards will provide greater oversight on the treatment phase of the pathway with the 31-day standard providing improved visibility to support focused improvements in milestones, MDT and treatment capacity.

12. Other Contractual KPI – by exception

12.1. Cancelled Operations

Table 9 28 Day Rebook Breaches

	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Cancellations to rebook	43	54	30	55	40	26	39	40	33	54	25	62
28 day rebook breaches	3	5	6	7	11	4	3	4	3	1	0	3

3 breaches of the re-booking target occurred in January due to industrial action. February is expected to deliver similar 28-day breaches because of 5 days of industrial action and reduced capacity due to increased annual leave.

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-Dec 2023	Jan 2024 Projected
SSNAP level	C	C	C	C
1) Scanning	C	B	B	B
2) Stroke unit	E	E	E	E
3) Thrombolysis	D	E	D	D
4) Specialist Assessments	C	D	D	C
5) Occupational therapy	B	B	B	A
6) Physiotherapy	B	B	B	B
7) Speech and Language therapy	C	C	C	B
8) MDT working	B	C	C	C
9) Standards by discharge	A	A	A	A
10) Discharge processes	A	A	A	A

Ward 9 opened in December as a neurorehabilitation unit, initially with 12 beds, increasing stroke capacity from 27 to 49 beds with a further 7 beds due in Spring 2024. This will relieve pressure on Ward 6, facilitating constant availability of HASU capacity and enabling swifter transfer of patients from A&E.

The stroke response team have now recruited all 4 Physicians Associate (PA) positions; 3 are awaiting a start date and 1 has begun training. A locum SHO continues to provide interim support to the stroke responder team as a dedicated resource from 0800 to 1600 daily. This has improved the time for scanning from D in Nov 2023 to B in Jan 2024 and Thrombolysis from E to D in the same period.

The projected SSNAP score for January is C with performance either sustained or improved across most metrics. Weekly breach review meetings continue to take place within the team to understand the specific pressure points and ensure there is mitigation where possible. 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 are also ongoing.

A major gap has been identified in the community stroke workforce due to long term sickness which is impacting our ability to manage post-discharge stroke patients with their 6-month follow-ups. A plan is being made to redeploy some resources into this team, but it is anticipated there will be some impact on performance during the transition period.

Significant work is ongoing with our AGH 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.

Meeting Title	Open Board of Directors Meeting		
Date	14 March	Agenda item	Bo.3.24.14

APPENDIX 2

SUMMARY OF CONTRACTUAL KPI

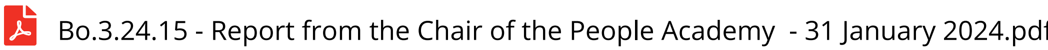
Operational Planning	Month	Threshold	Trajectory Target	Performance
Elective Day Case Spells	Jan-24	110%	107%	105%
Elective Ordinary Spells	Jan-24	110%	102%	75%
First Outpatient Attendances	Jan-24	110%	112%	106%
Admitted Clock Stops	Jan-24	n/a	99%	94%
Non-Admitted Clock Stops	Jan-24	n/a	105%	102%
RTT - Patients waiting >52 weeks on incomplete pathways	Jan-24	476	235	484
RTT - Patients waiting >78 weeks on incomplete pathways	Jan-24	0	0	1
RTT - Total Waiting List size	Jan-24	39,122	36,784	34260
Cancer - Patients waiting over 62 days	Dec-23	42	42	51
Operational Standards	**Month**	**Threshold**	**Trajectory Target**	**Performance**
A&E Emergency Care Standard	Jan-24	95.00%	81.90%	81.98%
Ambulance handovers taking between 30-60 minutes	Jan-24	0	30	184
Ambulance handovers taking longer than 60 minutes	Jan-24	0	10	80
Trolley waits in A&E longer than 12 hours	Jan-24	0	0	175
Emergency Inpatient Length Of Stay >=21days	Jan-24	100	101	124
Cancer 2 week wait	Dec-23	93.00%	93.00%	93.40%
Cancer 2 week wait - breast symptomatic	Dec-23	93.00%	93.00%	90.70%
Cancer 28 day Faster Diagnosis	Dec-23	75.00%	75.00%	91.80%
Cancer 31 day First Treatment	Dec-23	96.00%	96.00%	90.50%
Cancer 31 day Subsequent Surgery	Dec-23	94.00%	94.00%	92.70%
Cancer 31 days for subsequent treatment - anti-cancer drug regimen	Dec-23	98.00%	98.00%	93.80%
Cancer 62 day First Treatment	Dec-23	85.00%	85.00%	67.40%
Cancer 62 days from referral - NHS screening service to first definitive treatment for all cancers	Dec-23	90.00%	90.00%	47.80%
Diagnostics - patients waiting under 6 weeks for test	Jan-24	99.00%	66.00%	67.11%
RTT - Patients waiting <18 weeks on incomplete pathways	Jan-24	92.00%	72.92%	65.03%
Cancelled Operations 28 day breach	Jan-24	0	0	3

**Latest prediction at the time of writing*

BO.3.24.15 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY ? JAN & FEB 2024

REFERENCES

Only PDFs are attached



Bo.3.24.15 - Report from the Chair of the People Academy - 31 January 2024.pdf

Bo.3.24.15 - Report from the Chair of the People Academy - 28 February 2024.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo3.24.15

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 31 January 2024

Key escalation and discussion points from the meeting
Alert:
Absence of NED Champions – through the Health and Safety (H&S) update, a concern was raised that with Jon Prasher's tenure coming to an end, there was no Non-Executive Director (NED) Champion for Health and Safety and therefore no NED Champion at the H&S Committee meeting. Jon was also the Maternity Champion and the absence of a NED Champion for this area was also raised. The Trust Chair is currently working on filling those vacancies. **Violence Prevention and Reduction** – the Violence Prevention and Reduction Standard was introduced in 2021 and the Trust is required to assess itself against the standard twice a year. The standard focuses on three areas 1) Clinically related challenging behaviour 2) Visitors and Public related non-patient related behaviour and 3) staff on staff behaviours, supported by education and training, and data and validation. A different executive lead has been allocated to each of these areas. There are 43 indicators and the Trust has been non-compliant against the standard for the last two years. 533 incidents were recorded last year. Attendance at the VPR meetings is low. The Academy agreed that more scrutiny and engagement, with one named Executive lead, was required and the risk should be escalated to the Board. **Industrial Action** – Faeem Lal updated the Academy on the latest news. The offer put to Consultants was declined by a 1% margin, significantly weakening the position and there is no further planned action at this stage. Junior Doctors are currently balloting for further strike action, with the ballot closing on 20 March and there is no further insight on how this will progress.
Advise:
Workforce Civility – Faeem updated the Academy on how the Trust is embedding Civility in the Workplace with the latest Programme Board focused on triangulating data and consistency of approach, recognising that in an organisation of the Trust's size, there will inevitably be disagreements and relationship issues. There is a need for line managers to be skilled in nipping issues in the bud as soon as they arise. Civility in the Workplace training has commenced for all staff with an ambition to train everyone over the next 12-18 months, following a successful pilot in the Pharmacy team. Training is two hours long and includes discussing video scenarios of incivility and the options for addressing this. Trainees are also given access to the many resources available to help them, such as the Civility Toolkit, People Charter, Staff Advocacy service and wellbeing

information. There is a desire to triangulate data covering Freedom to Speak Up (FTSU) referrals, National Educational Training survey (NETs) and General Medical Council (GMC) surveys with disciplinary data and annual people survey data to identify patterns or themes that can then be addressed.

Assure:

Outstanding Theatre Services – following two years of intense work to transform Theatre Services through the Outstanding Theatres programme, this was the last day of the initiative and the reins have been handed over to the Theatres team to continue to transform the service. The team have devised a brand 'Bradford Theatres – Moving to Outstanding' and a continuation plan along the lines of the CQC categories of well-led, safe, effective, caring and responsive. The safe pathway covers how civility saves lives and the well-led pathway includes targeted staff progression, mentors and preceptors, integration of Band 5s and leadership development. The Academy congratulated the team on the amazing progress over the last 2 years to change the culture, create meaningful change and take ownership.

Dashboard – we reviewed the dashboard and it was great to see turnover at 9.73% at the end of December 23. Turnover has reduced month on month since June 22. The absence rate as at the end of December was 5.78%, down from 5.9% in November 23; a brilliant achievement against increased winter pressures. Recruitment is strong, vacancies are lower and combined with the increased retention rate, this has allowed the Trust to reduce the Nursing and Midwifery staffing risk from 20 to 16.

Disciplinary policy and procedure – Faeem and Samia Hussain sought approval for the revised policy aligned to principles to ensure potential disciplinary cases are dealt with at an early stage, with a view to resolving cases quickly and seeking improved behaviours and conduct. The review has taken some time and follows the 'Just' culture aspirations, with early fact finds, training for investigating managers and support for the individual accused as well as the accuser. We heard from Ammy (Staff Side) who acknowledged that the policy was a complete shift in attitude and culture and the time taken was to ensure the policy was right. He credited Faeem for his pragmatism on this.

Overall, a more realistic agenda meant that we got to cover all items. Once again, there was an absence of NEDs with only the NED Chair present. They highlighted the need for other attendees to challenge Academy content. The Execs, and other attendees, did a great job of challenging and questioning.

Report completed by:

Karen Walker
Academy Chair and Non-Executive Director

31 January 2024

Meeting Title	Board of Directors		
Date	14.3.24	Agenda item	Bo.24.15

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 28 February 2024

Key escalation and discussion points from the meeting
Alert:
Nursing Recruitment and Retention – Ray fairly challenged recruitment to the 16 bed Intensive Care Unit (ICU) where only 7 beds are currently open due to lack of staff. He feels the time to hire is too long, especially when specialist nurse turnaround takes longer, and that the legacy impacts of Covid on those working in ICU has left scars and it's now difficult to attract people. He believes it's needs a 'hearts and minds' approach. Karen Dawber agreed to work with him to give this the focused attention it needs. **Non-medical appraisal rate** - the non-medical appraisal rate has dropped from 79.07% to 78.25%. Whilst increases were seen in Corporate Services and Planned Services, decreases were seen in all other areas. An area the Academy agreed to escalate to the Board.
Advise:
Freedom to Speak Up (FTSU) – 31 concerns were raised in Q3, the highest number since reporting began. October was speak up month and the Lucy Letby findings were released – it's possible there's correlation between awareness and concerns raised. 12 of the concerns were raised anonymously. BTHFT has a FTSU app that allows staff to raise concerns anonymously whereas across the North East and Yorkshire region, 43% of FTSU Guardians have no official route for anonymous concerns to be raised. 14 of the 31 concerns related to inappropriate attitudes and behaviours, 9 had an element of worker safety or wellbeing, 5 related to patient safety/quality and 5 had an element of bullying and harassment. The National Guardian's Office (NGO) have seen an increase in concerns raised nationally. BTHFT is one of 3 organisations chosen by the NGO to participate in a short film about the role of the NED/Trustee in supporting FTSU. I had the privilege of representing the Trust in London on 4th March to share my experience of FTSU and the strength of the relationship with the Guardian, Sue Franklin, who does such a fantastic job with FTSU on BTHFT's behalf.
Assure:
Dashboard – turnover has decreased again, from 9.73% in December to 9.48% in January. Whilst absence decreased from 5.77% in December to 5.78% in January, this is a strong performance against a backdrop of winter illnesses. Short term 'on the day' absence in Nursing and Midwifery is challenging. The absence policy and the way in which absence is recorded using the Bradford Score will be reviewed, with Human Resources (HR) working with the networks and staff side on the revised policy.

Staffing – average fill rates over the last 3 months have improved to above 80%. Registered Nurse vacancies have reduced from 20.5% in April 23 to 12.6% in December 23, with an aim to reduce below 10% by the end of March 24. The number of leavers has reduced, too although the Trust is still reporting 160 healthcare assistant vacancies across wards. The current pipeline of new starters will help to close the gap.

Recruitment Process Improvements – the recruitment process has been reviewed to address the slow nature of the process leading to the loss of good candidates, poor quality communications with candidates, the complexity of the process (particularly for internal vacancies) and low confidence in the TRAC system. The Recruitment team have made several improvements including a simplification of the TRAC approval process, TRAC training, a TRAC intranet page, improved communications, and a reorganisation of the recruitment team with recruitment up to required headcount. The changes have significantly reduced email traffic between HR and those recruiting and it is now 57% quicker to review/approve vacancies. The stages within the Recruitment teams' control have improved significantly but there is much work to do to see improvements from those areas outside of the Recruitment team's control, such as recruitment manager shortlisting, delays in paperwork, induction, Occupational Health referrals and reporting. There are further system improvements to come and there will be a big focus on improving the onboarding experience next. Initiatives to broaden the talent pool with entry level requirements, apprenticeships, refugee support and volunteer to career are in plan, as well as improved advertising through social media.

Report completed by:

Karen Walker
Academy Chair and Non-Executive Director

28 February 2024

BO.3.24.16 - EDI STRATEGY ANNUAL UPDATE / EQUALITY, DIVERSITY & INCLUSION UPDATE (WRES, WDES)

REFERENCES

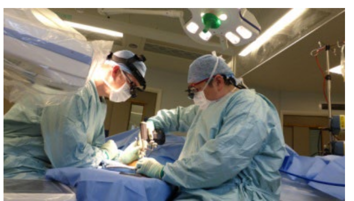
Only PDFs are attached

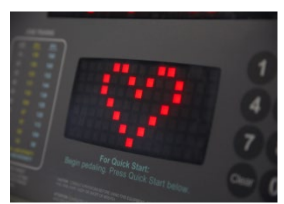
B.3.24.16 - EDI Update March 2024 Final.pdf

Equality, Diversity & Inclusion Update

The Trust's approach, progress and future direction.

Kez Hayat, Head of Equality, Diversity & Inclusion
(Trust Board – 14th March 2024)





Together, putting patients first

Overview & Contents

The purpose of this presentation is to provide an annual update on the Trust's approach and progress to EDI, including our future direction, and progress on the EDI Strategy

EDI Landscape, Contractual & Legal Obligations

Together, putting patients first

Public Sector Equality Duty

A public authority must, in the exercise of its functions, have due regard to the need to:

Eliminate discrimination, harassment and victimisation

Advance equality of opportunity amongst protected characteristics

Foster good relations between protected characteristics

Equality Act 2010 Protected Characteristics

Race
Disability
Marriage and civil partnership
Religion or belief
Gender reassignment, expression and identity
Maternity and pregnancy
Sexual orientation
Age
Sex

Our approach to EDI

- Dedicated and committed EDI Team whose role is to help facilitate and advance the EDI agenda across the Trust, including the 5 key strategic objectives identified in our EDI Strategy.

- Strategic Equality and Diversity Council, chaired by CEO to help us identify and align our workforce and population health inequalities priorities.

- People Academy – Workforce with staff networks represented at each meeting

- Wider focus on Inclusion & Belonging recognising 'intersectionality' (NHS People Plan, Regional People Plan & District wide focus)

- Increased focus on engagement and Involvement (communities and workforce)

- Equality Impact Assessments – Identifying impact on the 9 protected groups

Our EDI Strategy and Objectives
2023-2025

Objective 1 — **Education, Empowerment and Support**

Ensure all our staff are aware of their own and the Trust's responsibilities for advancing a culture of equality of opportunity and fostering good relations, achieved through targeted training and development, with particular focus on cultural competency.

Objective 2 — **Effective Community and Staff Engagement and Involvement**

Build community and staff trust and confidence through effective community engagement and involvement

Objective 3 — **Population Health Inequalities**

Tackle health inequalities and strengthen the system approach to population/place-based health and care management.

Objective 4 — **Promoting Inclusive Behaviours**

Ensure all our staff, contractors, visitors and the wider community are aware of the effects of their behaviour on others and are equipped to challenge and report inappropriate behaviour when they experience or witness it.

Objective 5 — **Reflective and Diverse Workforce**

Develop and enhance our approach to recruitment, selection and promotion to positively attract, retain and support the progression of diverse staff across the Trust.

Our Progress

Last 12 months:

We continue to work on ensuring our legal and contractual obligations are fulfilled for example annual WRES and WDES submissions with up to date action plans in place annually

Launched the Trust's first EDI Strategy 'We are Bradford: We value diversity and champion inclusion' in May 2023 as part of national day for staff networks

EDI strategy discussions at CSU/ Management meetings: supporting teams and departments in the development of individual EDI action plans aligned to our EDI strategy.

Launch of both the EDI & Workplace Civility training for managers: Face-to-face sessions, empowering managers and providing safe spaces for learning and discussion. Utilising the drama-based workplace civility training videos.

Our Progress

Last 12 months:

Review and refresh of the Trust Harassment & Bullying Policy: replaced with the Respect, Civility & Resolution Policy

EDC championing the Health Inequalities Agenda:

- Using data to reduce DNA rates and prioritise patient groups with multiple deprivations
- Introducing HEAT training/ analysis and data monitoring for CSU's

Influenced the development of the newly launched Patient Engagement Strategy by recognising and acknowledging the diverse communities and patients we serve

Our Achievements

Last 12 months:

Exceeded our target of an overall workforce representative of the local community, the target was 35% we are at 40%

Nursing Times Workforce Award 2023 **"Best Employer for Equality, Diversity & Inclusion"** This was for our approach to EDI and the infra-structure we have developed to embed and mainstream EDI in everything we do

Significant improvements in our most recent Staff Survey Results for our diverse staff and with improvements overall for Equality & Diversity, Inclusion and Staff Engagement measures

Further raised the profile of Race, Disability, LGBT+ and Gender equality across the Trust: Working with our Staff Equality Networks to celebrate national equality days and religious/ cultural festivals.

Established Support for Staff aligned to the Workplace Civility agenda:

- Success of the Workplace Mediation Service
- Reviewed and Refreshed of the Trust Advocacy Service (trained 5 new recruits)

The Equality Delivery System 2022

- Accountability & Improvement tool for NHS Organisations
- Contractual Requirement/ Supports delivery of the PSED
- Collaborative approach
- Task & Finish Groups *(Evidence & Insights)*
- Staff and Community Engagement events
    - Good turnout
    - Diverse representation
    - Positive feedback
    - Recognition of the good work taking place across the Trust
    - Areas where improvements can be made

Commissioned or provided services

Workforce health and wellbeing

Inclusive leadership

11 Outcome measures across 3 domains:

Rated: Achieving

The NHS EDI Improvement Plan

High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

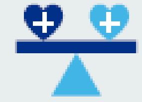
Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2



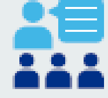
Comprehensive induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff



Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

Reflections on the last 12 months

- Great progress over the last 12 months, working with our diverse staff and engaging others to raise the profile of EDI across the Trust.
- Staff Equality Networks are now thriving, have a real voice in the organisation and are influencing change at a strategic level. Events on the concourse is creating lots of dialogue on EDI
- We have a clear focus on tackling health inequalities as an acute hospital and more clear around our role as an anchor organisation, work with CSU's has commenced around the HEAT process and key areas of focus (recent update report to ETM)
- Our efforts are reflected in some of the external recognition we have received, but also in our recent staff survey results (with improvements on virtually all EDI related indicators and with staff generally feeling more valued and supported)
- We have created some innovative tools (civility training) being received really well and staff finding contents empowering and useful

Next Steps:

- **Proactively work towards improving our performance on WRES & WDES:** Ensuring our workforce is reflective of the communities and patients we serve across all levels of the organisation, and with specific focus **at Senior Leadership levels** and ensuring our diverse staff have a good experience in the workplace

- **Continue to develop our approaches to civility & respect in the workplace:** Looking ahead to the launch of the refreshed "**Civility, Respect & Resolution Policy"** accompanied by a range of training and resources, with focus on:
  - "Nipping issues in the bud" at an early stage
  - Raising the profile of the refreshed Staff Advocacy and Workplace Mediation service
  - Ensuring there is a zero-tolerance approach to harassment & bullying/ violence from patients and members of the public

- Proactive focus on the national EDI plan and the 6 high impact actions

Next Steps:

- Renewing our approaches to "**Root out Racism**", ensuring the Trust is actively engaged in this movement and our response to the "Too Hot to Handle" report

- Focus on **Cultural Competency** and training from a patient perspective, resources and capacity required for this to happen

- **Focus on staff experience and retention** (including our approach to Onboarding and Exit Interviews)

- Renewed efforts to improve gender equality in the Trust with focus on women in leadership and men into traditionally female roles **(IWD event March 24)**

Next Steps:

- Continue with our active involvement, collaboration and partnering with Bradford & Craven District partners on EDI activity utilising the **‘Act as One’** approach – recent example, EDS22

- **Ensure our EDI agenda is aligned to local, regional and national priorities** (ICB currently in the process of developing their EDI strategy.

- We are keen to organise and deliver a place based **EDI conference** in late 2024 showcasing EDI across the District.

Questions & Discussion

BO.3.24.17 - STAFF SURVEY RESULTS

REFERENCES

Only PDFs are attached

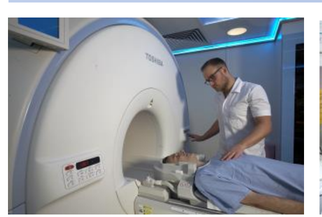
Bo.3.24.17 - Staff Survey Results (presentation).pdf

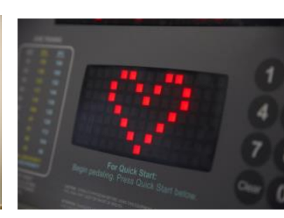
Bo.3.24.17 - NSS23 Benchmark Reports_RAE.pdf

Bo.3.24.17 - NSS23 Breakdown Reports_RAE.pdf

2023 Staff Survey Results

Faeem Lal, Interim HR Director





Together, putting patients first

2023 NHS Staff Survey results overview of national average scores

Promise Element/ Theme	2021 National Average Score	2022 National Average Score	2023 National Average Score	2023 Acute and Acute Community Trusts	2023 Community Trusts	2023 Acute Specialist Trusts	2023 MH/LD and MH/LD Community Trusts	2023 Ambulance Trusts	BTHFT 2023
We are compassionate and inclusive	**7.24**	**7.23**	7.30	7.23	7.71	7.55	7.58	6.80	**7.37**
We are recognised and rewarded	**5.89**	**5.80**	6.00	5.91	6.42	6.13	6.43	5.30	**6.12**
We each have a voice that counts	**6.72**	**6.68**	6.72	6.67	7.12	6.93	6.98	5.93	**6.87**
We are safe and healthy	**5.94**	**5.94**	#	#	#	#	#	#	**6.12**
We are always learning	**5.28**	**5.39**	5.64	5.59	6.00	5.79	5.92	4.85	**5.94**
We work flexibly	**6.06**	**6.09**	6.28	6.17	6.87	6.40	6.83	5.33	**6.28**
We are a team	**6.64**	**6.69**	6.80	6.72	7.18	6.93	7.17	6.16	**6.88**
Employee Engagement	**6.84**	**6.79**	**6.89**	6.86	7.23	7.29	7.11	6.01	**7.02**
Morale	**5.77**	**5.74**	5.95	5.90	6.20	6.14	6.18	5.52	**6.06**

Green numbers show where Trust Type scores are higher than the 2023 NHS national average.
Red numbers show where Trust type scores are lower than the 2023 NHS national average.
Black numbers show where the Trust type score is the same as the 2023 NHS national average.

Together, putting patients first

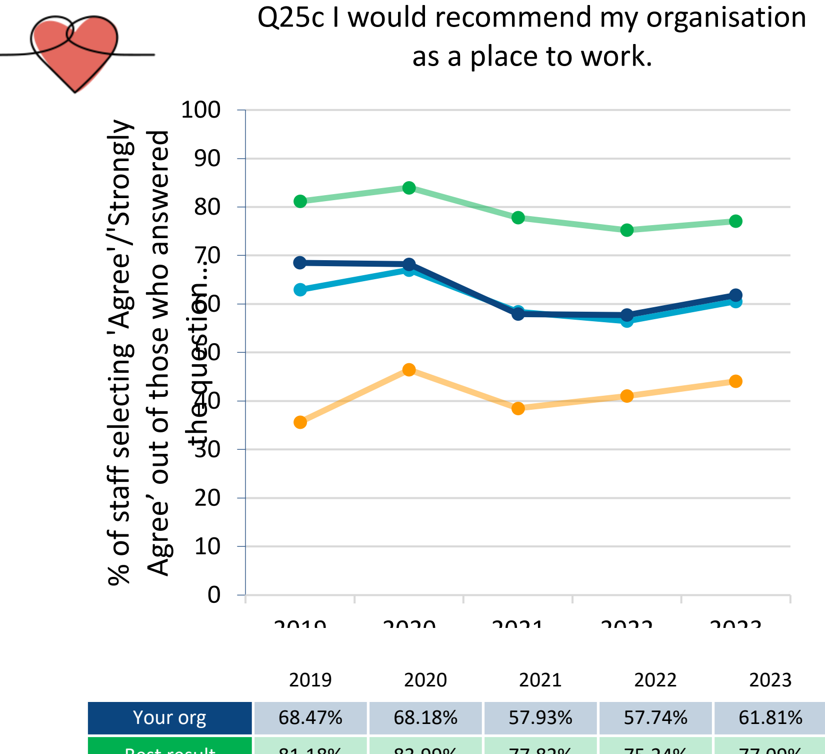
People Promise Elements and Themes – National

People Promise Element/ Theme/Sub-score	Score					Change				BTHFT 2023
	2019	2020	2021	2022	2023	19-20	20-21	21-22	22-23	
We are compassionate and inclusive			**7.24**	**7.23**	**7.30**			**-0.01**	**+0.07**	7.37
Compassionate culture			7.11	6.98	7.09			-0.13	+0.12	7.12
Compassionate leadership			6.88	6.95	7.06			+0.07	+0.11	7.12
Diversity and equality			8.10	8.10	8.11			-0.01	+0.02	8.26
Inclusion			6.86	6.89	6.92			+0.03	+0.03	7.00
We are recognised and rewarded			**5.89**	**5.80**	**6.00**			**-0.09**	**+0.19**	6.12
We each have a voice that counts			**6.72**	**6.68**	**6.72**			**-0.04**	**+0.04**	6.87
Autonomy and control			6.90	6.92	6.97			+0.02	+0.05	7.24
Raising concerns			6.54	6.44	6.46			-0.10	+0.02	6.50
We are safe and healthy			**5.94**	**5.94**	**#**			**0.00**	**#**	6.12
Health and safety climate			5.29	5.26	#			-0.03	#	5.53
Burnout			4.84	4.86	5.04			+0.01	+0.18	5.01
Negative experiences			7.70	7.70	#			+0.01	#	7.82

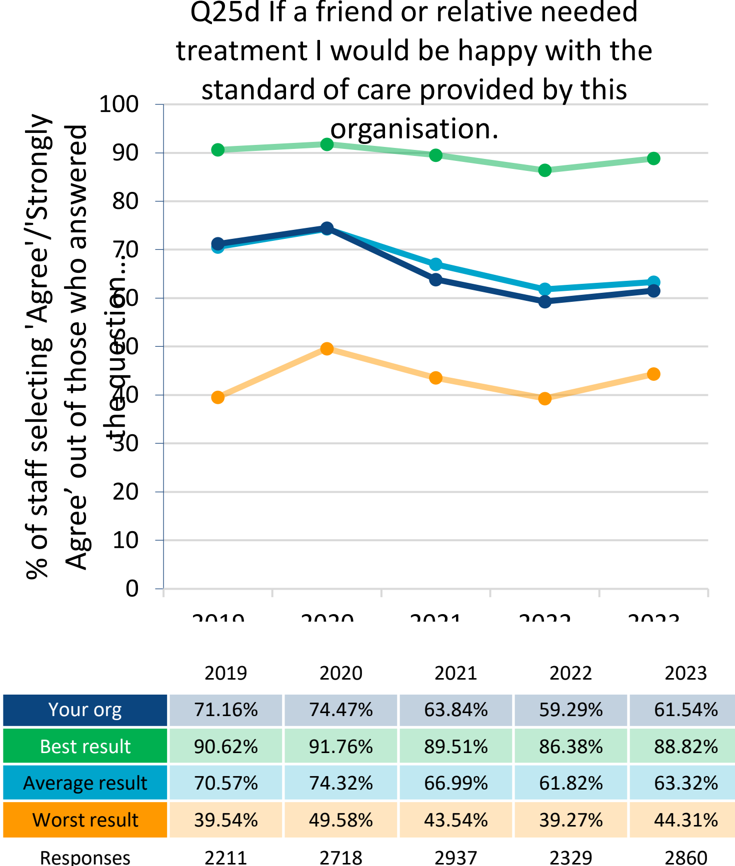
People Promise Elements and Themes

										BTHFT 2023
We are always learning			5.28	5.39	5.64			+0.10	+0.25	5.94
Development			6.31	6.38	6.49			+0.07	+0.11	6.71
Appraisals			4.25	4.38	4.77			+0.14	+0.39	5.12
We work flexibly			6.06	6.09	6.28			+0.04	+0.19	6.28
Support for work-life balance			6.06	6.12	6.32			+0.06	+0.20	6.30
Flexible working			6.05	6.07	6.25			+0.01	+0.18	6.26
We are a team			6.64	6.69	6.80			+0.05	+0.11	6.88
Team working			6.58	6.61	6.70			+0.02	+0.10	6.79
Line management			6.70	6.77	6.89			+0.07	+0.12	6.98
Staff Engagement	7.04	7.05	6.84	6.79	6.89	0.00	-0.20	-0.05	+0.10	7.02
Motivation	7.30	7.23	6.96	6.94	7.02	-0.08	-0.26	-0.02	+0.08	7.14
Involvement	6.82	6.76	6.74	6.78	6.85	-0.06	-0.01	+0.04	+0.07	7.11
Advocacy	7.02	7.16	6.83	6.66	6.81	0.14	-0.33	-0.17	+0.14	6.82
Morale	5.95	6.08	5.77	5.74	5.95	0.13	-0.31	-0.04	+0.21	6.06
Thinking about leaving	6.16	6.28	5.96	5.87	6.06	0.13	-0.32	-0.09	+0.19	6.31
Work pressure	5.29	5.55	5.07	5.01	5.34	0.27	-0.48	-0.06	+0.33	5.32
Stressors	6.43	6.41	6.30	6.33	6.43	-0.02	-0.11	+0.03	+0.10	6.56

People Promise Elements and Themes Results - We are compassionate and inclusive: Compassionate culture



	2019	2020	2021	2022	2023
Your org	68.47%	68.18%	57.93%	57.74%	61.81%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2226	2717	2938	2337	2867



	2019	2020	2021	2022	2023
Your org	71.16%	74.47%	63.84%	59.29%	61.54%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2211	2718	2937	2329	2860

Workforce Race Equality Standard (WRES)

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months out of those who answered the question

	2019	2020	2021	2022	2023
White staff: Your org	20.44%	24.80%	22.20%	24.43%	20.78%
All other ethnic groups*: Your org	24.95%	26.72%	30.47%	28.84%	21.76%
White staff: Average	24.44%	24.37%	23.65%	23.25%	22.37%
All other ethnic groups*: Average	28.39%	29.07%	28.53%	28.81%	26.20%
White staff: Responses	1654	2020	2194	1707	1968
All other ethnic groups*: Responses	525	655	699	593	850

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

	2019	2020	2021	2022	2023
White staff: Your org	63.02%	63.00%	63.60%	65.65%	64.97%
All other ethnic groups*: Your org	44.02%	46.66%	43.71%	46.09%	50.60%
White staff: Average	60.00%	59.39%	58.64%	58.65%	58.84%
All other ethnic groups*: Average	46.62%	45.24%	44.56%	47.00%	49.64%
White staff: Responses	1644	2027	2184	1697	1964
All other ethnic groups*: Responses	527	658	700	588	832

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.

	2019	2020	2021	2022	2023
White staff: Your org	4.88%	4.98%	6.52%	5.69%	6.56%
All other ethnic groups*: Your org	14.37%	15.68%	15.44%	18.27%	12.66%
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
White staff: Responses	1640	2007	2179	1686	1966
All other ethnic groups*: Responses	515	644	693	591	845

*Staff from all other ethnic groups combined

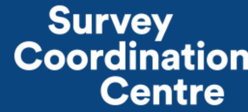
Appendix B: Significance testing – 2022 vs 2023

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.26	2353	7.37	2878	Significantly higher
We are recognised and rewarded	5.86	2349	6.12	2881	Significantly higher
We each have a voice that counts	6.79	2316	6.87	2838	Not significant
We are safe and healthy	5.92	2333	6.12	2857	Significantly higher
We are always learning	5.58	2236	5.94	2738	Significantly higher
We work flexibly	6.07	2331	6.28	2858	Significantly higher
We are a team	6.70	2347	6.88	2873	Significantly higher
Themes					
Staff Engagement	6.90	2358	7.02	2887	Significantly higher
Morale	5.81	2356	6.06	2884	Significantly higher

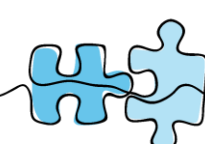
* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Questions?



Bradford Teaching Hospitals NHS Foundation Trust

NHS Staff Survey Benchmark report 2023



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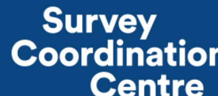
Survey Coordination Centre

Introduction

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this Report



About this report

This benchmark report for Bradford Teaching Hospitals NHS Foundation Trust contains results for the 2023 NHS Staff Survey, and historical results back to 2019 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations*.

Please note: Results for Q1, Q10a, Q26d, Q27a-c, Q28, Q29, Q30, Q31a, Q32a-b, Q33, Q34a-b and Q35 are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from the Staff Survey website.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and subscores are related and mapped to individual survey questions.

* The data included in this report are weighted to the national benchmarking groups. The figures in this report may be different to the figures produced by your contractor. Please see Appendix C for a note on the revision to 2019 historical benchmarking for Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trust benchmarking groups.

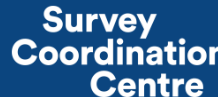
People Promise elements, themes and sub-scores

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q21
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
	Other questions [Not scored]	Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Questions not linked to the People Promise elements or themes

Q1, Q10a, Q10b, Q10c, Q11e, Q15, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q26d, Q31b

Report structure



Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, themes and sub-scores, as well as features of the charts used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise elements, themes and sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise elements, themes and sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These charts are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

Note where there are fewer than 10 responses for a question this data is not shown to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores: Questions

This section provides trend results for **questions**. The questions are presented in sections for each of the People Promise elements and themes.

Not all questions reported within the section for a People Promise element or theme feed into the score and sub-scores for that element or theme. The first slide in the section for each People Promise element or theme lists which of the questions that are included in the section feed into the score and sub-scores, and which do not.

Questions not linked to People Promise

Results for the questions that are not related to any People Promise element or theme and do not contribute to the scores and sub-scores are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

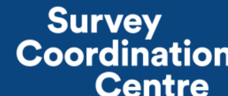
This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and theme results for 2022 vs 2023.
- Guidance on data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

Using the report



Note this is example data

Key features

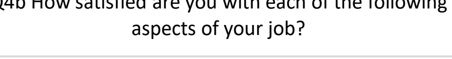
Question number and text (or summary measure) specified at the top of each slide.

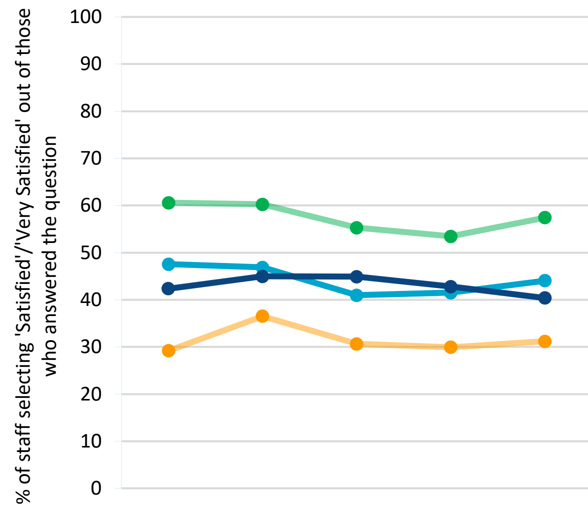
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

	2021	2022	2023
Your org	32.6%	30.6%	30.0%
Best result	21.8%	21.7%	18.0%
Average result	30.2%	29.8%	28.1%
Worst result	37.6%	36.9%	38.5%
Responses	480	500	515

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is a better or worse result.

'Best result', 'Average result', and 'Worst result' refer to the **benchmarking group's** best, average and worst **results.**





	2019	2020	2021	2022	2023
Your org	42.3%	45.0%	44.9%	42.8%	40.4%
Best result	60.6%	60.3%	55.3%	53.5%	57.4%
Average result	47.5%	46.9%	41.0%	41.5%	44.0%
Worst result	29.2%	36.5%	30.6%	29.9%	31.2%
Responses	835	1255	1491	1325	517

Number of responses for the organisation for the given question.

Tips on how to read, interpret and use the data are included in the Appendices

Note charts will only display data for the years where an organisation has data. For example, an organisation with three years of trend data will see charts such as q4b with data only in the 2021, 2022 and 2023 portions of the chart and table.

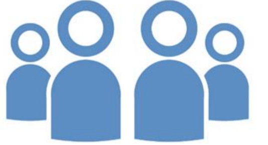
Survey Coordination Centre

Organisation details

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Bradford Teaching Hospitals NHS Foundation Trust

2023 NHS Staff Survey



Organisation details

Completed questionnaires	2905
2023 response rate	43%

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2023 benchmarking group details

Organisations in group: 122

Median response rate: 45%

No. of completed questionnaires: 477643

Survey details

Survey mode	Mixed

For more information on benchmarking group definitions please see the Technical document.

People Promise elements, themes and sub-score results

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

People Promise elements, themes and sub-scores: Overview

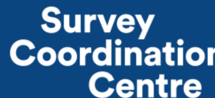
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Overview

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

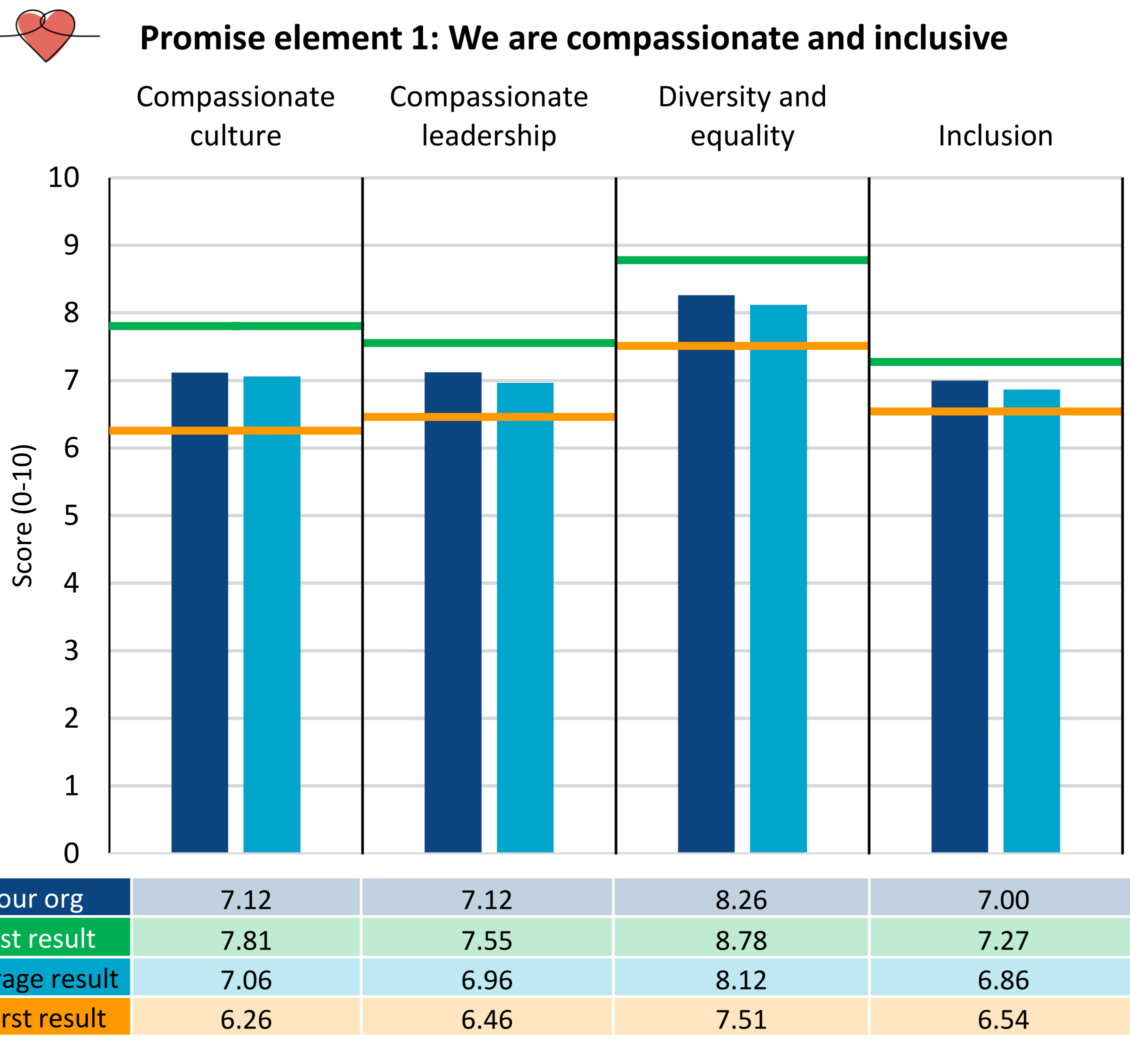
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.37	6.12	6.87	6.12	5.94	6.28	6.88	7.02	6.06
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2878	2881	2838	2857	2738	2858	2873	2887	2884

People Promise elements, themes and sub-scores: Sub-score overview



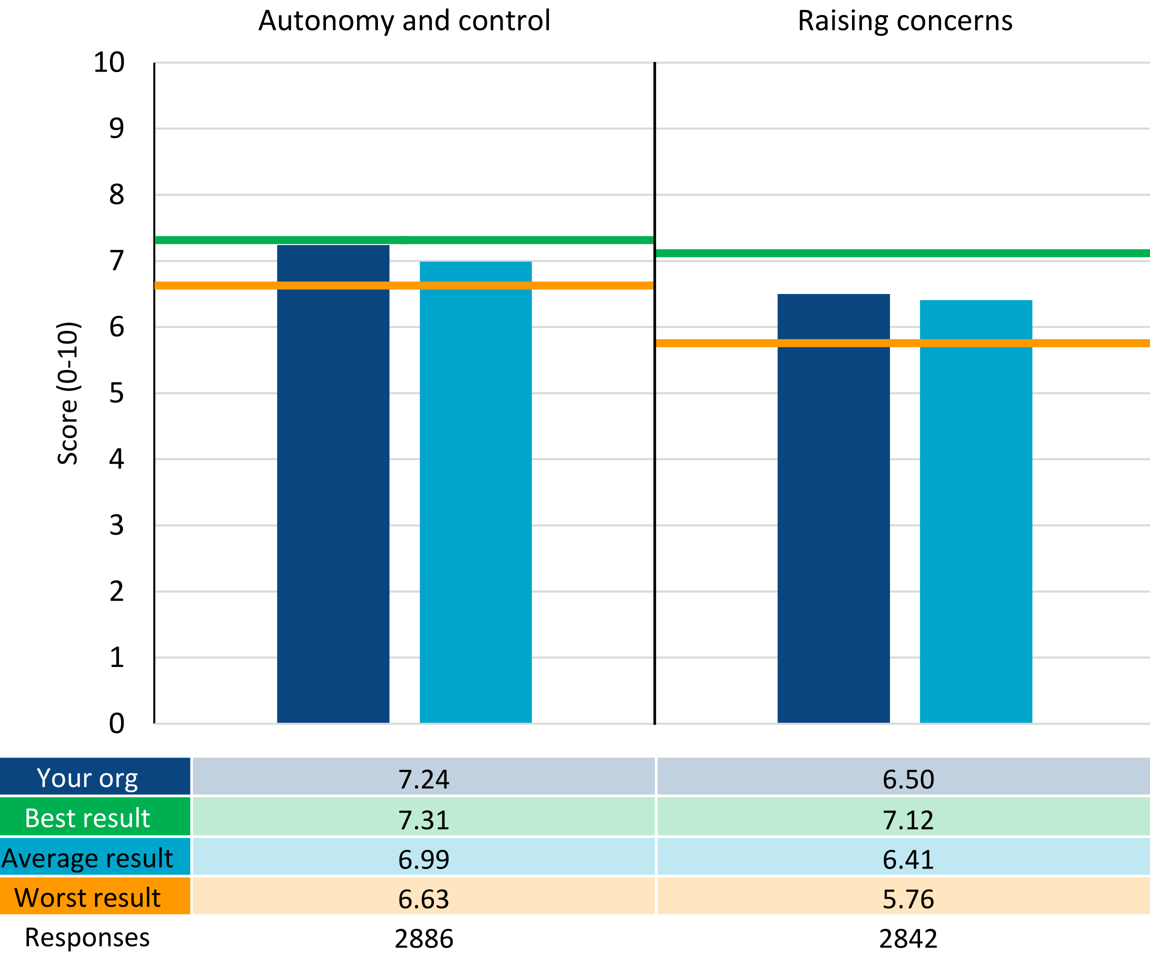
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.12	7.12	8.26	7.00
Best result	7.81	7.55	8.78	7.27
Average result	7.06	6.96	8.12	6.86
Worst result	6.26	6.46	7.51	6.54
Responses	2869	2876	2867	2865

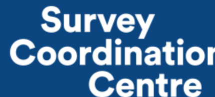
Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	7.24	6.50
Best result	7.31	7.12
Average result	6.99	6.41
Worst result	6.63	5.76
Responses	2886	2842

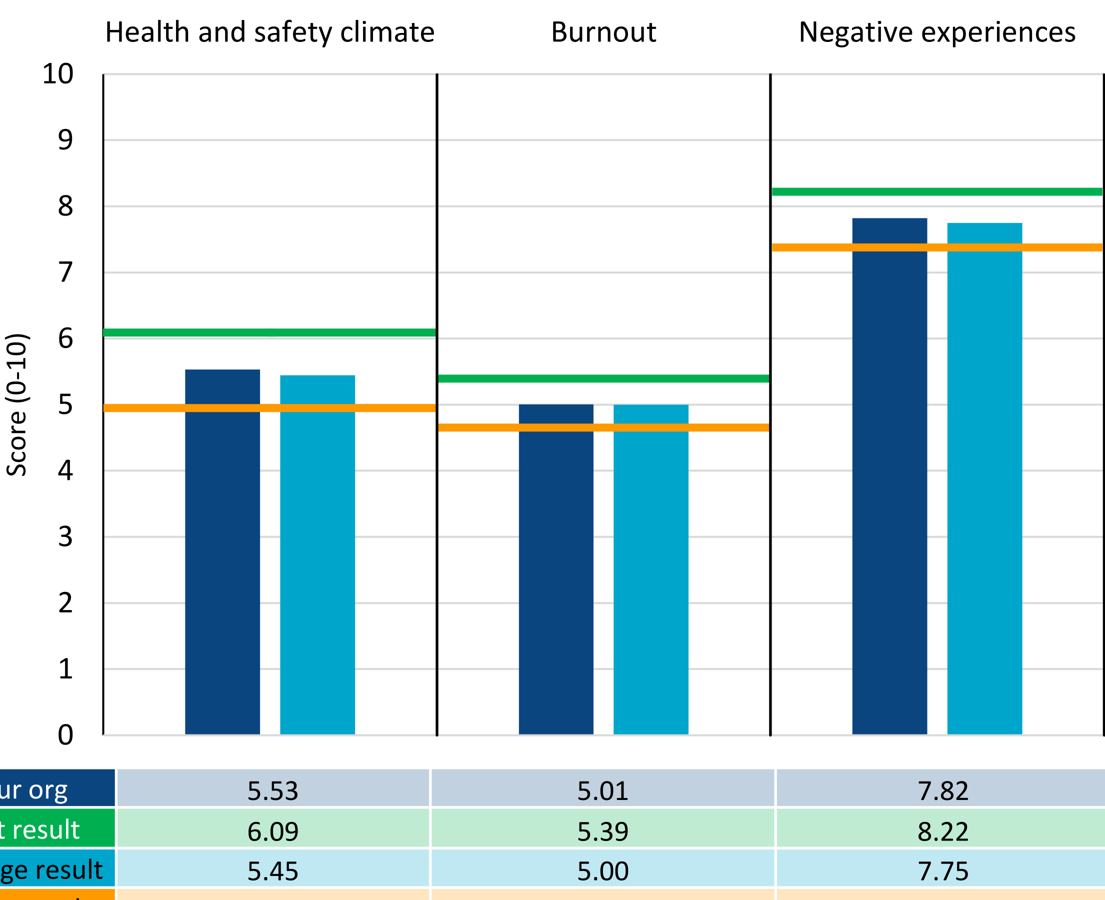
Note. People Promise element 2 ‘We are recognised and rewarded’ does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview



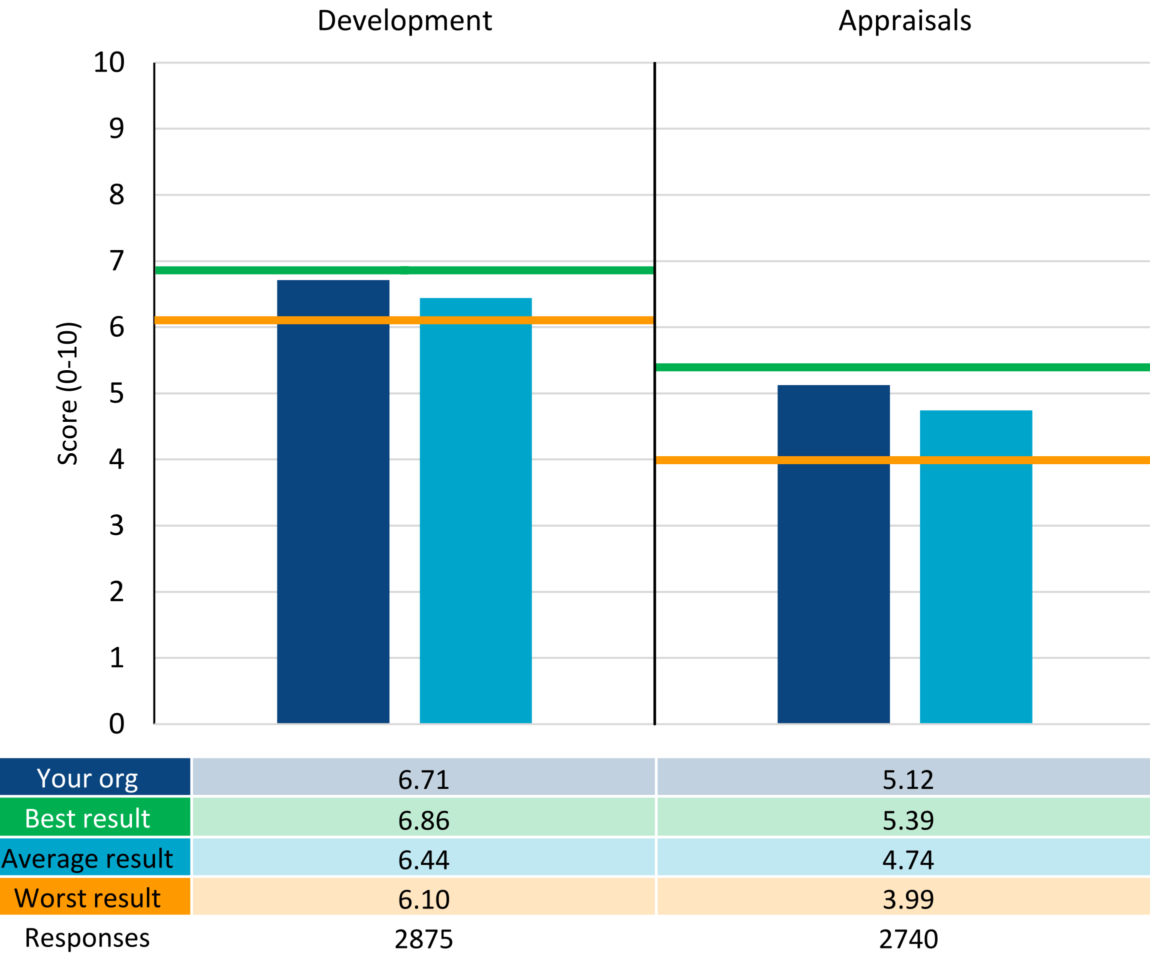
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



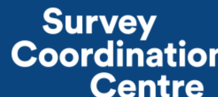
	Health and safety climate	Burnout	Negative experiences
Your org	5.53	5.01	7.82
Best result	6.09	5.39	8.22
Average result	5.45	5.00	7.75
Worst result	4.95	4.65	7.38
Responses	2884	2875	2866

Promise element 5: We are always learning

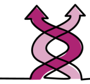


	Development	Appraisals
Your org	6.71	5.12
Best result	6.86	5.39
Average result	6.44	4.74
Worst result	6.10	3.99
Responses	2875	2740

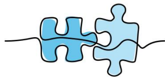
People Promise elements, themes and sub-scores: Sub-score overview



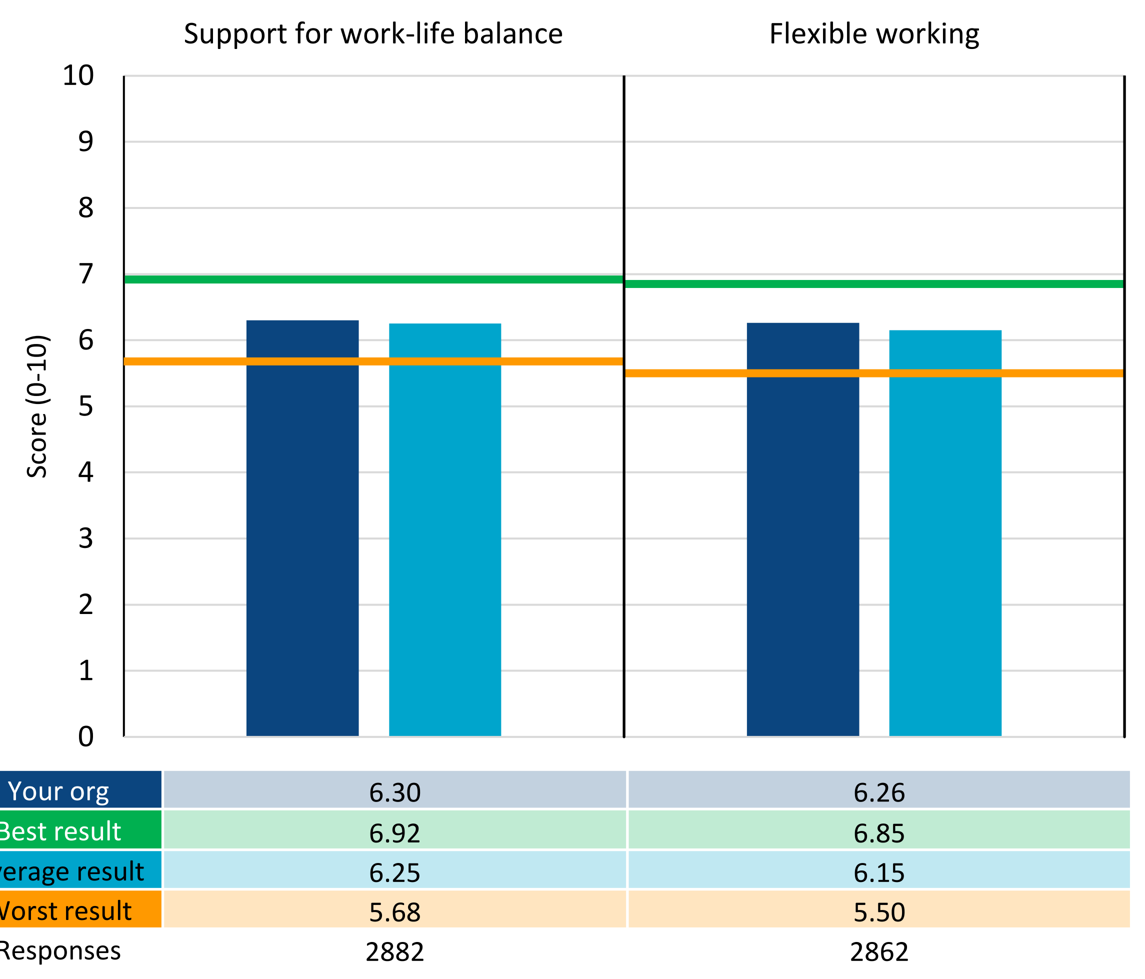
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



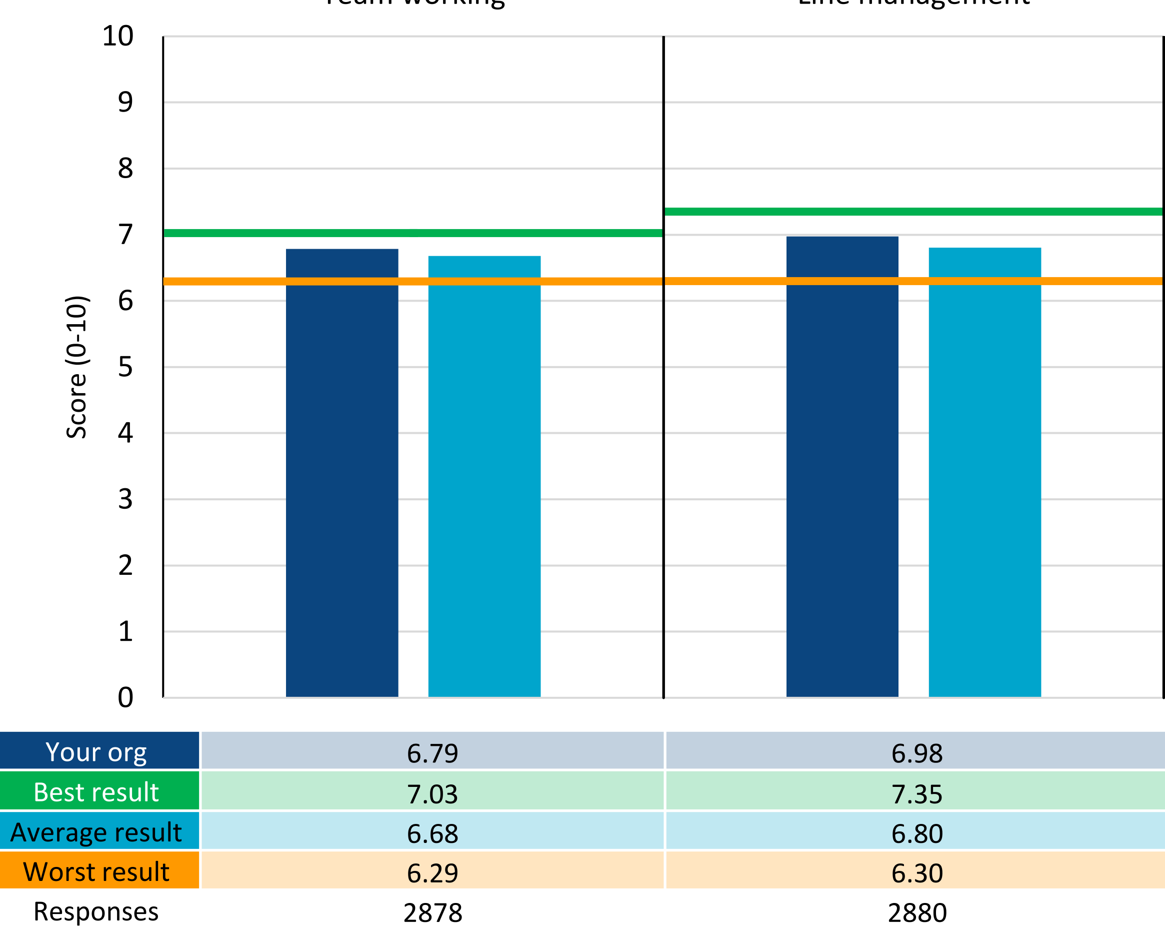
Promise element 6: We work flexibly



Promise element 7: We are a team

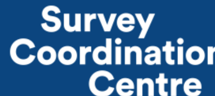


	Support for work-life balance	Flexible working
Your org	6.30	6.26
Best result	6.92	6.85
Average result	6.25	6.15
Worst result	5.68	5.50
Responses	2882	2862



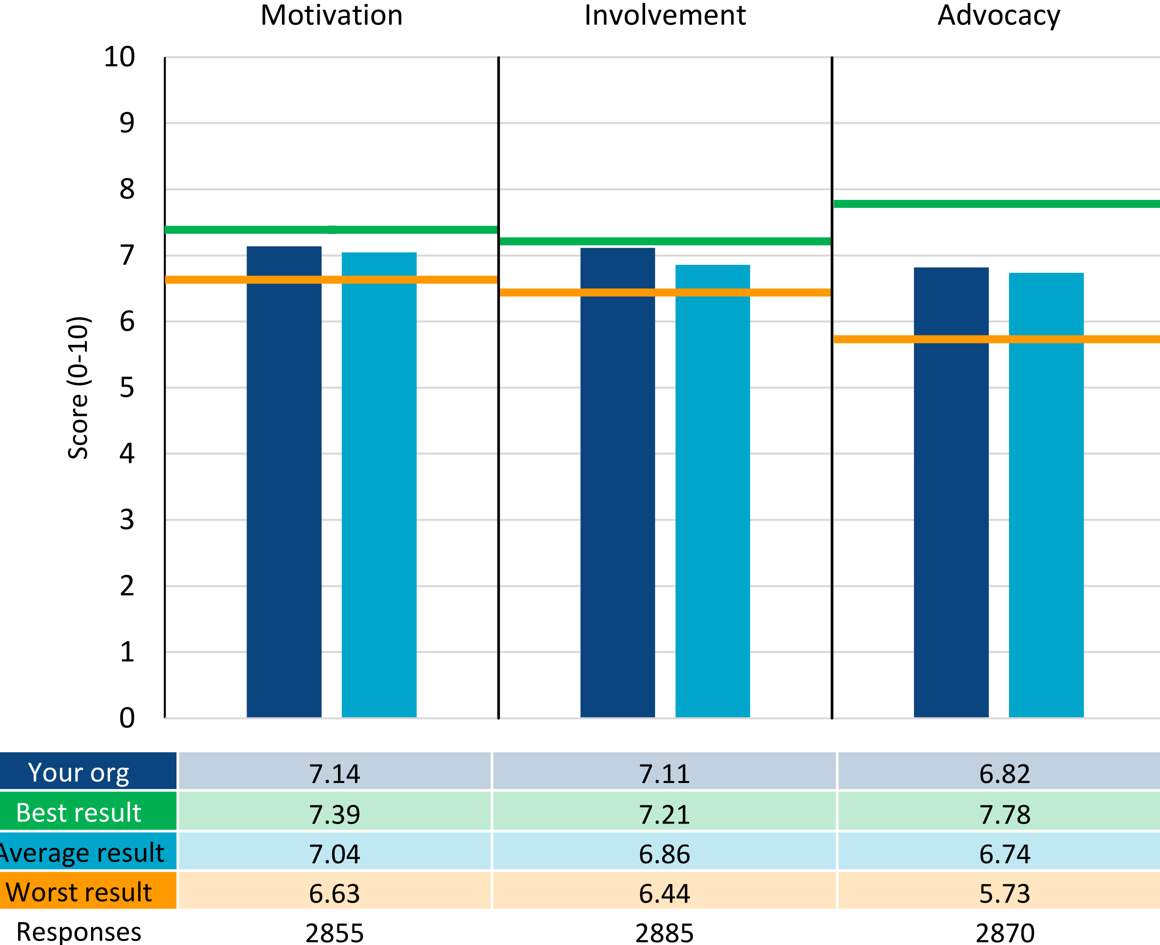
	Team working	Line management
Your org	6.79	6.98
Best result	7.03	7.35
Average result	6.68	6.80
Worst result	6.29	6.30
Responses	2878	2880

People Promise elements, themes and sub-scores: Sub-score overview



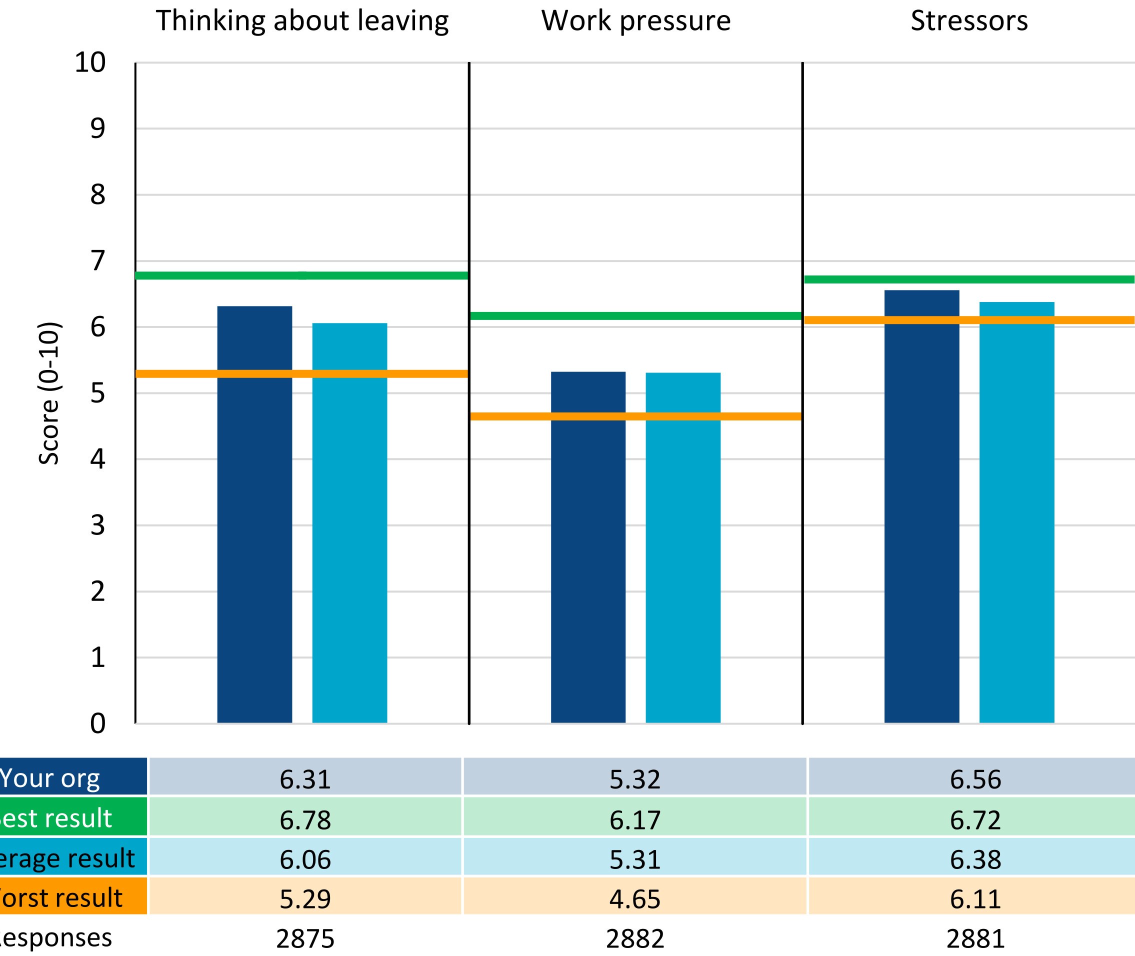
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.14	7.11	6.82
Best result	7.39	7.21	7.78
Average result	7.04	6.86	6.74
Worst result	6.63	6.44	5.73
Responses	2855	2885	2870

Theme: Morale



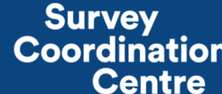
	Thinking about leaving	Work pressure	Stressors
Your org	6.31	5.32	6.56
Best result	6.78	6.17	6.72
Average result	6.06	5.31	6.38
Worst result	5.29	4.65	6.11
Responses	2875	2882	2881

Survey Coordination Centre

People Promise elements, themes and sub-scores: Trends

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Trends



People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

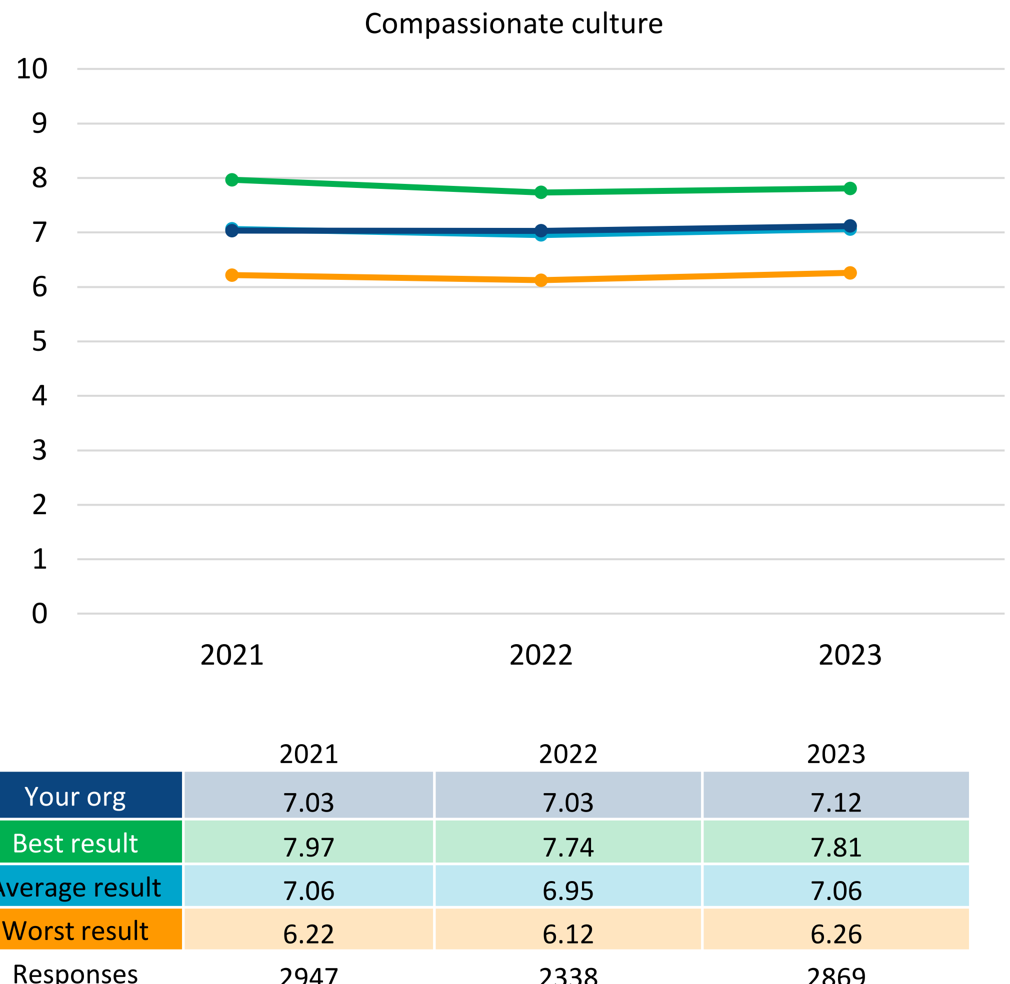
Promise element 1: We are compassionate and inclusive

	2021	2022	2023
Your org	7.13	7.26	7.37
Best result	7.78	7.67	7.71
Average result	7.20	7.18	7.24
Worst result	6.75	6.76	6.85
Responses	2957	2353	2878

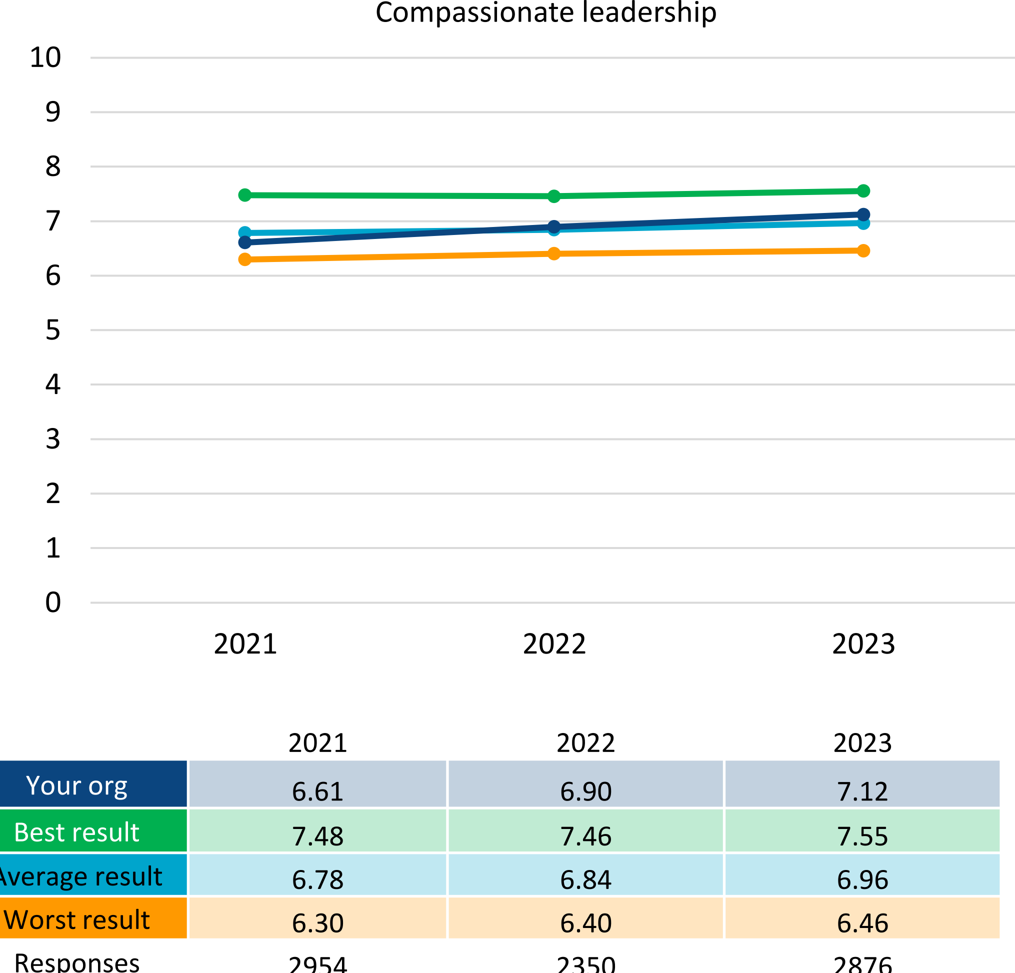
People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive (1)

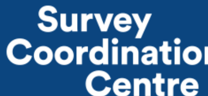


	2021	2022	2023
Your org	7.03	7.03	7.12
Best result	7.97	7.74	7.81
Average result	7.06	6.95	7.06
Worst result	6.22	6.12	6.26
Responses	2947	2338	2869



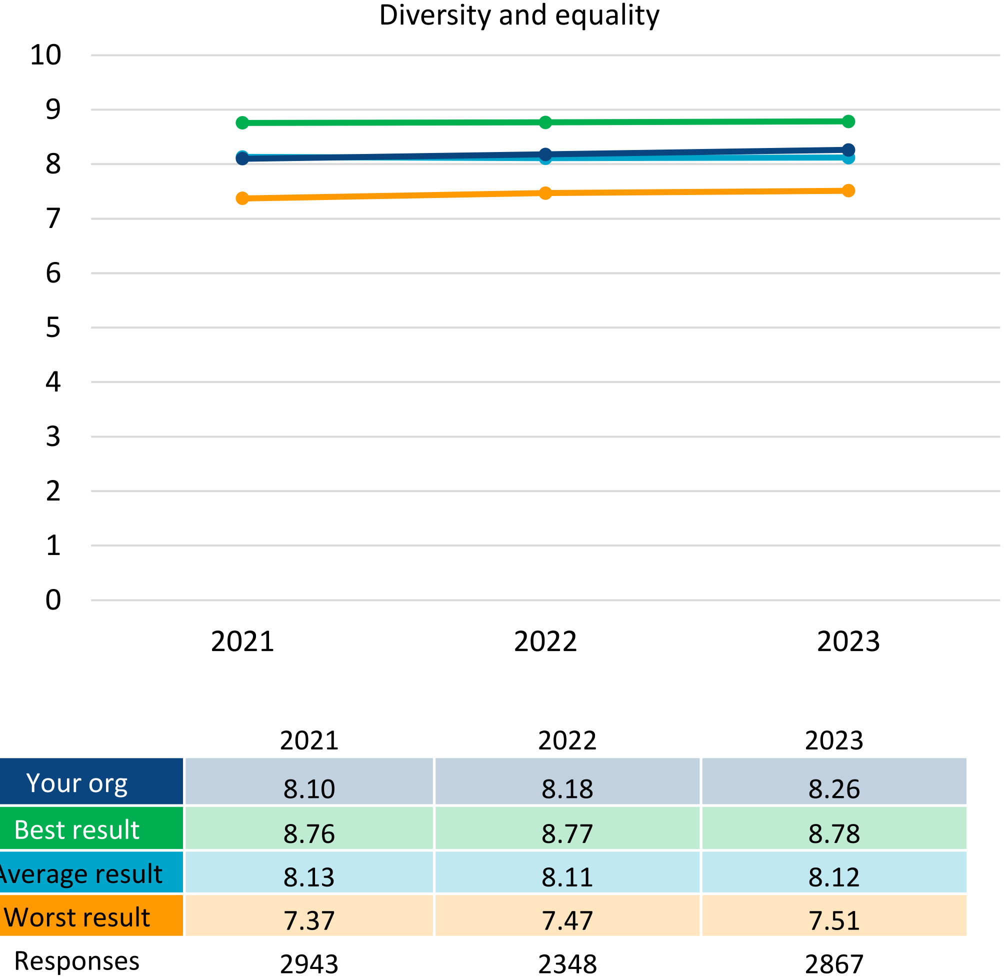
	2021	2022	2023
Your org	6.61	6.90	7.12
Best result	7.48	7.46	7.55
Average result	6.78	6.84	6.96
Worst result	6.30	6.40	6.46
Responses	2954	2350	2876

People Promise elements, themes and sub-scores: Sub-score trends

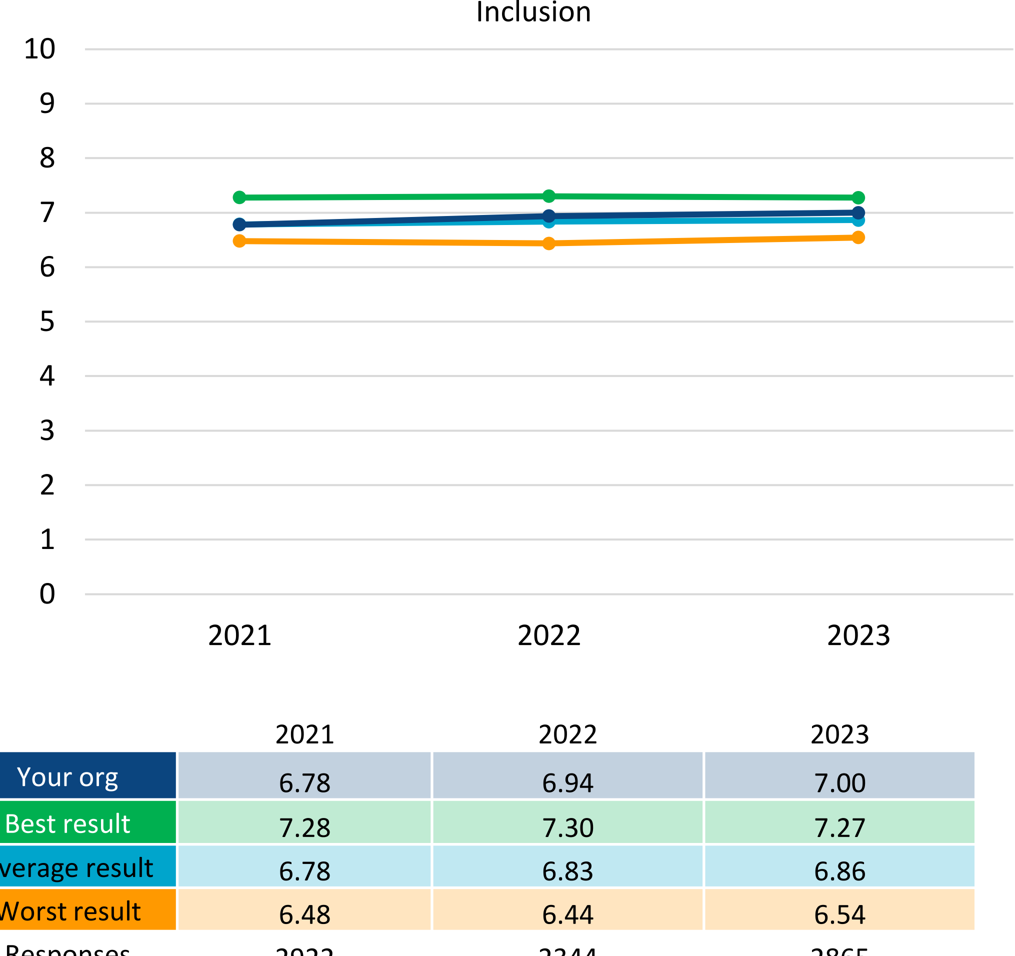


People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive (2)



	2021	2022	2023
Your org	8.10	8.18	8.26
Best result	8.76	8.77	8.78
Average result	8.13	8.11	8.12
Worst result	7.37	7.47	7.51
Responses	2943	2348	2867



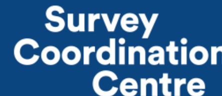
	2021	2022	2023
Your org	6.78	6.94	7.00
Best result	7.28	7.30	7.27
Average result	6.78	6.83	6.86
Worst result	6.48	6.44	6.54
Responses	2922	2344	2865

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

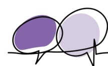
Promise element 2: We are recognised and rewarded

	2021	2022	2023
Your org	5.77	5.86	6.12
Best result	6.47	6.36	6.37
Average result	5.82	5.73	5.94
Worst result	5.34	5.24	5.50
Responses	2934	2349	2881

People Promise elements and themes: Trends



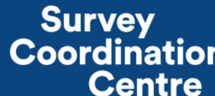
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



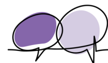
Promise element 3: We each have a voice that counts

	2021	2022	2023
Your org	6.67	6.79	6.87
Best result	7.31	7.14	7.16
Average result	6.67	6.65	6.70
Worst result	6.16	6.16	6.21
Responses	2928	2316	2838

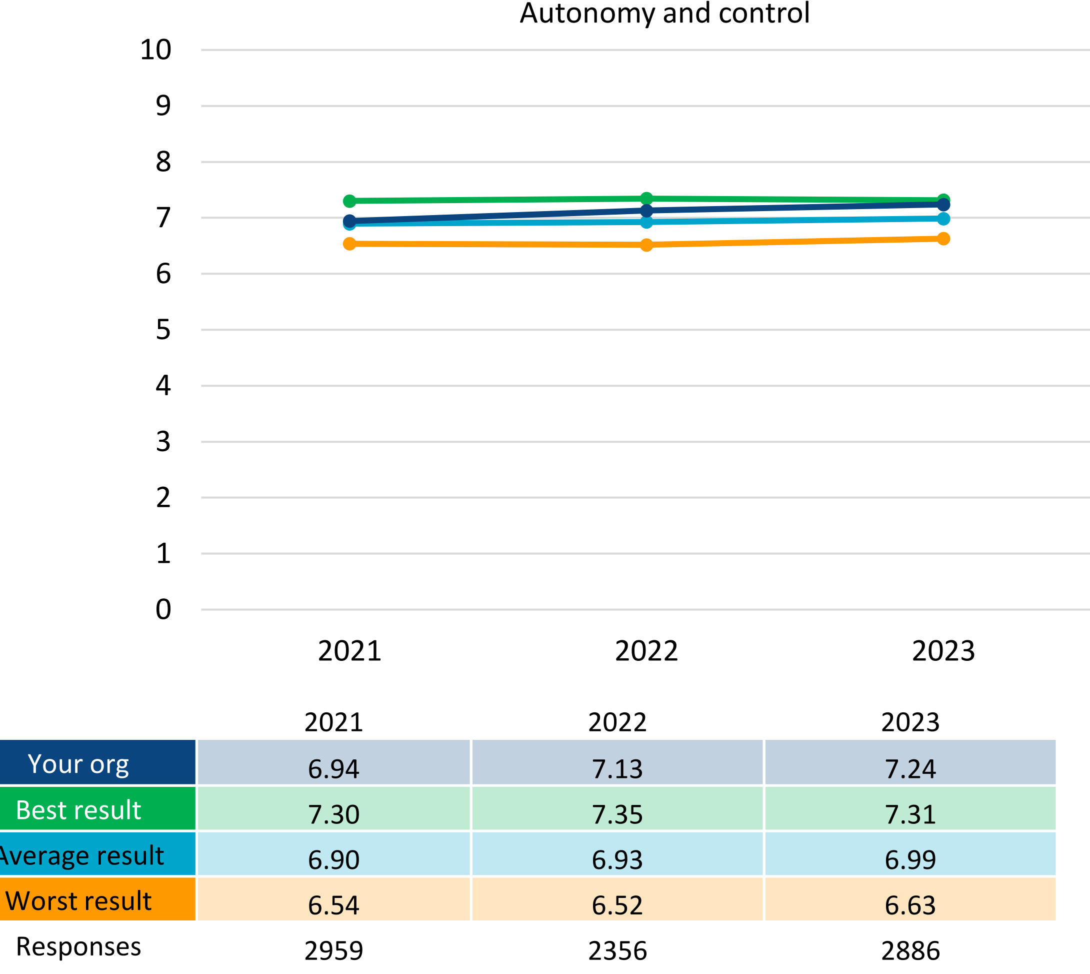
People Promise elements, themes and sub-scores: Sub-score trends



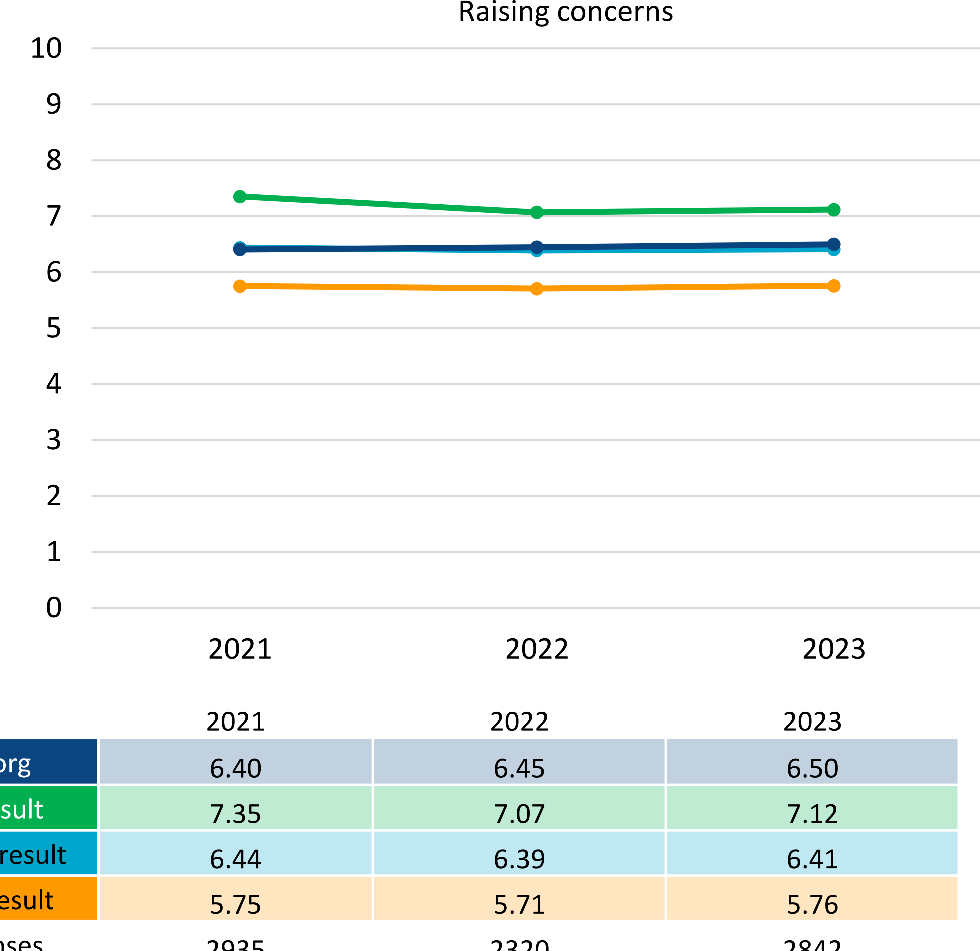
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



Promise element 3: We each have a voice that counts



	2021	2022	2023
Your org	6.94	7.13	7.24
Best result	7.30	7.35	7.31
Average result	6.90	6.93	6.99
Worst result	6.54	6.52	6.63
Responses	2959	2356	2886



	2021	2022	2023
Your org	6.40	6.45	6.50
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	2935	2320	2842

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

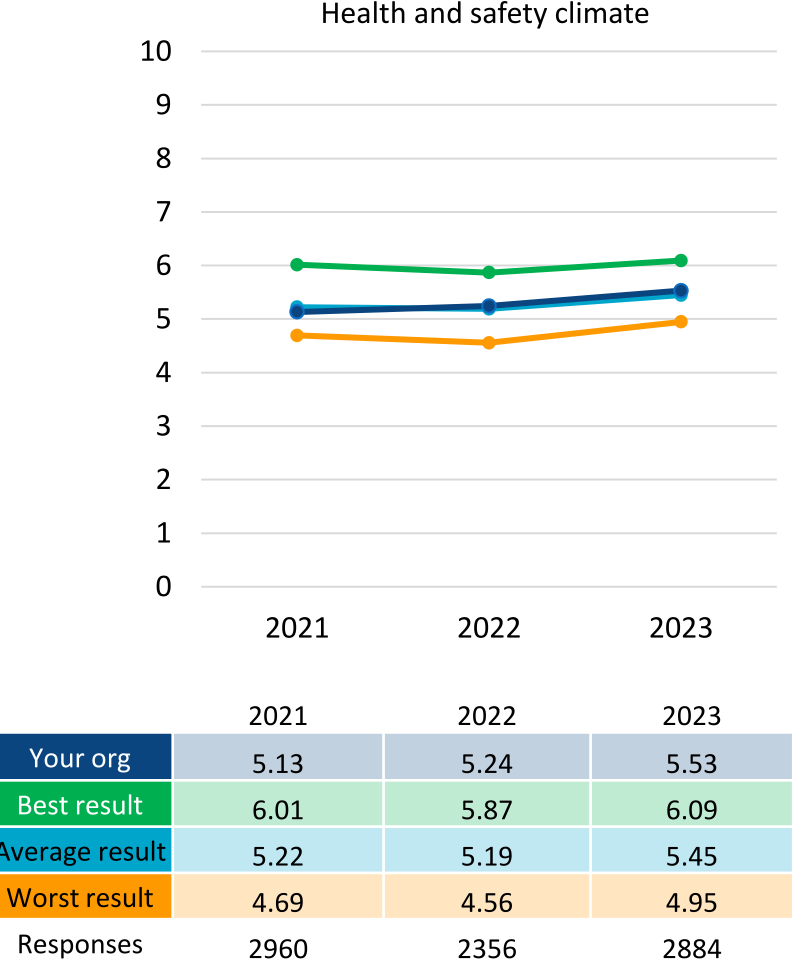
Promise element 4: We are safe and healthy

We are safe and healthy

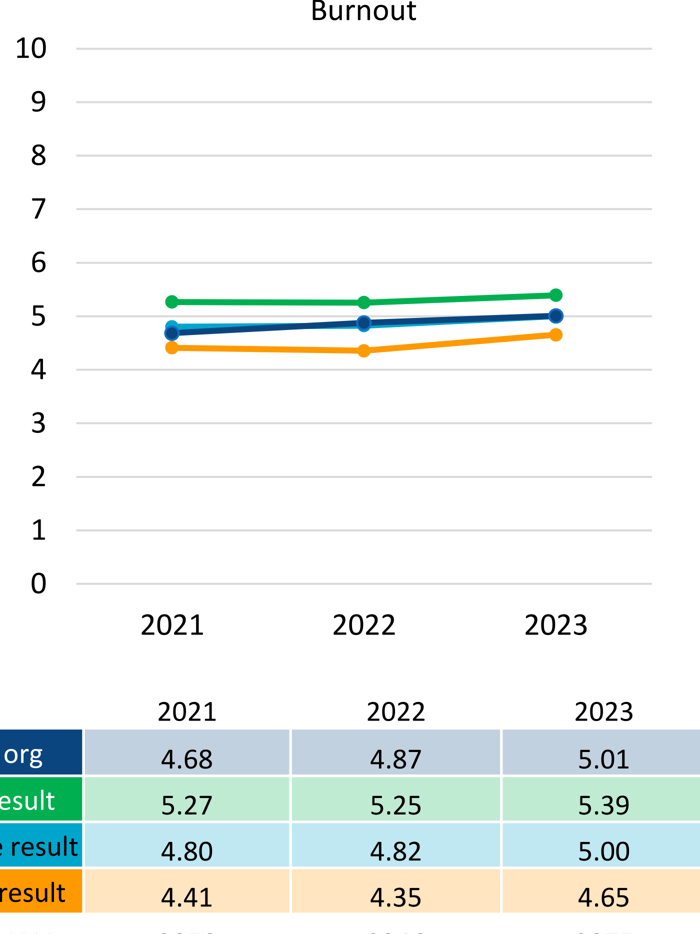
	2021	2022	2023
Your org	5.82	5.92	6.12
Best result	6.47	6.41	6.55
Average result	5.90	5.89	6.06
Worst result	5.50	5.42	5.75
Responses	2927	2333	2857

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

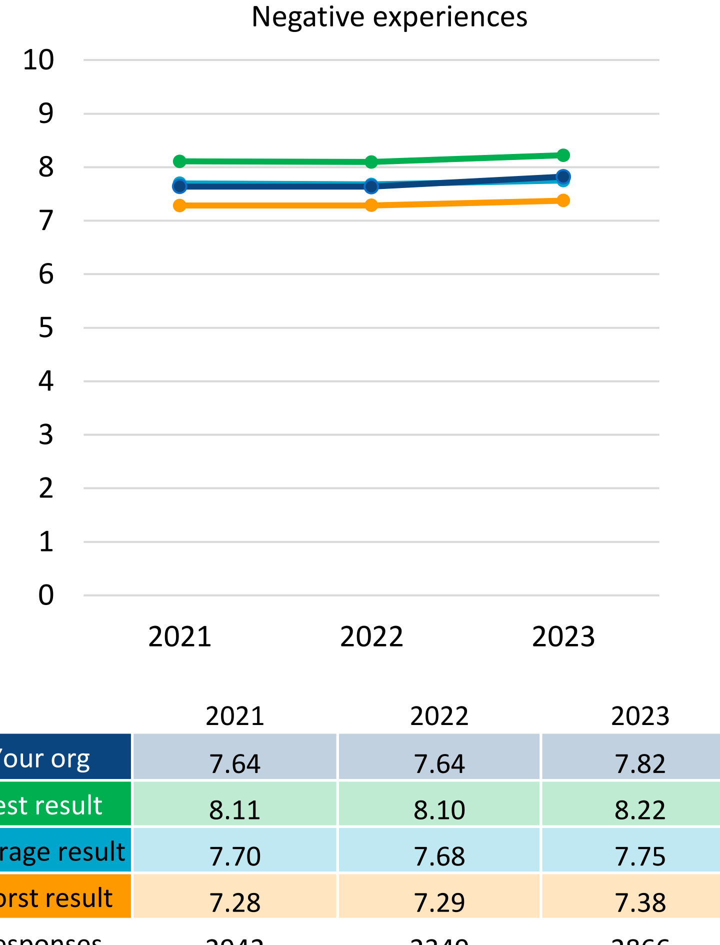
Promise element 4: We are safe and healthy



	2021	2022	2023
Your org	5.13	5.24	5.53
Best result	6.01	5.87	6.09
Average result	5.22	5.19	5.45
Worst result	4.69	4.56	4.95
Responses	2960	2356	2884

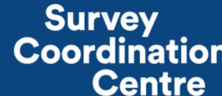


	2021	2022	2023
Your org	4.68	4.87	5.01
Best result	5.27	5.25	5.39
Average result	4.80	4.82	5.00
Worst result	4.41	4.35	4.65
Responses	2958	2346	2875



	2021	2022	2023
Your org	7.64	7.64	7.82
Best result	8.11	8.10	8.22
Average result	7.70	7.68	7.75
Worst result	7.28	7.29	7.38
Responses	2942	2349	2866

People Promise elements and themes: Trends



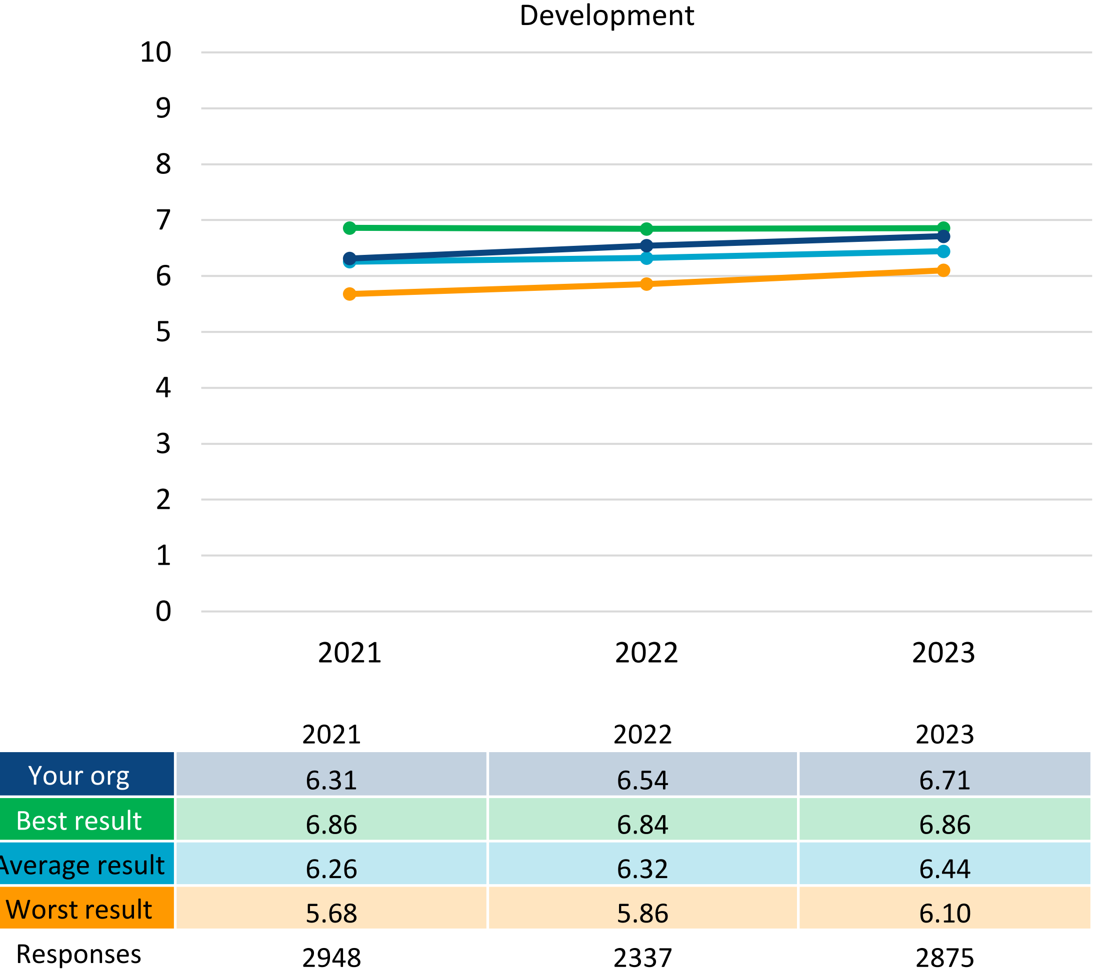
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning

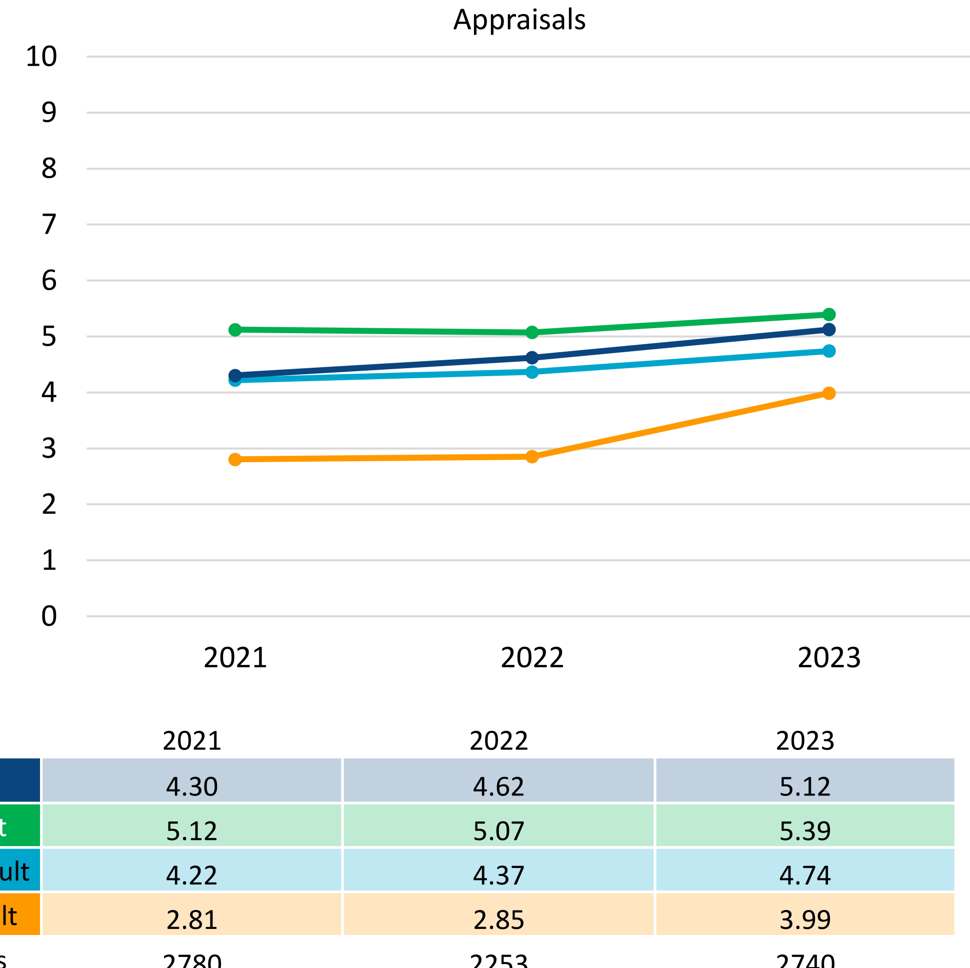
	2021	2022	2023
Your org	5.32	5.58	5.94
Best result	6.00	5.92	6.07
Average result	5.23	5.35	5.61
Worst result	4.30	4.38	5.05
Responses	2767	2236	2738

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning

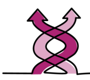


	2021	2022	2023
Your org	6.31	6.54	6.71
Best result	6.86	6.84	6.86
Average result	6.26	6.32	6.44
Worst result	5.68	5.86	6.10
Responses	2948	2337	2875



	2021	2022	2023
Your org	4.30	4.62	5.12
Best result	5.12	5.07	5.39
Average result	4.22	4.37	4.74
Worst result	2.81	2.85	3.99
Responses	2780	2253	2740

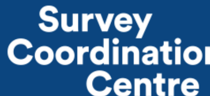
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



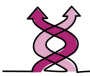
Promise element 6: We work flexibly

	2021	2022	2023
Your org	5.80	6.07	6.28
Best result	6.70	6.64	6.87
Average result	5.96	6.01	6.20
Worst result	5.44	5.57	5.60
Responses	2917	2331	2858

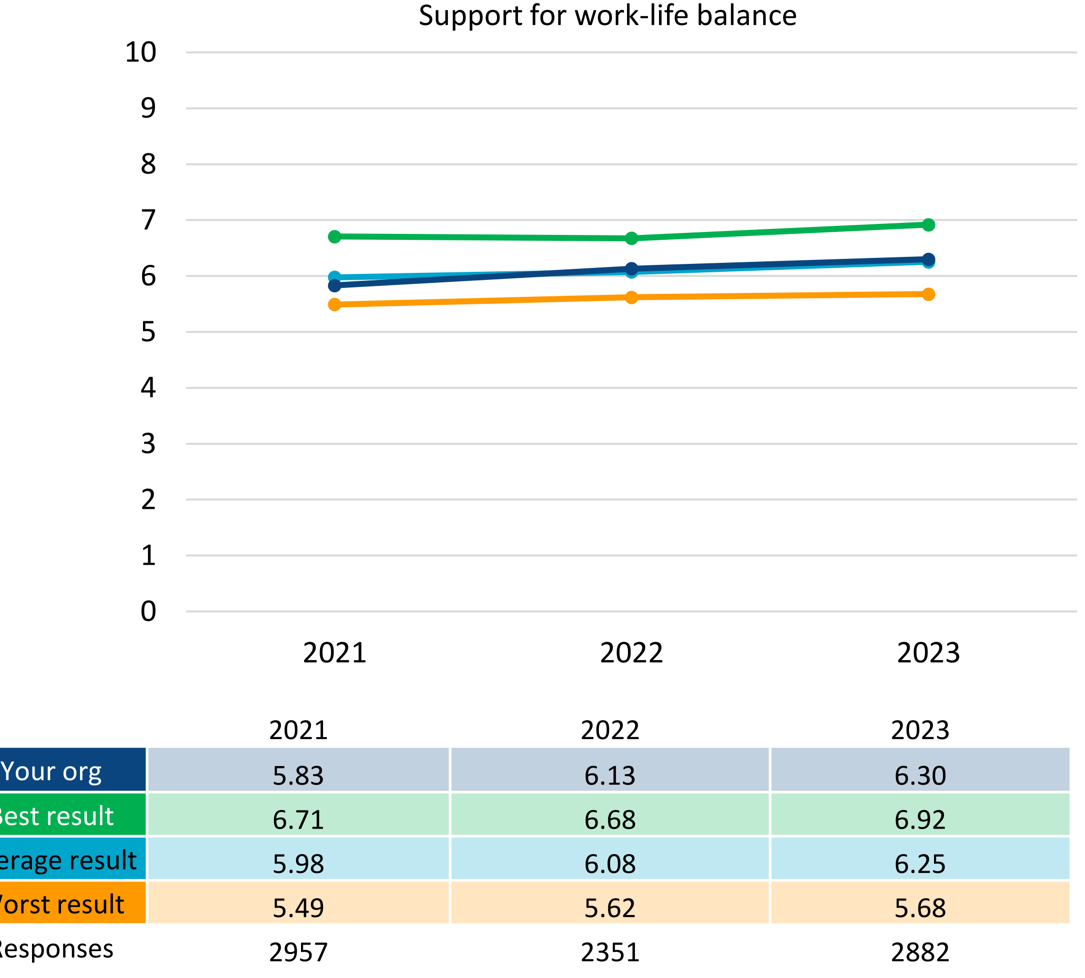
People Promise elements, themes and sub-scores: Sub-score trends



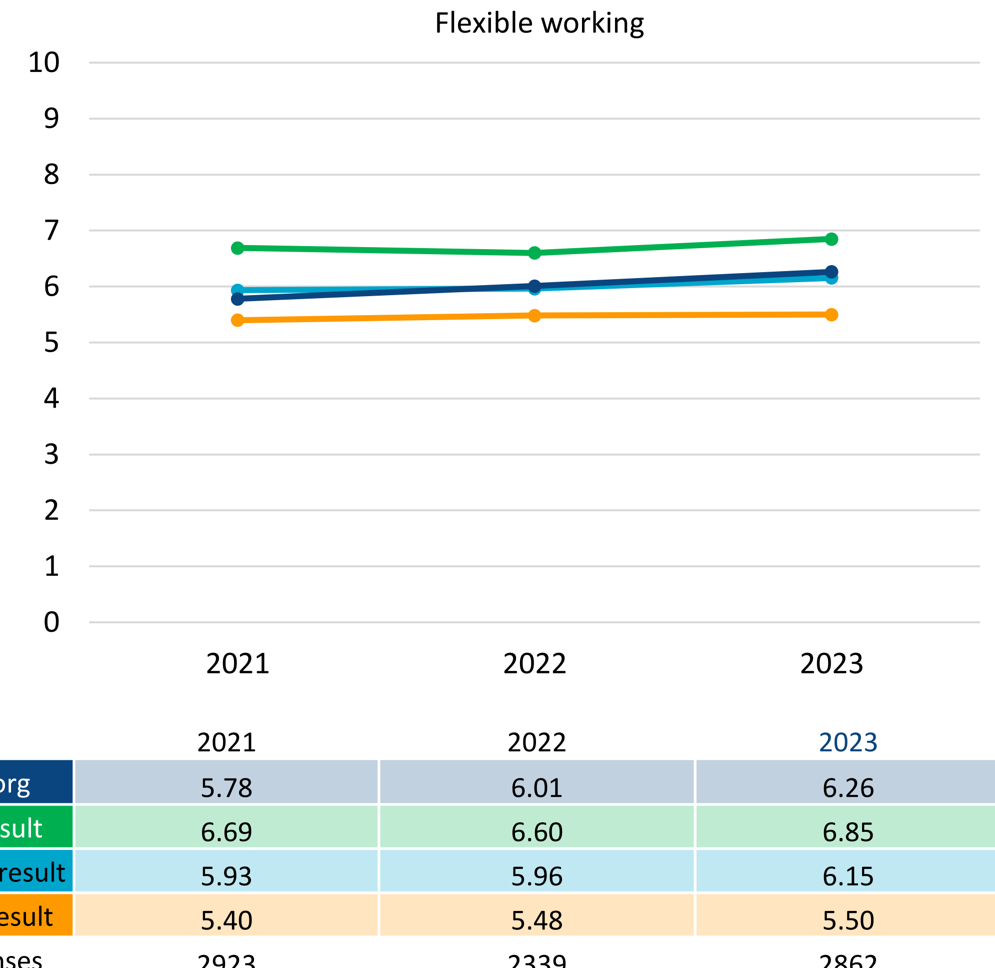
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



Promise element 6: We work flexibly

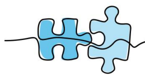


	2021	2022	2023
Your org	5.83	6.13	6.30
Best result	6.71	6.68	6.92
Average result	5.98	6.08	6.25
Worst result	5.49	5.62	5.68
Responses	2957	2351	2882



	2021	2022	2023
Your org	5.78	6.01	6.26
Best result	6.69	6.60	6.85
Average result	5.93	5.96	6.15
Worst result	5.40	5.48	5.50
Responses	2923	2339	2862

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

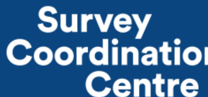


Promise element 7: We are a team

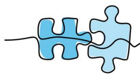
We are a team

	2021	2022	2023
Your org	6.44	6.70	6.88
Best result	7.15	7.15	7.19
Average result	6.58	6.64	6.75
Worst result	6.18	6.25	6.35
Responses	2942	2347	2873

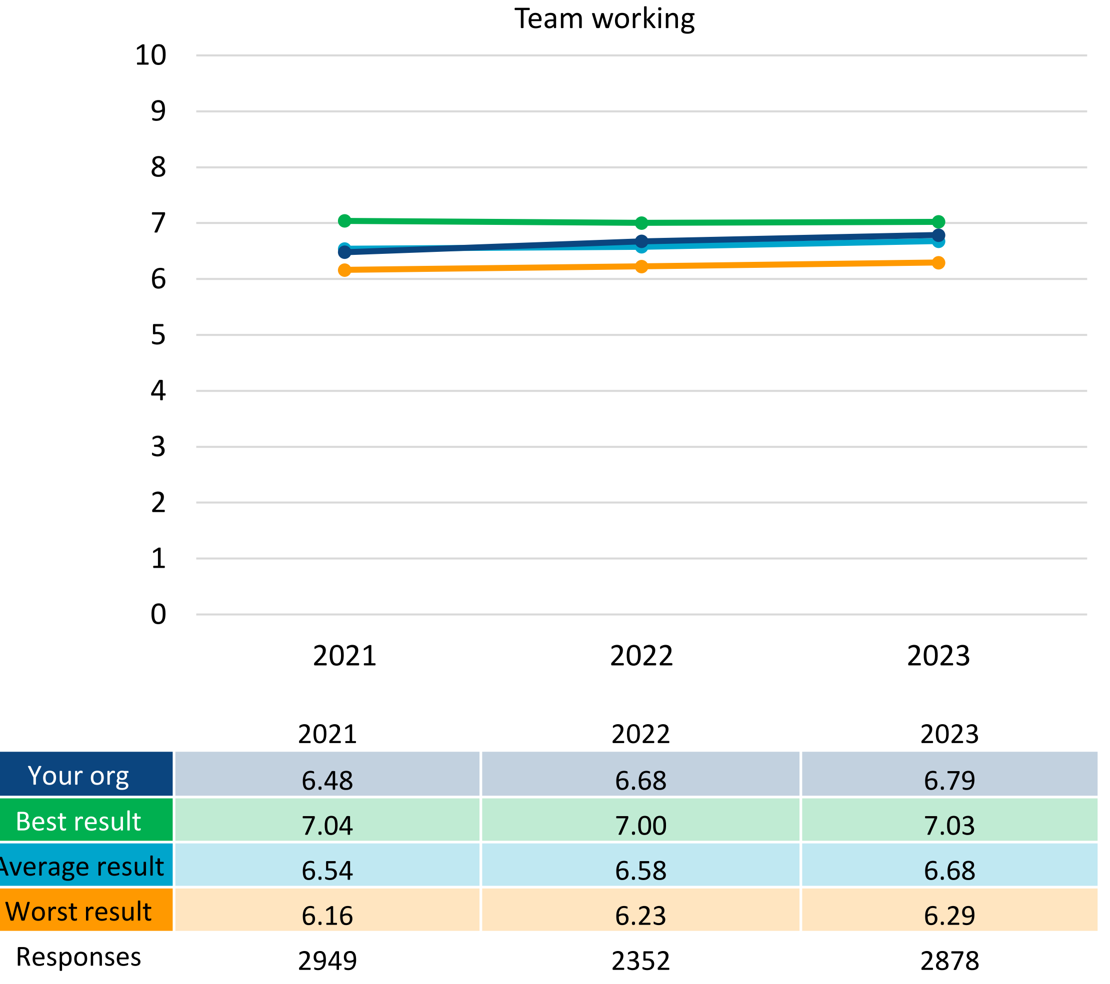
People Promise elements, themes and sub-scores: Sub-score trends



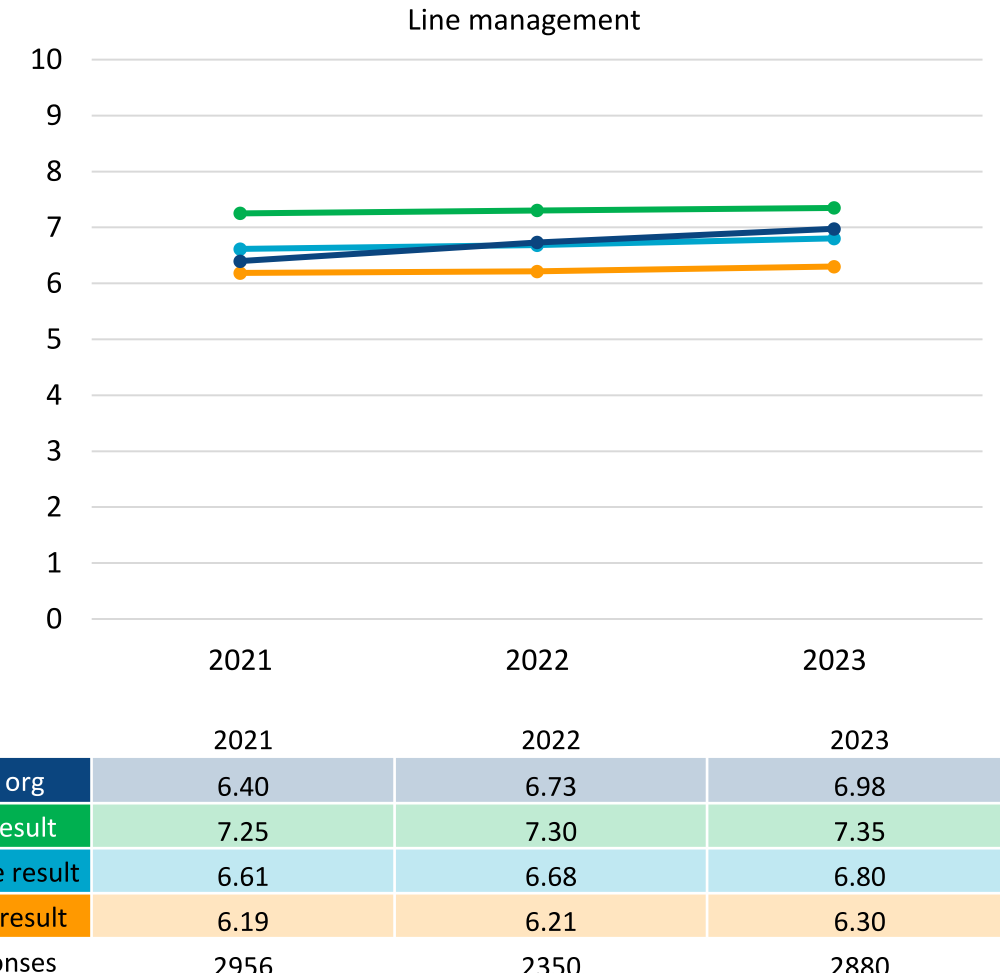
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



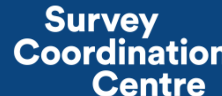
Promise element 7: We are a team



	2021	2022	2023
Your org	6.48	6.68	6.79
Best result	7.04	7.00	7.03
Average result	6.54	6.58	6.68
Worst result	6.16	6.23	6.29
Responses	2949	2352	2878



	2021	2022	2023
Your org	6.40	6.73	6.98
Best result	7.25	7.30	7.35
Average result	6.61	6.68	6.80
Worst result	6.19	6.21	6.30
Responses	2956	2350	2880



People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement

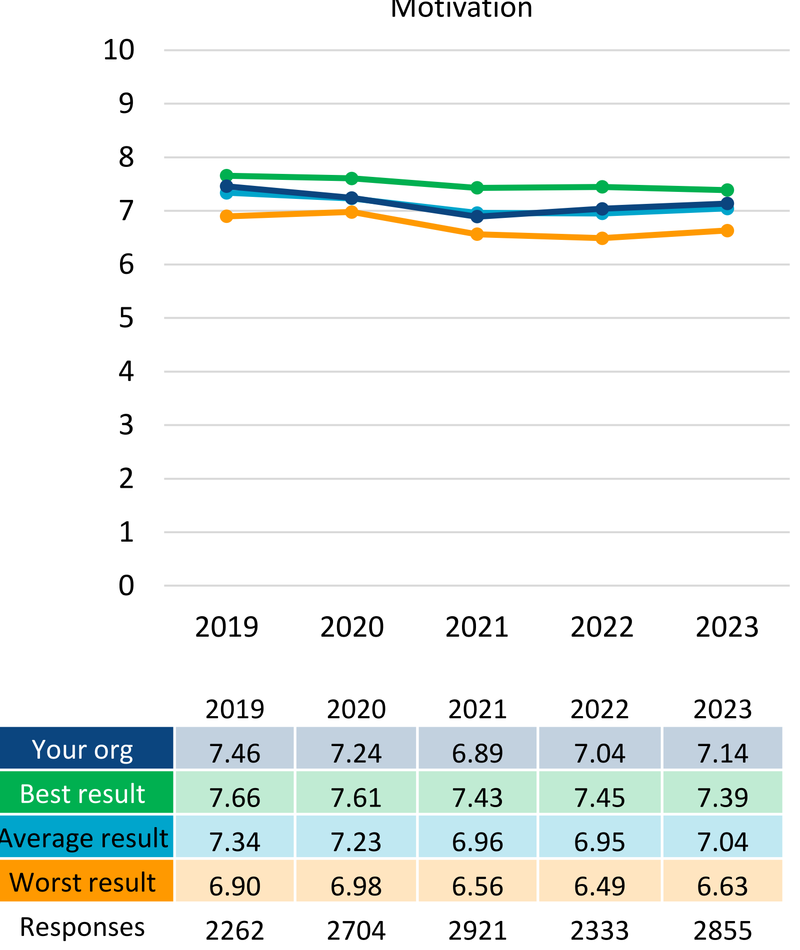
Staff Engagement

	2019	2020	2021	2022	2023
Your org	7.23	7.08	6.80	6.90	7.02
Best result	7.58	7.59	7.44	7.28	7.32
Average result	7.04	7.03	6.84	6.80	6.91
Worst result	6.10	6.45	6.30	6.13	6.34
Responses	2283	2740	2962	2358	2887

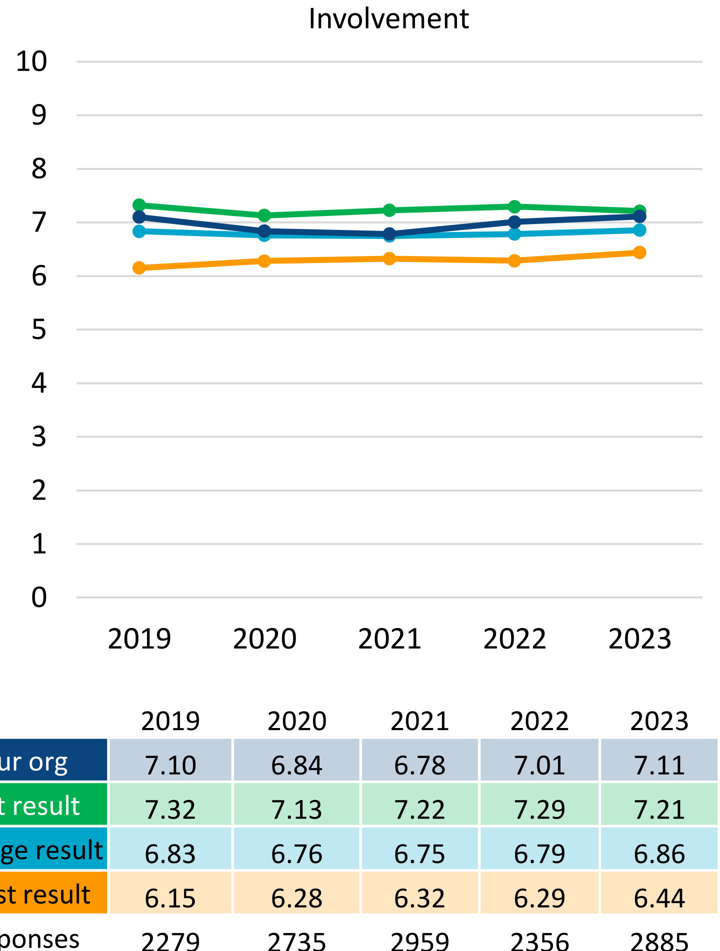
People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

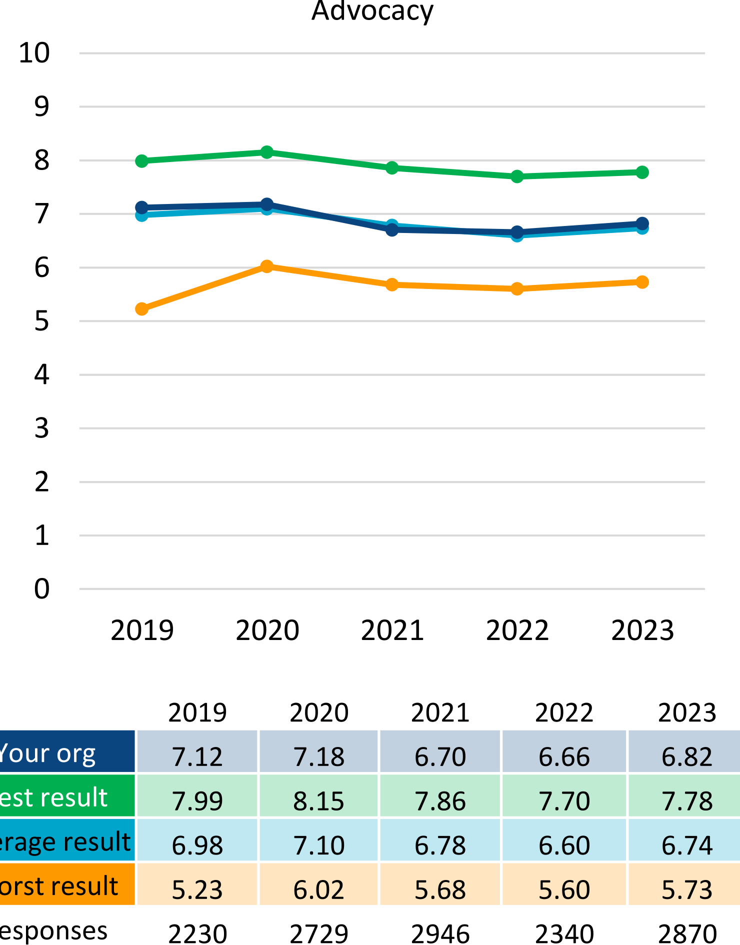
Theme: Staff Engagement



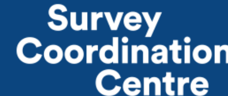
	2019	2020	2021	2022	2023
Your org	7.46	7.24	6.89	7.04	7.14
Best result	7.66	7.61	7.43	7.45	7.39
Average result	7.34	7.23	6.96	6.95	7.04
Worst result	6.90	6.98	6.56	6.49	6.63
Responses	2262	2704	2921	2333	2855



	2019	2020	2021	2022	2023
Your org	7.10	6.84	6.78	7.01	7.11
Best result	7.32	7.13	7.22	7.29	7.21
Average result	6.83	6.76	6.75	6.79	6.86
Worst result	6.15	6.28	6.32	6.29	6.44
Responses	2279	2735	2959	2356	2885



	2019	2020	2021	2022	2023
Your org	7.12	7.18	6.70	6.66	6.82
Best result	7.99	8.15	7.86	7.70	7.78
Average result	6.98	7.10	6.78	6.60	6.74
Worst result	5.23	6.02	5.68	5.60	5.73
Responses	2230	2729	2946	2340	2870



People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale

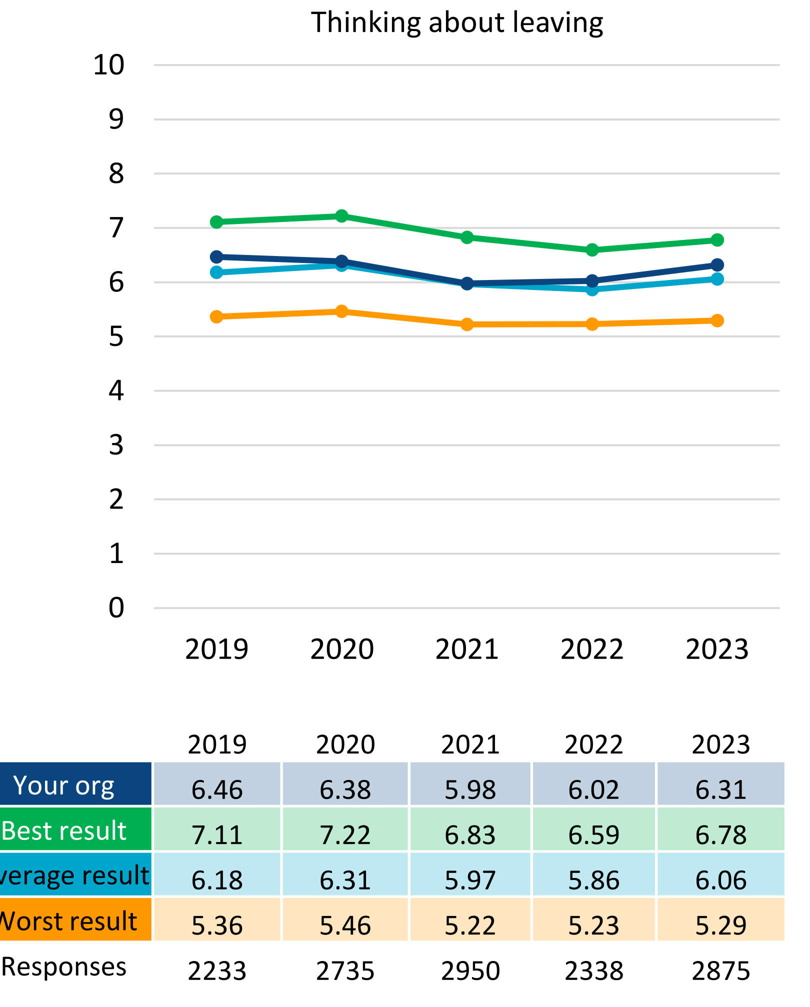
Morale

	2019	2020	2021	2022	2023
Your org	6.15	6.10	5.68	5.81	6.06
Best result	6.66	6.76	6.46	6.31	6.52
Average result	5.95	6.04	5.74	5.69	5.91
Worst result	5.23	5.47	5.26	5.17	5.54
Responses	2280	2738	2962	2356	2884

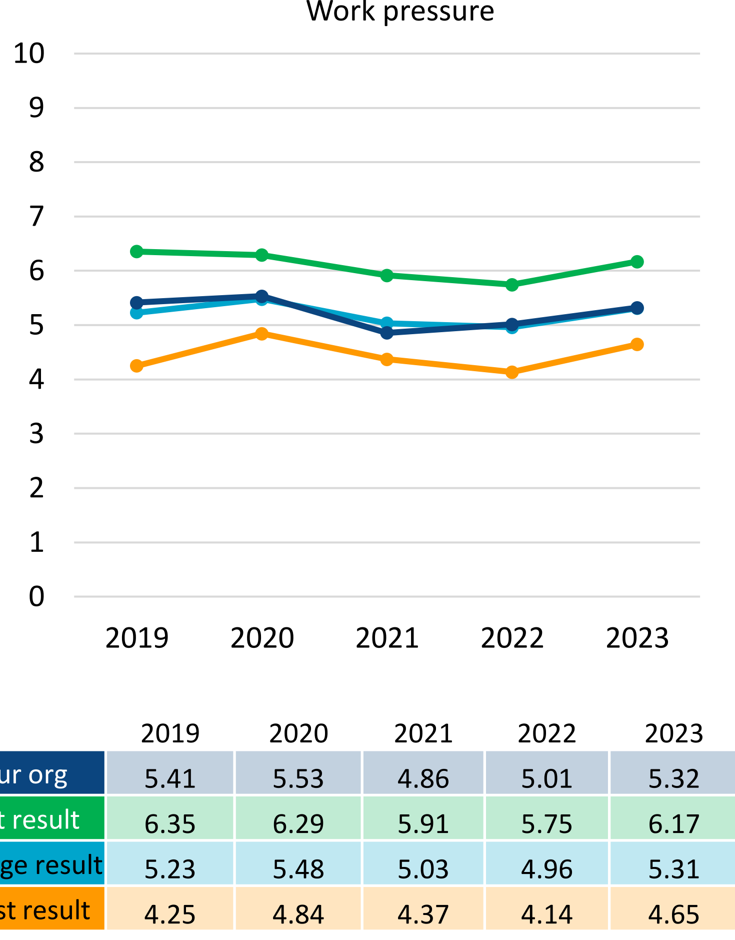
People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

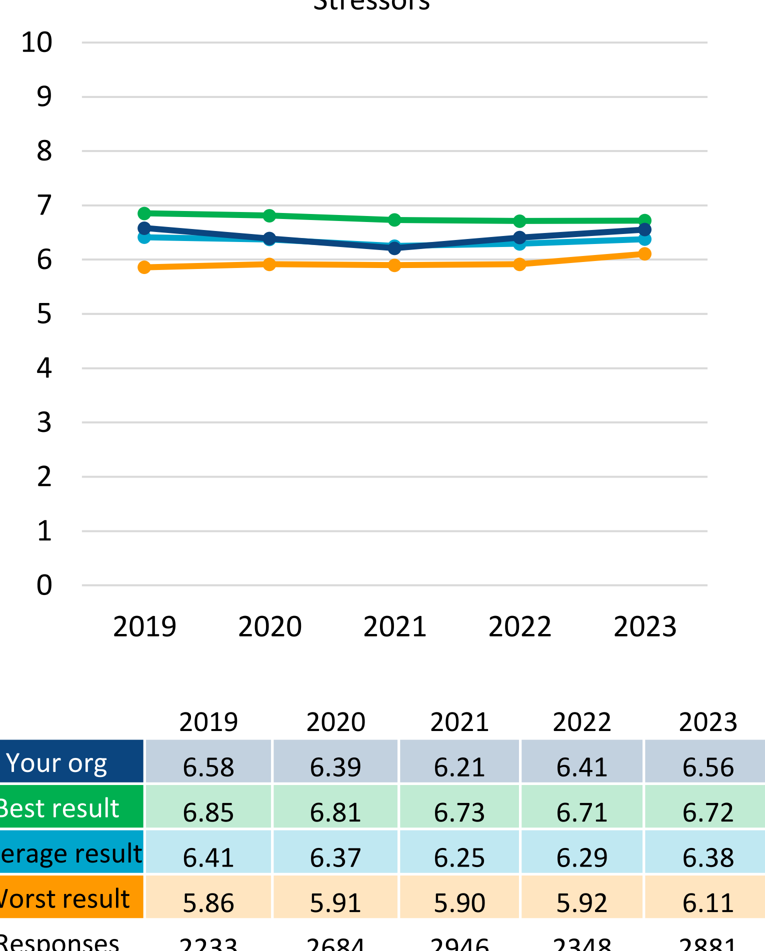
Theme: Morale



	2019	2020	2021	2022	2023
Your org	6.46	6.38	5.98	6.02	6.31
Best result	7.11	7.22	6.83	6.59	6.78
Average result	6.18	6.31	5.97	5.86	6.06
Worst result	5.36	5.46	5.22	5.23	5.29
Responses	2233	2735	2950	2338	2875



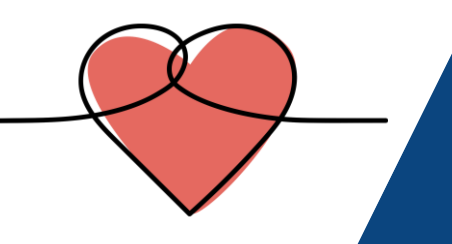
	2019	2020	2021	2022	2023
Your org	5.41	5.53	4.86	5.01	5.32
Best result	6.35	6.29	5.91	5.75	6.17
Average result	5.23	5.48	5.03	4.96	5.31
Worst result	4.25	4.84	4.37	4.14	4.65
Responses	2279	2733	2956	2353	2882



	2019	2020	2021	2022	2023
Your org	6.58	6.39	6.21	6.41	6.56
Best result	6.85	6.81	6.73	6.71	6.72
Average result	6.41	6.37	6.25	6.29	6.38
Worst result	5.86	5.91	5.90	5.92	6.11
Responses	2233	2684	2946	2348	2881

Survey Coordination Centre

People Promise element – We are compassionate and inclusive



Questions included:

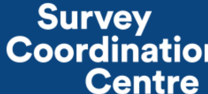
Compassionate culture – Q6a, Q25a, Q25b, Q25c, Q25d

Compassionate leadership – Q9f, Q9g, Q9h, Q9i

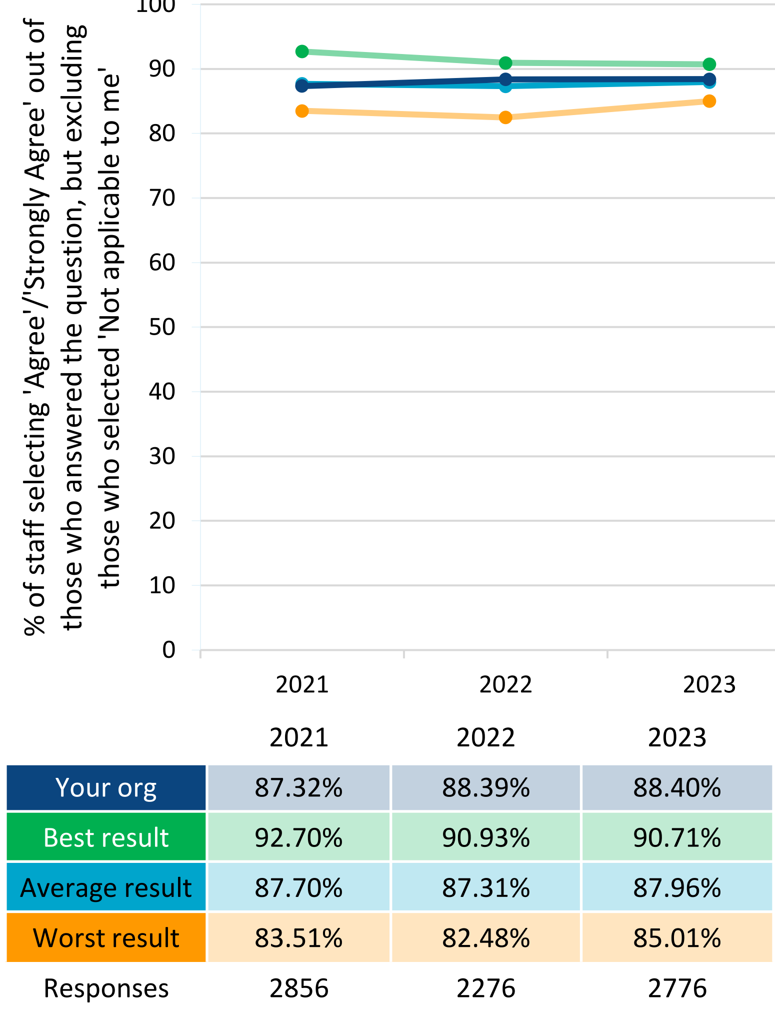
Diversity and equality – Q15, Q16a, Q16b, Q21

Inclusion – Q7h, Q7i, Q8b, Q8c

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

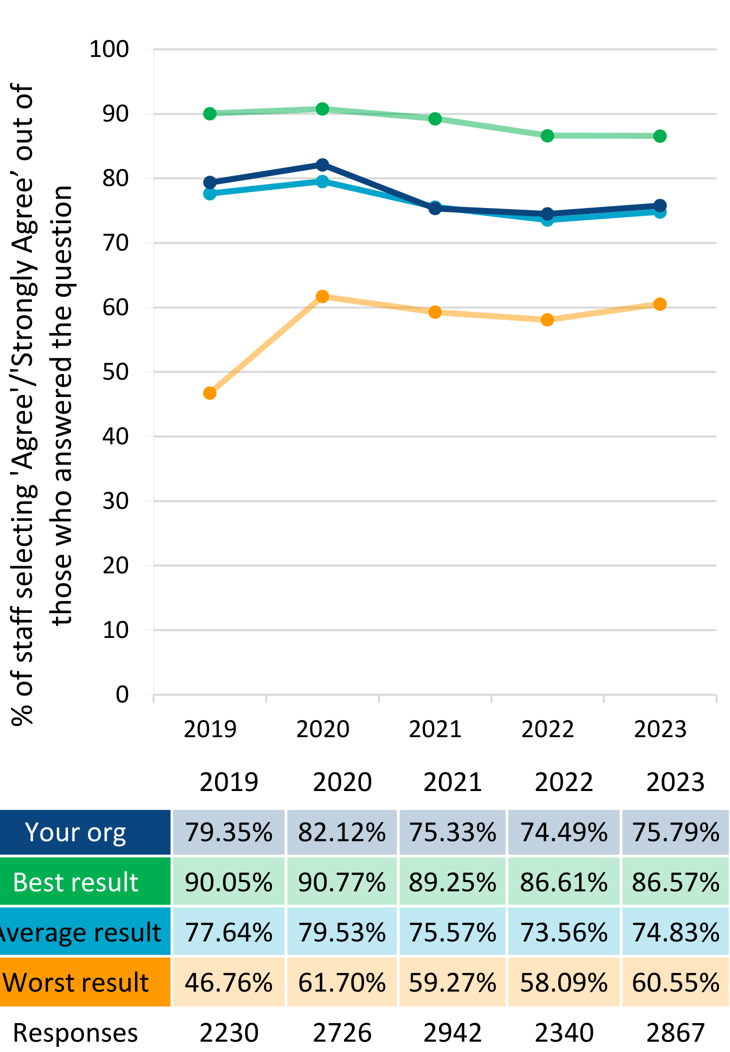


Q6a I feel that my role makes a difference to patients / service users.



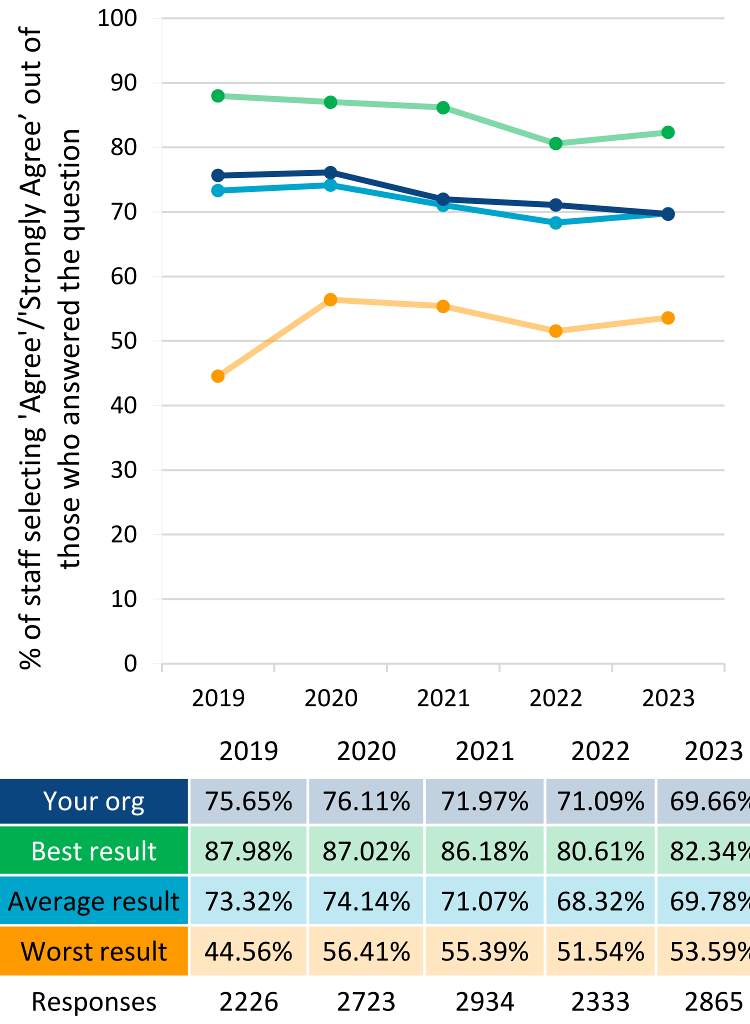
	2021	2022	2023
Your org	87.32%	88.39%	88.40%
Best result	92.70%	90.93%	90.71%
Average result	87.70%	87.31%	87.96%
Worst result	83.51%	82.48%	85.01%
Responses	2856	2276	2776

Q25a Care of patients / service users is my organisation's top priority.



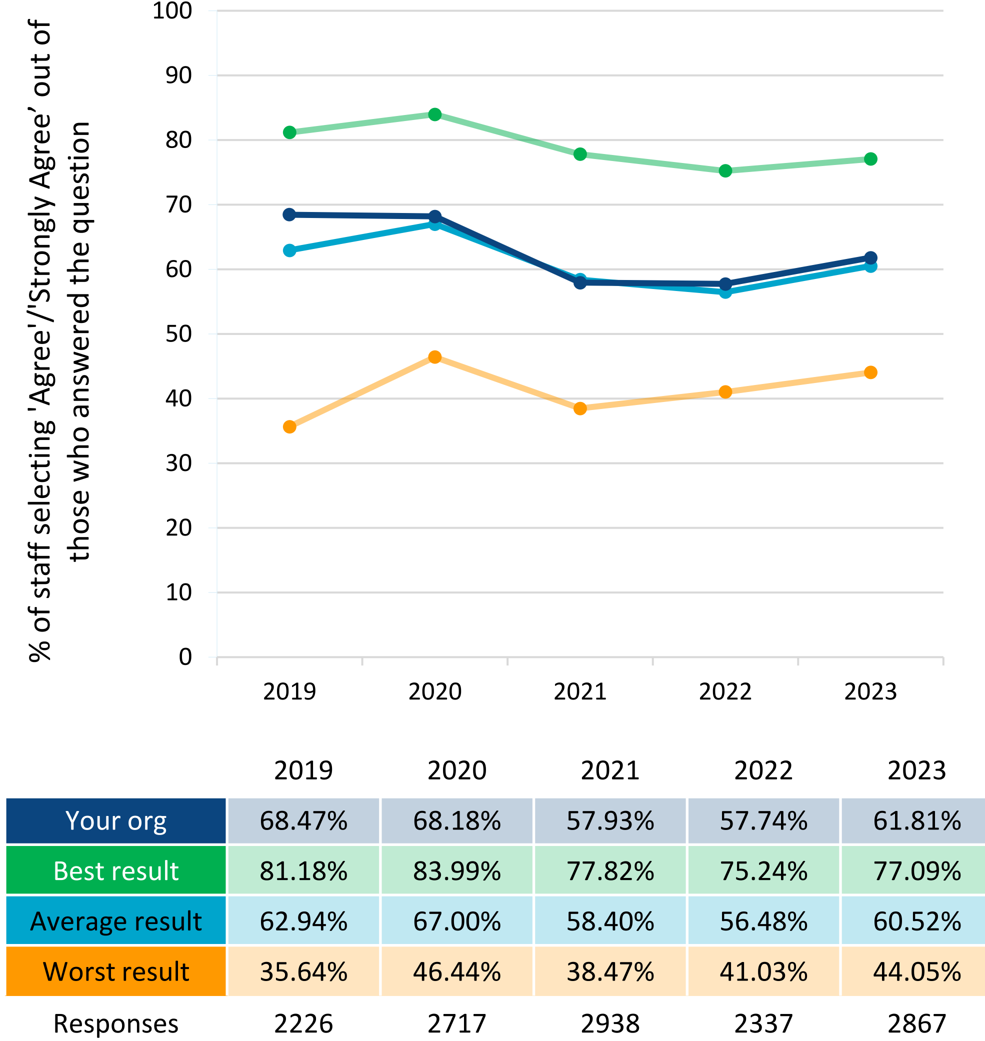
	2019	2020	2021	2022	2023
Your org	79.35%	82.12%	75.33%	74.49%	75.79%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	2230	2726	2942	2340	2867

Q25b My organisation acts on concerns raised by patients / service users.



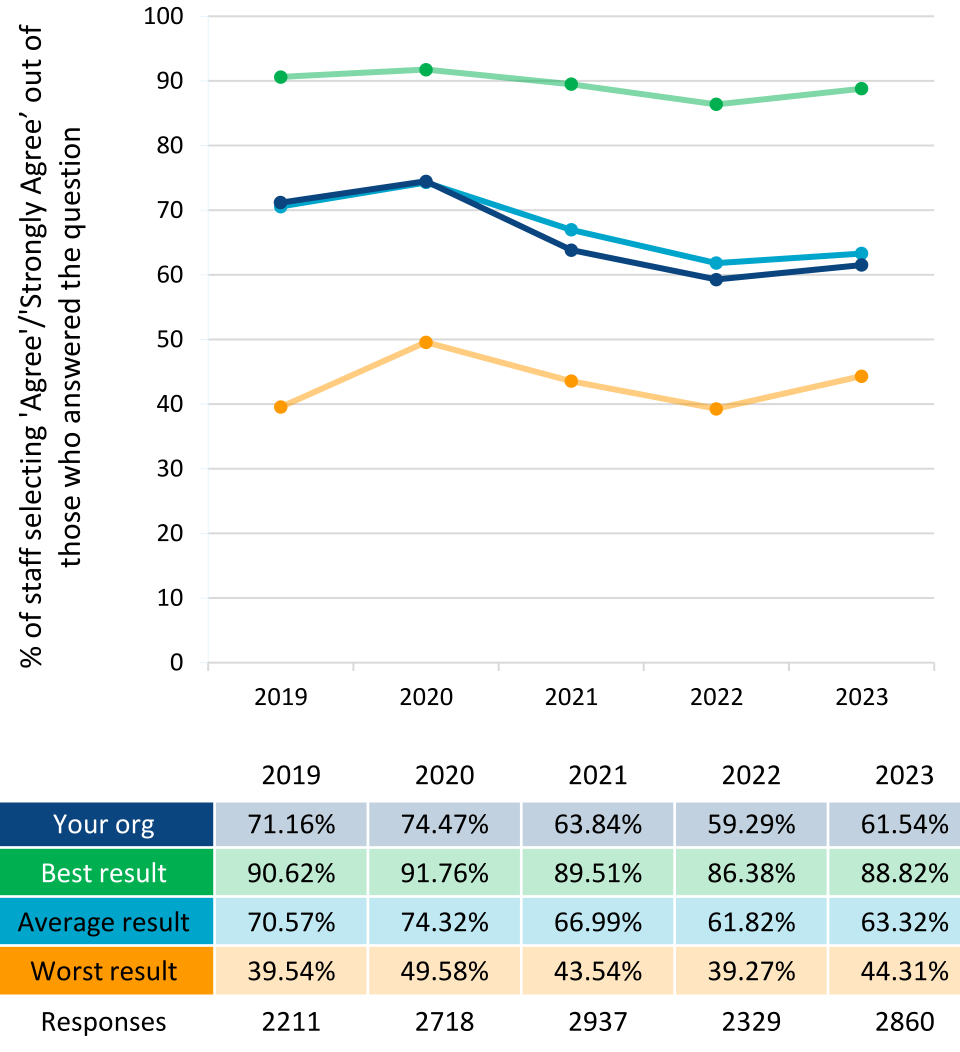
	2019	2020	2021	2022	2023
Your org	75.65%	76.11%	71.97%	71.09%	69.66%
Best result	87.98%	87.02%	86.18%	80.61%	82.34%
Average result	73.32%	74.14%	71.07%	68.32%	69.78%
Worst result	44.56%	56.41%	55.39%	51.54%	53.59%
Responses	2226	2723	2934	2333	2865

Q25c I would recommend my organisation as a place to work.



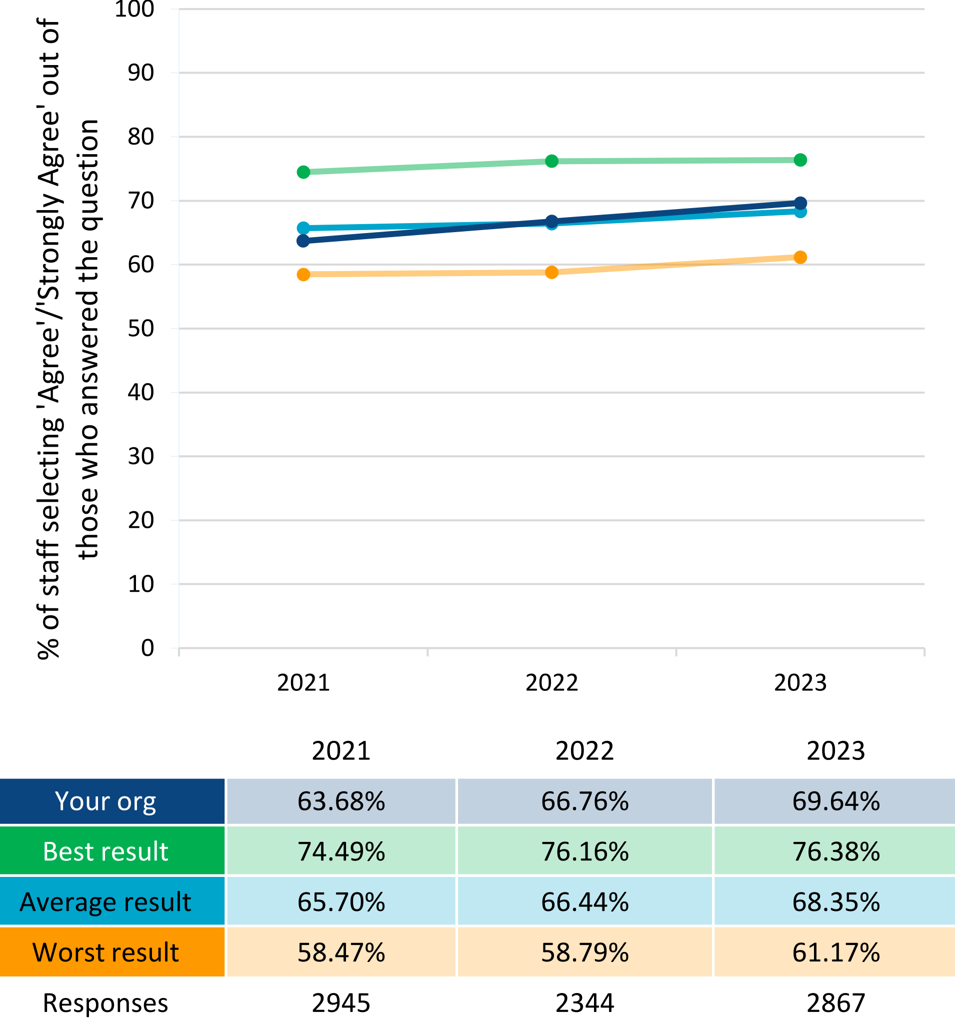
	2019	2020	2021	2022	2023
Your org	68.47%	68.18%	57.93%	57.74%	61.81%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2226	2717	2938	2337	2867

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



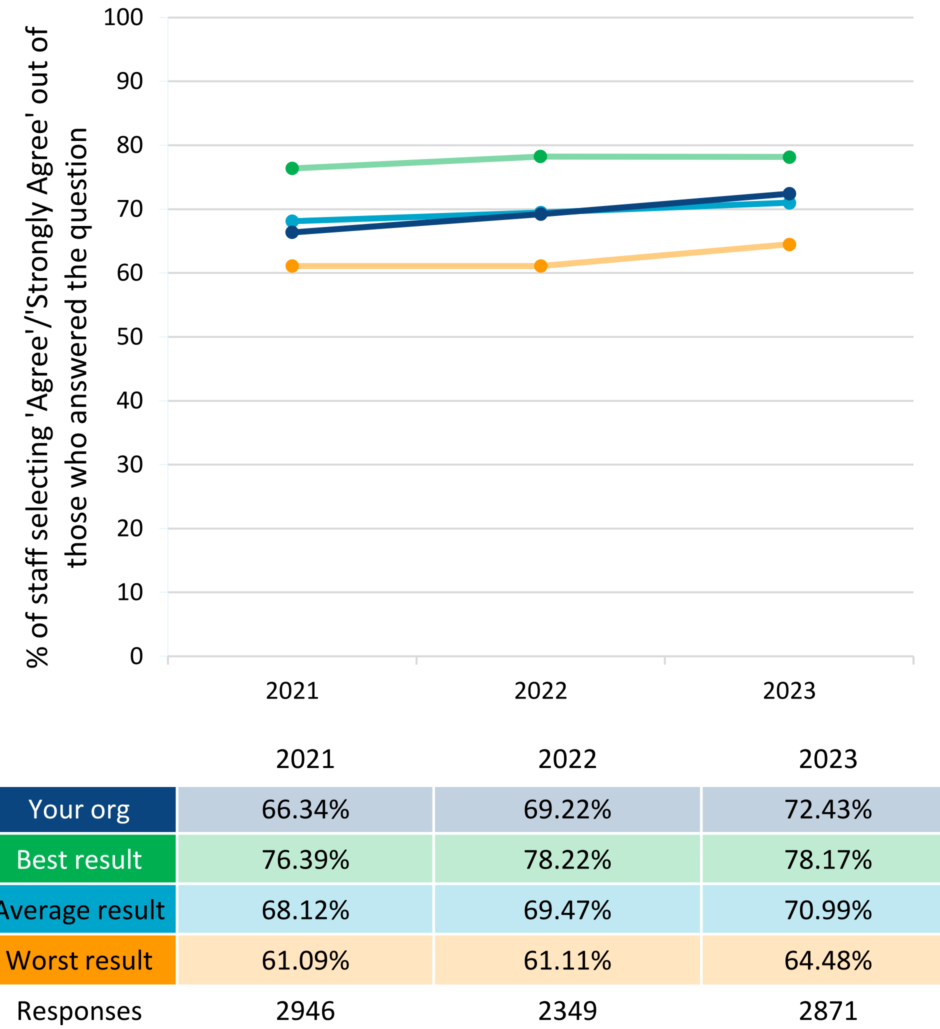
	2019	2020	2021	2022	2023
Your org	71.16%	74.47%	63.84%	59.29%	61.54%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2211	2718	2937	2329	2860

Q9f My immediate manager works together with me to come to an understanding of problems.

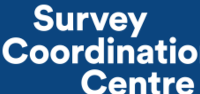


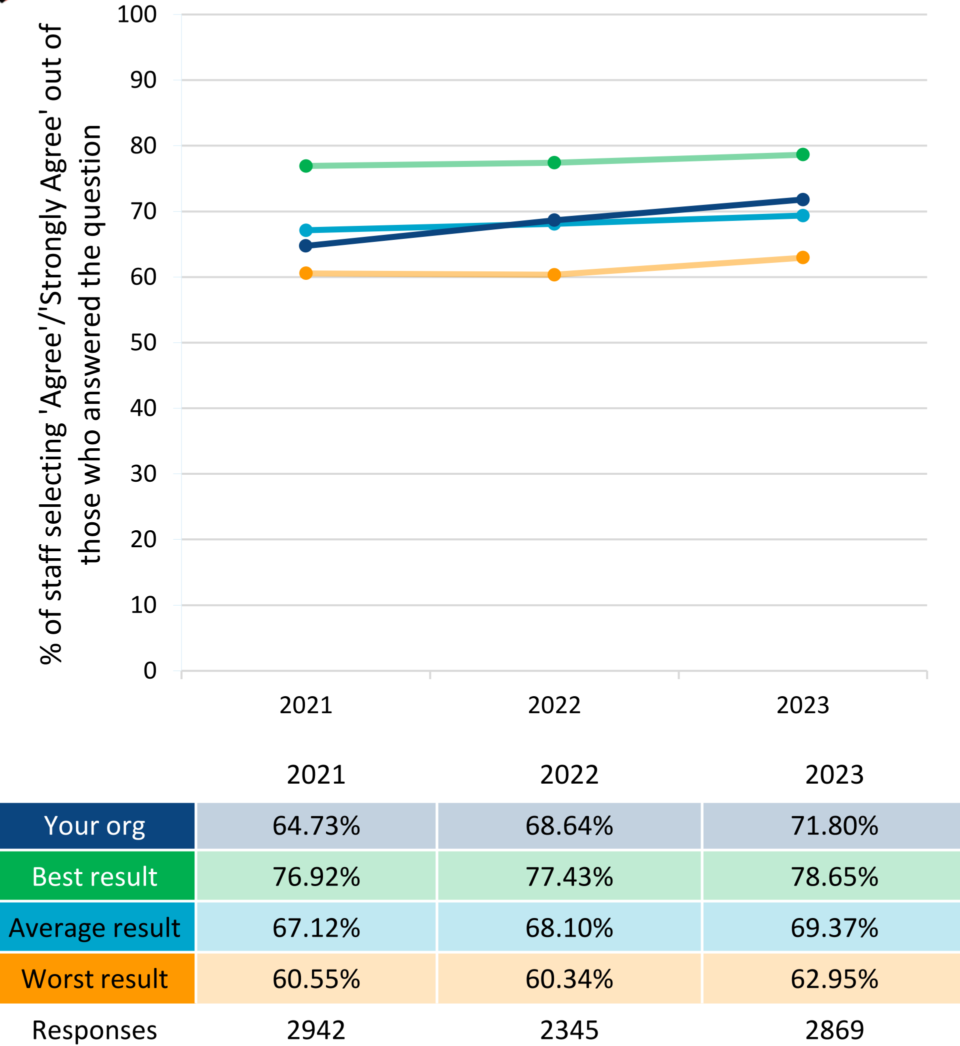
	2021	2022	2023
Your org	63.68%	66.76%	69.64%
Best result	74.49%	76.16%	76.38%
Average result	65.70%	66.44%	68.35%
Worst result	58.47%	58.79%	61.17%
Responses	2945	2344	2867

Q9g My immediate manager is interested in listening to me when I describe challenges I face.

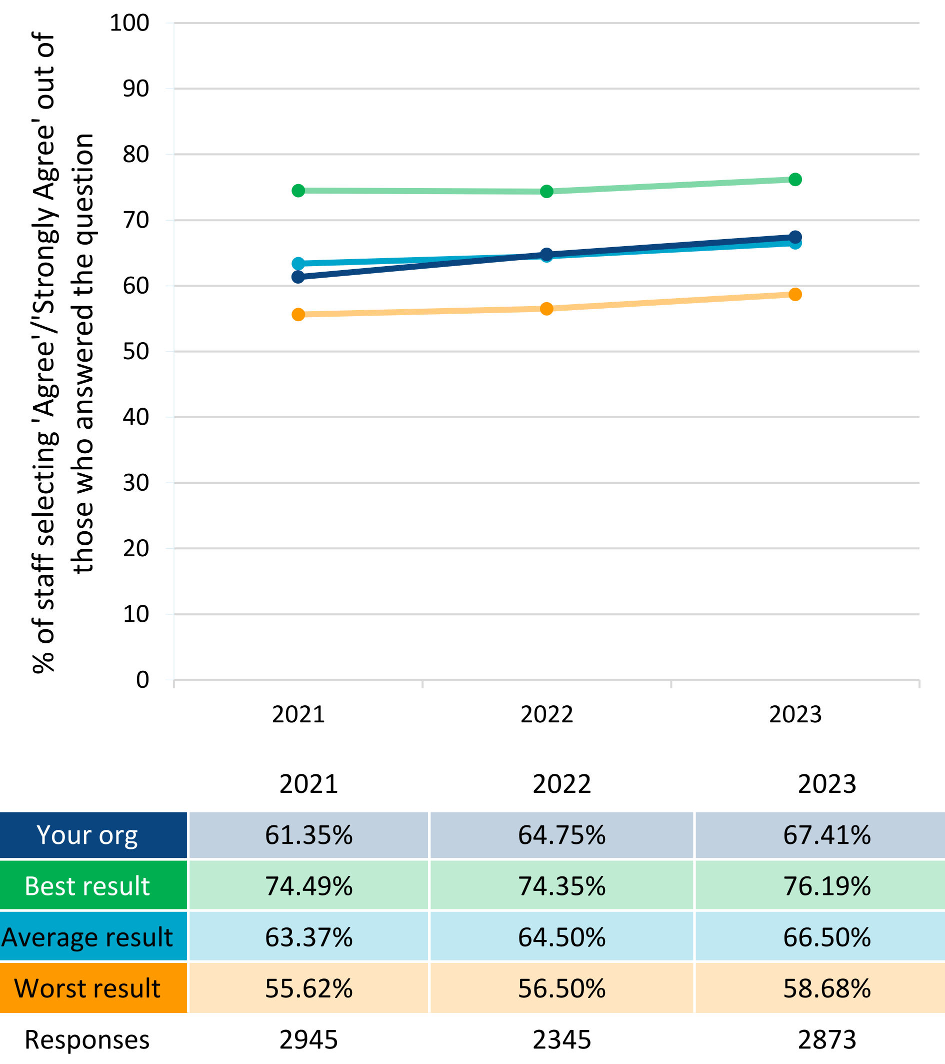


	2021	2022	2023
Your org	66.34%	69.22%	72.43%
Best result	76.39%	78.22%	78.17%
Average result	68.12%	69.47%	70.99%
Worst result	61.09%	61.11%	64.48%
Responses	2946	2349	2871



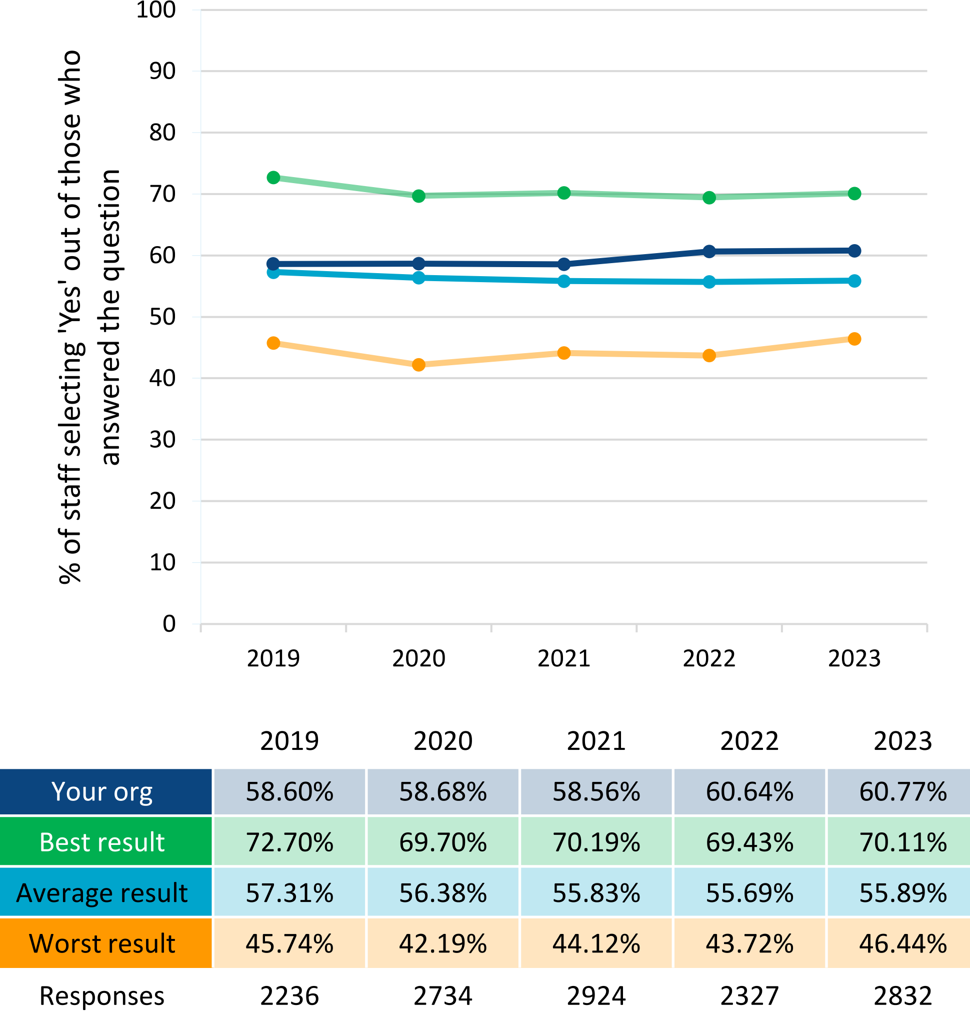


	2021	2022	2023
Your org	64.73%	68.64%	71.80%
Best result	76.92%	77.43%	78.65%
Average result	67.12%	68.10%	69.37%
Worst result	60.55%	60.34%	62.95%
Responses	2942	2345	2869



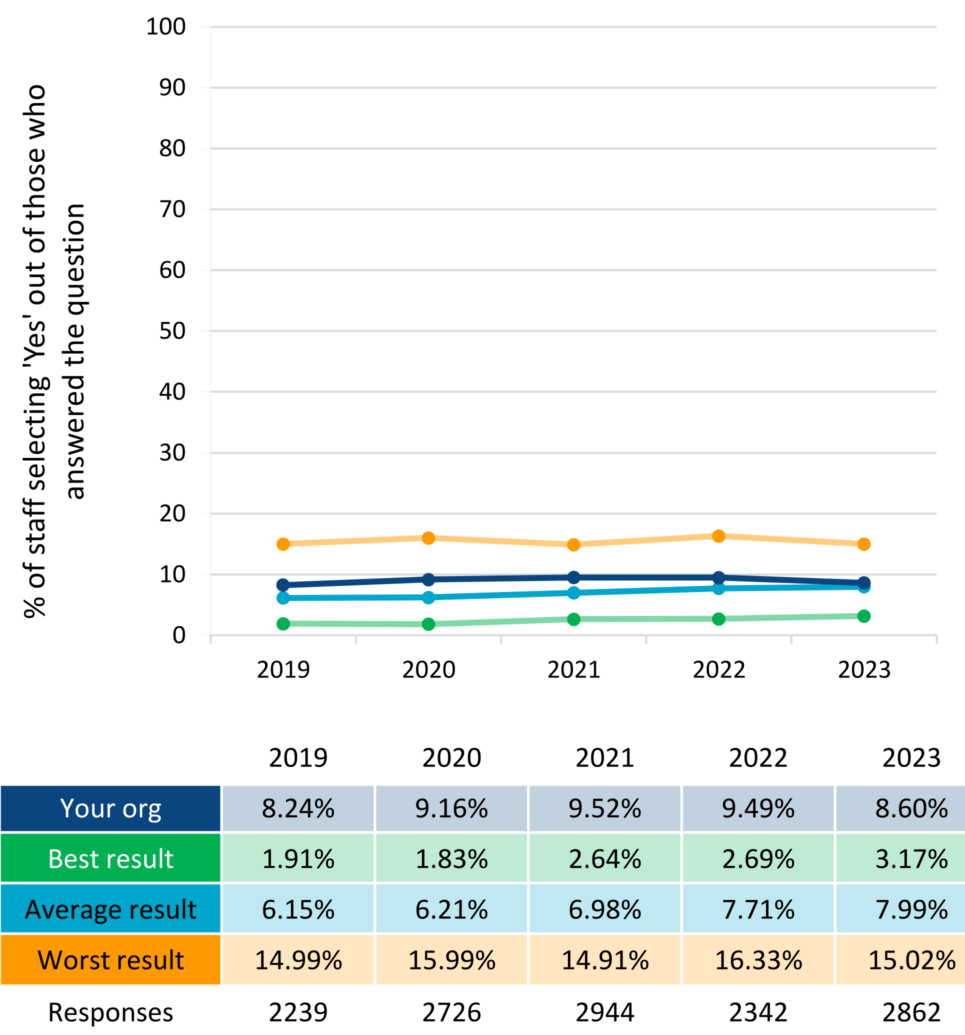
	2021	2022	2023
Your org	61.35%	64.75%	67.41%
Best result	74.49%	74.35%	76.19%
Average result	63.37%	64.50%	66.50%
Worst result	55.62%	56.50%	58.68%
Responses	2945	2345	2873

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



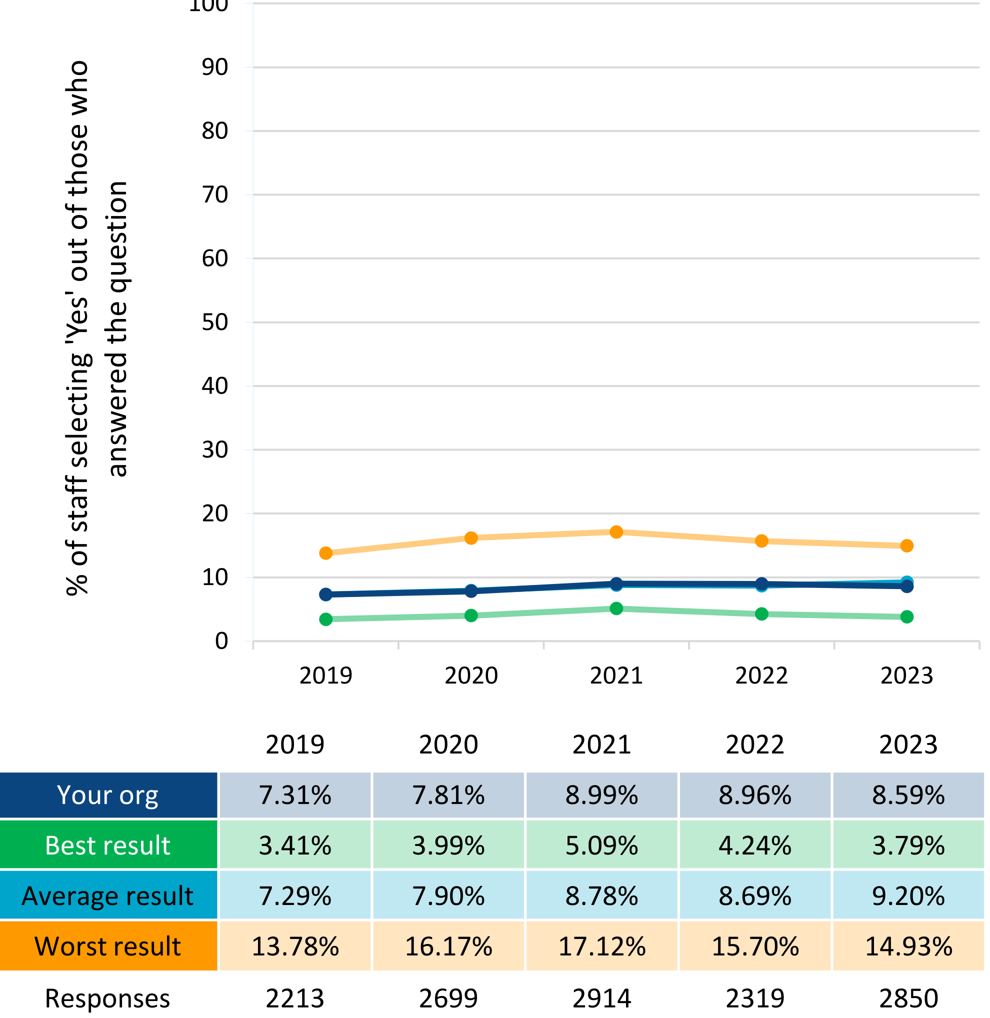
	2019	2020	2021	2022	2023
Your org	58.60%	58.68%	58.56%	60.64%	60.77%
Best result	72.70%	69.70%	70.19%	69.43%	70.11%
Average result	57.31%	56.38%	55.83%	55.69%	55.89%
Worst result	45.74%	42.19%	44.12%	43.72%	46.44%
Responses	2236	2734	2924	2327	2832

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



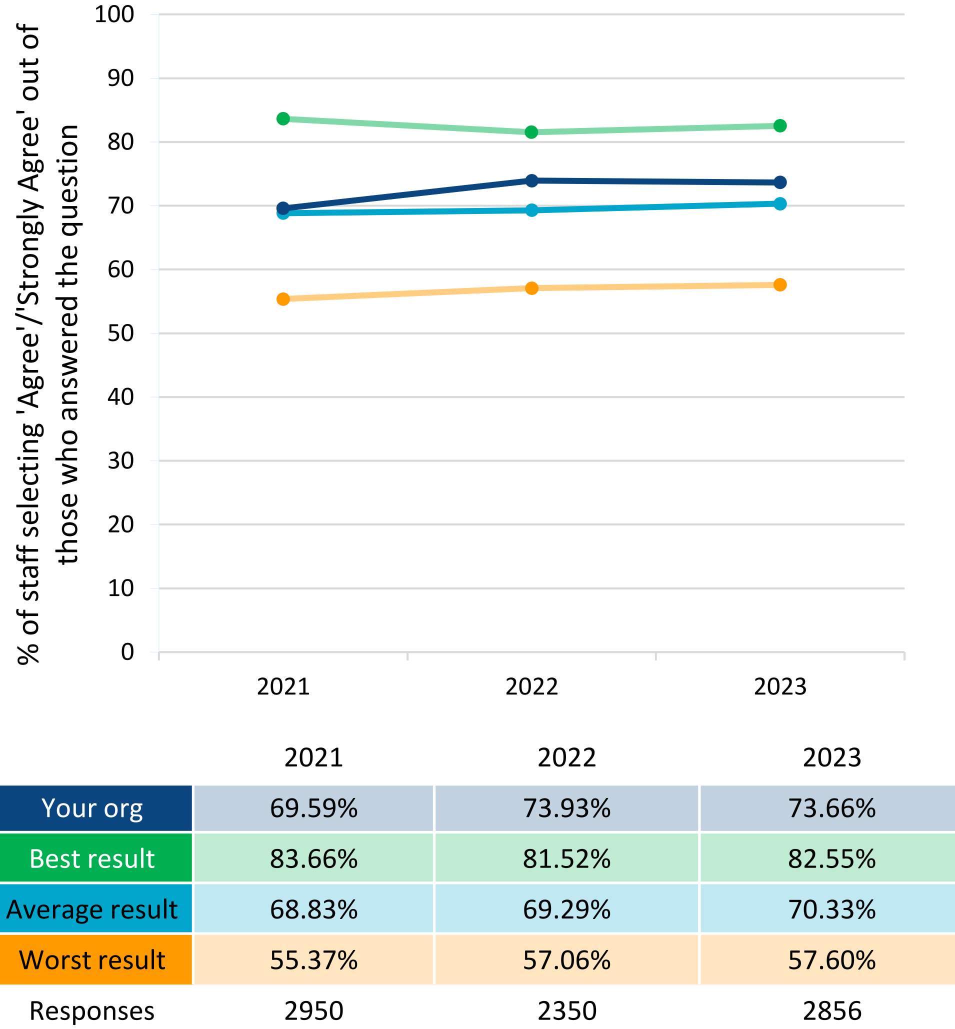
	2019	2020	2021	2022	2023
Your org	8.24%	9.16%	9.52%	9.49%	8.60%
Best result	1.91%	1.83%	2.64%	2.69%	3.17%
Average result	6.15%	6.21%	6.98%	7.71%	7.99%
Worst result	14.99%	15.99%	14.91%	16.33%	15.02%
Responses	2239	2726	2944	2342	2862

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?

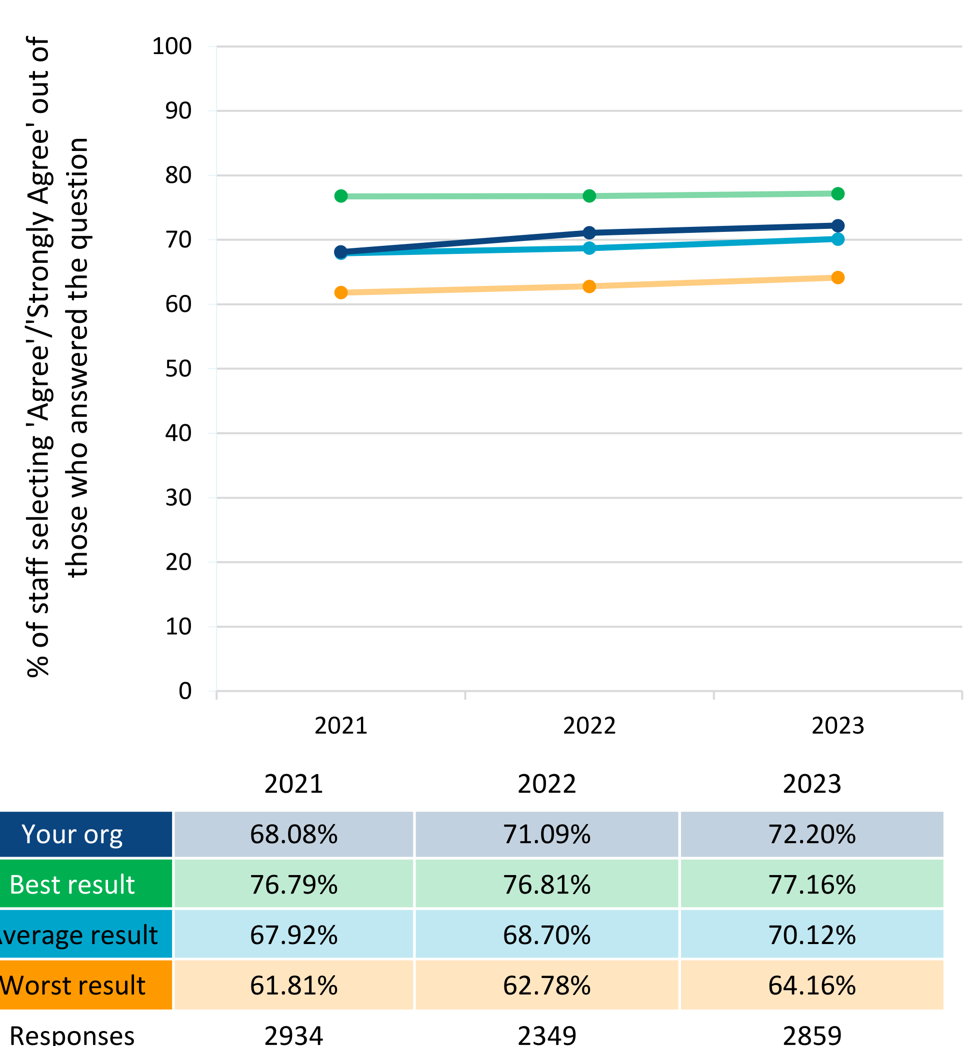


	2019	2020	2021	2022	2023
Your org	7.31%	7.81%	8.99%	8.96%	8.59%
Best result	3.41%	3.99%	5.09%	4.24%	3.79%
Average result	7.29%	7.90%	8.78%	8.69%	9.20%
Worst result	13.78%	16.17%	17.12%	15.70%	14.93%
Responses	2213	2699	2914	2319	2850

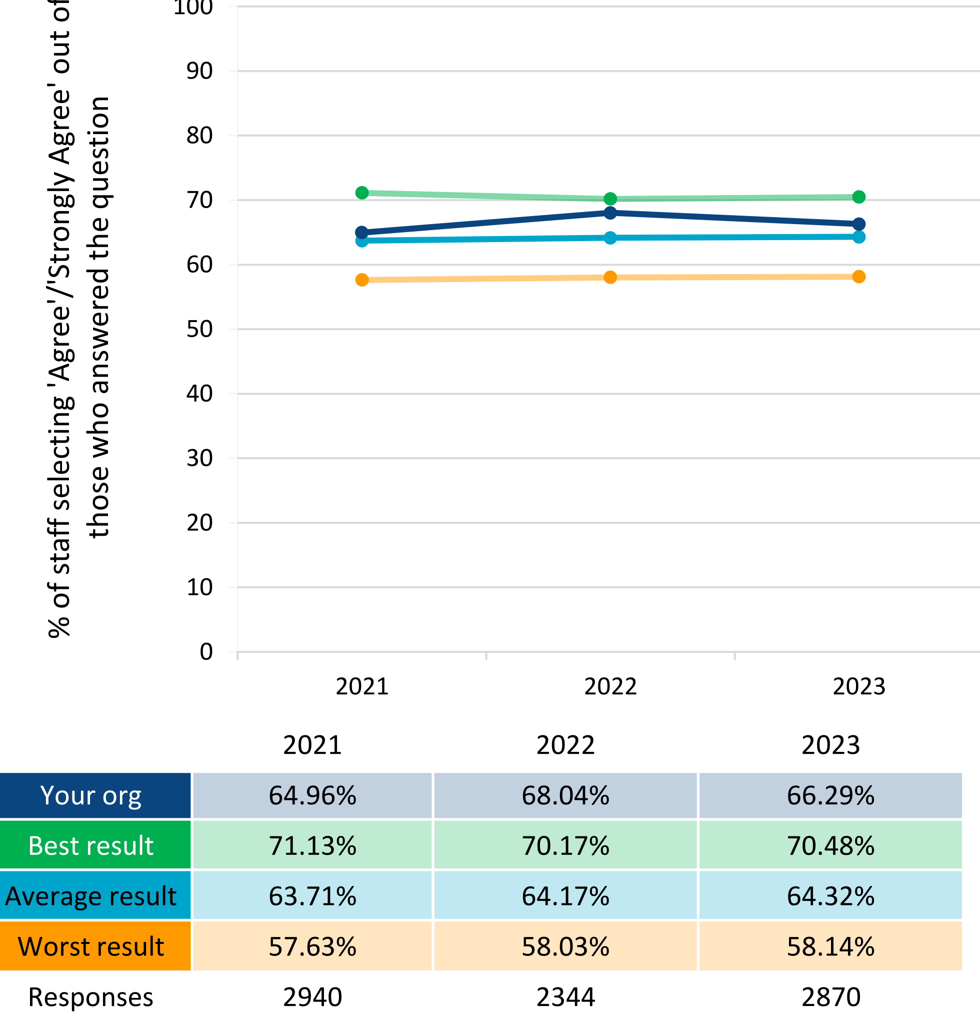
Q21 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).



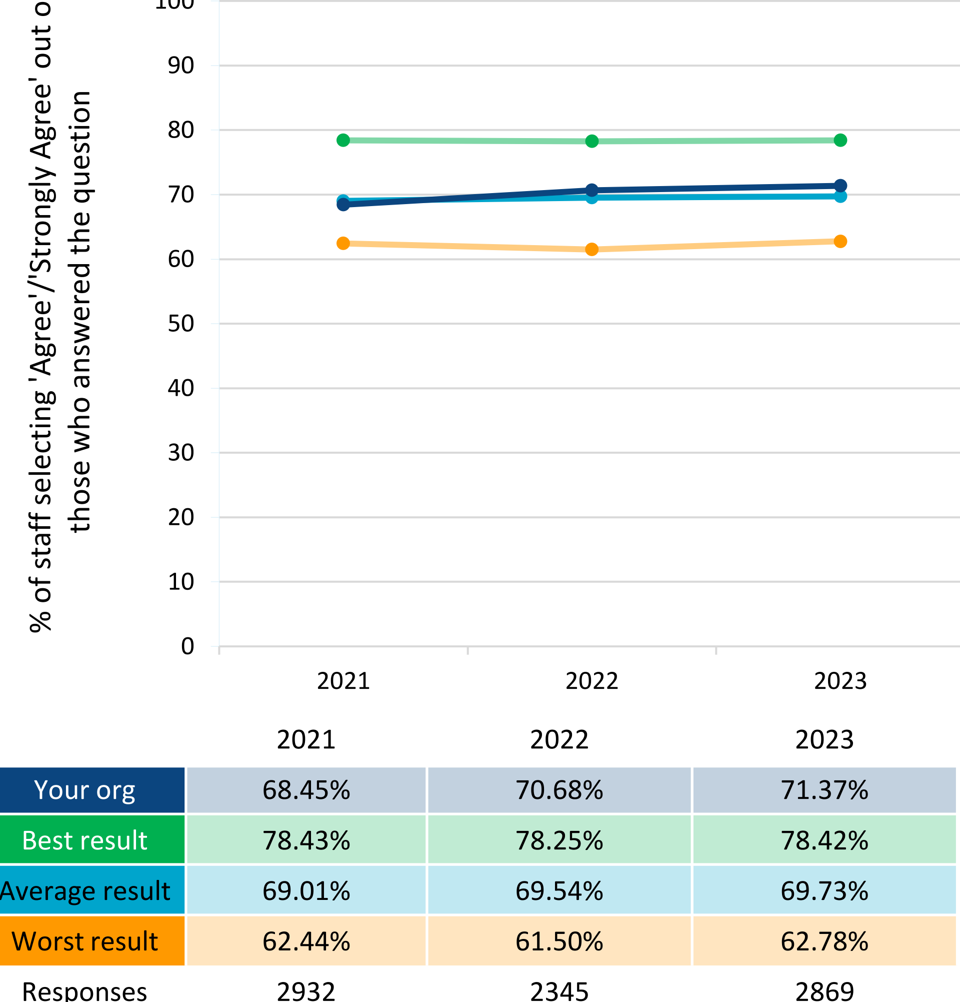
	2021	2022	2023
Your org	69.59%	73.93%	73.66%
Best result	83.66%	81.52%	82.55%
Average result	68.83%	69.29%	70.33%
Worst result	55.37%	57.06%	57.60%
Responses	2950	2350	2856



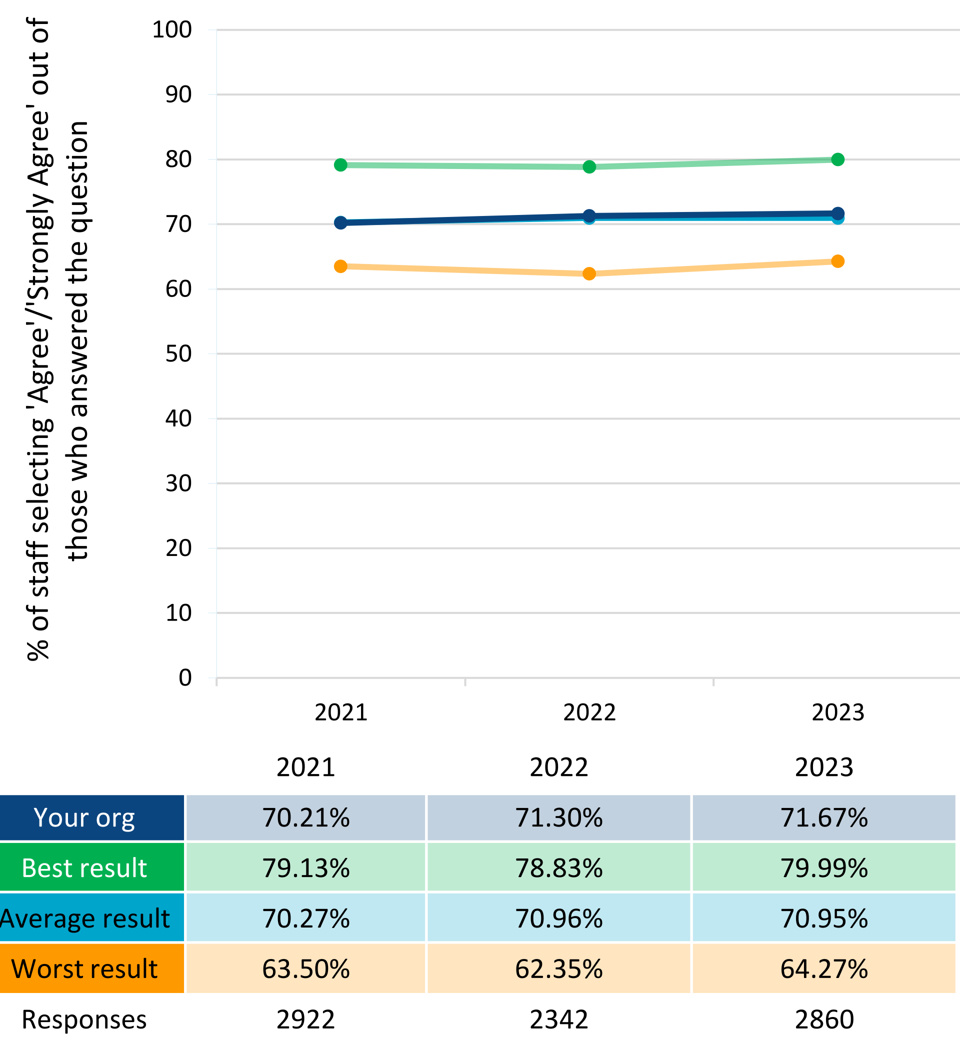
	2021	2022	2023
Your org	68.08%	71.09%	72.20%
Best result	76.79%	76.81%	77.16%
Average result	67.92%	68.70%	70.12%
Worst result	61.81%	62.78%	64.16%
Responses	2934	2349	2859



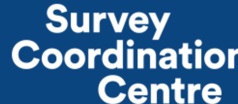
	2021	2022	2023
Your org	64.96%	68.04%	66.29%
Best result	71.13%	70.17%	70.48%
Average result	63.71%	64.17%	64.32%
Worst result	57.63%	58.03%	58.14%
Responses	2940	2344	2870



	2021	2022	2023
Your org	68.45%	70.68%	71.37%
Best result	78.43%	78.25%	78.42%
Average result	69.01%	69.54%	69.73%
Worst result	62.44%	61.50%	62.78%
Responses	2932	2345	2869



	2021	2022	2023
Your org	70.21%	71.30%	71.67%
Best result	79.13%	78.83%	79.99%
Average result	70.27%	70.96%	70.95%
Worst result	63.50%	62.35%	64.27%
Responses	2922	2342	2860



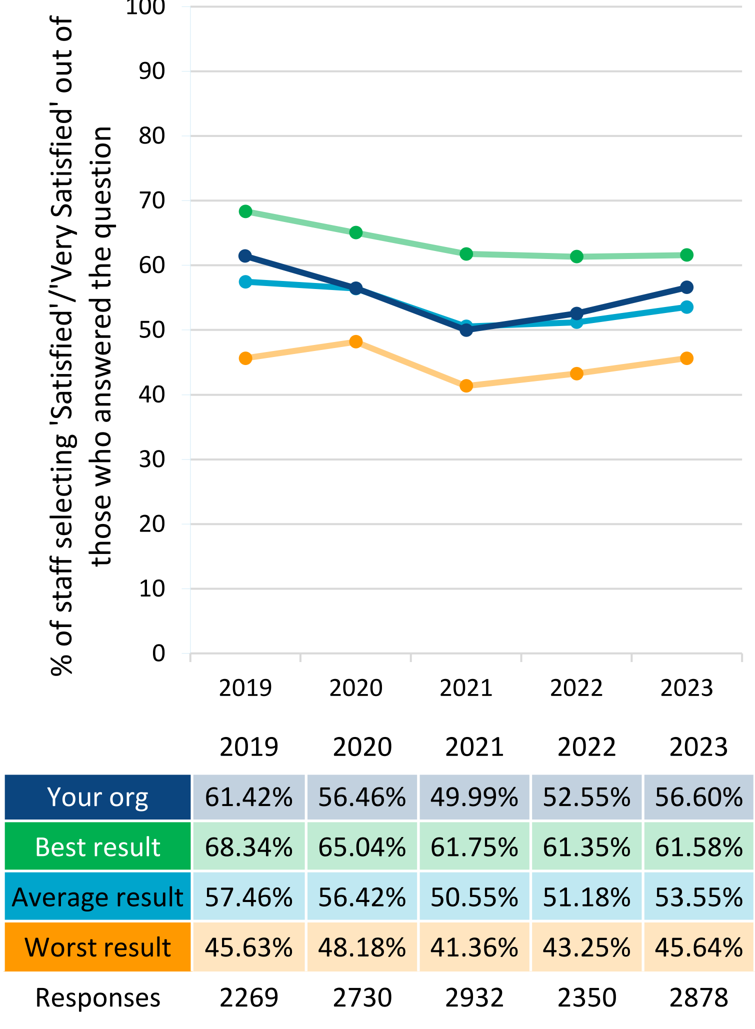
People Promise element – We are recognised and rewarded

Questions included:

Q4a, Q4b, Q4c, Q8d, Q9e

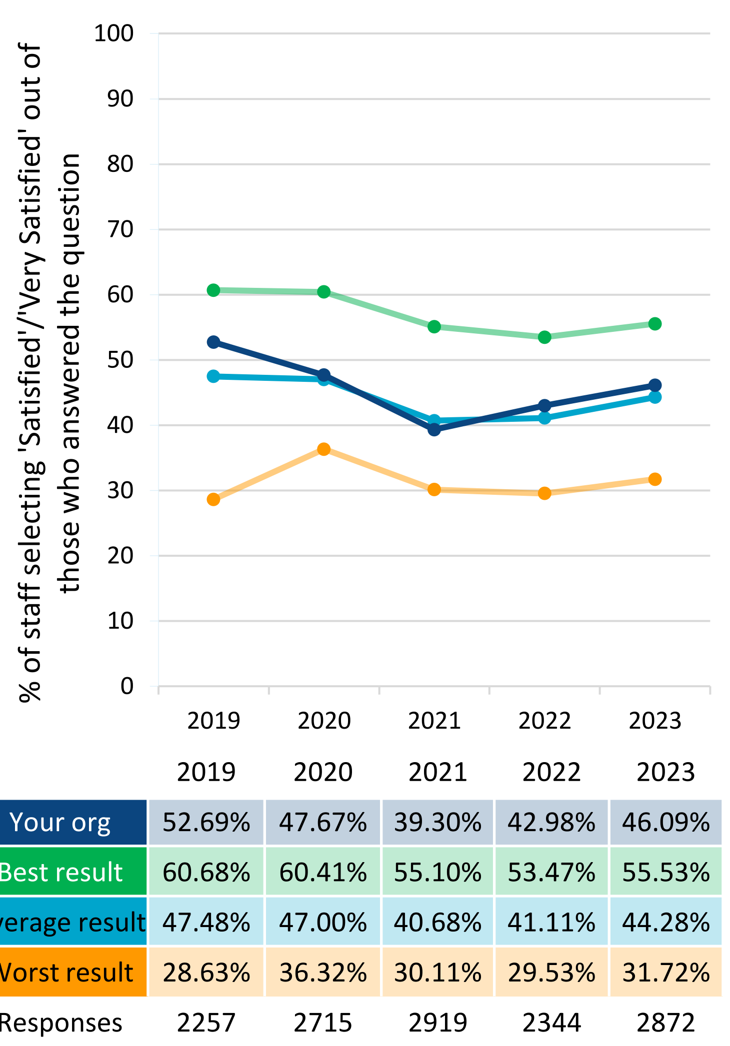
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



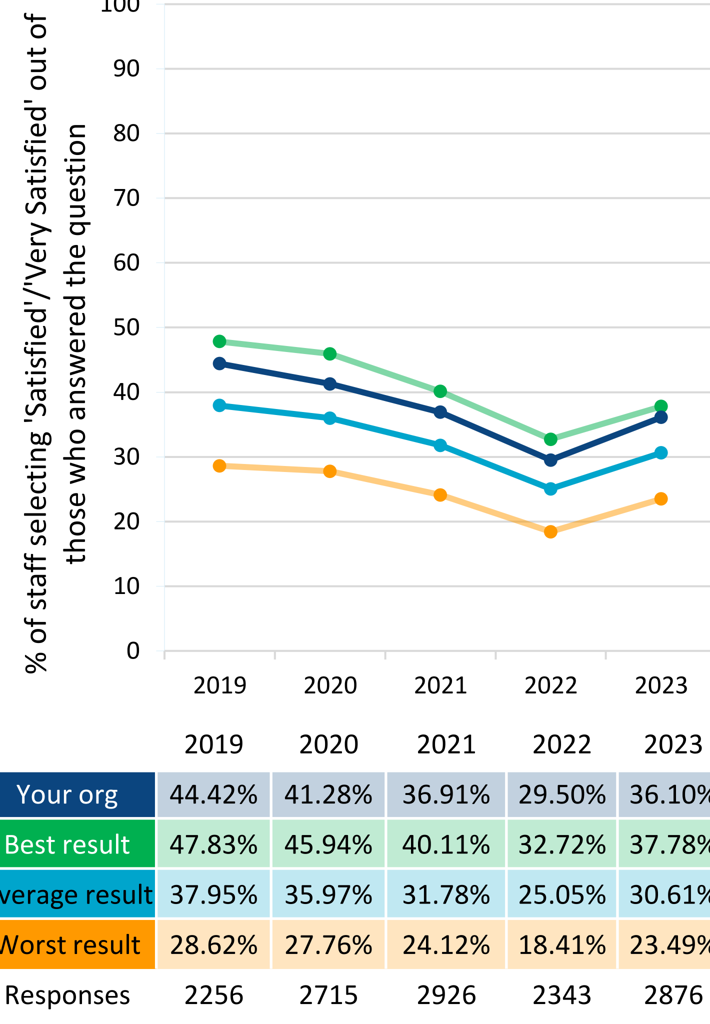
	2019	2020	2021	2022	2023
Your org	61.42%	56.46%	49.99%	52.55%	56.60%
Best result	68.34%	65.04%	61.75%	61.35%	61.58%
Average result	57.46%	56.42%	50.55%	51.18%	53.55%
Worst result	45.63%	48.18%	41.36%	43.25%	45.64%
Responses	2269	2730	2932	2350	2878

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.

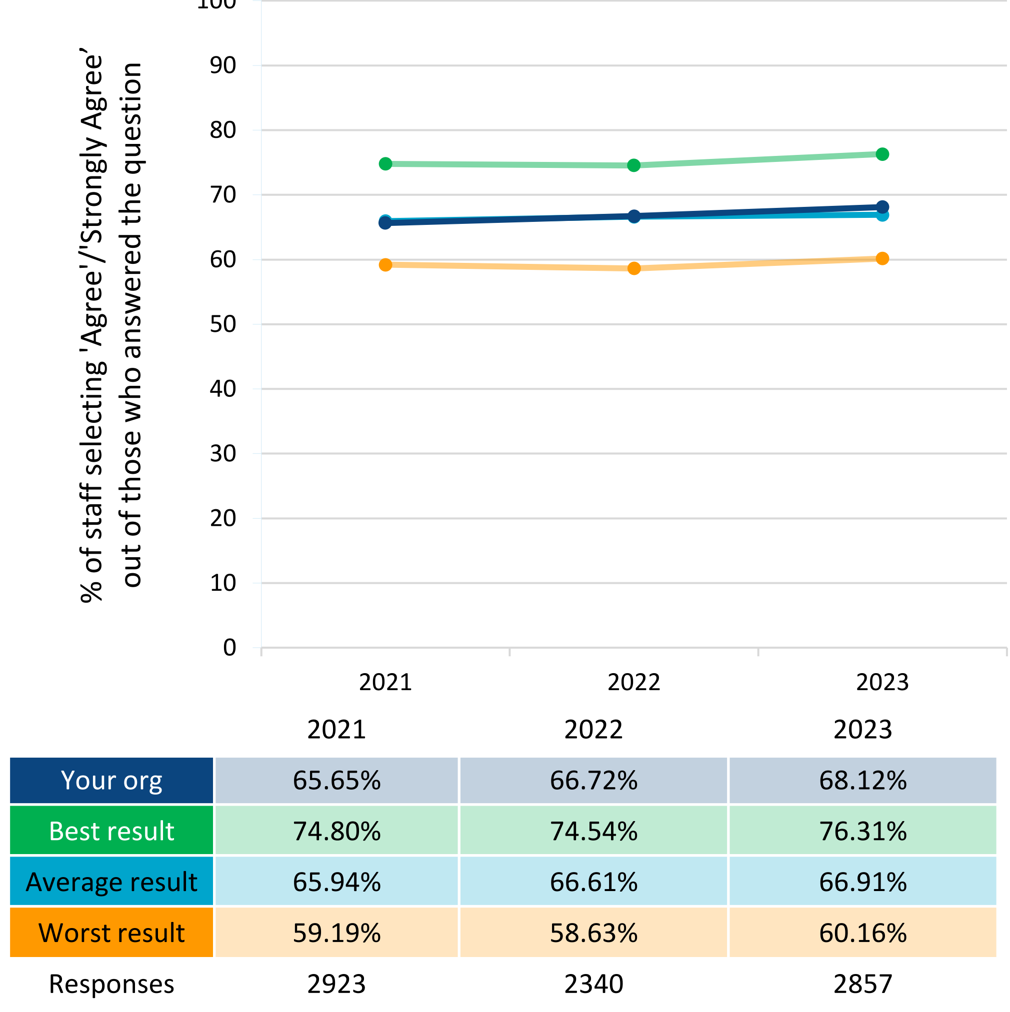


	2019	2020	2021	2022	2023
Your org	52.69%	47.67%	39.30%	42.98%	46.09%
Best result	60.68%	60.41%	55.10%	53.47%	55.53%
Average result	47.48%	47.00%	40.68%	41.11%	44.28%
Worst result	28.63%	36.32%	30.11%	29.53%	31.72%
Responses	2257	2715	2919	2344	2872

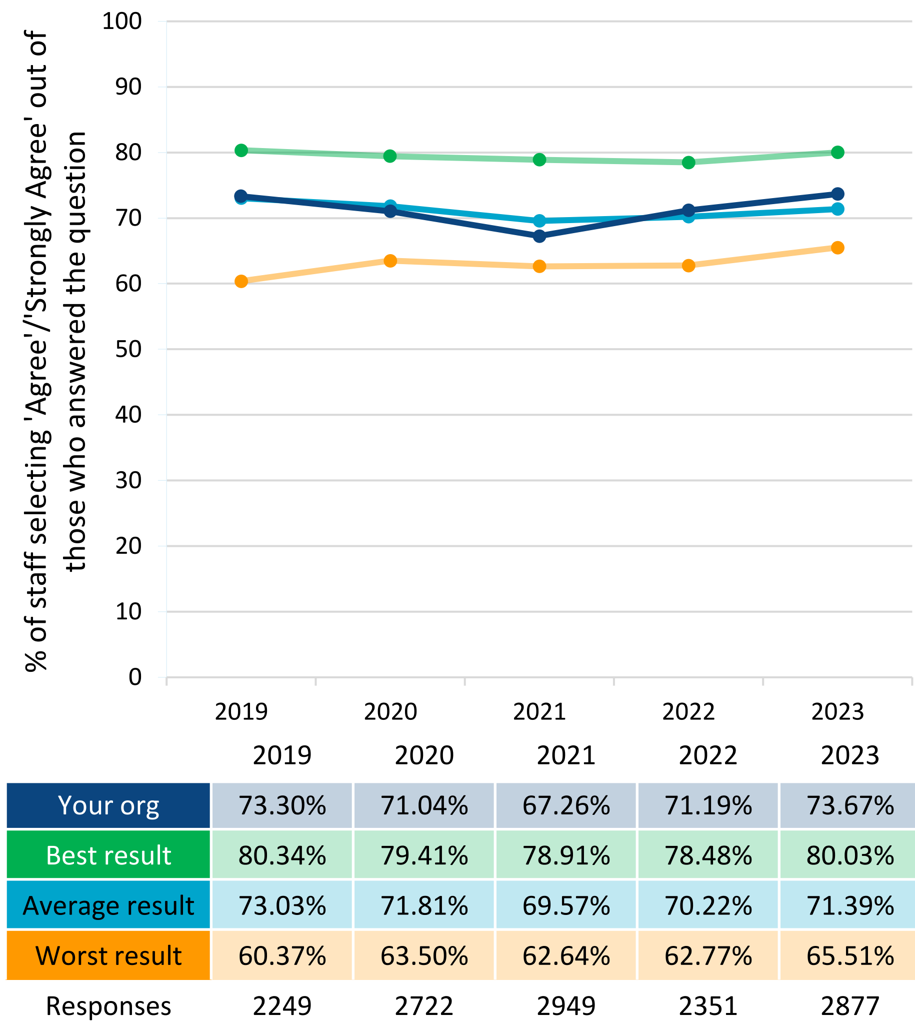
Q4c How satisfied are you with each of the following aspects of your job? My level of pay.



	2019	2020	2021	2022	2023
Your org	44.42%	41.28%	36.91%	29.50%	36.10%
Best result	47.83%	45.94%	40.11%	32.72%	37.78%
Average result	37.95%	35.97%	31.78%	25.05%	30.61%
Worst result	28.62%	27.76%	24.12%	18.41%	23.49%
Responses	2256	2715	2926	2343	2876



	2021	2022	2023
Your org	65.65%	66.72%	68.12%
Best result	74.80%	74.54%	76.31%
Average result	65.94%	66.61%	66.91%
Worst result	59.19%	58.63%	60.16%
Responses	2923	2340	2857



	2019	2020	2021	2022	2023
Your org	73.30%	71.04%	67.26%	71.19%	73.67%
Best result	80.34%	79.41%	78.91%	78.48%	80.03%
Average result	73.03%	71.81%	69.57%	70.22%	71.39%
Worst result	60.37%	63.50%	62.64%	62.77%	65.51%
Responses	2249	2722	2949	2351	2877

Survey Coordination Centre

People Promise element – We each have a voice that counts

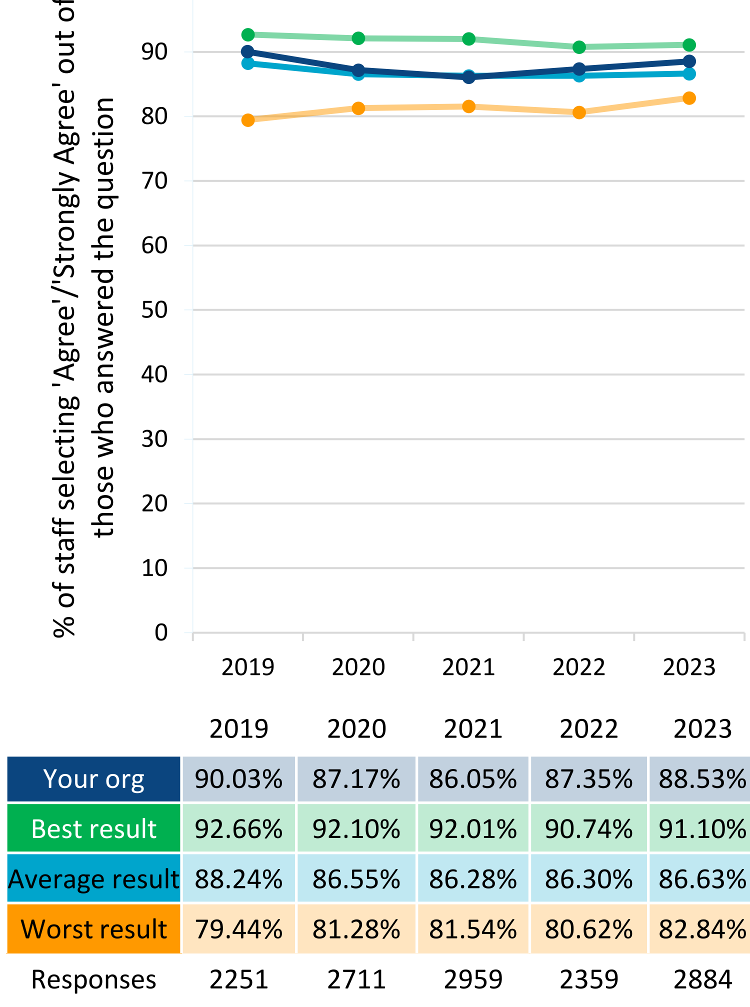
Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

Raising concerns – Q20a, Q20b, Q25e, Q25f

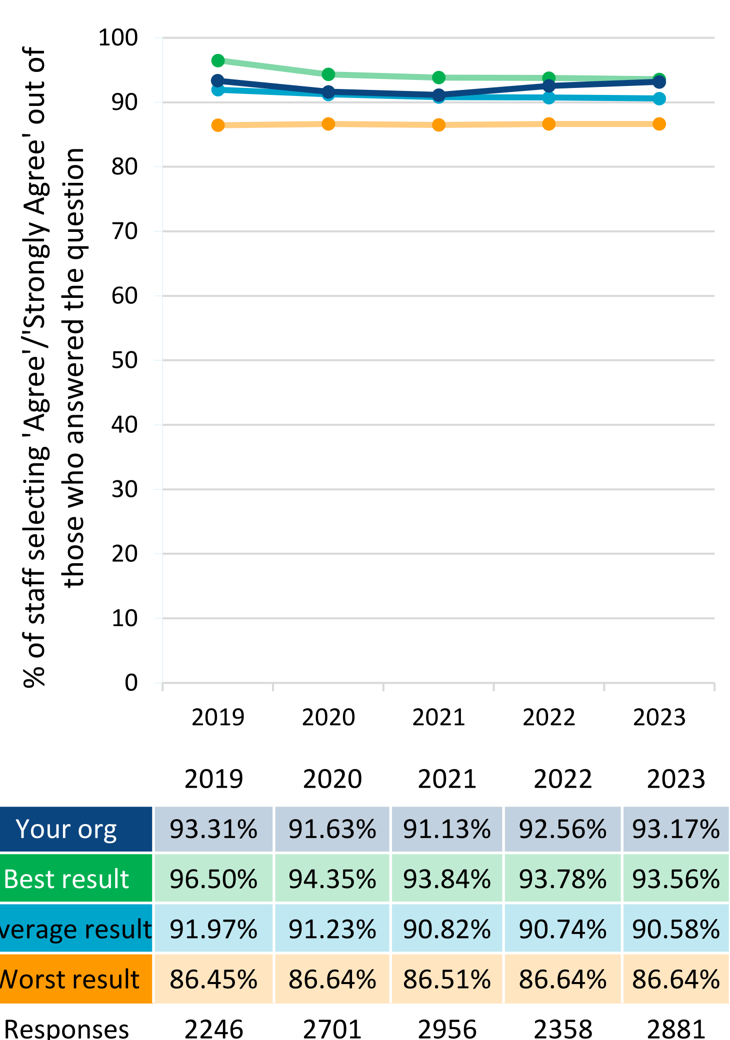
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3a I always know what my work responsibilities are.



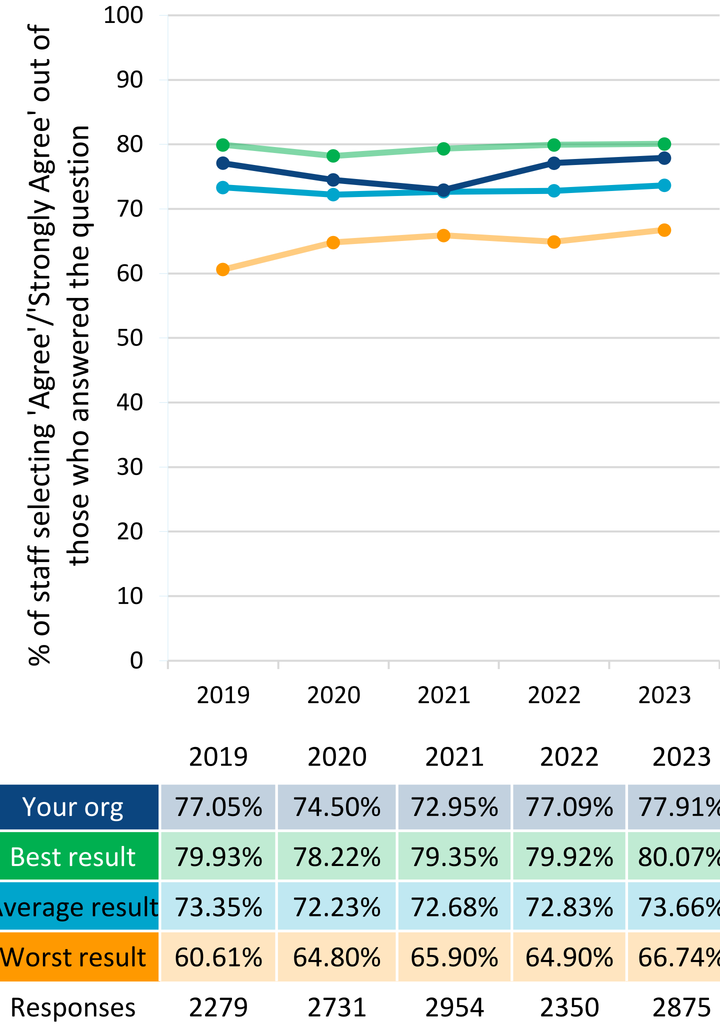
	2019	2020	2021	2022	2023
Your org	90.03%	87.17%	86.05%	87.35%	88.53%
Best result	92.66%	92.10%	92.01%	90.74%	91.10%
Average result	88.24%	86.55%	86.28%	86.30%	86.63%
Worst result	79.44%	81.28%	81.54%	80.62%	82.84%
Responses	2251	2711	2959	2359	2884

Q3b I am trusted to do my job.

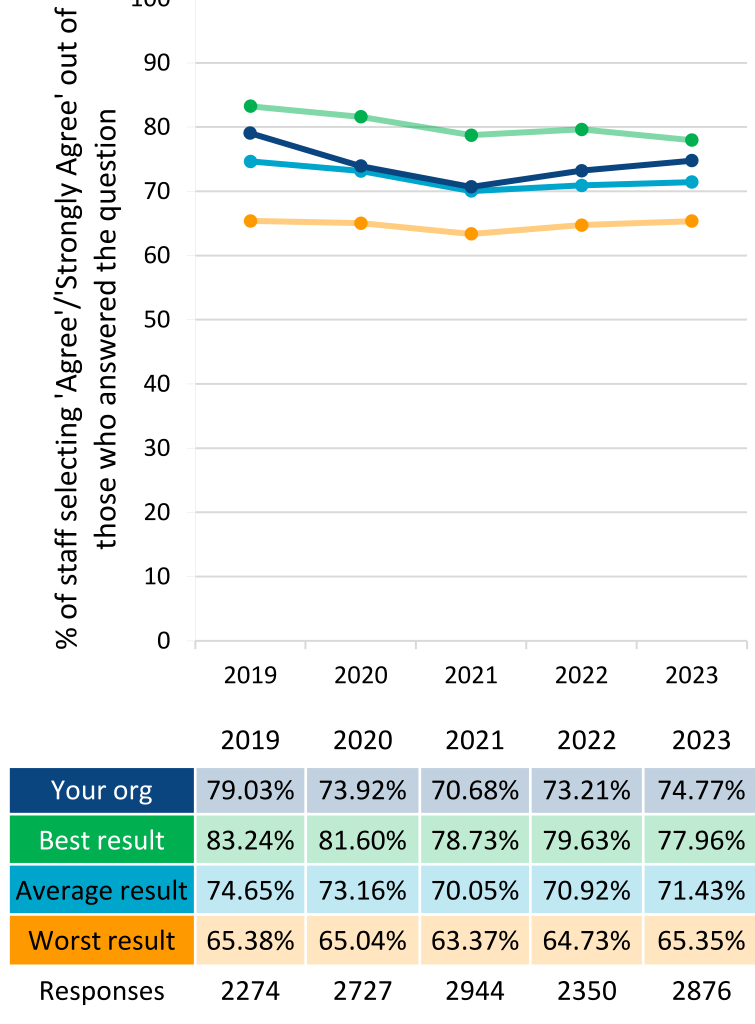


	2019	2020	2021	2022	2023
Your org	93.31%	91.63%	91.13%	92.56%	93.17%
Best result	96.50%	94.35%	93.84%	93.78%	93.56%
Average result	91.97%	91.23%	90.82%	90.74%	90.58%
Worst result	86.45%	86.64%	86.51%	86.64%	86.64%
Responses	2246	2701	2956	2358	2881

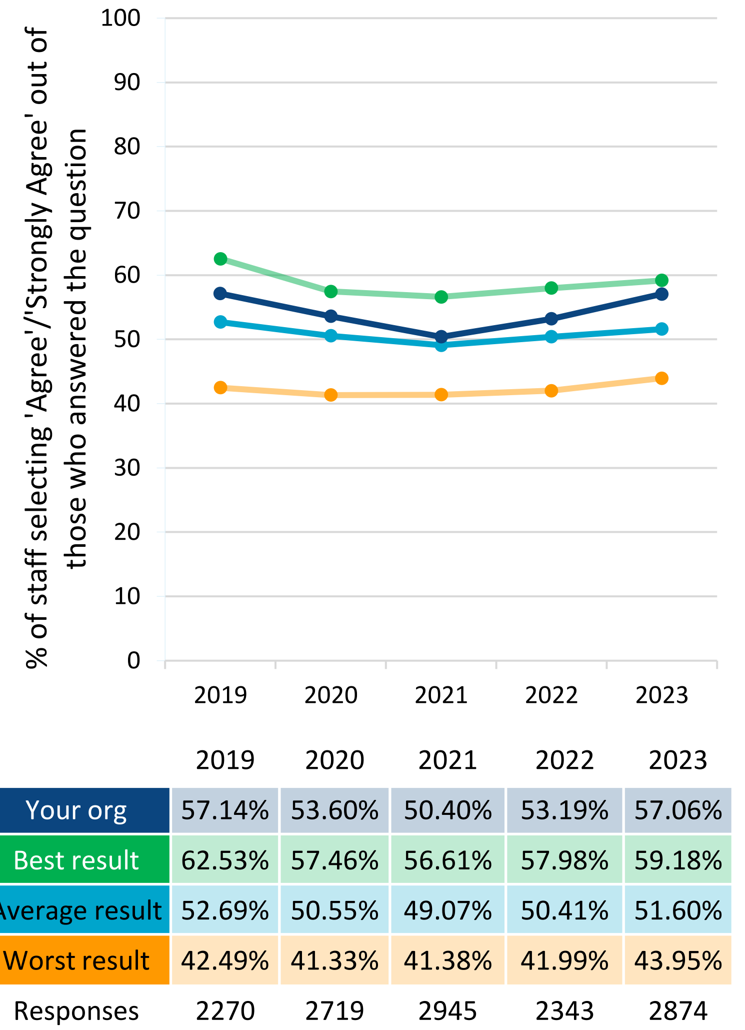
Q3c There are frequent opportunities for me to show initiative in my role.



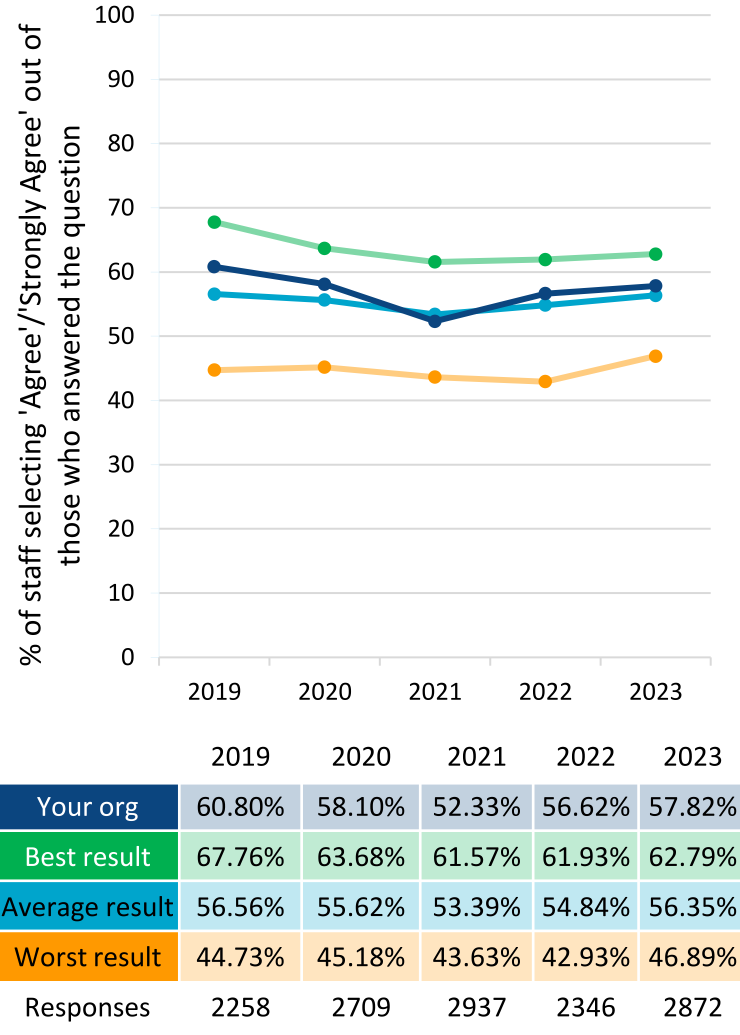
	2019	2020	2021	2022	2023
Your org	77.05%	74.50%	72.95%	77.09%	77.91%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	2279	2731	2954	2350	2875



	2019	2020	2021	2022	2023
Your org	79.03%	73.92%	70.68%	73.21%	74.77%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	2274	2727	2944	2350	2876

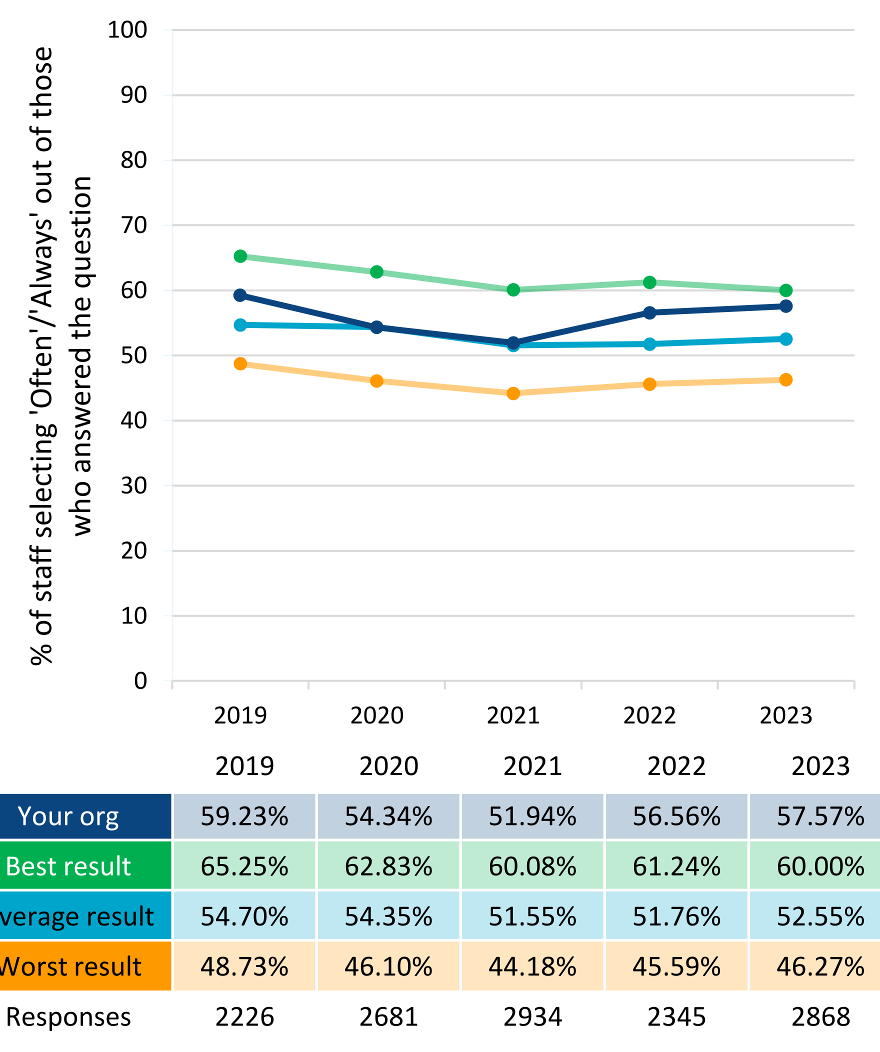


	2019	2020	2021	2022	2023
Your org	57.14%	53.60%	50.40%	53.19%	57.06%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	2270	2719	2945	2343	2874

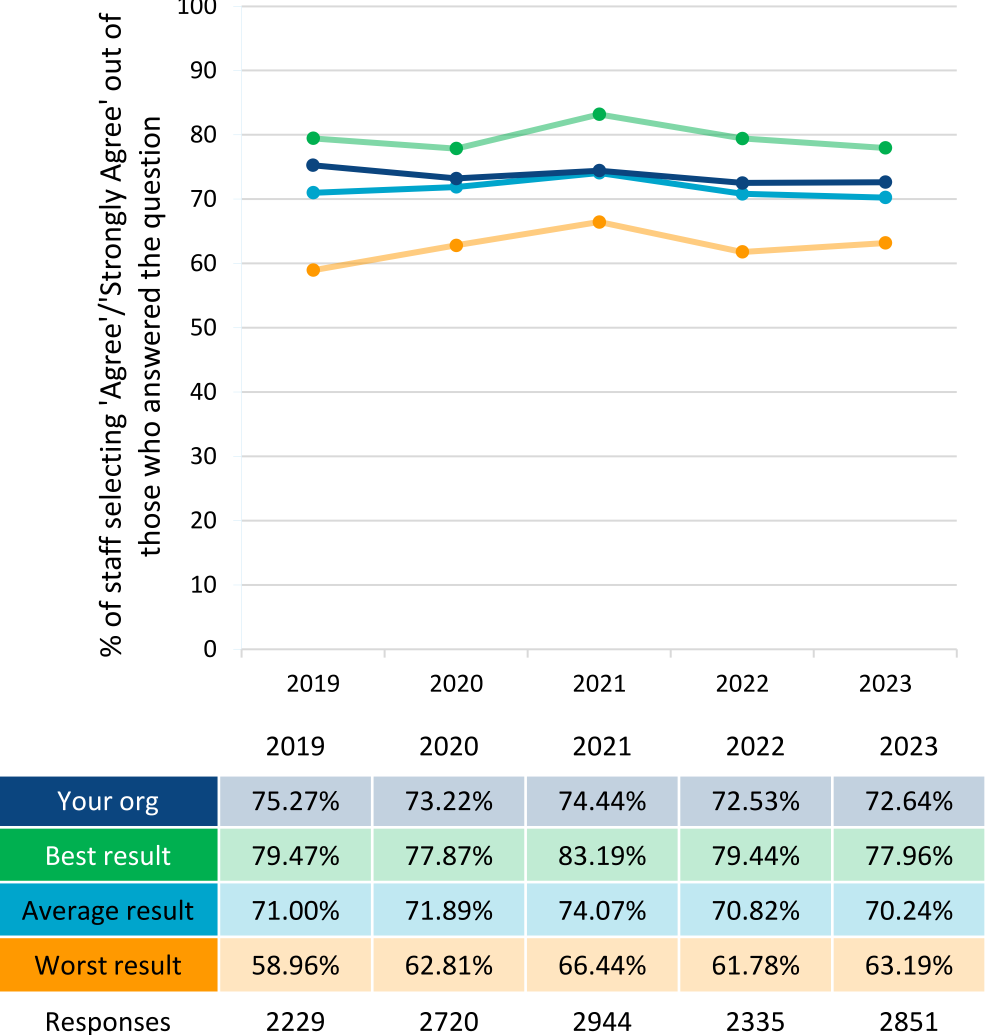


	2019	2020	2021	2022	2023
Your org	60.80%	58.10%	52.33%	56.62%	57.82%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	2258	2709	2937	2346	2872

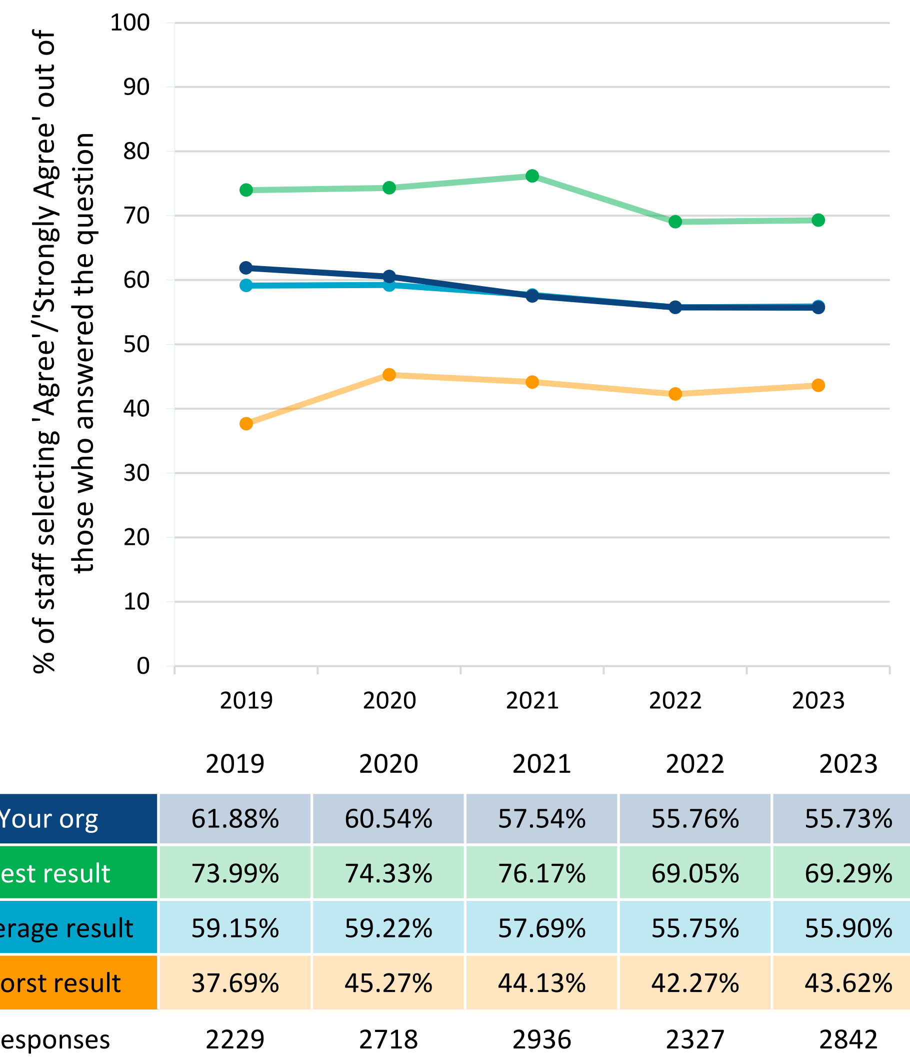
Q5b I have a choice in deciding how to do my work.



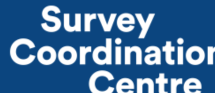
	2019	2020	2021	2022	2023
Your org	59.23%	54.34%	51.94%	56.56%	57.57%
Best result	65.25%	62.83%	60.08%	61.24%	60.00%
Average result	54.70%	54.35%	51.55%	51.76%	52.55%
Worst result	48.73%	46.10%	44.18%	45.59%	46.27%
Responses	2226	2681	2934	2345	2868

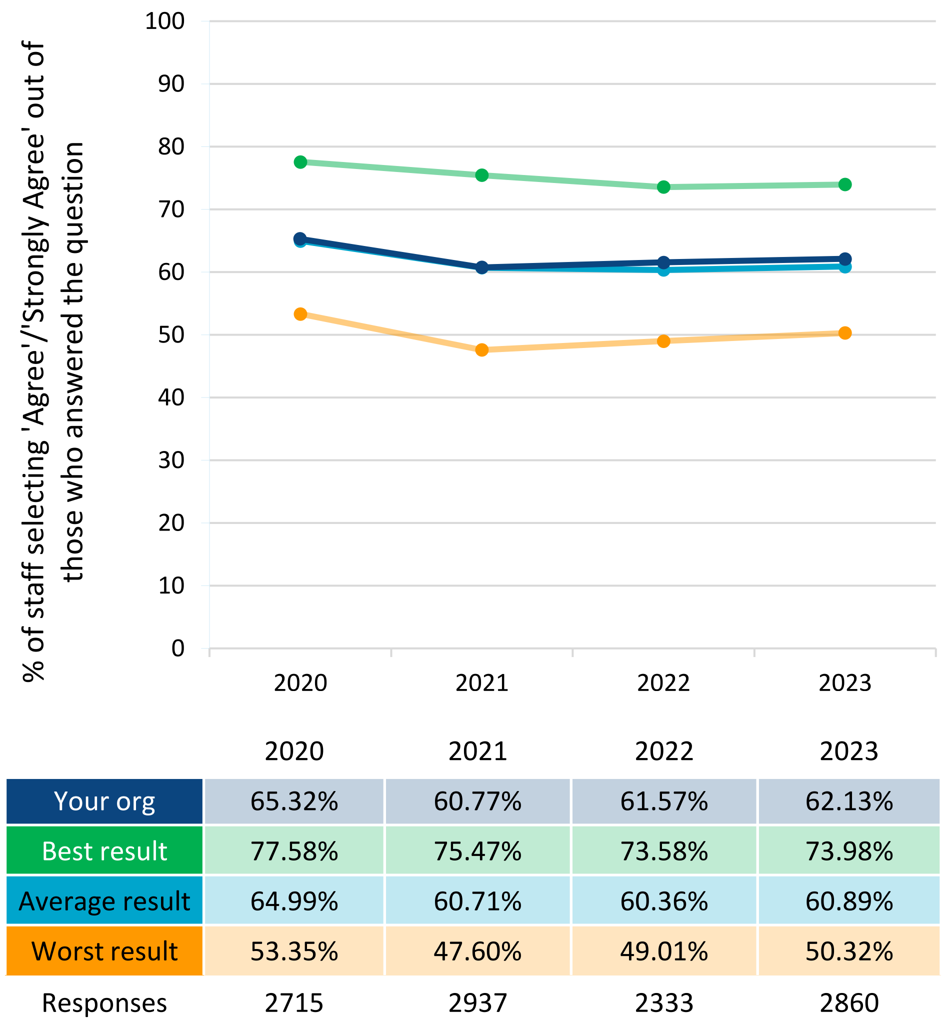


	2019	2020	2021	2022	2023
Your org	75.27%	73.22%	74.44%	72.53%	72.64%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	2229	2720	2944	2335	2851

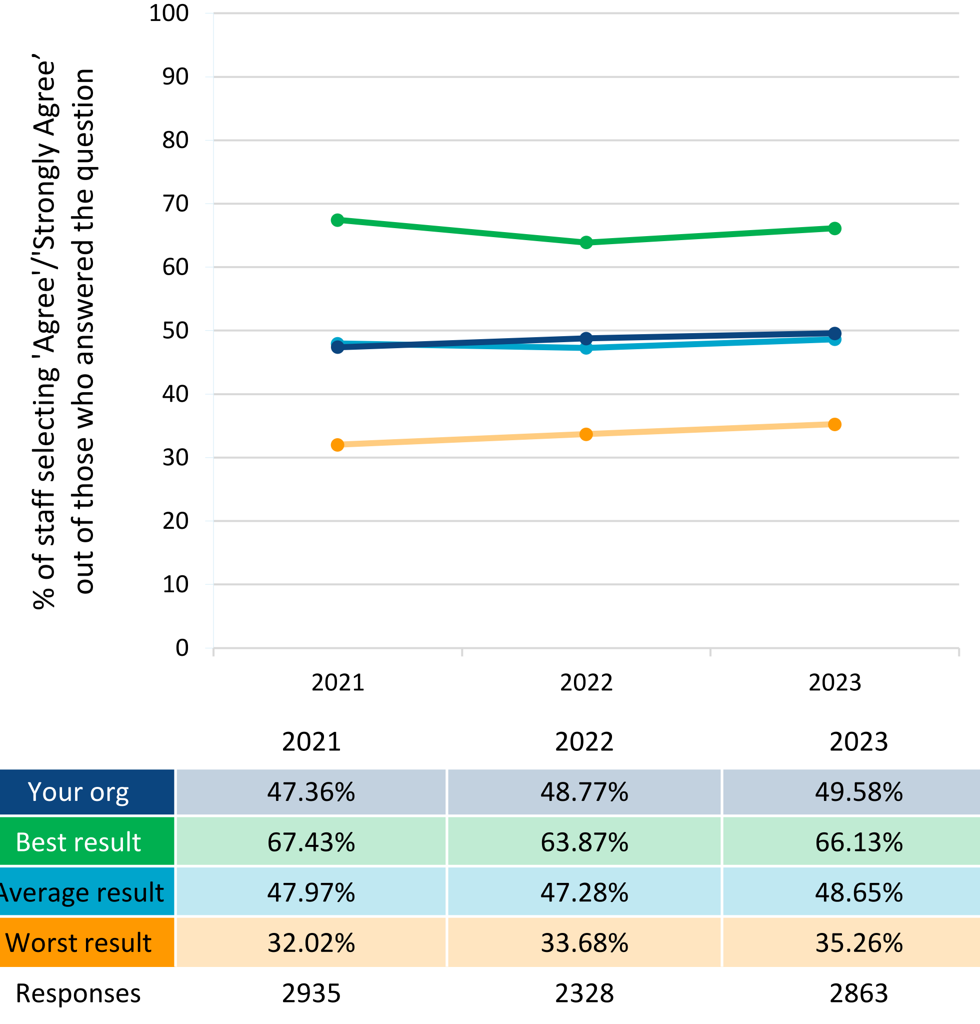


	2019	2020	2021	2022	2023
Your org	61.88%	60.54%	57.54%	55.76%	55.73%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	2229	2718	2936	2327	2842





	2020	2021	2022	2023
Your org	65.32%	60.77%	61.57%	62.13%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	2715	2937	2333	2860



	2021	2022	2023
Your org	47.36%	48.77%	49.58%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	2935	2328	2863

Survey Coordination Centre

People Promise element – We are safe and healthy

Questions included:

Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d

Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g

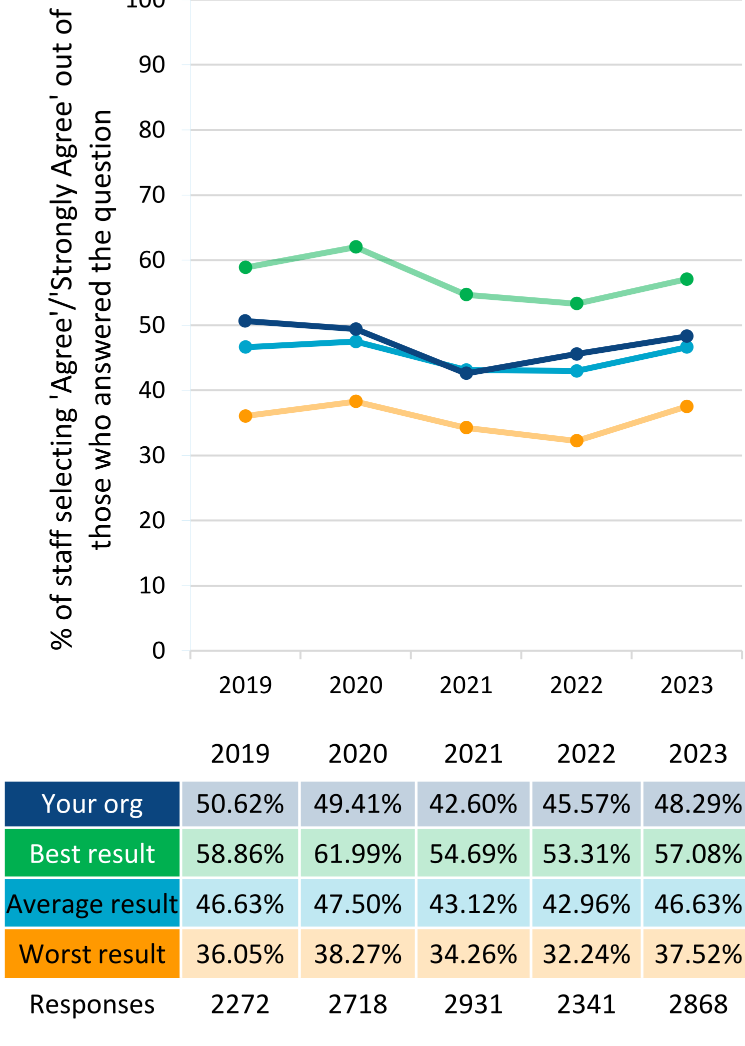
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Other questions:* Q17a, Q17b, Q22

*Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.

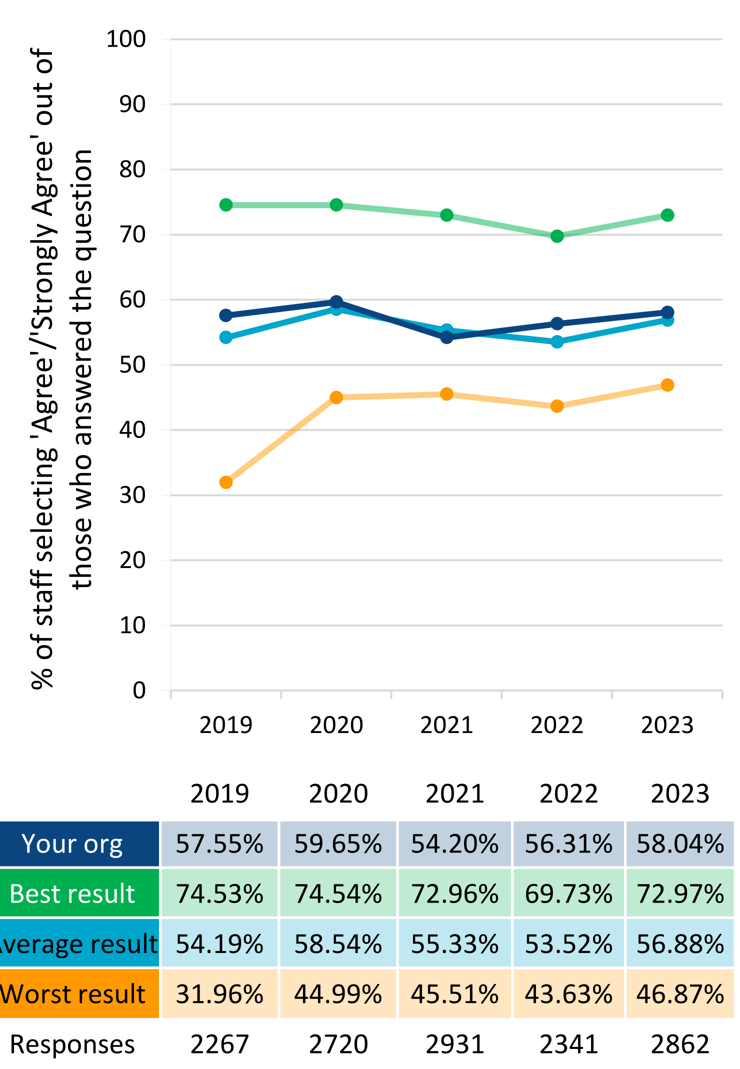
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3g I am able to meet all the conflicting demands on my time at work.



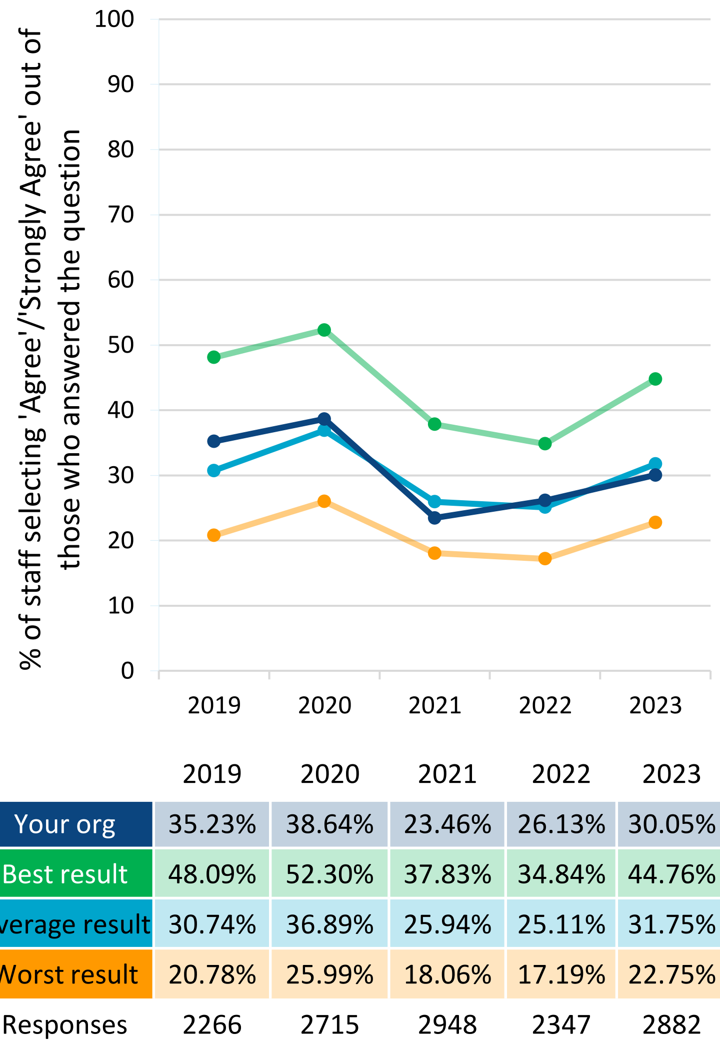
	2019	2020	2021	2022	2023
Your org	50.62%	49.41%	42.60%	45.57%	48.29%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	2272	2718	2931	2341	2868

Q3h I have adequate materials, supplies and equipment to do my work.



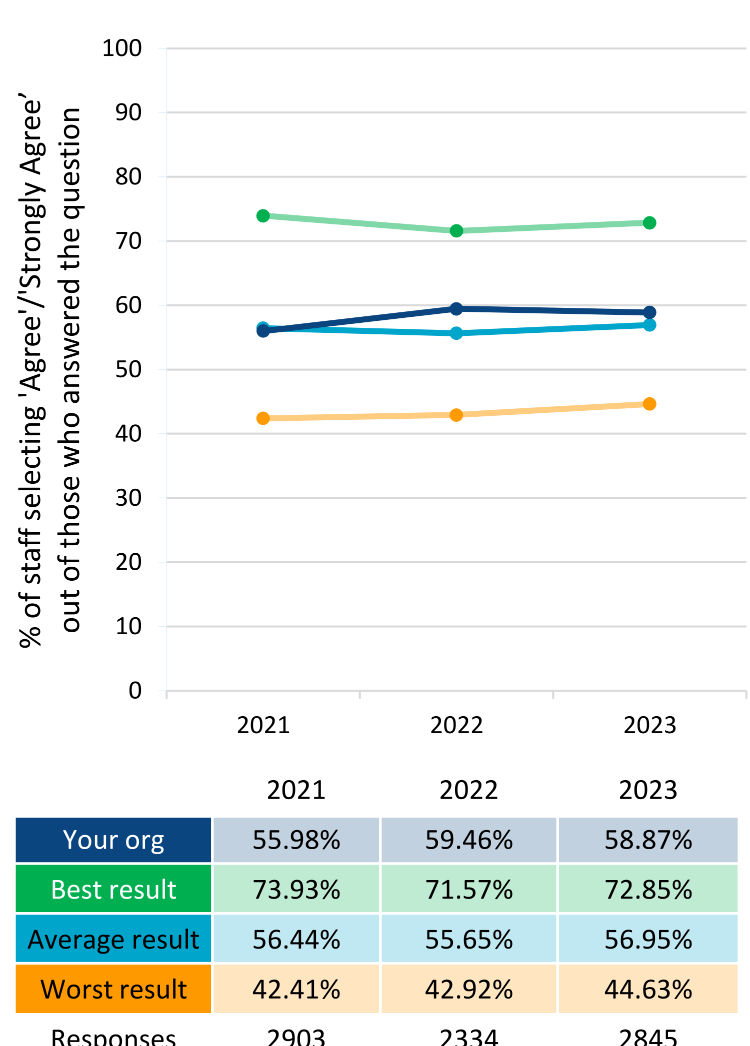
	2019	2020	2021	2022	2023
Your org	57.55%	59.65%	54.20%	56.31%	58.04%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	2267	2720	2931	2341	2862

Q3i There are enough staff at this organisation for me to do my job properly.

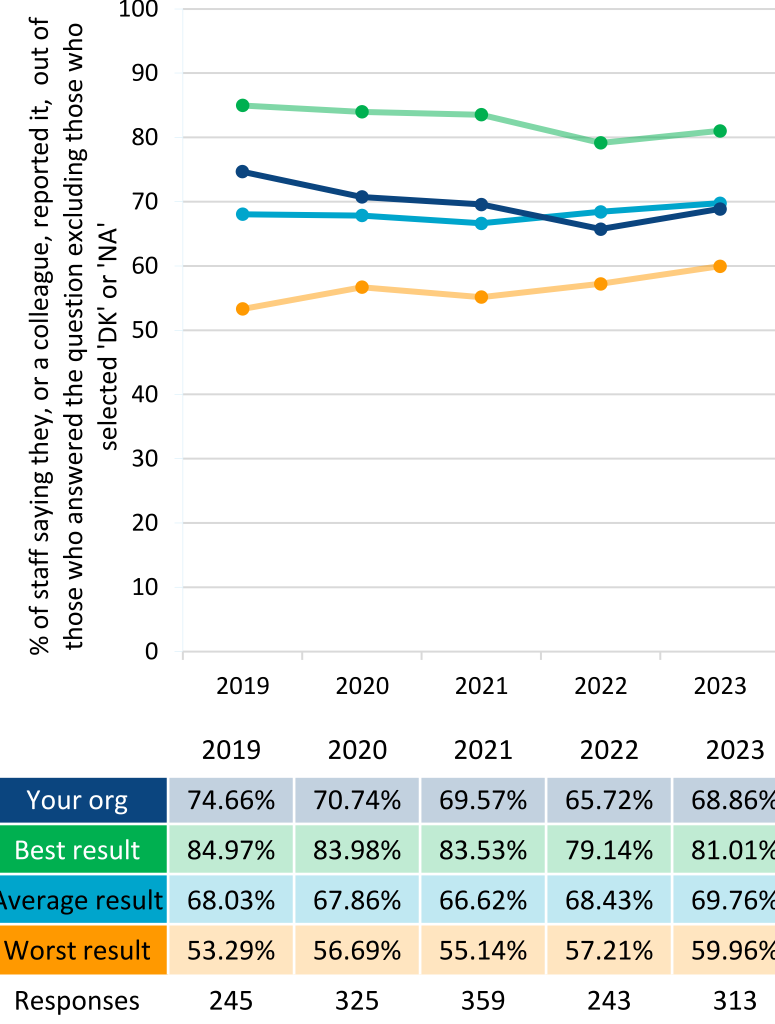


	2019	2020	2021	2022	2023
Your org	35.23%	38.64%	23.46%	26.13%	30.05%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	2266	2715	2948	2347	2882

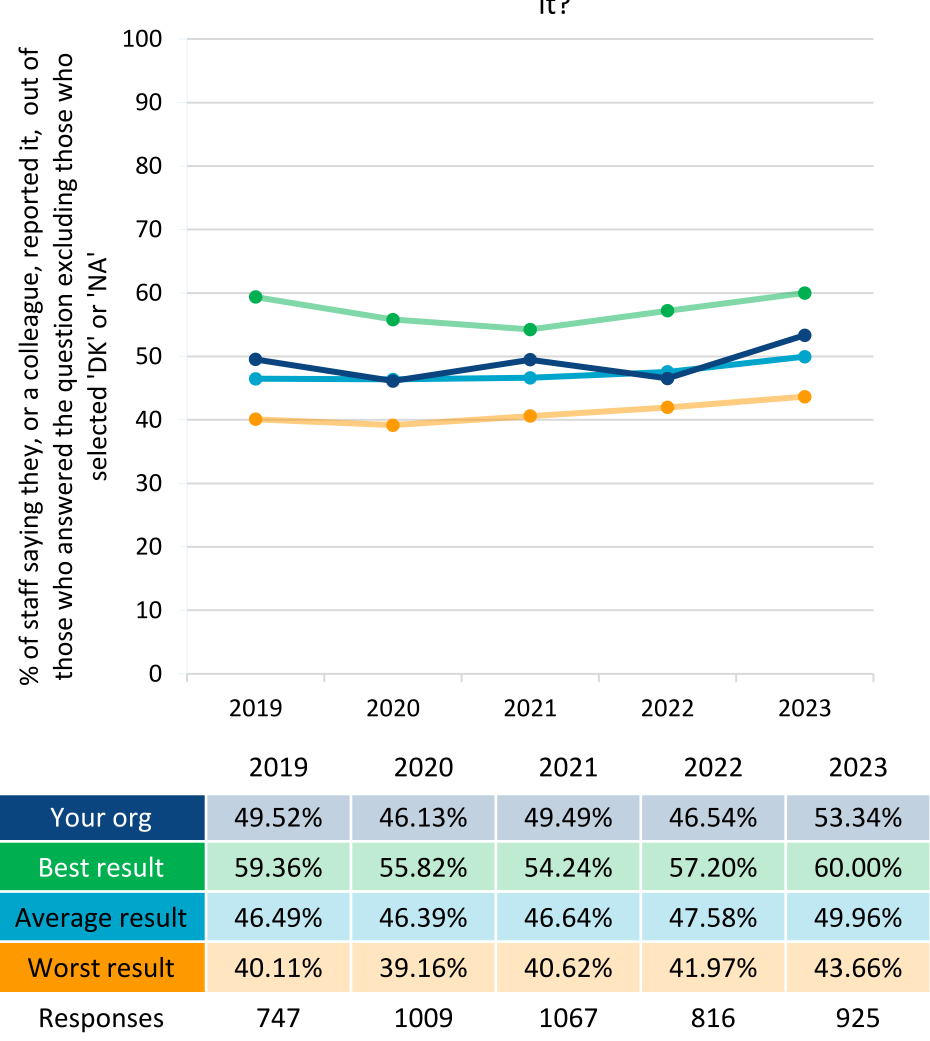
	2019	2020	2021	2022	2023
Your org	23.18%	24.98%	21.63%	23.00%	27.31%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	2225	2682	2937	2343	2875



	2021	2022	2023
Your org	55.98%	59.46%	58.87%
Best result	73.93%	71.57%	72.85%
Average result	56.44%	55.65%	56.95%
Worst result	42.41%	42.92%	44.63%
Responses	2903	2334	2845

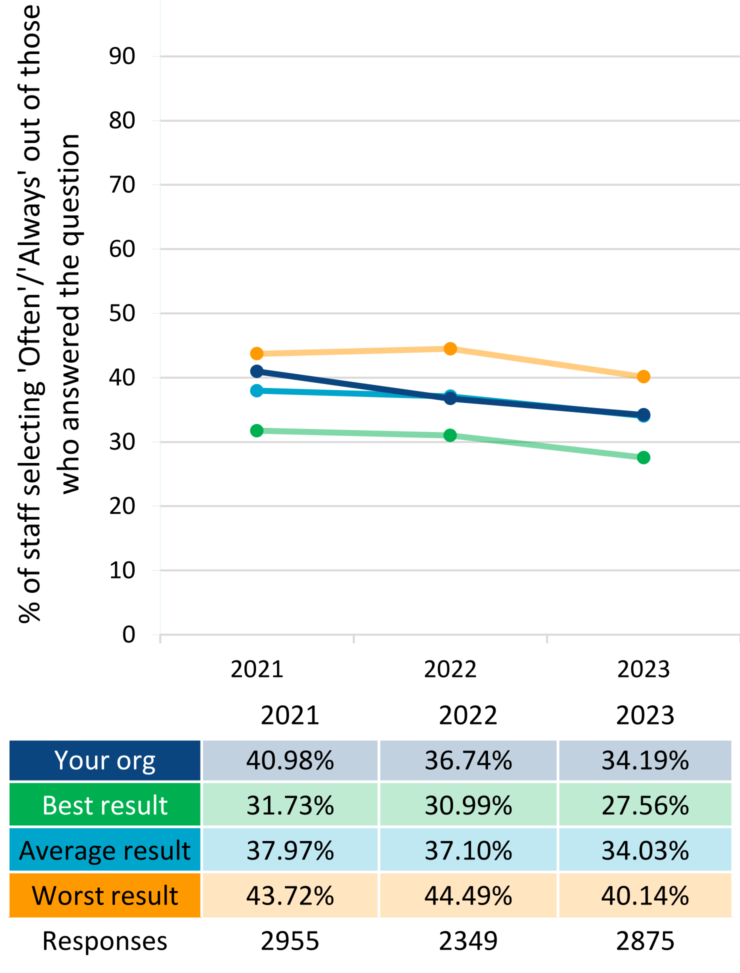


	2019	2020	2021	2022	2023
Your org	74.66%	70.74%	69.57%	65.72%	68.86%
Best result	84.97%	83.98%	83.53%	79.14%	81.01%
Average result	68.03%	67.86%	66.62%	68.43%	69.76%
Worst result	53.29%	56.69%	55.14%	57.21%	59.96%
Responses	245	325	359	243	313



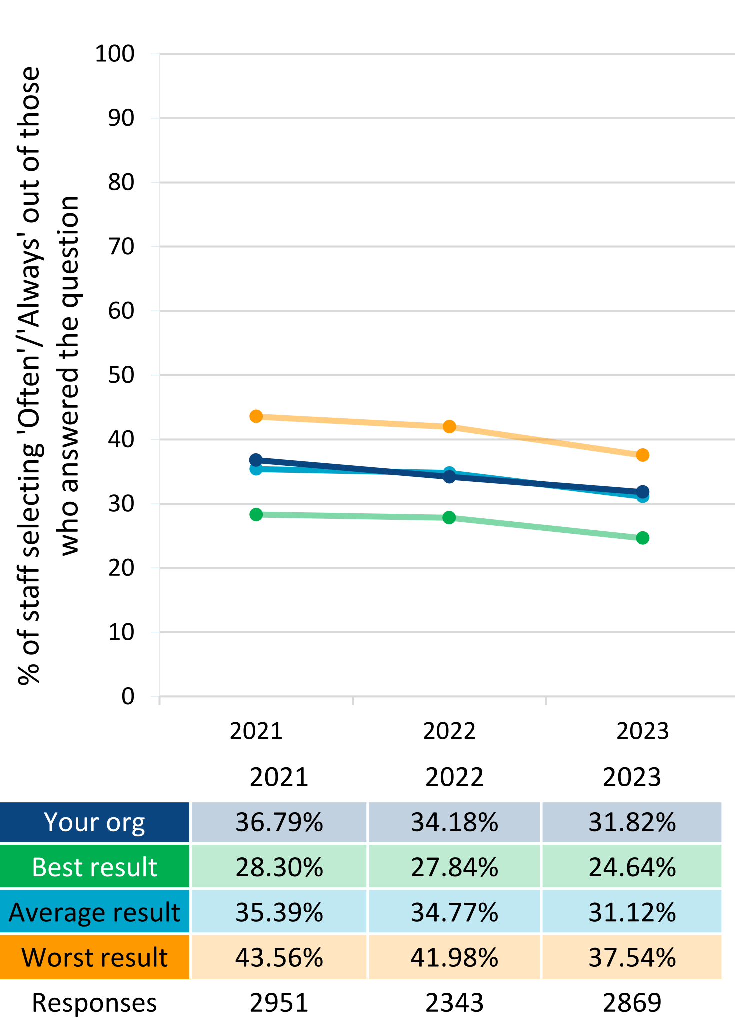
	2019	2020	2021	2022	2023
Your org	49.52%	46.13%	49.49%	46.54%	53.34%
Best result	59.36%	55.82%	54.24%	57.20%	60.00%
Average result	46.49%	46.39%	46.64%	47.58%	49.96%
Worst result	40.11%	39.16%	40.62%	41.97%	43.66%
Responses	747	1009	1067	816	925

Q12a How often, if at all, do you find your work emotionally exhausting?



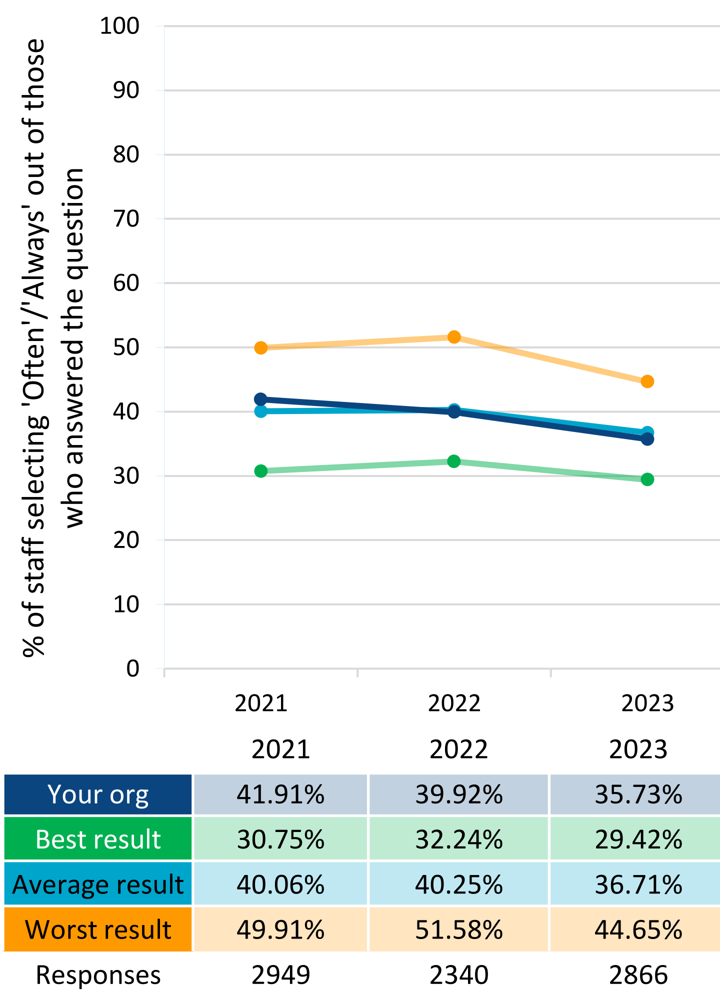
	2021	2022	2023
Your org	40.98%	36.74%	34.19%
Best result	31.73%	30.99%	27.56%
Average result	37.97%	37.10%	34.03%
Worst result	43.72%	44.49%	40.14%
Responses	2955	2349	2875

Q12b How often, if at all, do you feel burnt out because of your work?

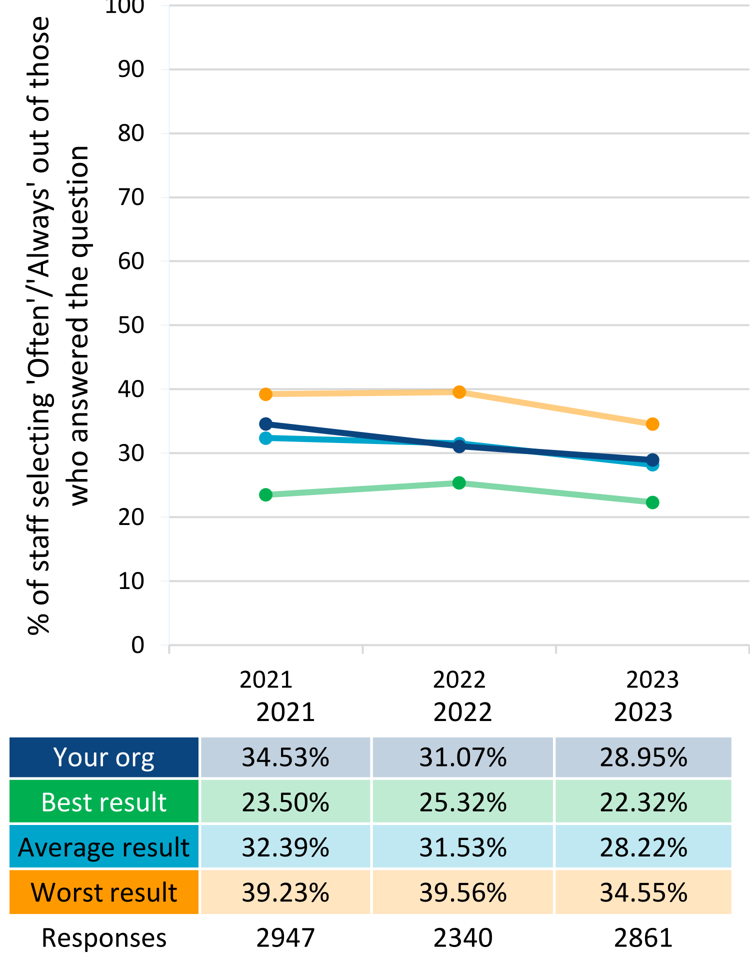


	2021	2022	2023
Your org	36.79%	34.18%	31.82%
Best result	28.30%	27.84%	24.64%
Average result	35.39%	34.77%	31.12%
Worst result	43.56%	41.98%	37.54%
Responses	2951	2343	2869

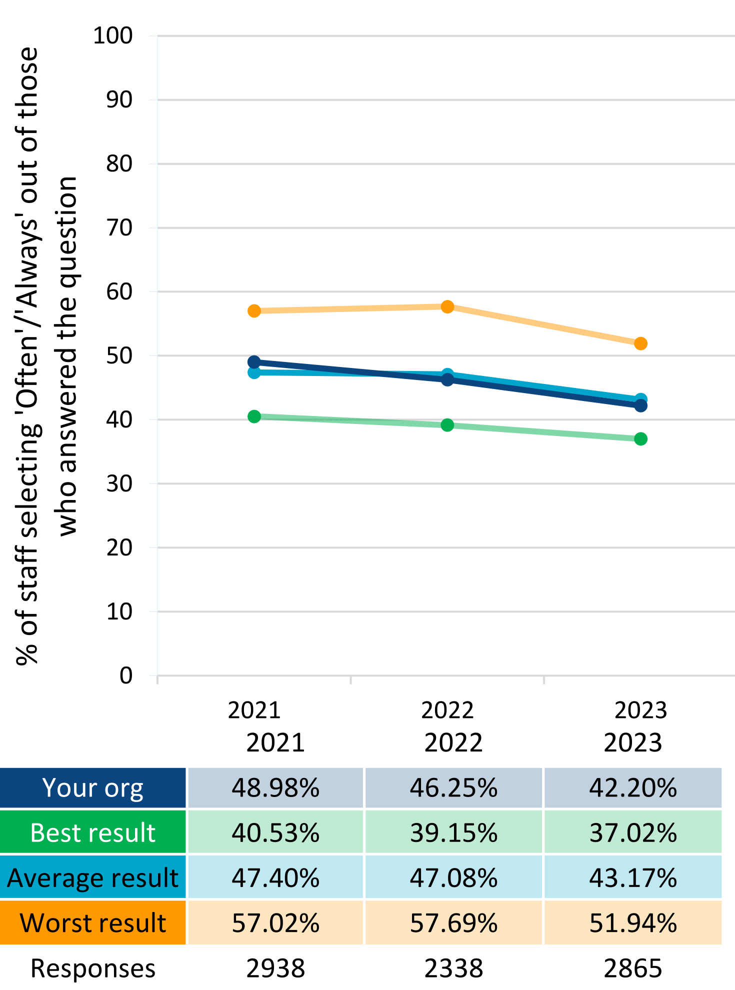
Q12c How often, if at all, does your work frustrate you?



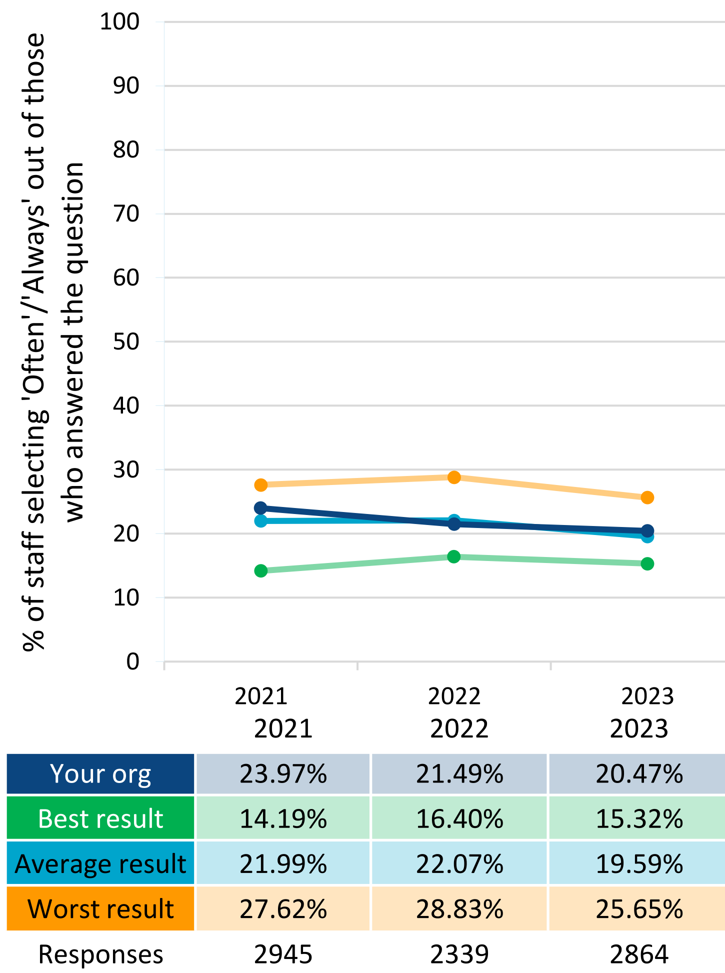
	2021	2022	2023
Your org	41.91%	39.92%	35.73%
Best result	30.75%	32.24%	29.42%
Average result	40.06%	40.25%	36.71%
Worst result	49.91%	51.58%	44.65%
Responses	2949	2340	2866



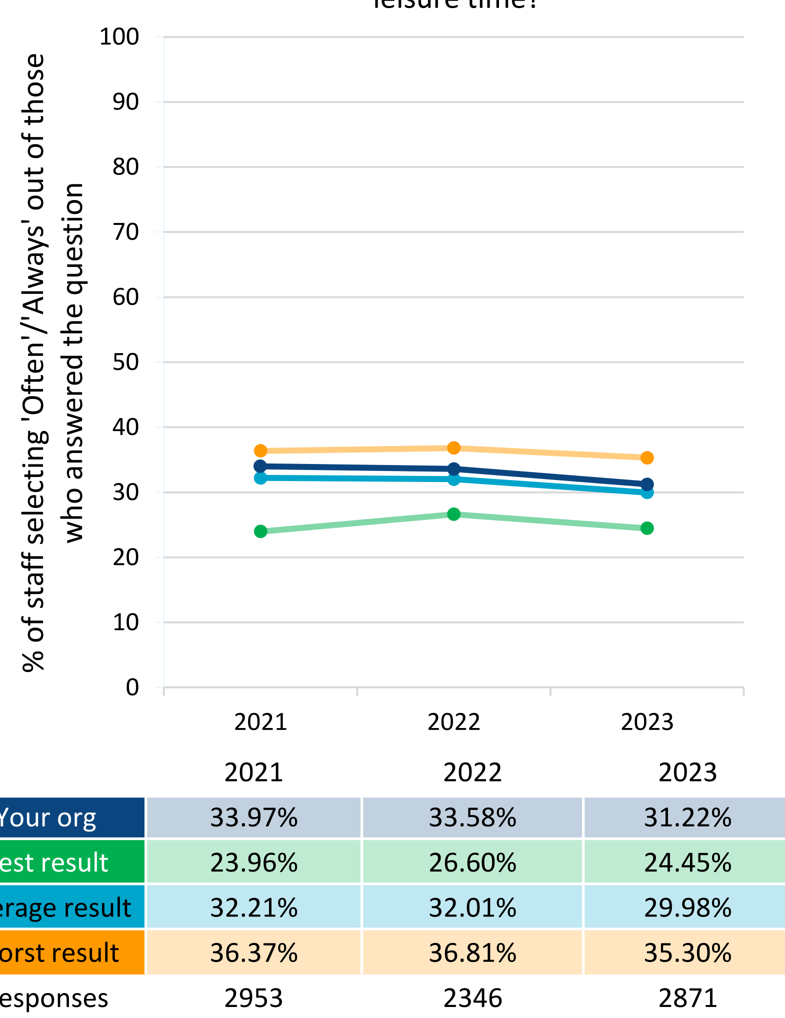
	2021	2022	2023
Your org	34.53%	31.07%	28.95%
Best result	23.50%	25.32%	22.32%
Average result	32.39%	31.53%	28.22%
Worst result	39.23%	39.56%	34.55%
Responses	2947	2340	2861



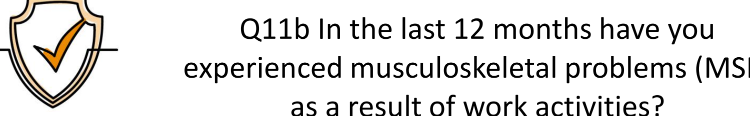
	2021	2022	2023
Your org	48.98%	46.25%	42.20%
Best result	40.53%	39.15%	37.02%
Average result	47.40%	47.08%	43.17%
Worst result	57.02%	57.69%	51.94%
Responses	2938	2338	2865



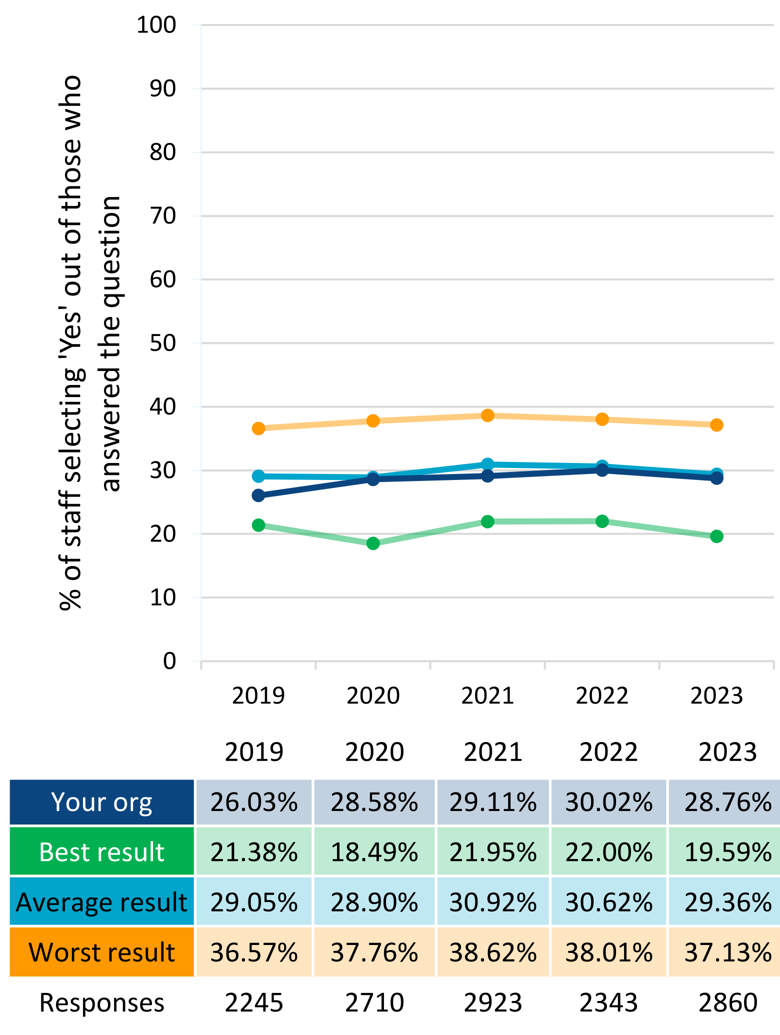
	2021	2022	2023
Your org	23.97%	21.49%	20.47%
Best result	14.19%	16.40%	15.32%
Average result	21.99%	22.07%	19.59%
Worst result	27.62%	28.83%	25.65%
Responses	2945	2339	2864



	2021	2022	2023
Your org	33.97%	33.58%	31.22%
Best result	23.96%	26.60%	24.45%
Average result	32.21%	32.01%	29.98%
Worst result	36.37%	36.81%	35.30%
Responses	2953	2346	2871

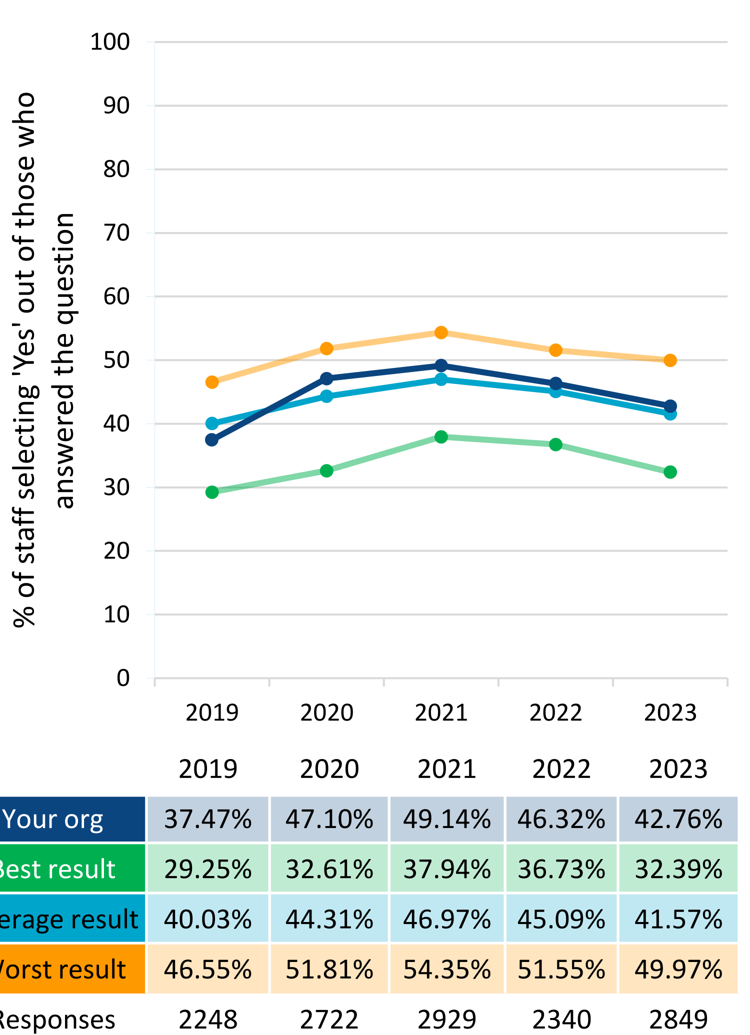


Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



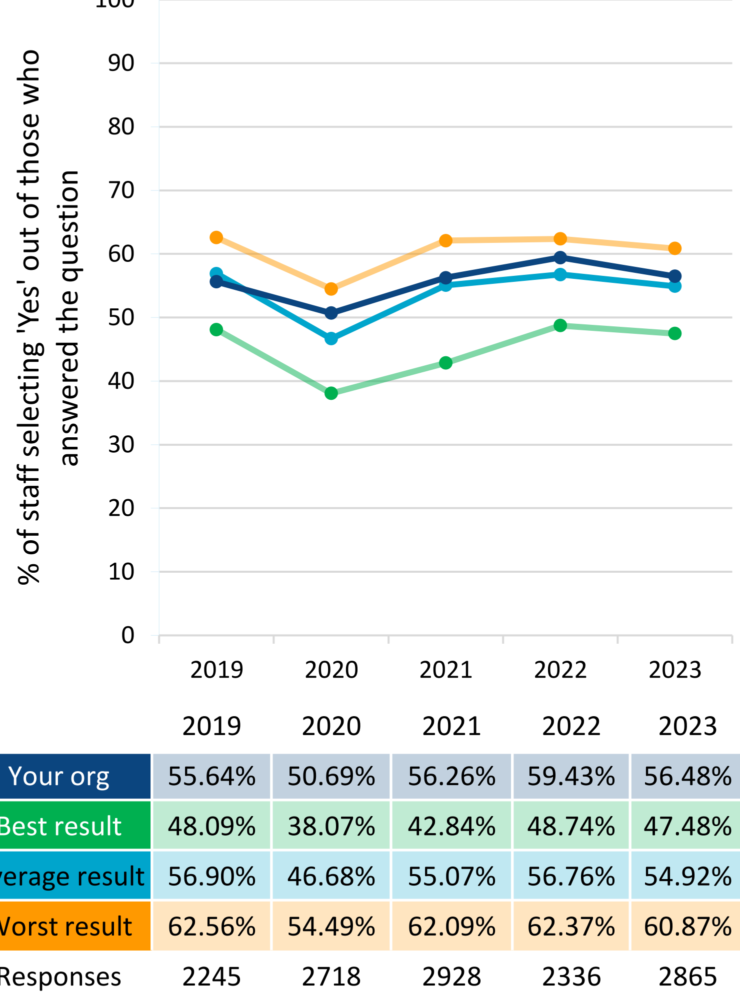
	2019	2020	2021	2022	2023
Your org	26.03%	28.58%	29.11%	30.02%	28.76%
Best result	21.38%	18.49%	21.95%	22.00%	19.59%
Average result	29.05%	28.90%	30.92%	30.62%	29.36%
Worst result	36.57%	37.76%	38.62%	38.01%	37.13%
Responses	2245	2710	2923	2343	2860

Q11c During the last 12 months have you felt unwell as a result of work related stress?



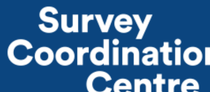
	2019	2020	2021	2022	2023
Your org	37.47%	47.10%	49.14%	46.32%	42.76%
Best result	29.25%	32.61%	37.94%	36.73%	32.39%
Average result	40.03%	44.31%	46.97%	45.09%	41.57%
Worst result	46.55%	51.81%	54.35%	51.55%	49.97%
Responses	2248	2722	2929	2340	2849

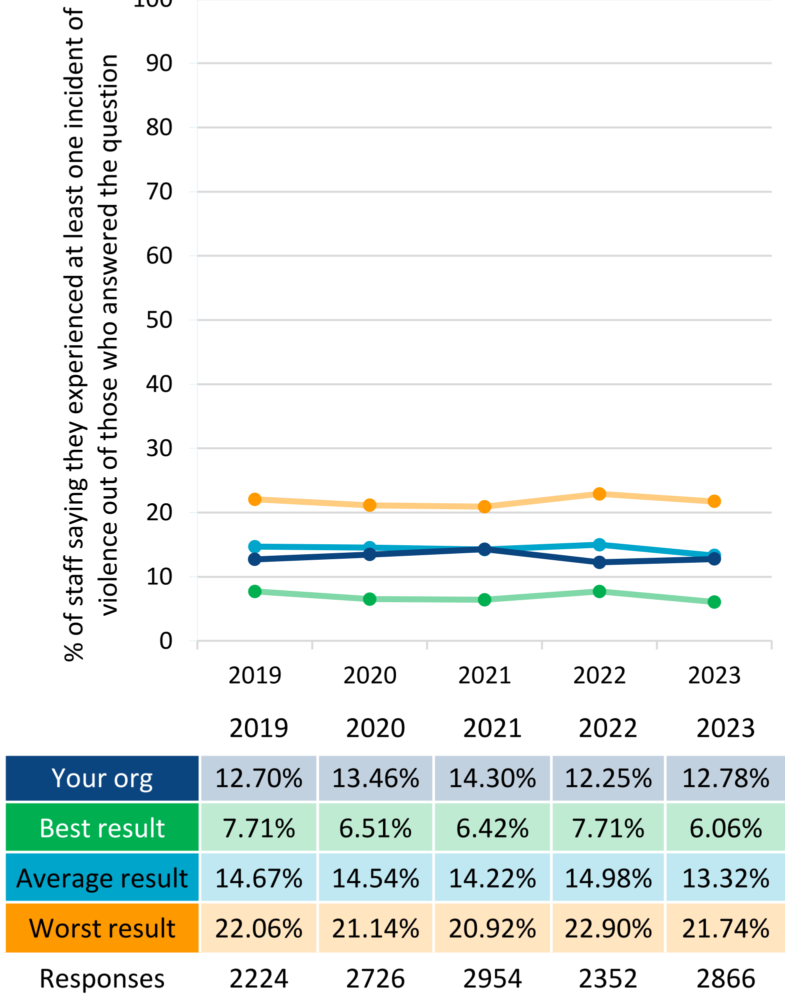
Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



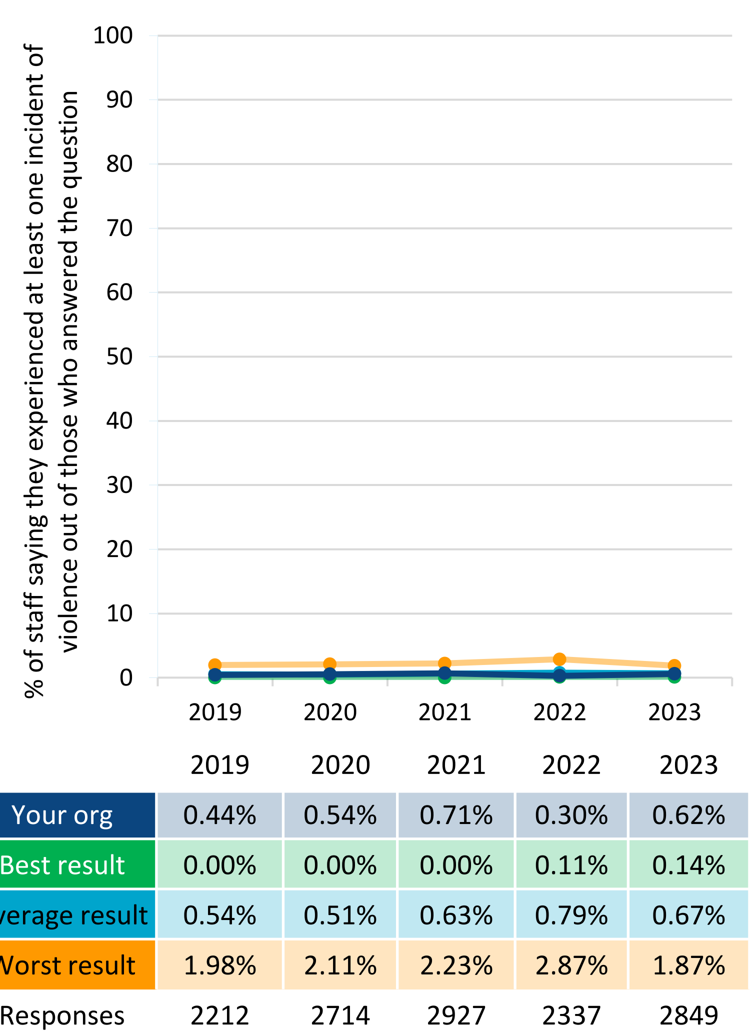
	2019	2020	2021	2022	2023
Your org	55.64%	50.69%	56.26%	59.43%	56.48%
Best result	48.09%	38.07%	42.84%	48.74%	47.48%
Average result	56.90%	46.68%	55.07%	56.76%	54.92%
Worst result	62.56%	54.49%	62.09%	62.37%	60.87%
Responses	2245	2718	2928	2336	2865

People Promise elements and theme results – We are safe and healthy: Negative experiences

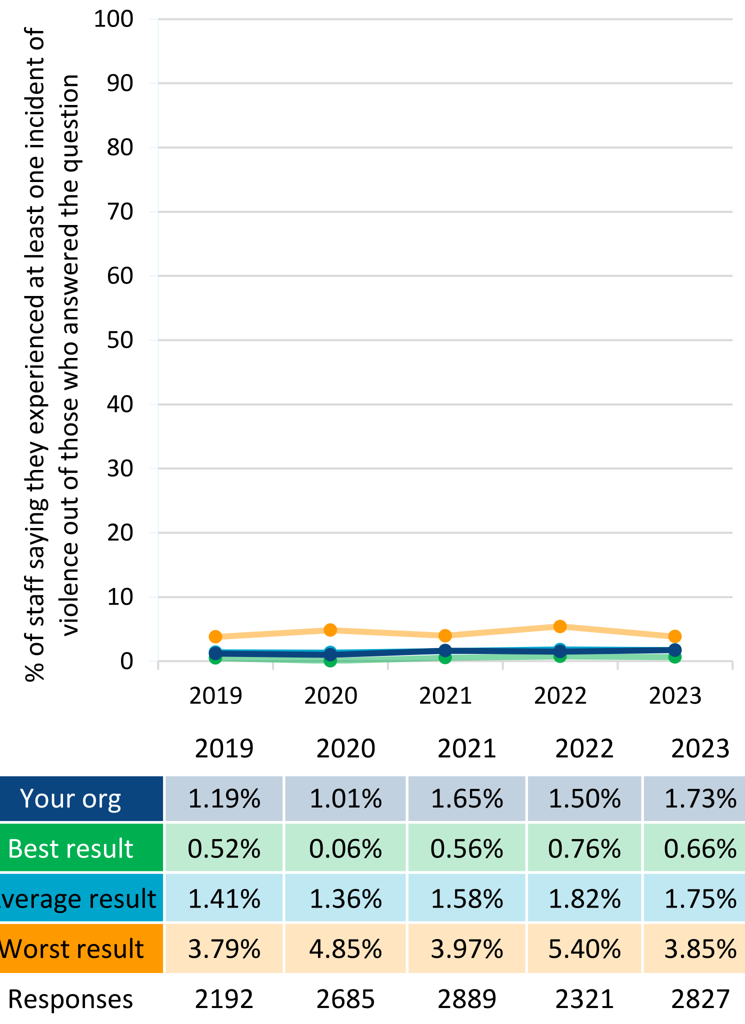




	2019	2020	2021	2022	2023
Your org	12.70%	13.46%	14.30%	12.25%	12.78%
Best result	7.71%	6.51%	6.42%	7.71%	6.06%
Average result	14.67%	14.54%	14.22%	14.98%	13.32%
Worst result	22.06%	21.14%	20.92%	22.90%	21.74%
Responses	2224	2726	2954	2352	2866



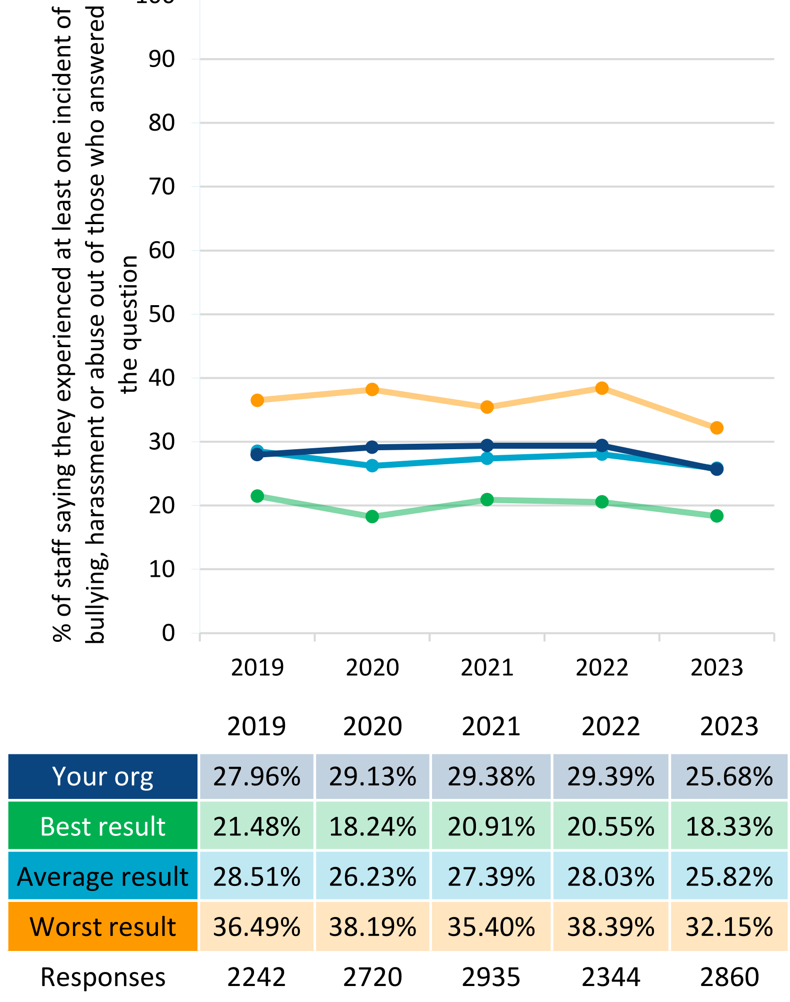
	2019	2020	2021	2022	2023
Your org	0.44%	0.54%	0.71%	0.30%	0.62%
Best result	0.00%	0.00%	0.00%	0.11%	0.14%
Average result	0.54%	0.51%	0.63%	0.79%	0.67%
Worst result	1.98%	2.11%	2.23%	2.87%	1.87%
Responses	2212	2714	2927	2337	2849



	2019	2020	2021	2022	2023
Your org	1.19%	1.01%	1.65%	1.50%	1.73%
Best result	0.52%	0.06%	0.56%	0.76%	0.66%
Average result	1.41%	1.36%	1.58%	1.82%	1.75%
Worst result	3.79%	4.85%	3.97%	5.40%	3.85%
Responses	2192	2685	2889	2321	2827

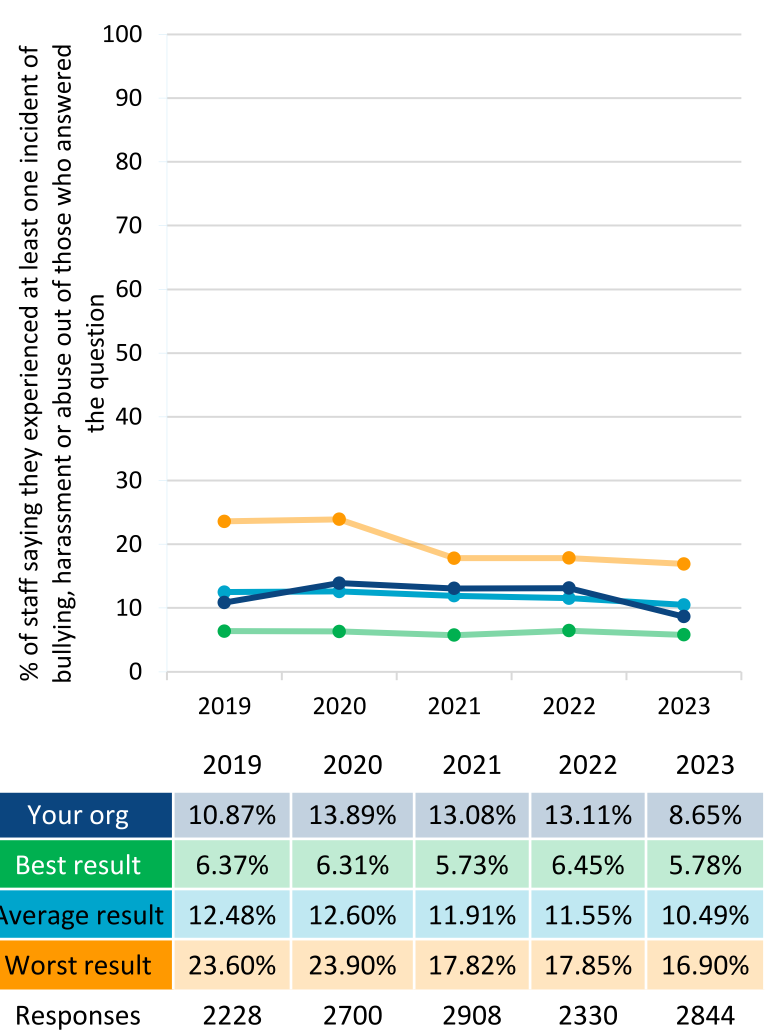
People Promise elements and theme results – We are safe and healthy: Negative experiences

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



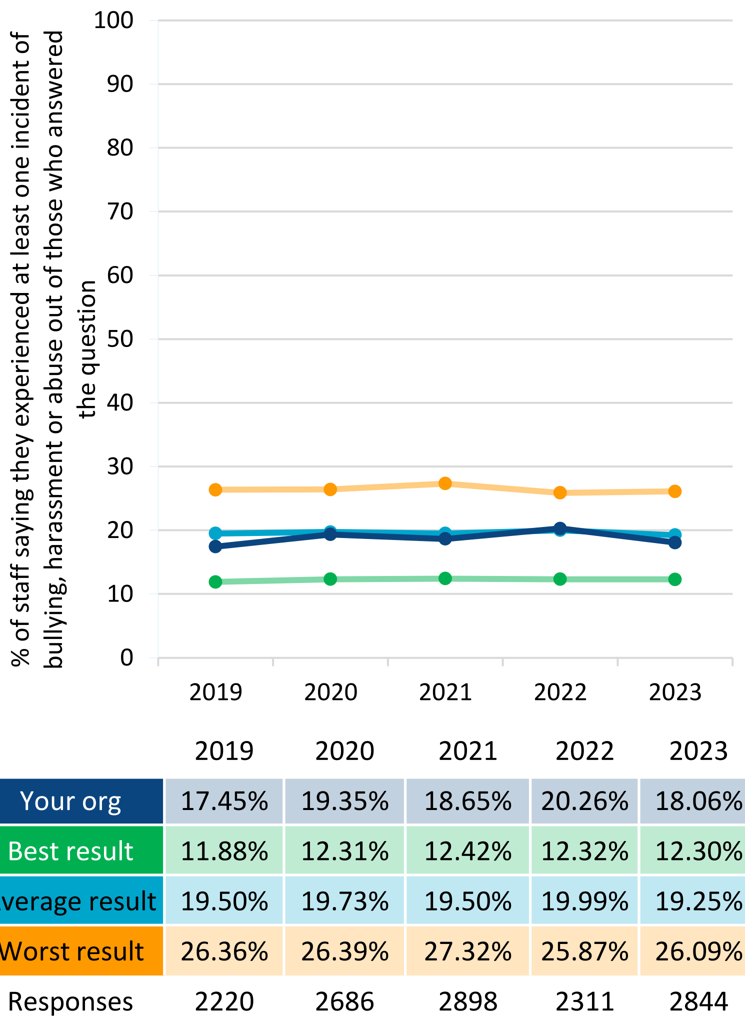
	2019	2020	2021	2022	2023
Your org	27.96%	29.13%	29.38%	29.39%	25.68%
Best result	21.48%	18.24%	20.91%	20.55%	18.33%
Average result	28.51%	26.23%	27.39%	28.03%	25.82%
Worst result	36.49%	38.19%	35.40%	38.39%	32.15%
Responses	2242	2720	2935	2344	2860

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.

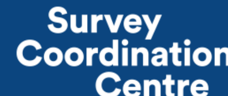


	2019	2020	2021	2022	2023
Your org	10.87%	13.89%	13.08%	13.11%	8.65%
Best result	6.37%	6.31%	5.73%	6.45%	5.78%
Average result	12.48%	12.60%	11.91%	11.55%	10.49%
Worst result	23.60%	23.90%	17.82%	17.85%	16.90%
Responses	2228	2700	2908	2330	2844

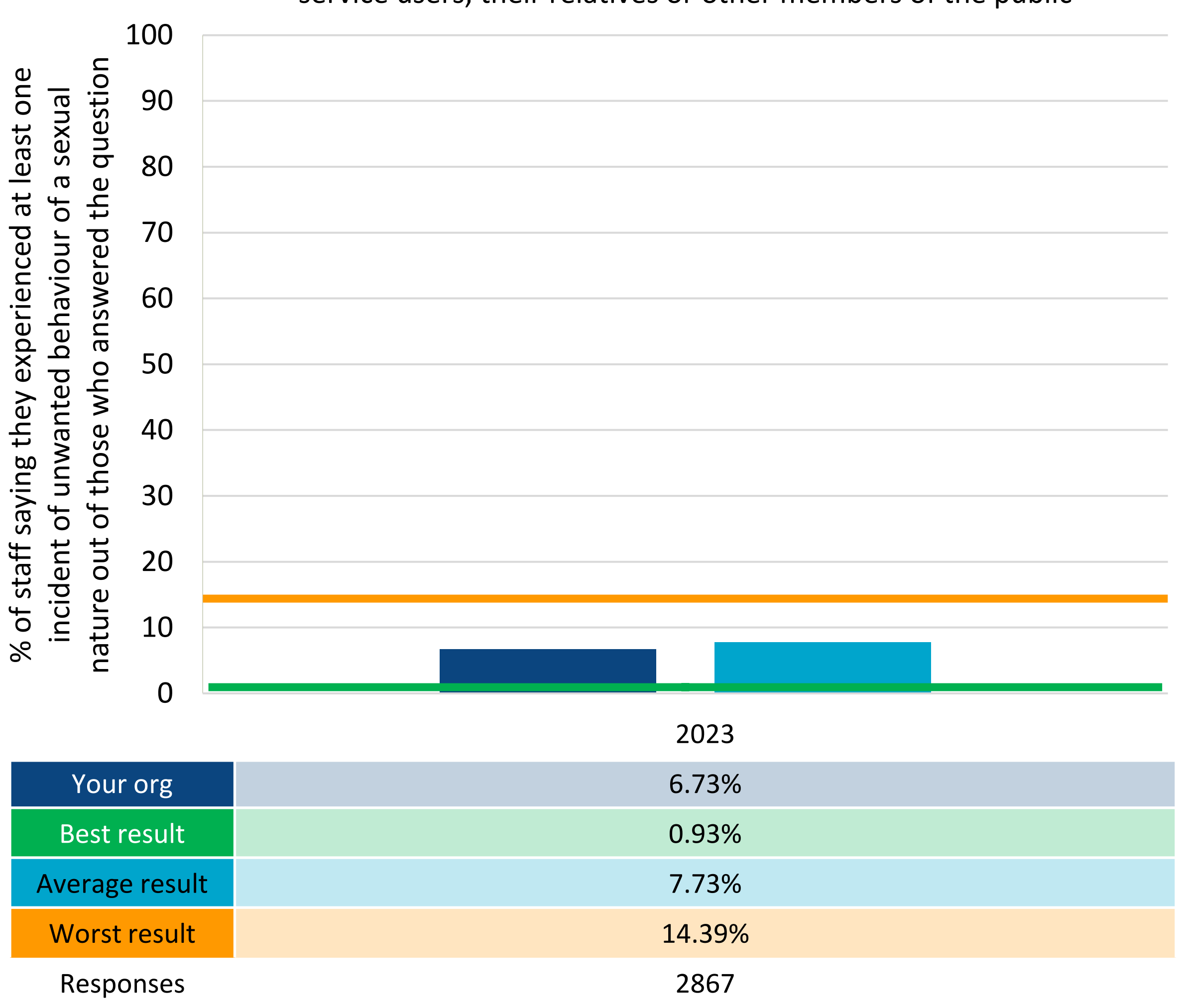
Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



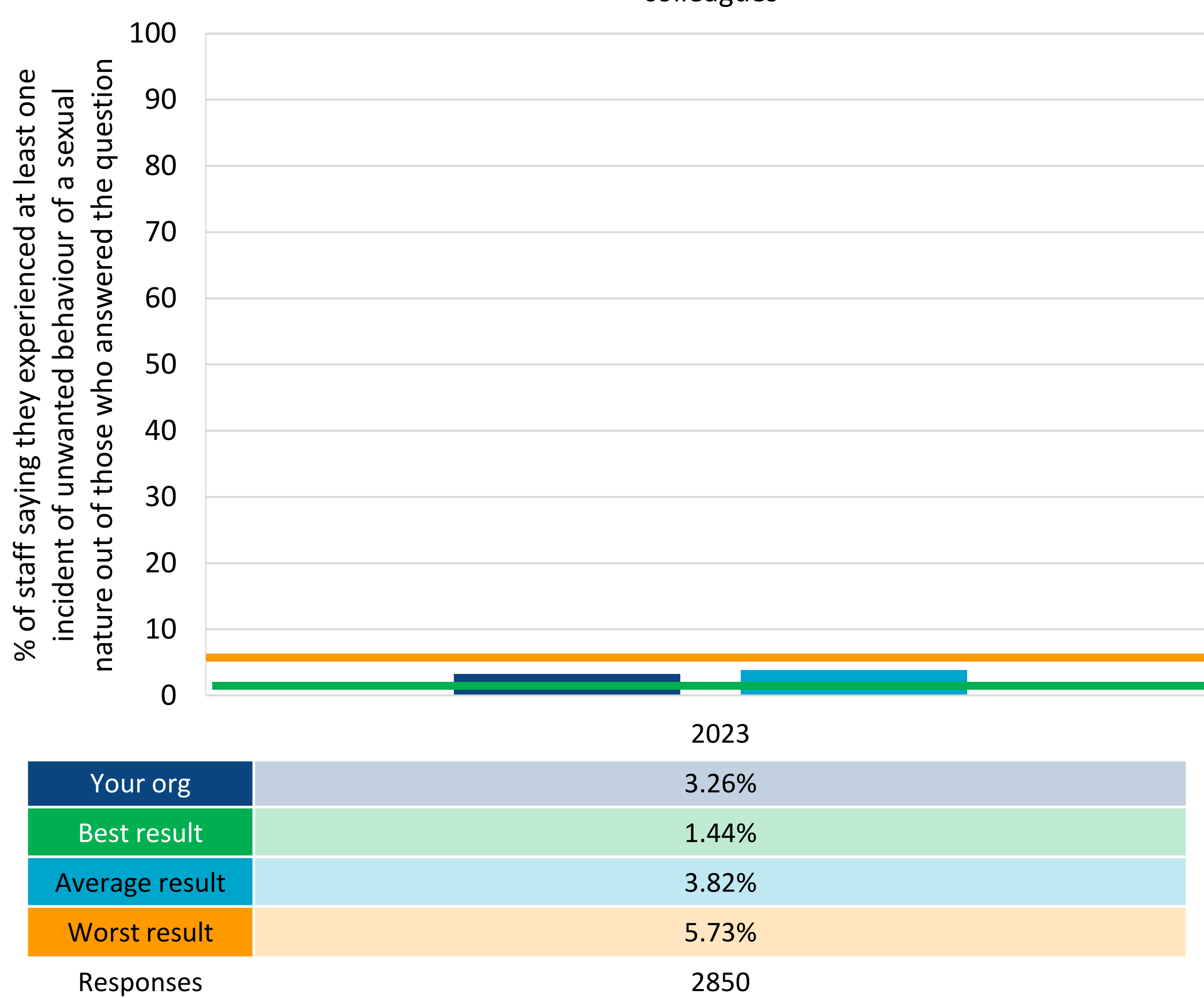
	2019	2020	2021	2022	2023
Your org	17.45%	19.35%	18.65%	20.26%	18.06%
Best result	11.88%	12.31%	12.42%	12.32%	12.30%
Average result	19.50%	19.73%	19.50%	19.99%	19.25%
Worst result	26.36%	26.39%	27.32%	25.87%	26.09%
Responses	2220	2686	2898	2311	2844



People Promise elements and theme results – We are safe and healthy: Other questions*

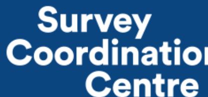


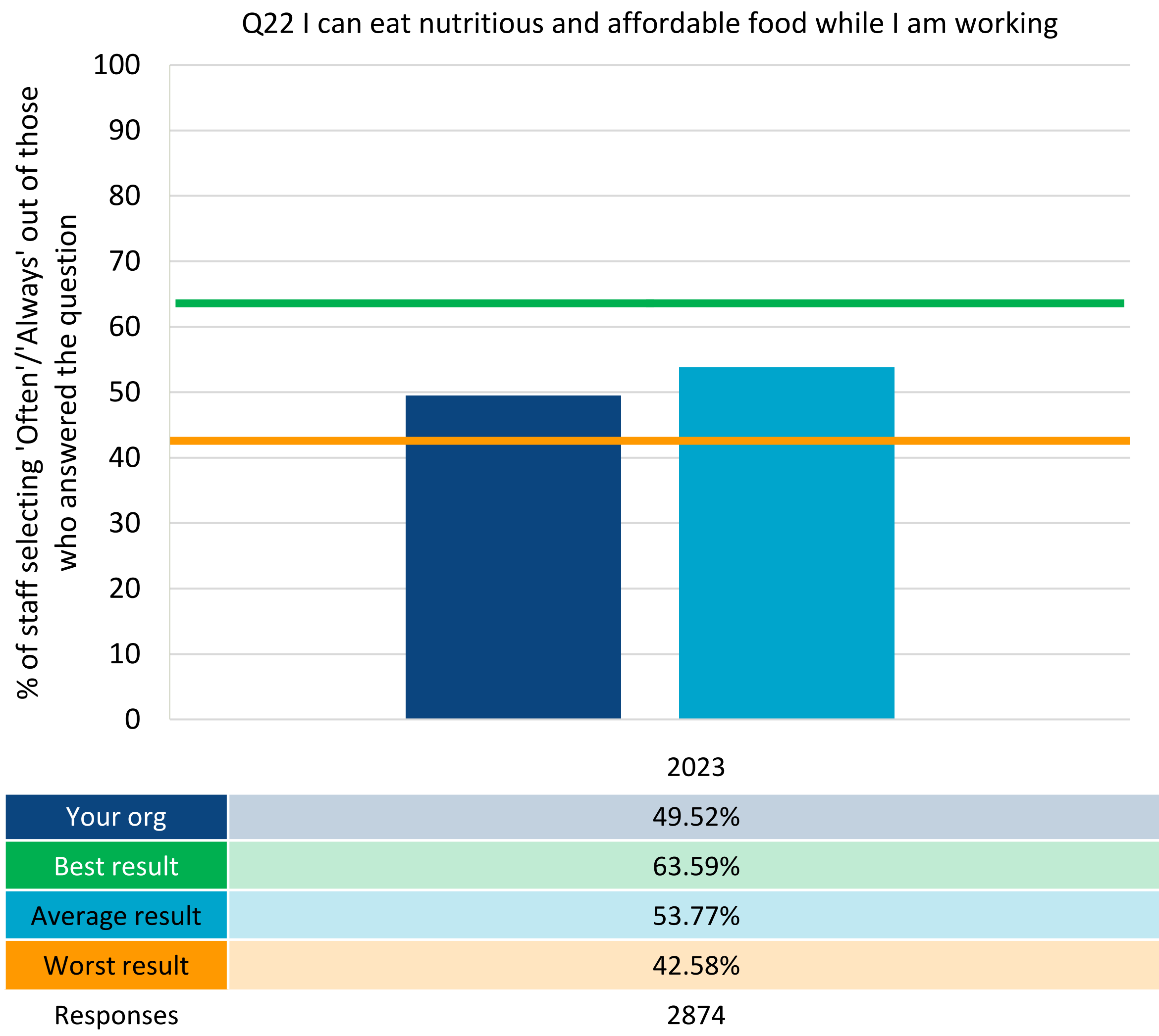
	2023
Your org	6.73%
Best result	0.93%
Average result	7.73%
Worst result	14.39%
Responses	2867



	2023
Your org	3.26%
Best result	1.44%
Average result	3.82%
Worst result	5.73%
Responses	2850

*These questions do not contribute towards any People Promise element score, theme score or sub-score



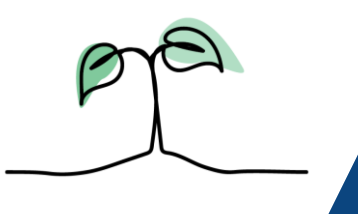


	2023
Your org	49.52%
Best result	63.59%
Average result	53.77%
Worst result	42.58%
Responses	2874

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

People Promise element – We are always learning



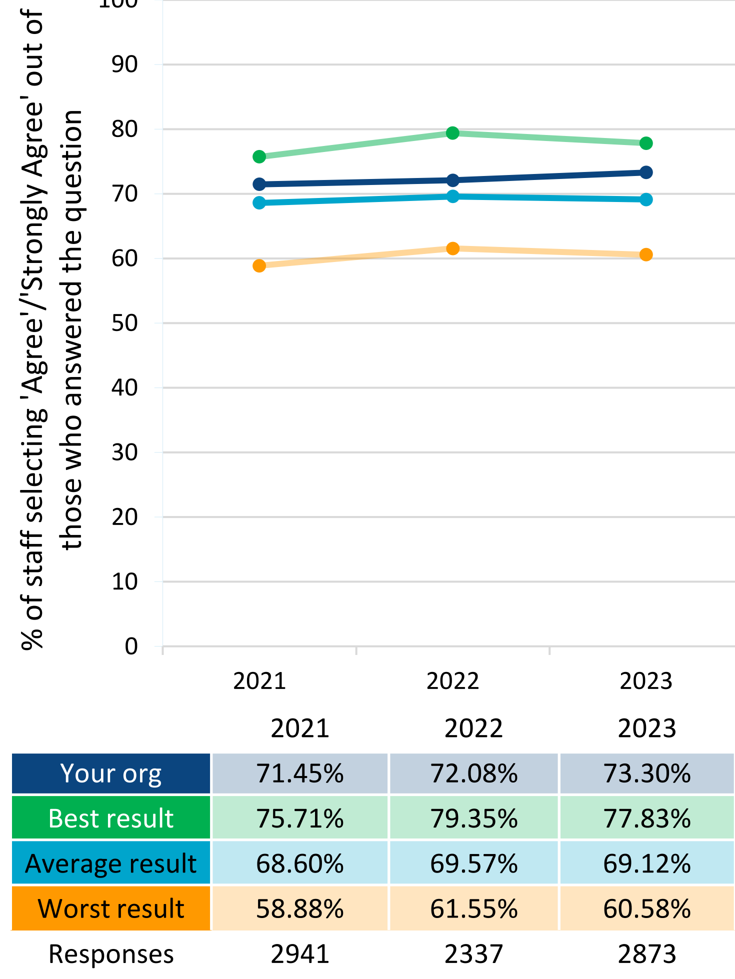
Questions included:

Development – Q24a, Q24b, Q24c, Q24d, Q24e

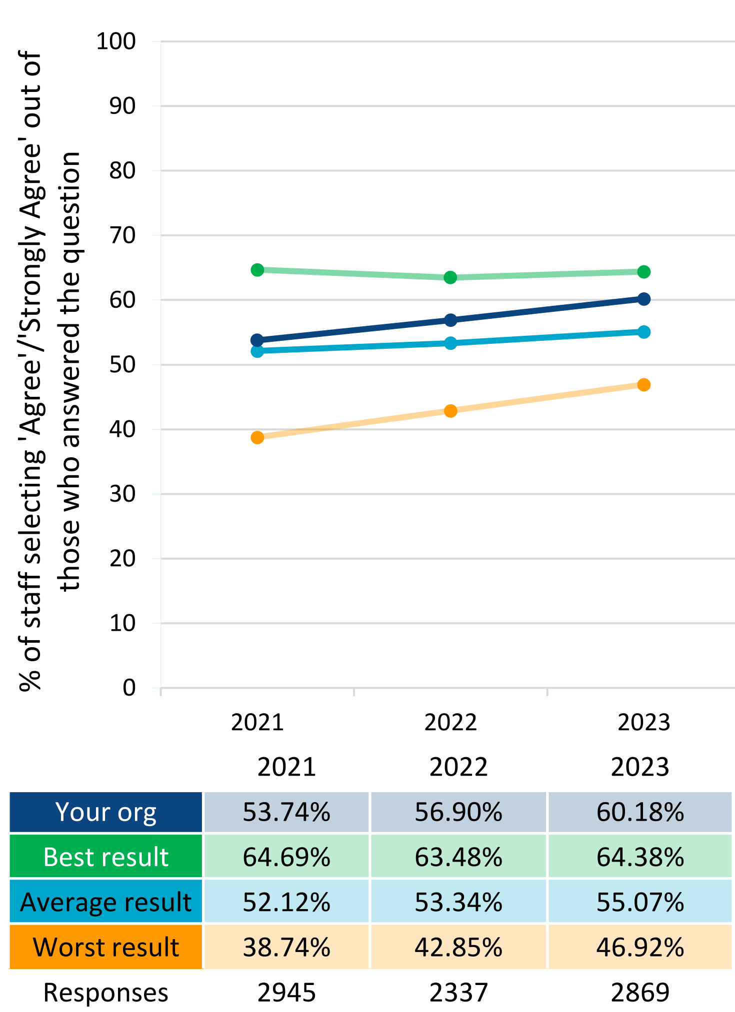
Appraisals – Q23a*, Q23b, Q23c, Q23d

*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

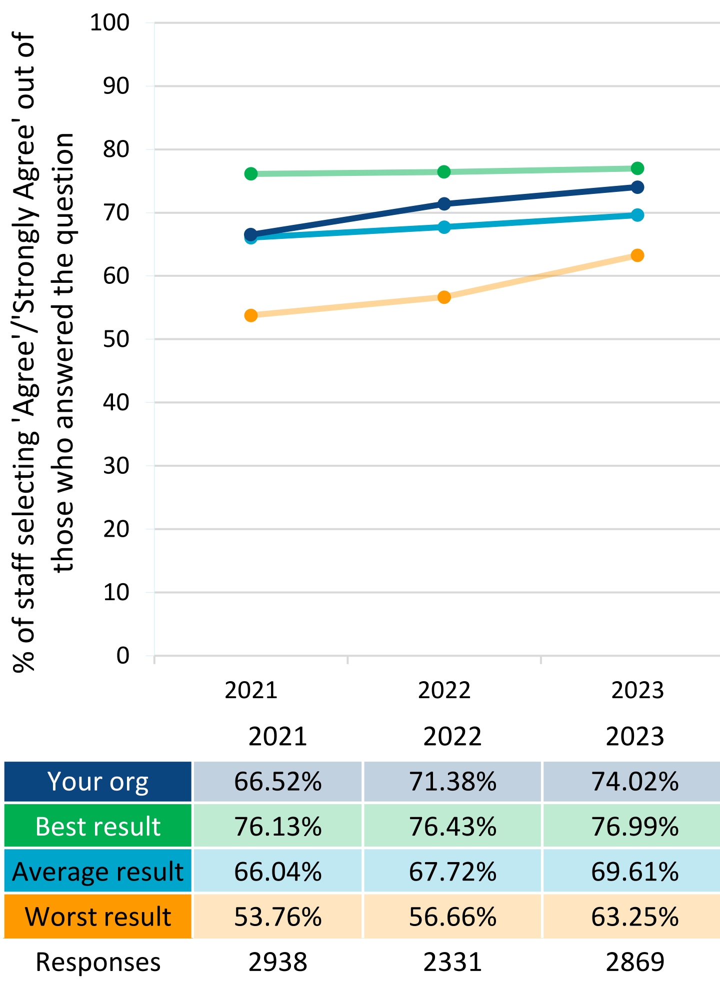
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.



	2021	2022	2023
Your org	71.45%	72.08%	73.30%
Best result	75.71%	79.35%	77.83%
Average result	68.60%	69.57%	69.12%
Worst result	58.88%	61.55%	60.58%
Responses	2941	2337	2873



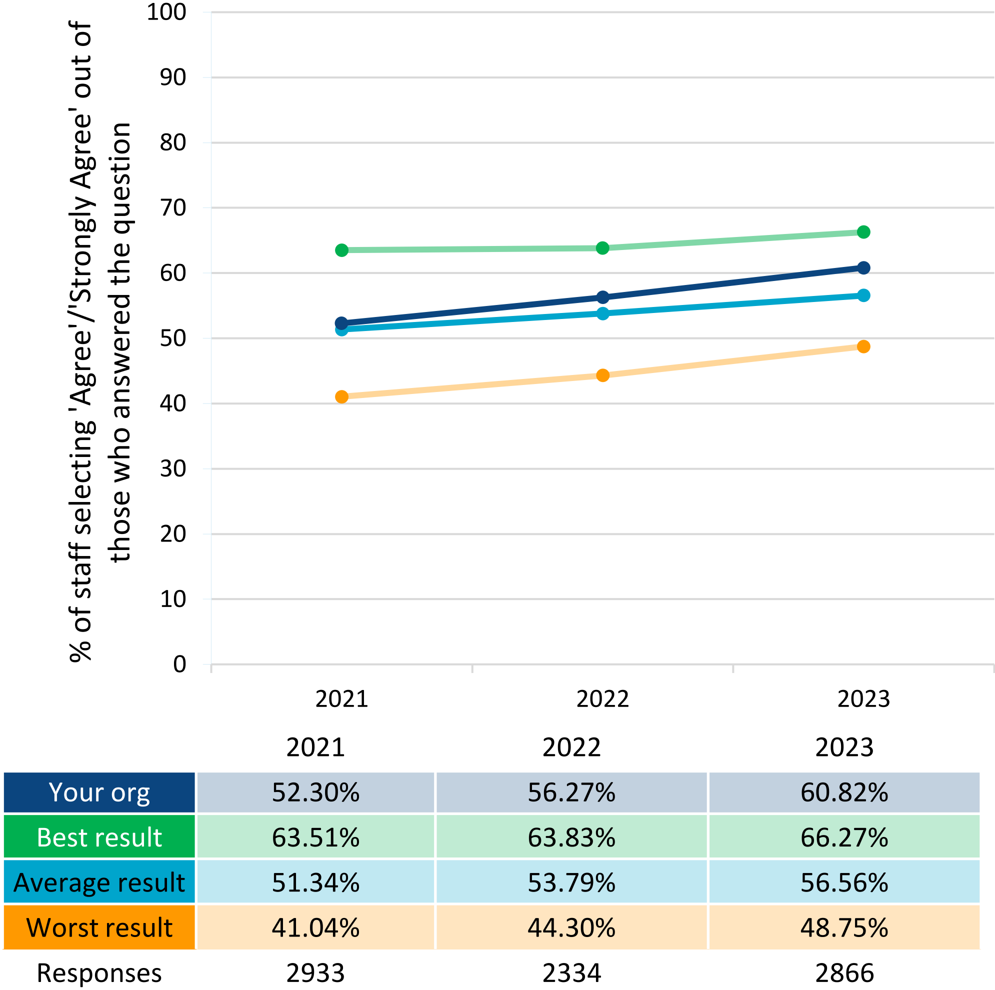
	2021	2022	2023
Your org	53.74%	56.90%	60.18%
Best result	64.69%	63.48%	64.38%
Average result	52.12%	53.34%	55.07%
Worst result	38.74%	42.85%	46.92%
Responses	2945	2337	2869



	2021	2022	2023
Your org	66.52%	71.38%	74.02%
Best result	76.13%	76.43%	76.99%
Average result	66.04%	67.72%	69.61%
Worst result	53.76%	56.66%	63.25%
Responses	2938	2331	2869

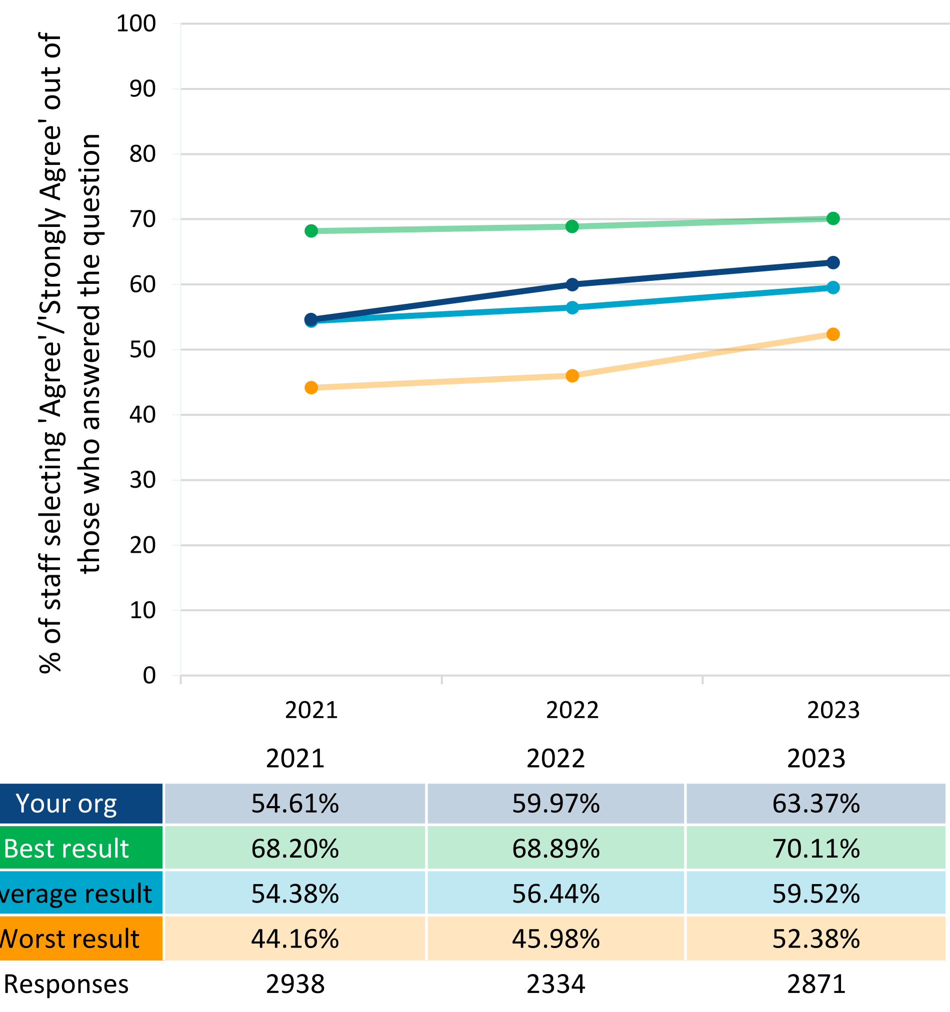
People Promise elements and theme results – We are always learning: Development

Q24d I feel supported to develop my potential.

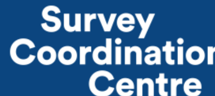


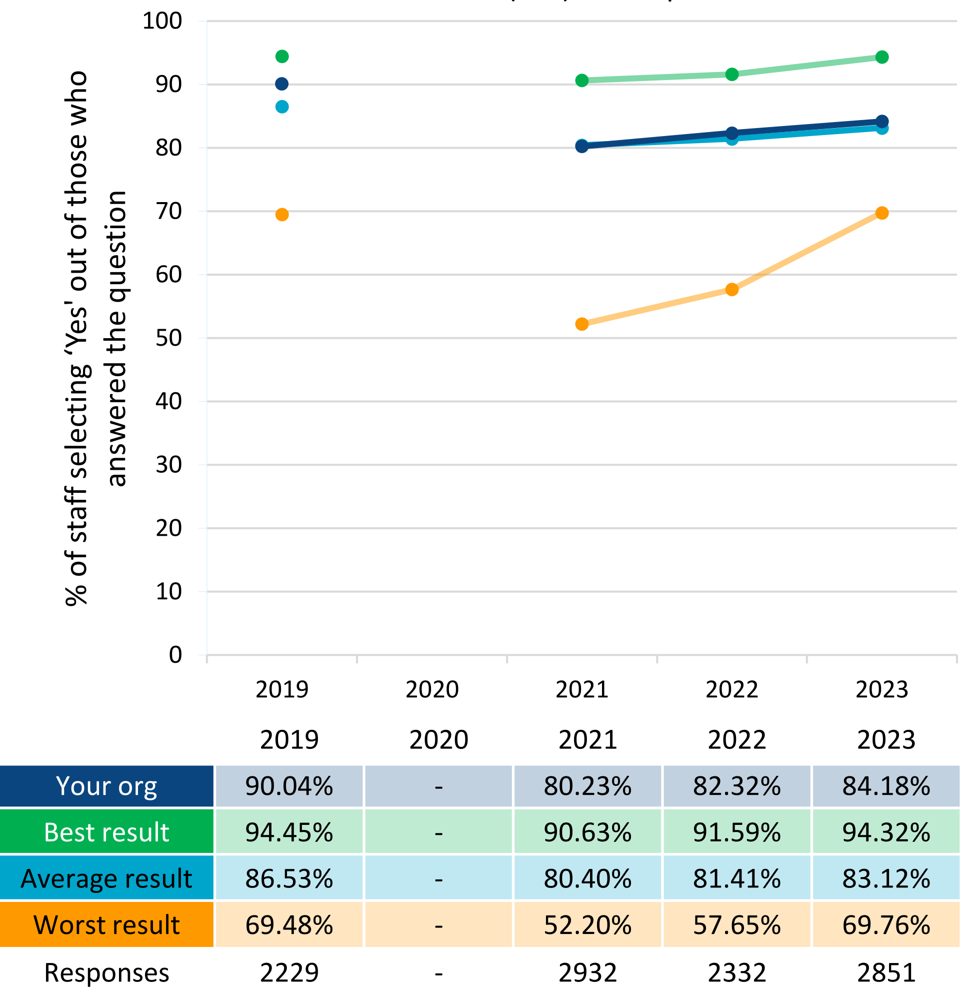
	2021	2022	2023
Your org	52.30%	56.27%	60.82%
Best result	63.51%	63.83%	66.27%
Average result	51.34%	53.79%	56.56%
Worst result	41.04%	44.30%	48.75%
Responses	2933	2334	2866

Q24e I am able to access the right learning and development opportunities when I need to.

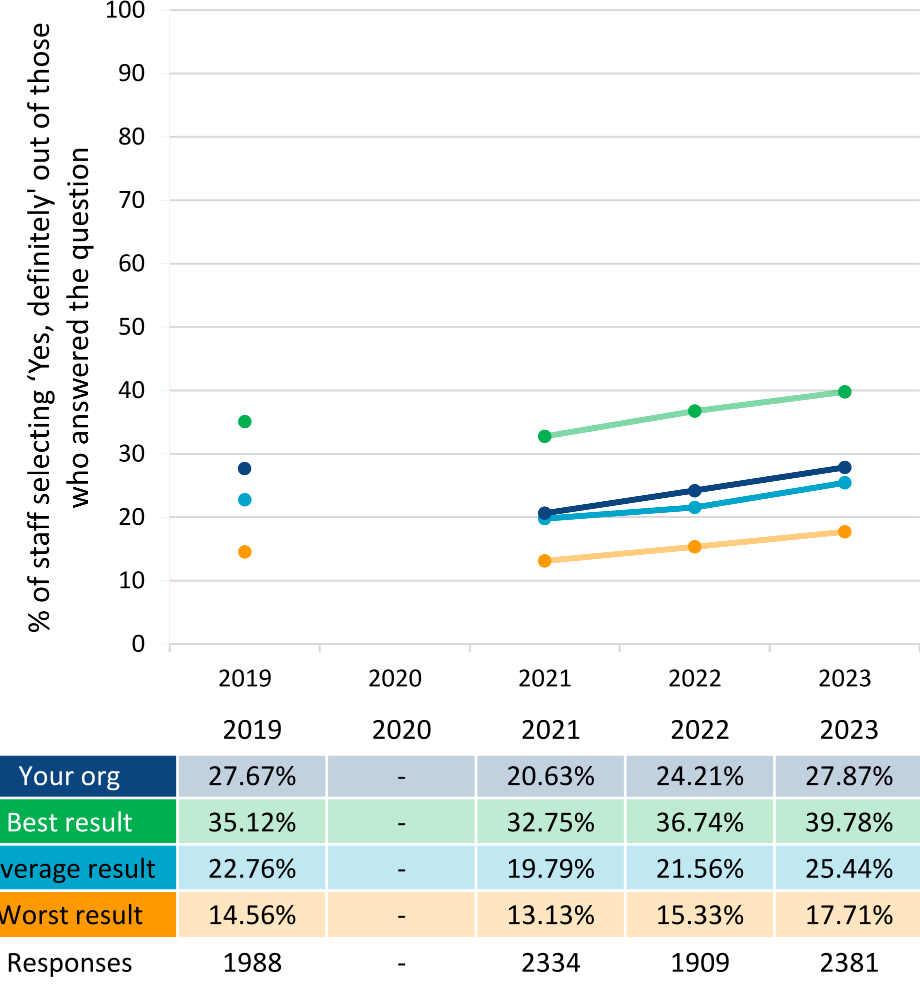


	2021	2022	2023
Your org	54.61%	59.97%	63.37%
Best result	68.20%	68.89%	70.11%
Average result	54.38%	56.44%	59.52%
Worst result	44.16%	45.98%	52.38%
Responses	2938	2334	2871



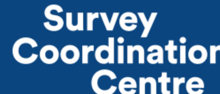


	2019	2020	2021	2022	2023
Your org	90.04%	-	80.23%	82.32%	84.18%
Best result	94.45%	-	90.63%	91.59%	94.32%
Average result	86.53%	-	80.40%	81.41%	83.12%
Worst result	69.48%	-	52.20%	57.65%	69.76%
Responses	2229	-	2932	2332	2851

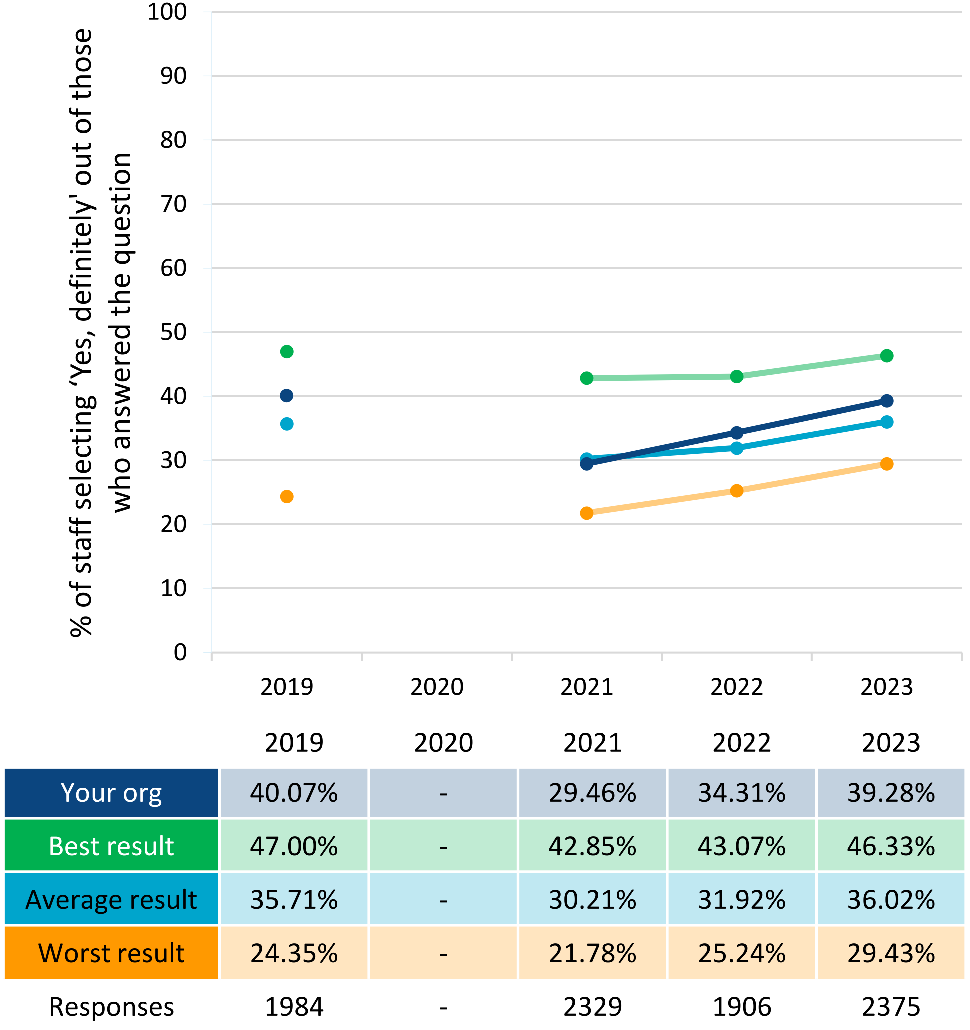


	2019	2020	2021	2022	2023
Your org	27.67%	-	20.63%	24.21%	27.87%
Best result	35.12%	-	32.75%	36.74%	39.78%
Average result	22.76%	-	19.79%	21.56%	25.44%
Worst result	14.56%	-	13.13%	15.33%	17.71%
Responses	1988	-	2334	1909	2381

*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

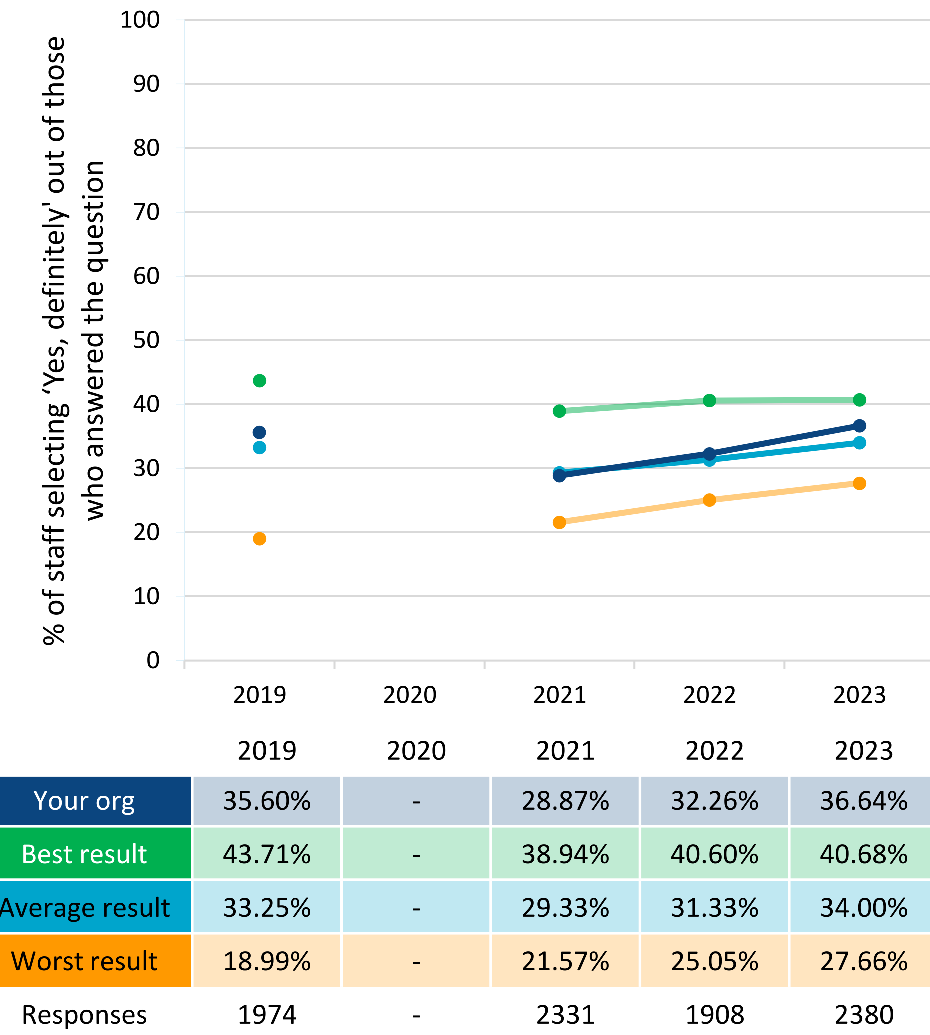


Q23c It helped me agree clear objectives for my work.



	2019	2020	2021	2022	2023
Your org	40.07%	-	29.46%	34.31%	39.28%
Best result	47.00%	-	42.85%	43.07%	46.33%
Average result	35.71%	-	30.21%	31.92%	36.02%
Worst result	24.35%	-	21.78%	25.24%	29.43%
Responses	1984	-	2329	1906	2375

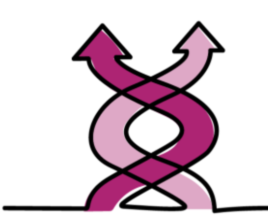
Q23d It left me feeling that my work is valued by my organisation.



	2019	2020	2021	2022	2023
Your org	35.60%	-	28.87%	32.26%	36.64%
Best result	43.71%	-	38.94%	40.60%	40.68%
Average result	33.25%	-	29.33%	31.33%	34.00%
Worst result	18.99%	-	21.57%	25.05%	27.66%
Responses	1974	-	2331	1908	2380

Survey Coordination Centre

People Promise element – We work flexibly

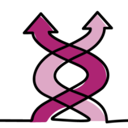


Questions included:

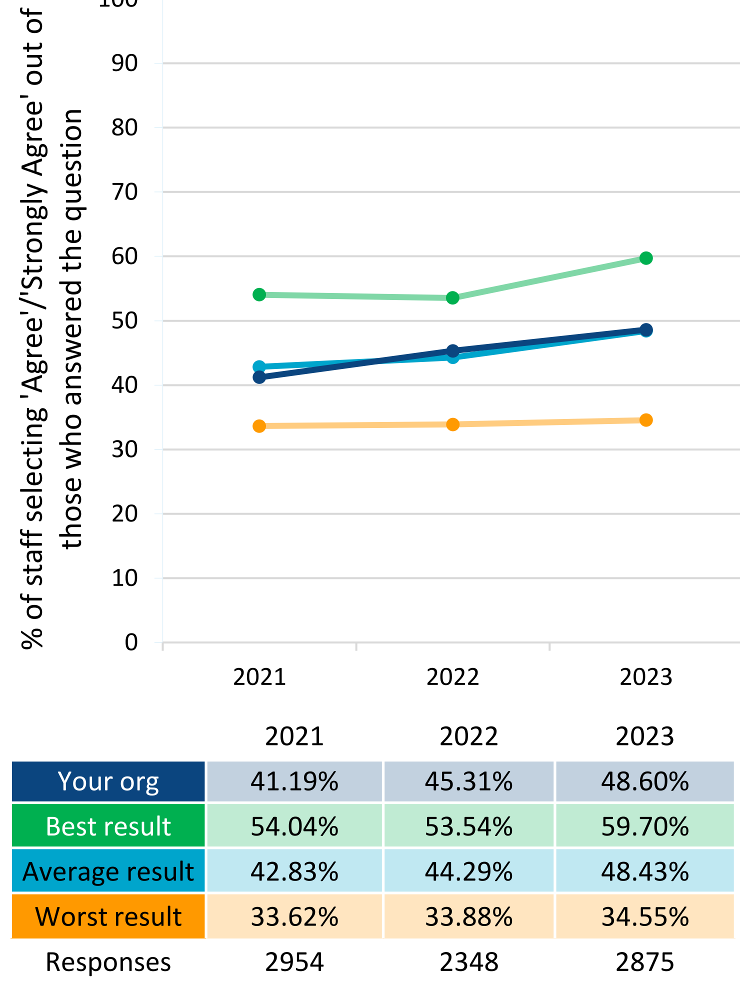
Support for work-life balance – Q6b, Q6c, Q6d

Flexible working – Q4d

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

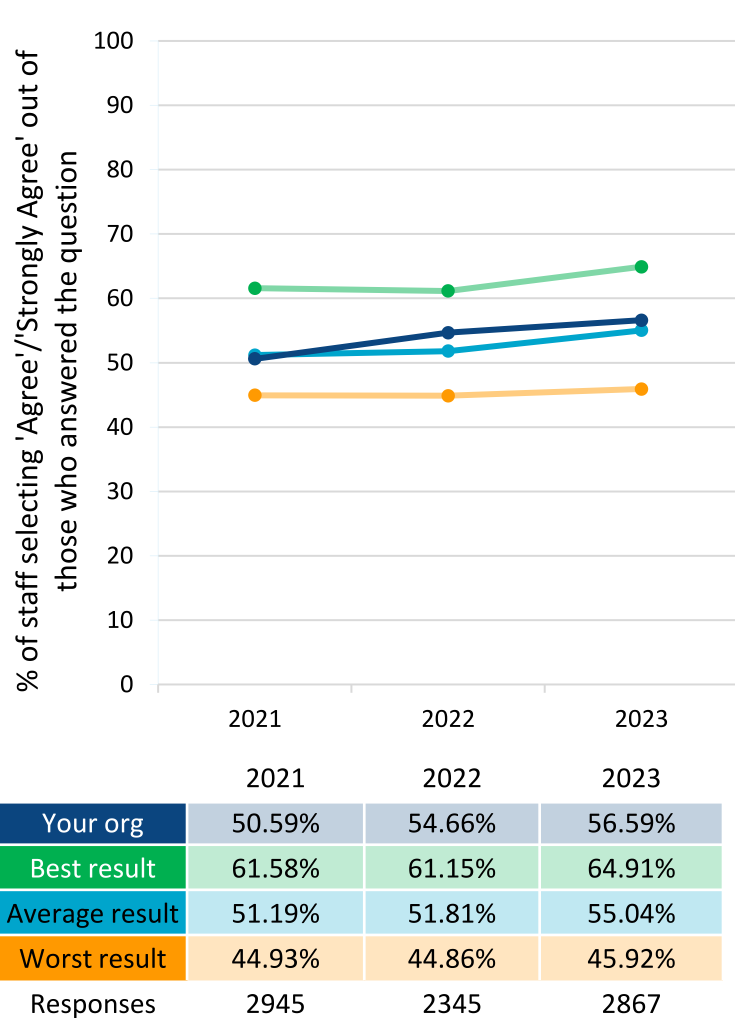


Q6b My organisation is committed to helping me balance my work and home life.



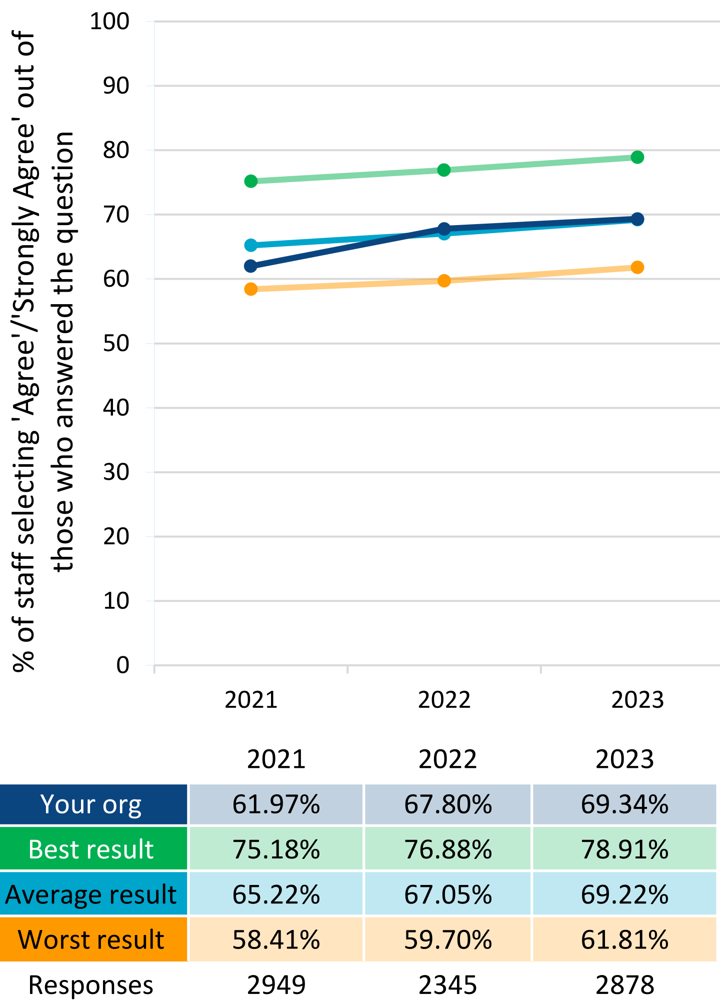
	2021	2022	2023
Your org	41.19%	45.31%	48.60%
Best result	54.04%	53.54%	59.70%
Average result	42.83%	44.29%	48.43%
Worst result	33.62%	33.88%	34.55%
Responses	2954	2348	2875

Q6c I achieve a good balance between my work life and my home life.

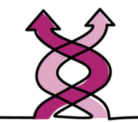


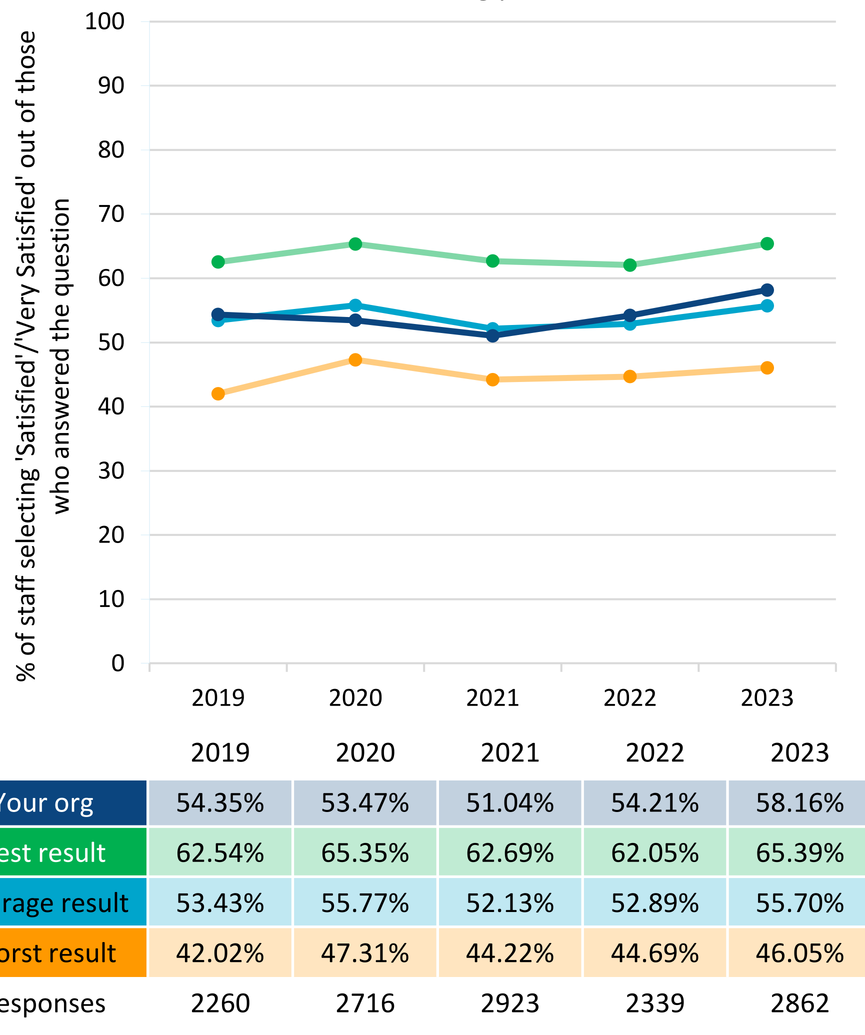
	2021	2022	2023
Your org	50.59%	54.66%	56.59%
Best result	61.58%	61.15%	64.91%
Average result	51.19%	51.81%	55.04%
Worst result	44.93%	44.86%	45.92%
Responses	2945	2345	2867

Q6d I can approach my immediate manager to talk openly about flexible working.

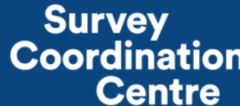


	2021	2022	2023
Your org	61.97%	67.80%	69.34%
Best result	75.18%	76.88%	78.91%
Average result	65.22%	67.05%	69.22%
Worst result	58.41%	59.70%	61.81%
Responses	2949	2345	2878

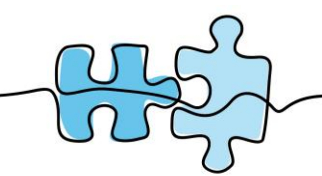




	2019	2020	2021	2022	2023
Your org	54.35%	53.47%	51.04%	54.21%	58.16%
Best result	62.54%	65.35%	62.69%	62.05%	65.39%
Average result	53.43%	55.77%	52.13%	52.89%	55.70%
Worst result	42.02%	47.31%	44.22%	44.69%	46.05%
Responses	2260	2716	2923	2339	2862



People Promise element – We are a team

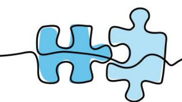


Questions included:

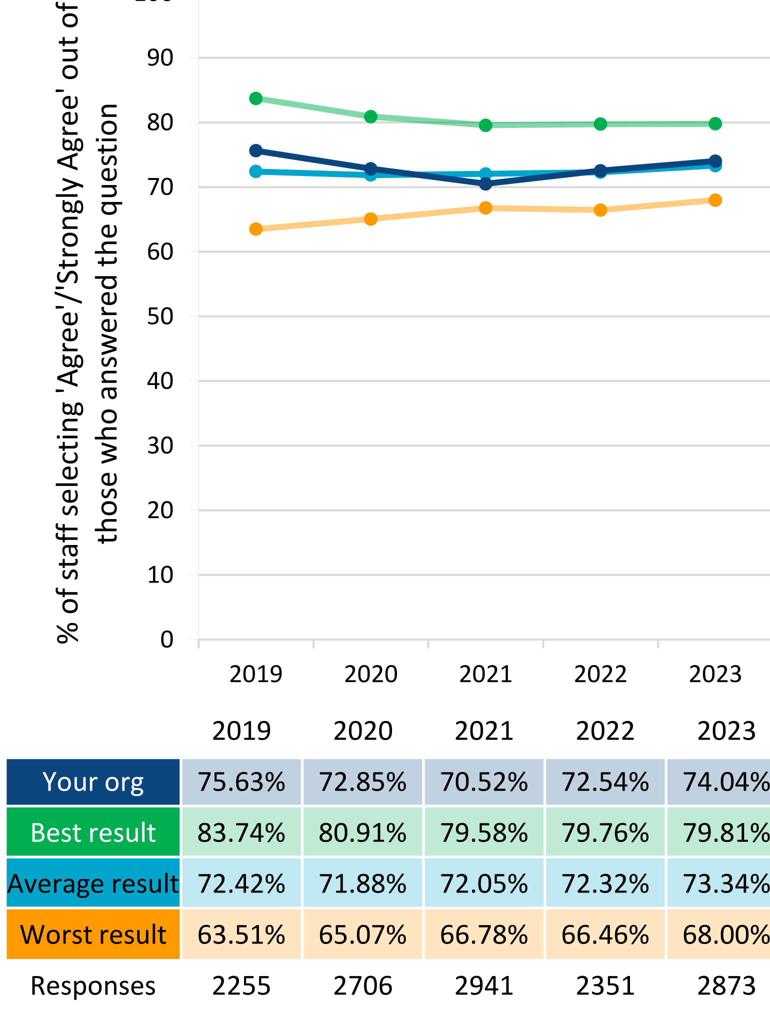
Team working – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

Line management – Q9a, Q9b, Q9c, Q9d

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

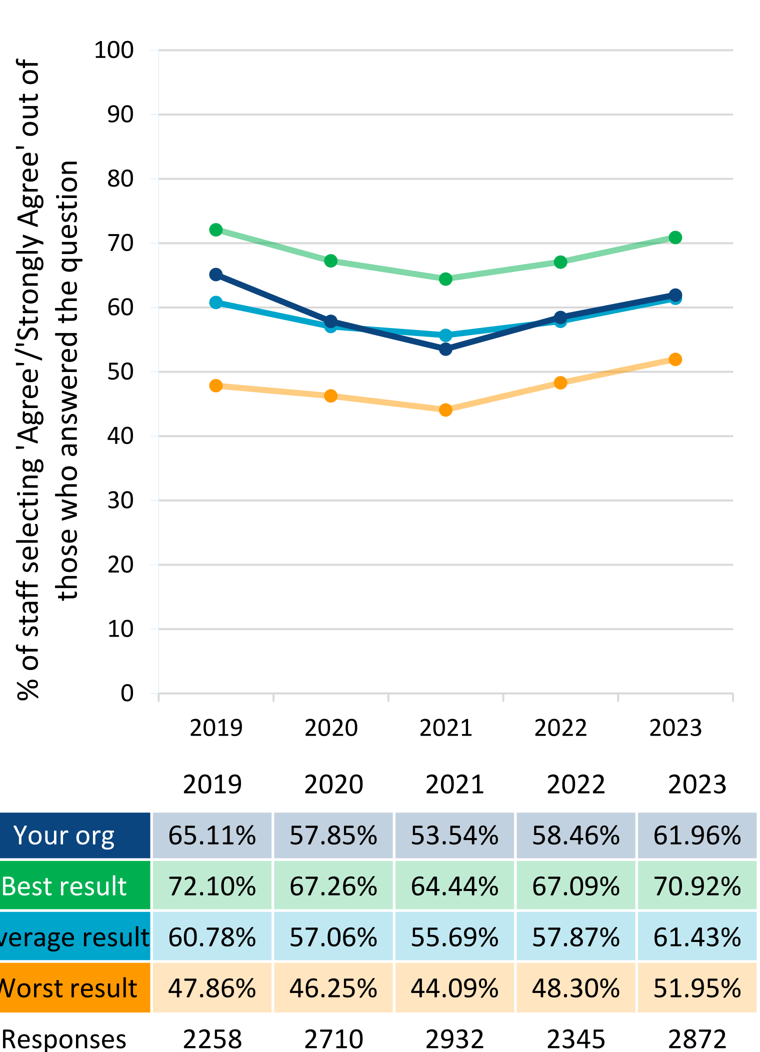


Q7a The team I work in has a set of shared objectives.



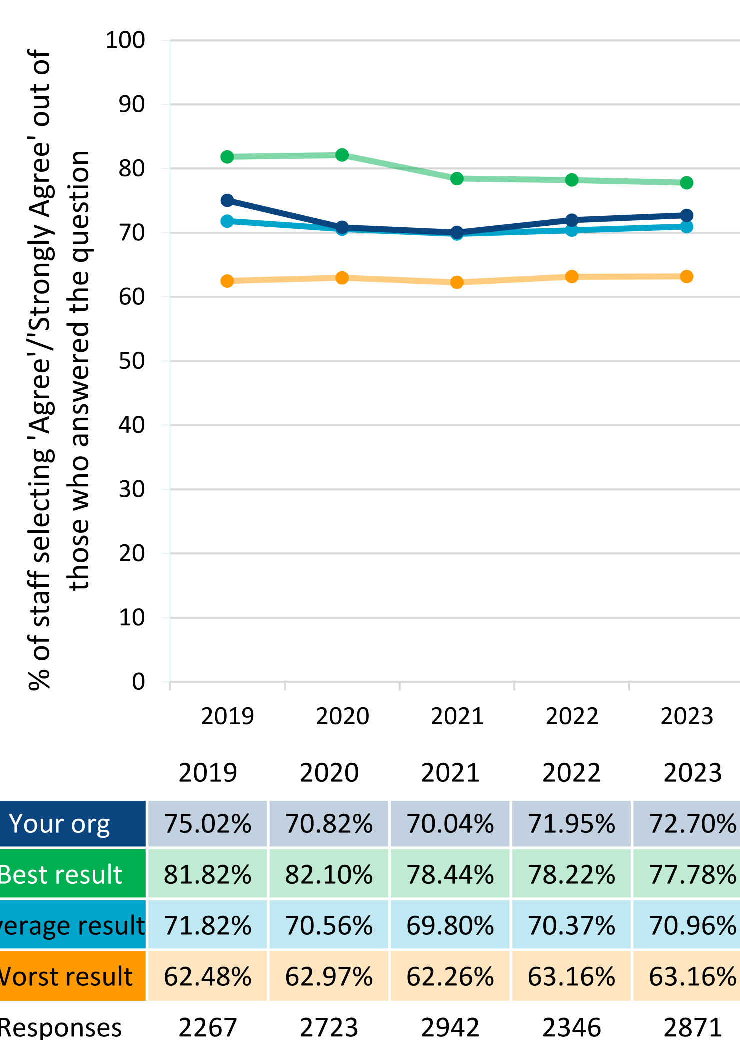
	2019	2020	2021	2022	2023
Your org	75.63%	72.85%	70.52%	72.54%	74.04%
Best result	83.74%	80.91%	79.58%	79.76%	79.81%
Average result	72.42%	71.88%	72.05%	72.32%	73.34%
Worst result	63.51%	65.07%	66.78%	66.46%	68.00%
Responses	2255	2706	2941	2351	2873

Q7b The team I work in often meets to discuss the team's effectiveness.

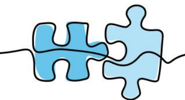


	2019	2020	2021	2022	2023
Your org	65.11%	57.85%	53.54%	58.46%	61.96%
Best result	72.10%	67.26%	64.44%	67.09%	70.92%
Average result	60.78%	57.06%	55.69%	57.87%	61.43%
Worst result	47.86%	46.25%	44.09%	48.30%	51.95%
Responses	2258	2710	2932	2345	2872

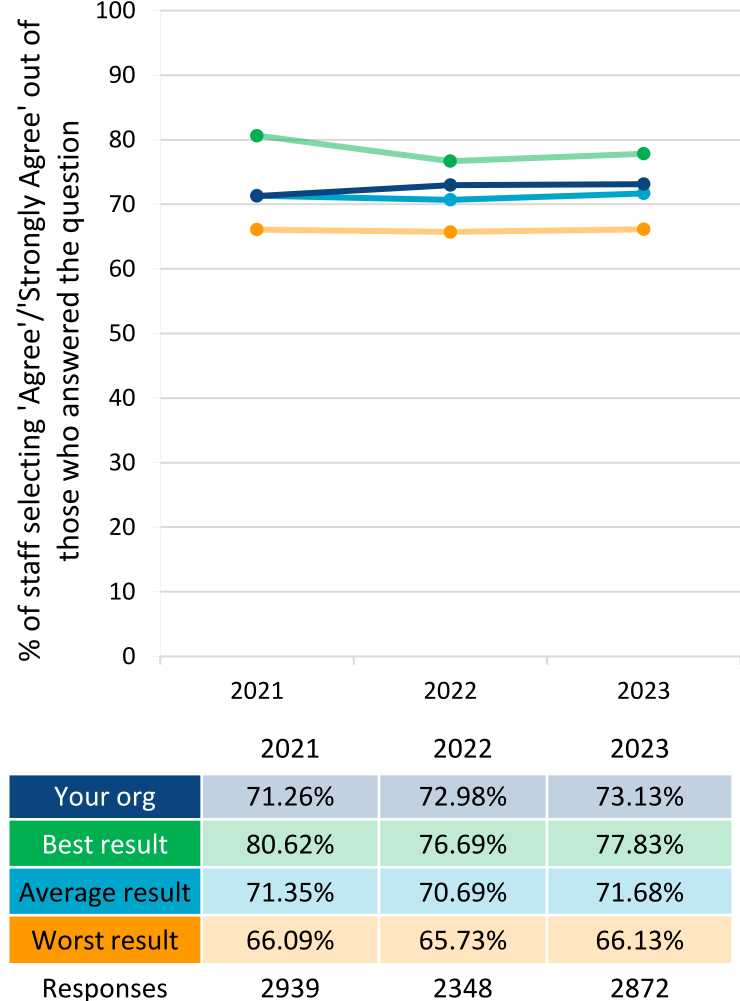
Q7c I receive the respect I deserve from my colleagues at work.



	2019	2020	2021	2022	2023
Your org	75.02%	70.82%	70.04%	71.95%	72.70%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	2267	2723	2942	2346	2871

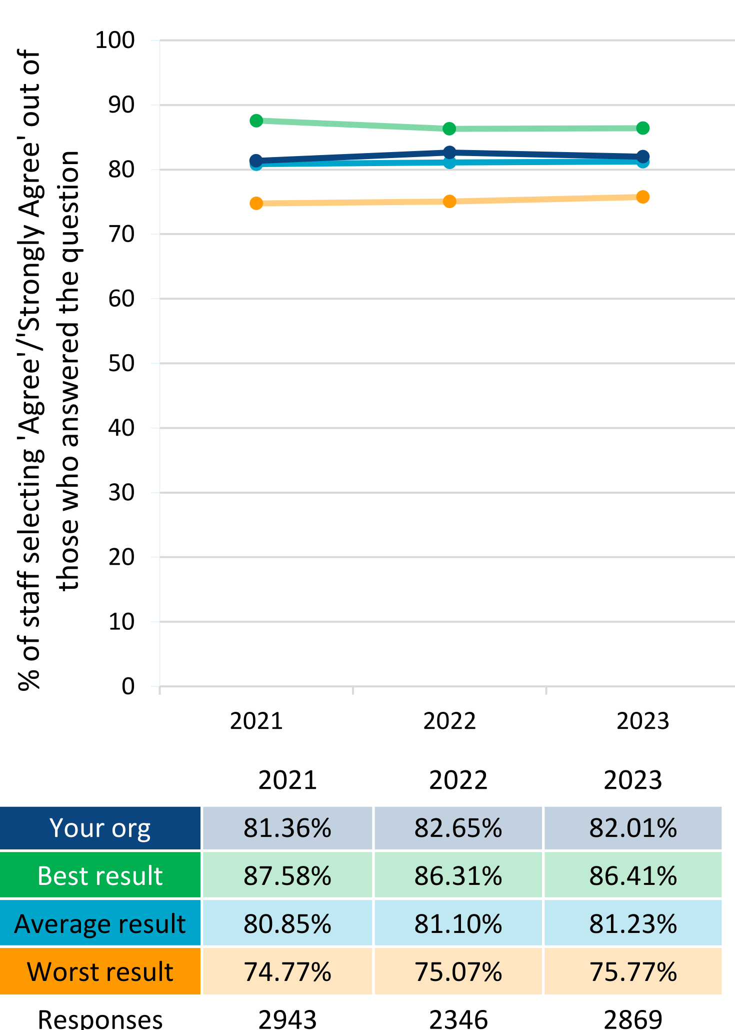


Q7d Team members understand each other's roles.



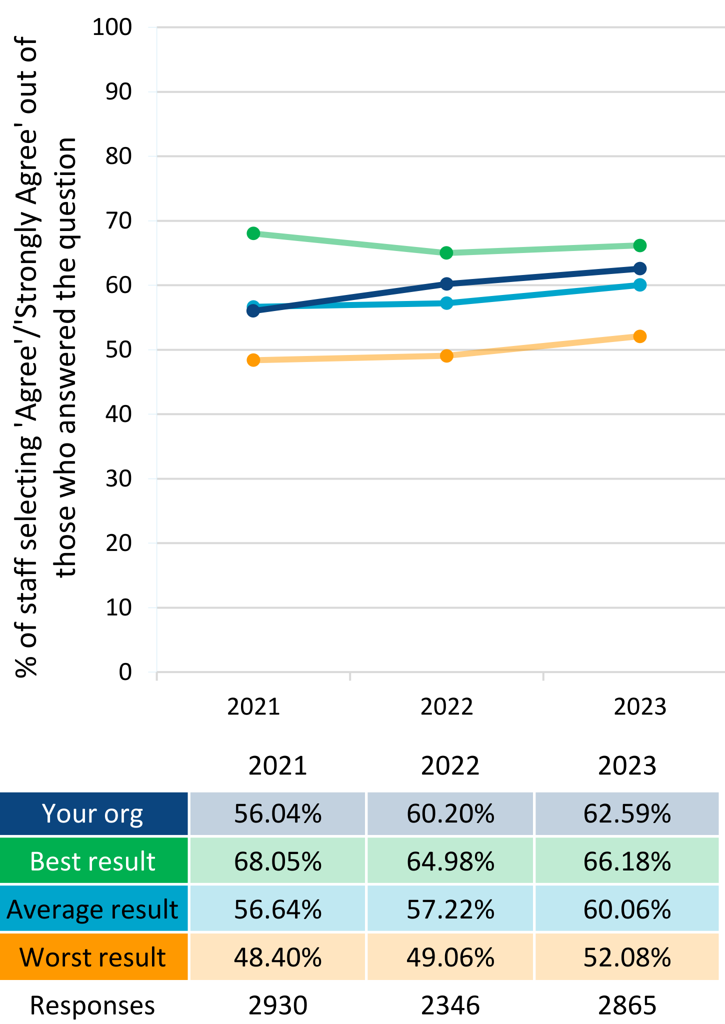
	2021	2022	2023
Your org	71.26%	72.98%	73.13%
Best result	80.62%	76.69%	77.83%
Average result	71.35%	70.69%	71.68%
Worst result	66.09%	65.73%	66.13%
Responses	2939	2348	2872

Q7e I enjoy working with the colleagues in my team.

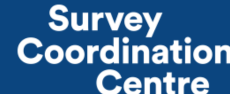


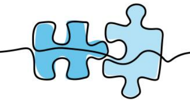
	2021	2022	2023
Your org	81.36%	82.65%	82.01%
Best result	87.58%	86.31%	86.41%
Average result	80.85%	81.10%	81.23%
Worst result	74.77%	75.07%	75.77%
Responses	2943	2346	2869

Q7f My team has enough freedom in how to do its work.

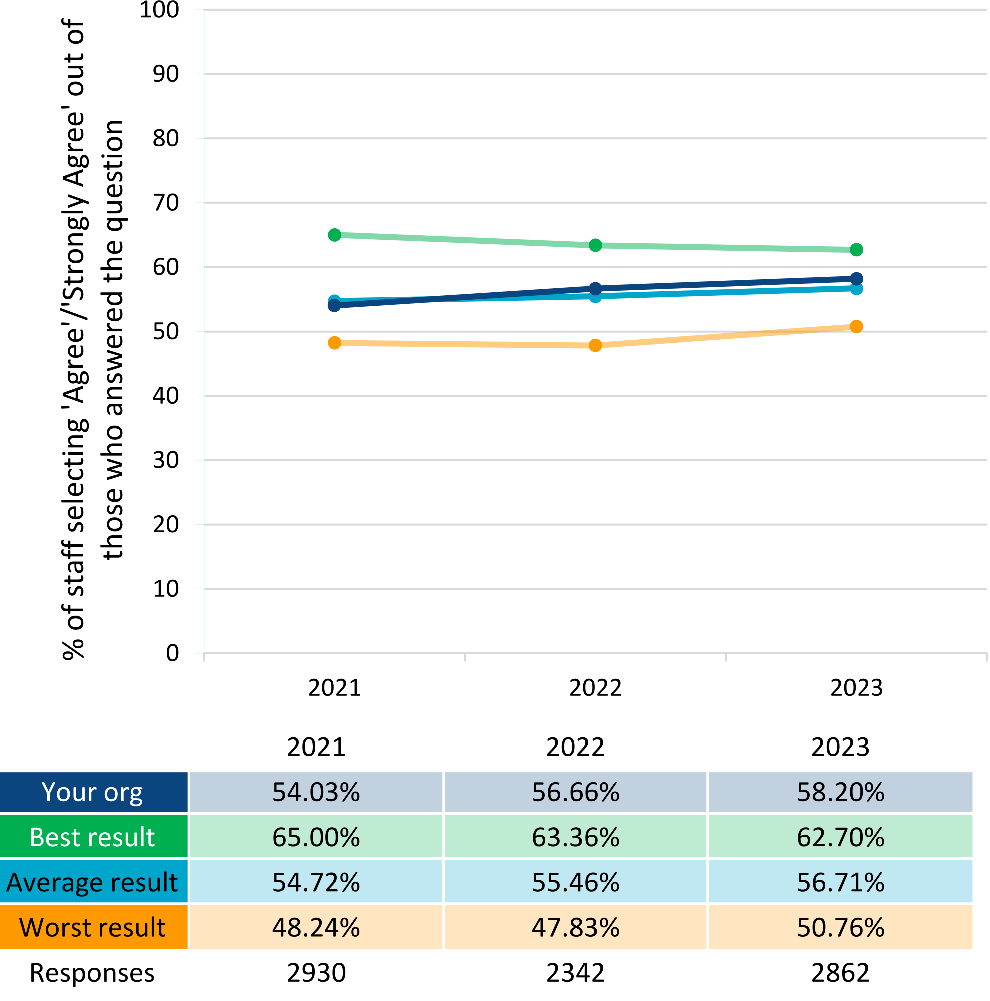


	2021	2022	2023
Your org	56.04%	60.20%	62.59%
Best result	68.05%	64.98%	66.18%
Average result	56.64%	57.22%	60.06%
Worst result	48.40%	49.06%	52.08%
Responses	2930	2346	2865



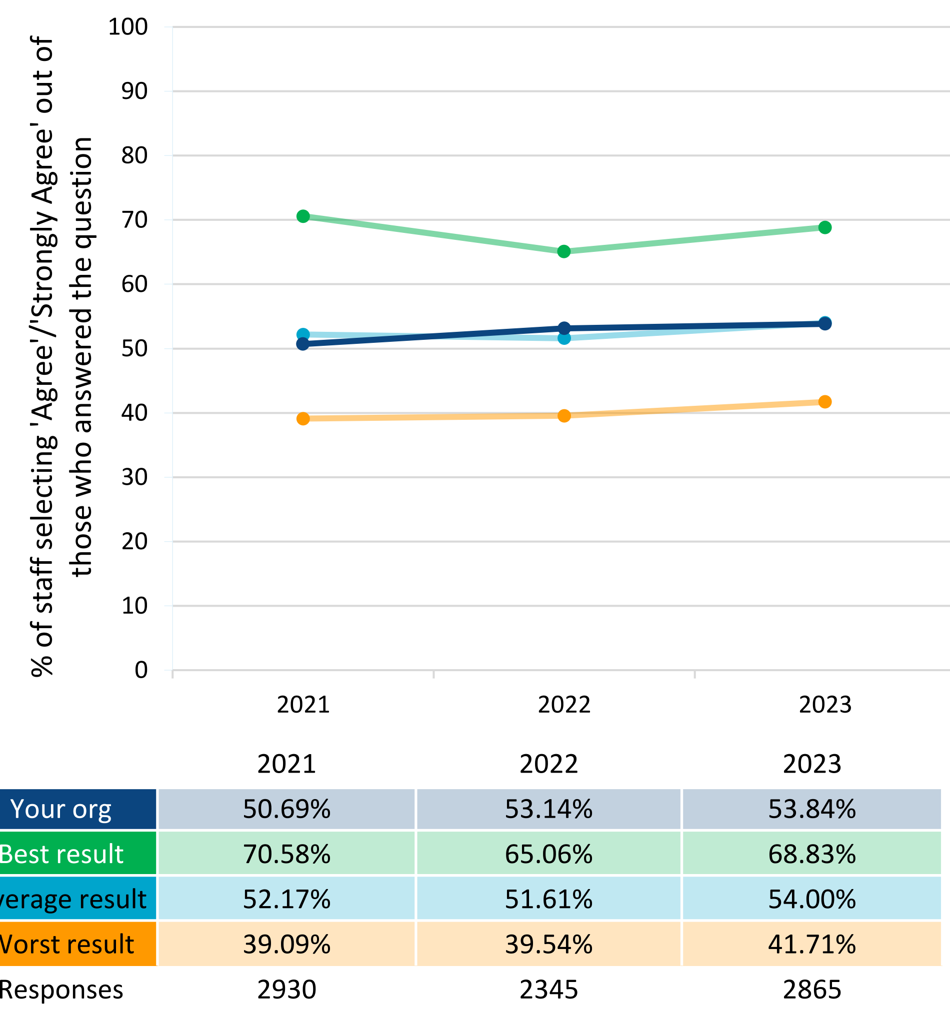


Q7g In my team disagreements are dealt with constructively.

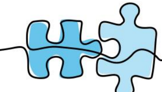


	2021	2022	2023
Your org	54.03%	56.66%	58.20%
Best result	65.00%	63.36%	62.70%
Average result	54.72%	55.46%	56.71%
Worst result	48.24%	47.83%	50.76%
Responses	2930	2342	2862

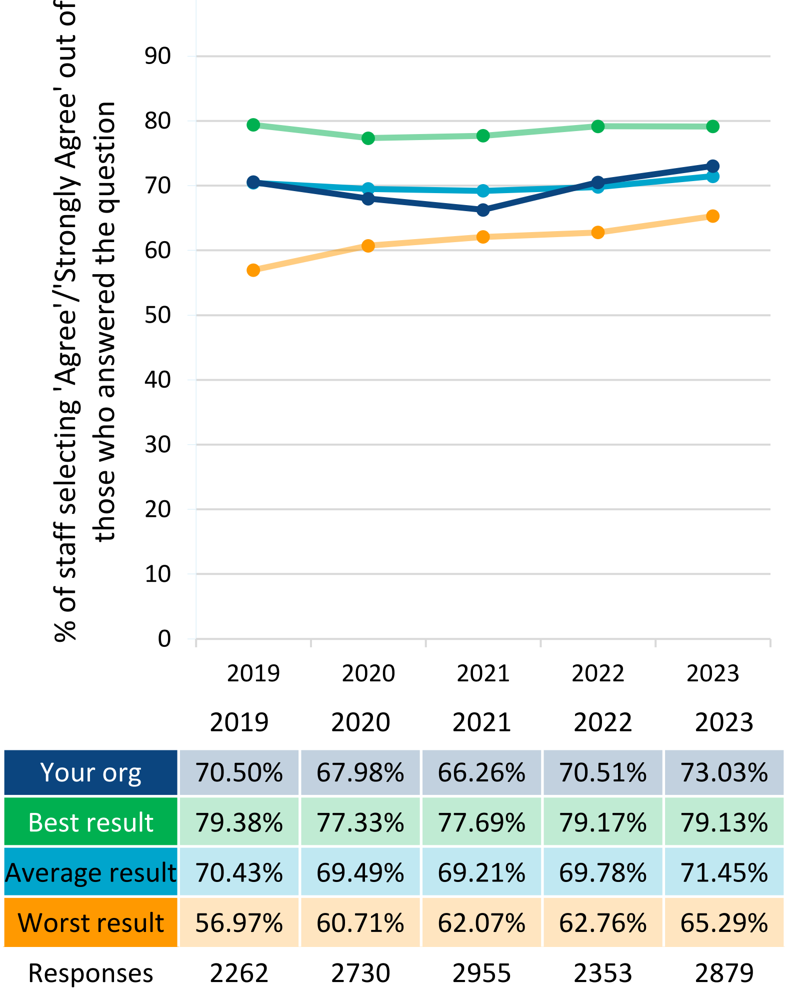
Q8a Teams within this organisation work well together to achieve their objectives.



	2021	2022	2023
Your org	50.69%	53.14%	53.84%
Best result	70.58%	65.06%	68.83%
Average result	52.17%	51.61%	54.00%
Worst result	39.09%	39.54%	41.71%
Responses	2930	2345	2865

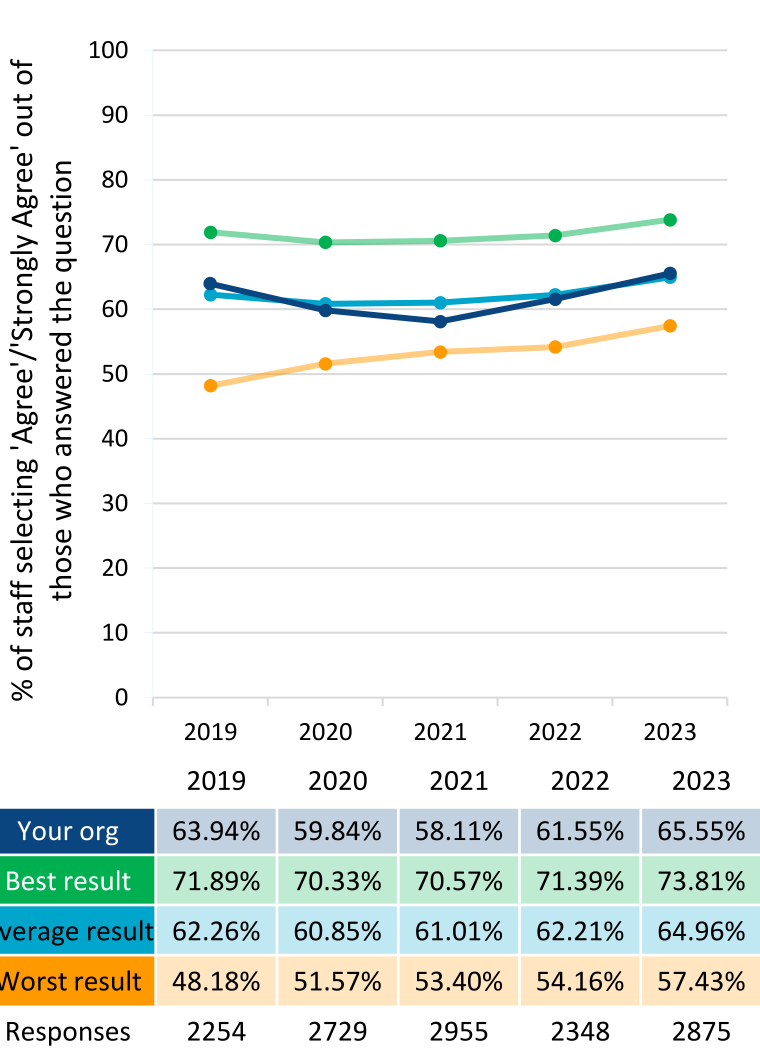


Q9a My immediate manager encourages me at work.



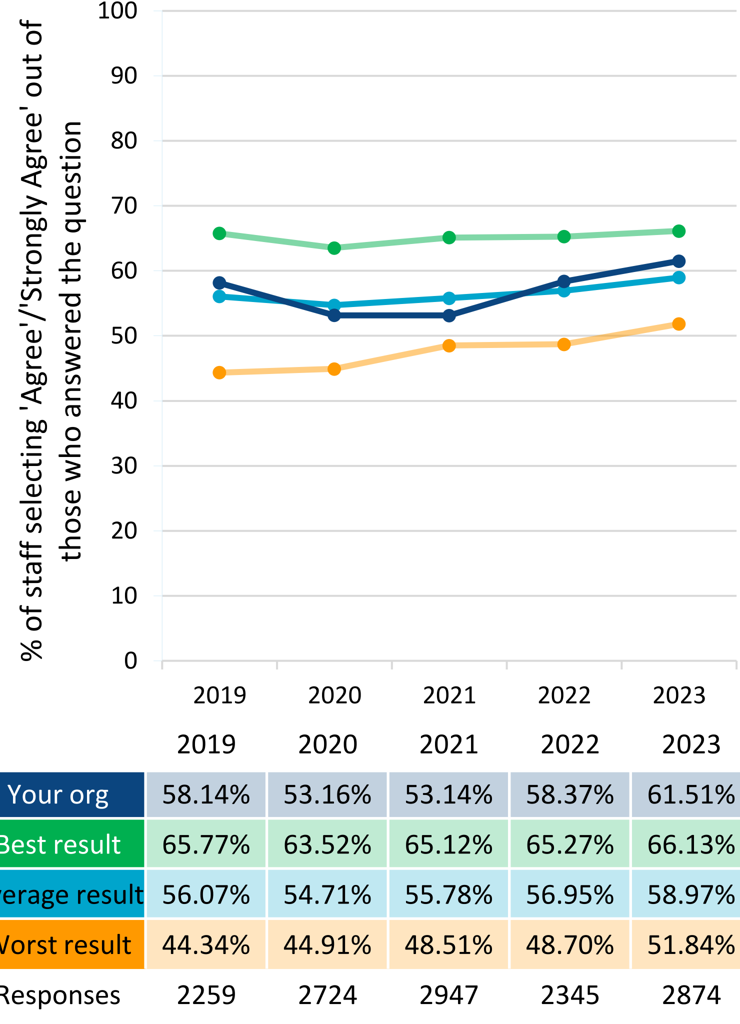
	2019	2020	2021	2022	2023
Your org	70.50%	67.98%	66.26%	70.51%	73.03%
Best result	79.38%	77.33%	77.69%	79.17%	79.13%
Average result	70.43%	69.49%	69.21%	69.78%	71.45%
Worst result	56.97%	60.71%	62.07%	62.76%	65.29%
Responses	2262	2730	2955	2353	2879

Q9b My immediate manager gives me clear feedback on my work.



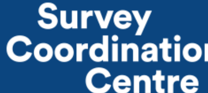
	2019	2020	2021	2022	2023
Your org	63.94%	59.84%	58.11%	61.55%	65.55%
Best result	71.89%	70.33%	70.57%	71.39%	73.81%
Average result	62.26%	60.85%	61.01%	62.21%	64.96%
Worst result	48.18%	51.57%	53.40%	54.16%	57.43%
Responses	2254	2729	2955	2348	2875

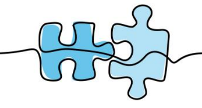
Q9c My immediate manager asks for my opinion before making decisions that affect my work.

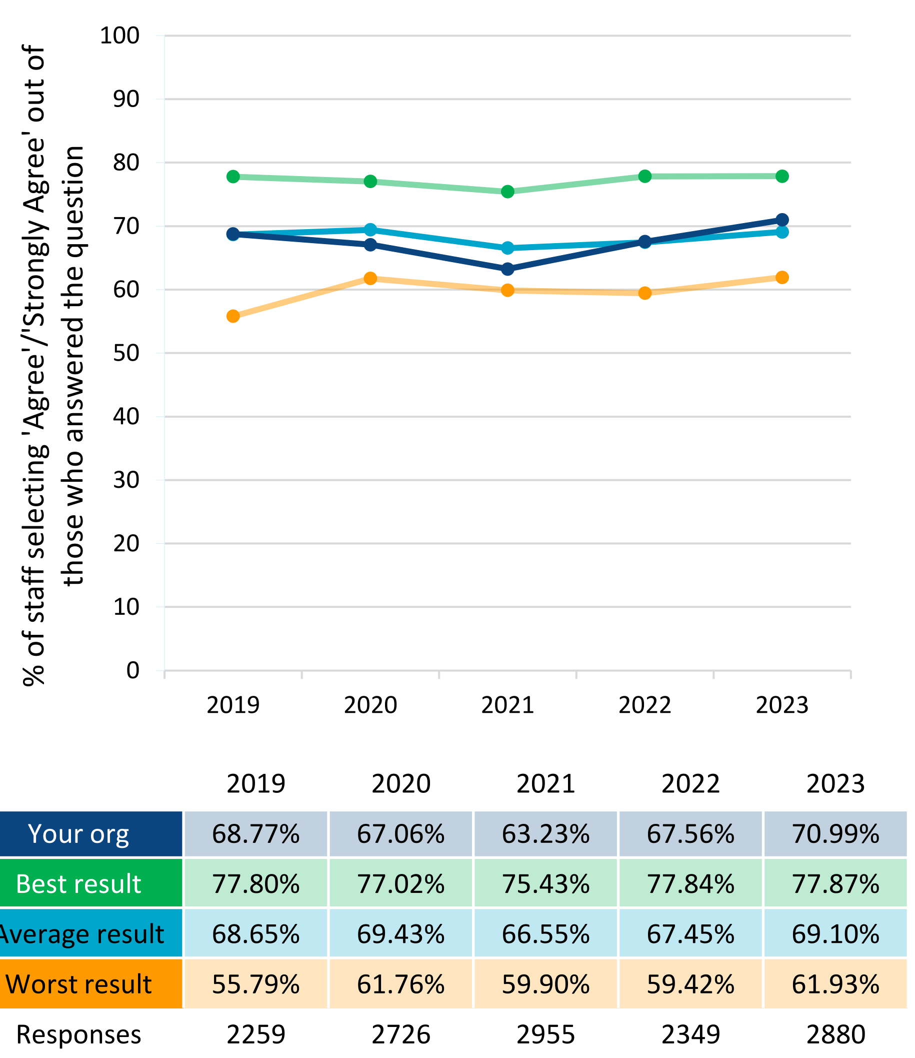


	2019	2020	2021	2022	2023
Your org	58.14%	53.16%	53.14%	58.37%	61.51%
Best result	65.77%	63.52%	65.12%	65.27%	66.13%
Average result	56.07%	54.71%	55.78%	56.95%	58.97%
Worst result	44.34%	44.91%	48.51%	48.70%	51.84%
Responses	2259	2724	2947	2345	2874

People Promise elements and theme results – We are a team: Line management







	2019	2020	2021	2022	2023
Your org	68.77%	67.06%	63.23%	67.56%	70.99%
Best result	77.80%	77.02%	75.43%	77.84%	77.87%
Average result	68.65%	69.43%	66.55%	67.45%	69.10%
Worst result	55.79%	61.76%	59.90%	59.42%	61.93%
Responses	2259	2726	2955	2349	2880

Theme – Staff engagement

Questions included:

Motivation – Q2a, Q2b, Q2c

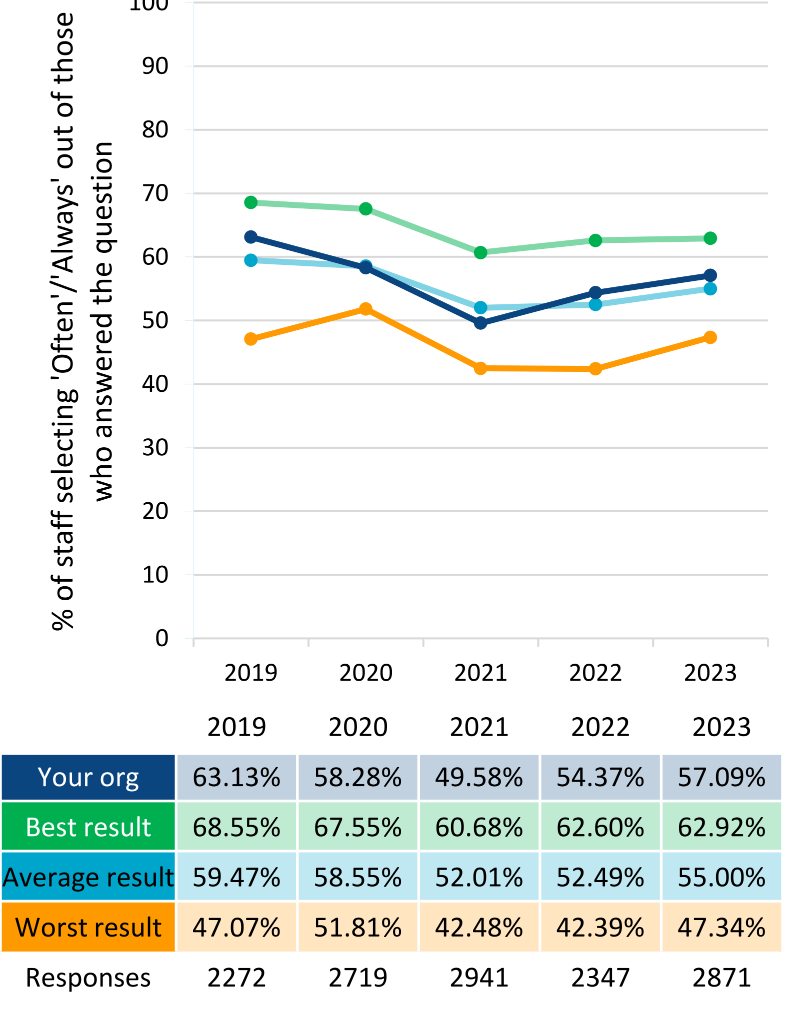
Involvement – Q3c, Q3d, Q3f

Advocacy – Q25a, Q25c, Q25d

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

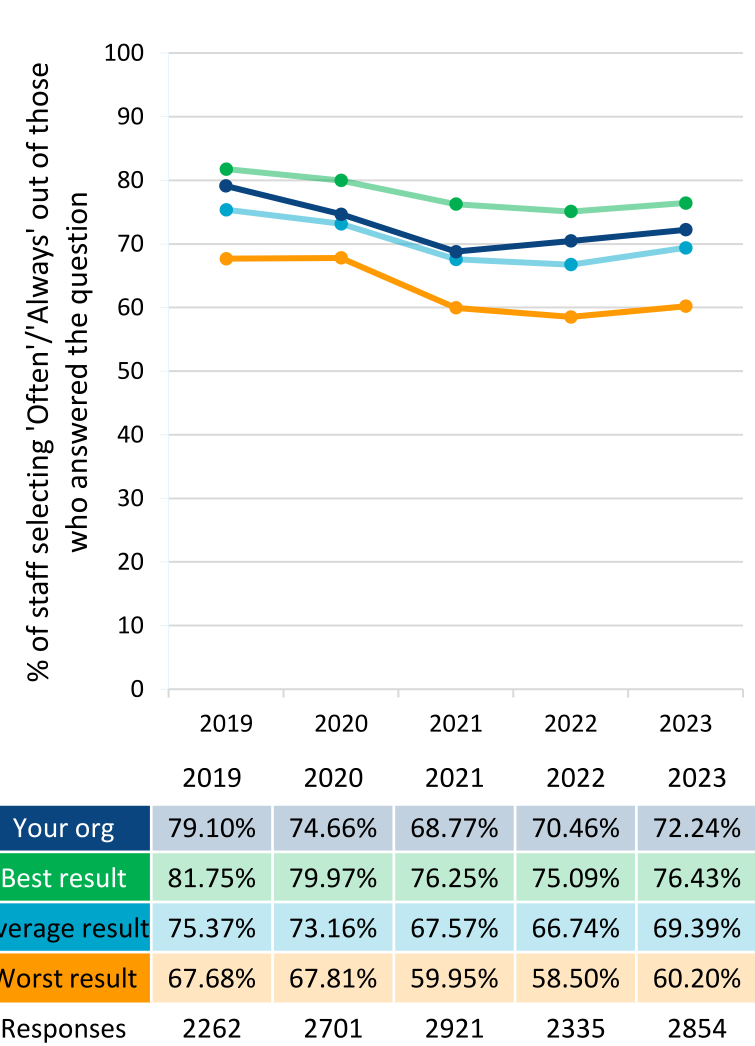
People Promise elements and theme results – Staff engagement: Motivation

Q2a I look forward to going to work.



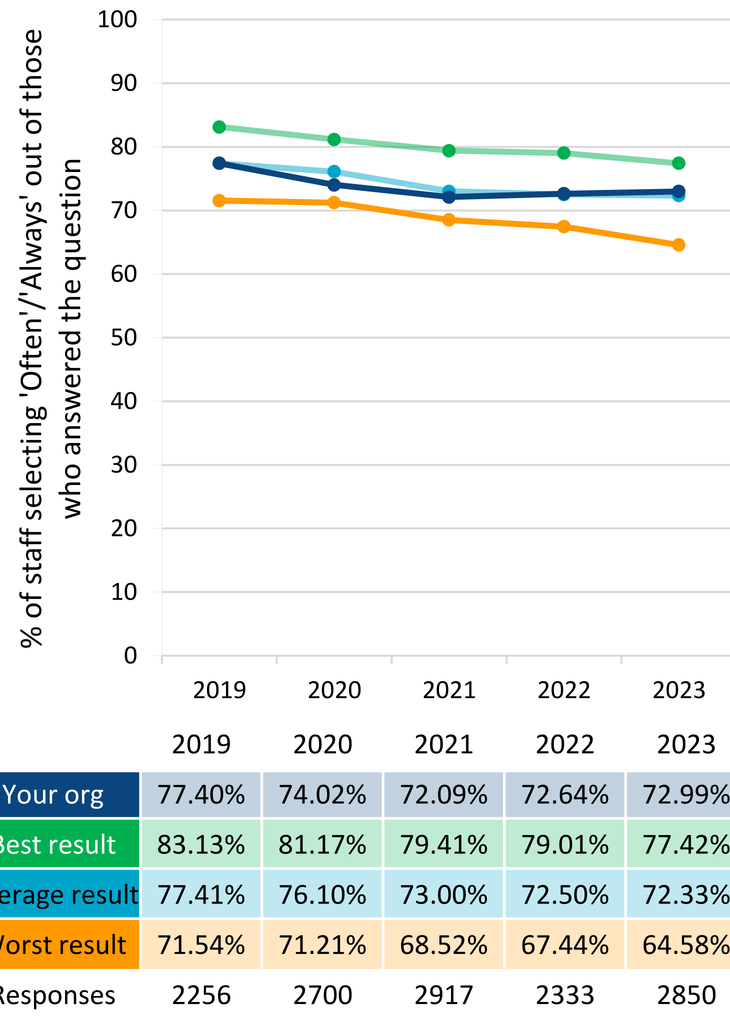
	2019	2020	2021	2022	2023
Your org	63.13%	58.28%	49.58%	54.37%	57.09%
Best result	68.55%	67.55%	60.68%	62.60%	62.92%
Average result	59.47%	58.55%	52.01%	52.49%	55.00%
Worst result	47.07%	51.81%	42.48%	42.39%	47.34%
Responses	2272	2719	2941	2347	2871

Q2b I am enthusiastic about my job.



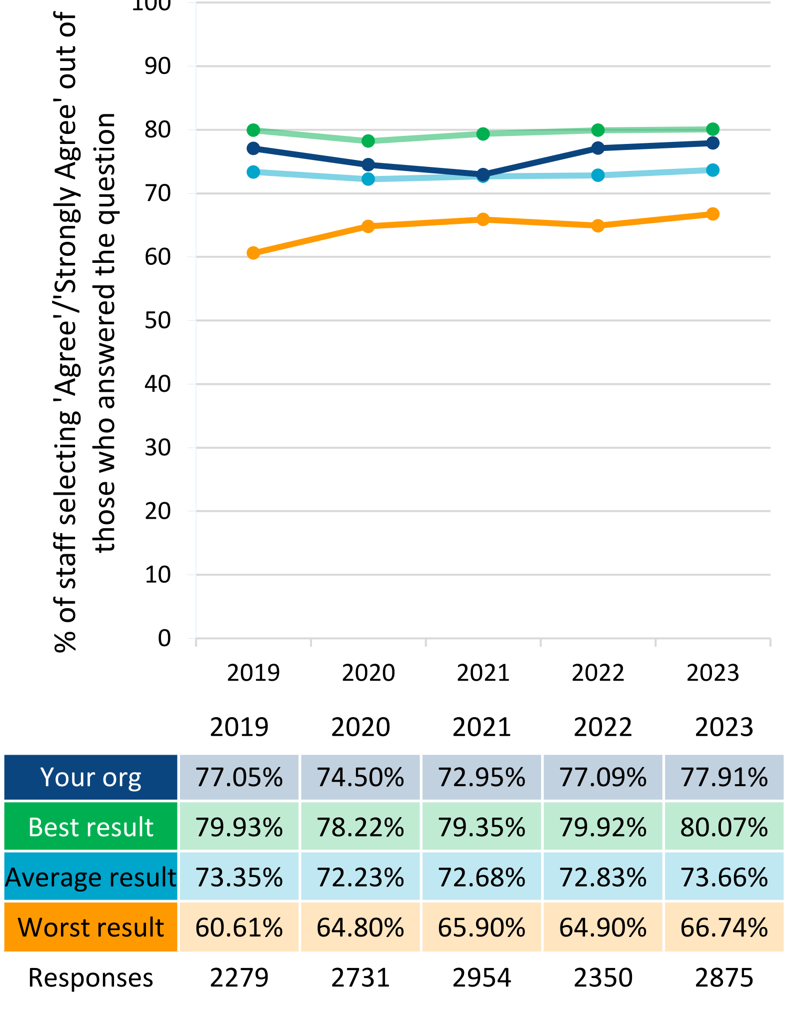
	2019	2020	2021	2022	2023
Your org	79.10%	74.66%	68.77%	70.46%	72.24%
Best result	81.75%	79.97%	76.25%	75.09%	76.43%
Average result	75.37%	73.16%	67.57%	66.74%	69.39%
Worst result	67.68%	67.81%	59.95%	58.50%	60.20%
Responses	2262	2701	2921	2335	2854

Q2c Time passes quickly when I am working.

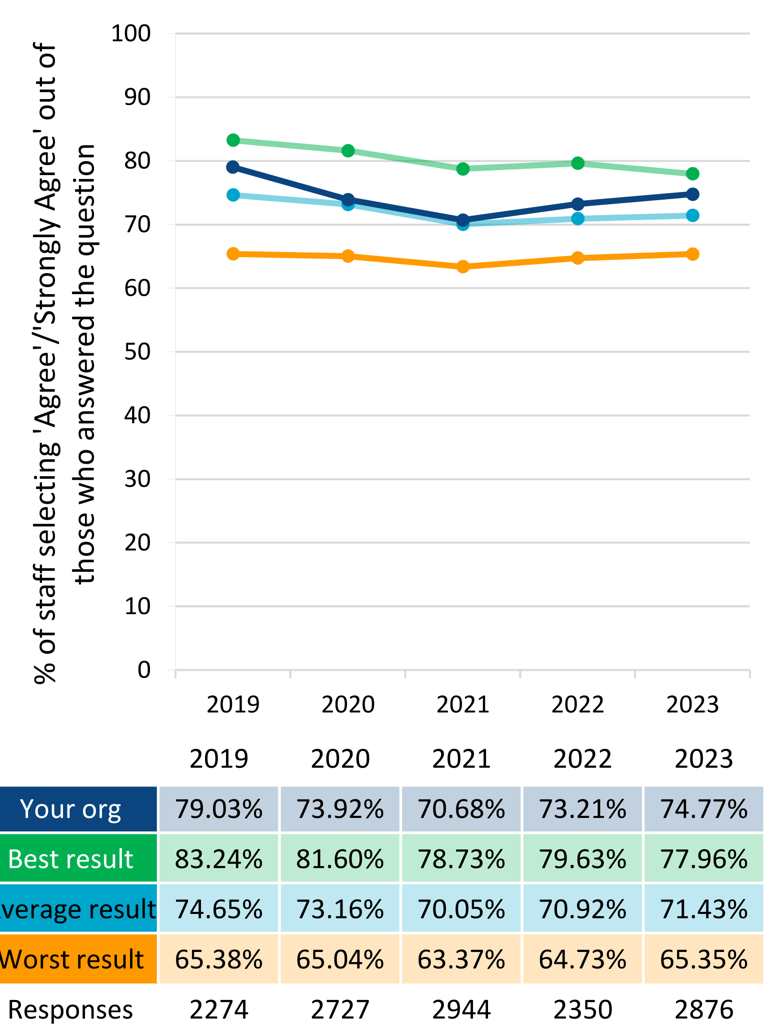


	2019	2020	2021	2022	2023
Your org	77.40%	74.02%	72.09%	72.64%	72.99%
Best result	83.13%	81.17%	79.41%	79.01%	77.42%
Average result	77.41%	76.10%	73.00%	72.50%	72.33%
Worst result	71.54%	71.21%	68.52%	67.44%	64.58%
Responses	2256	2700	2917	2333	2850

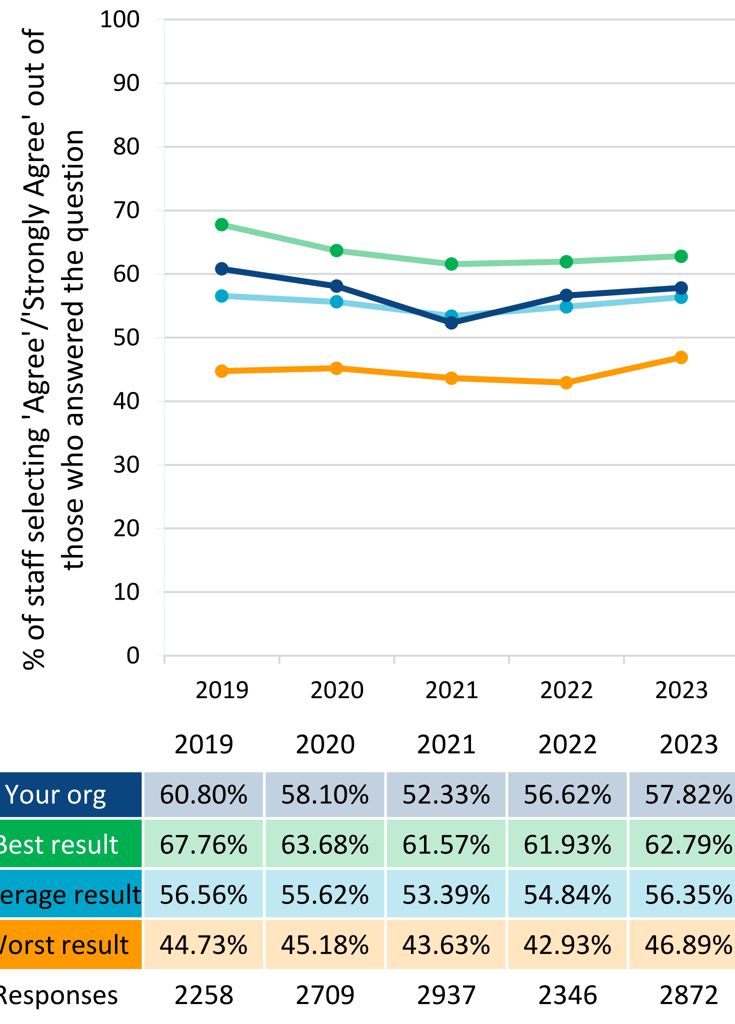
People Promise elements and theme results – Staff engagement: Involvement



	2019	2020	2021	2022	2023
Your org	77.05%	74.50%	72.95%	77.09%	77.91%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	2279	2731	2954	2350	2875

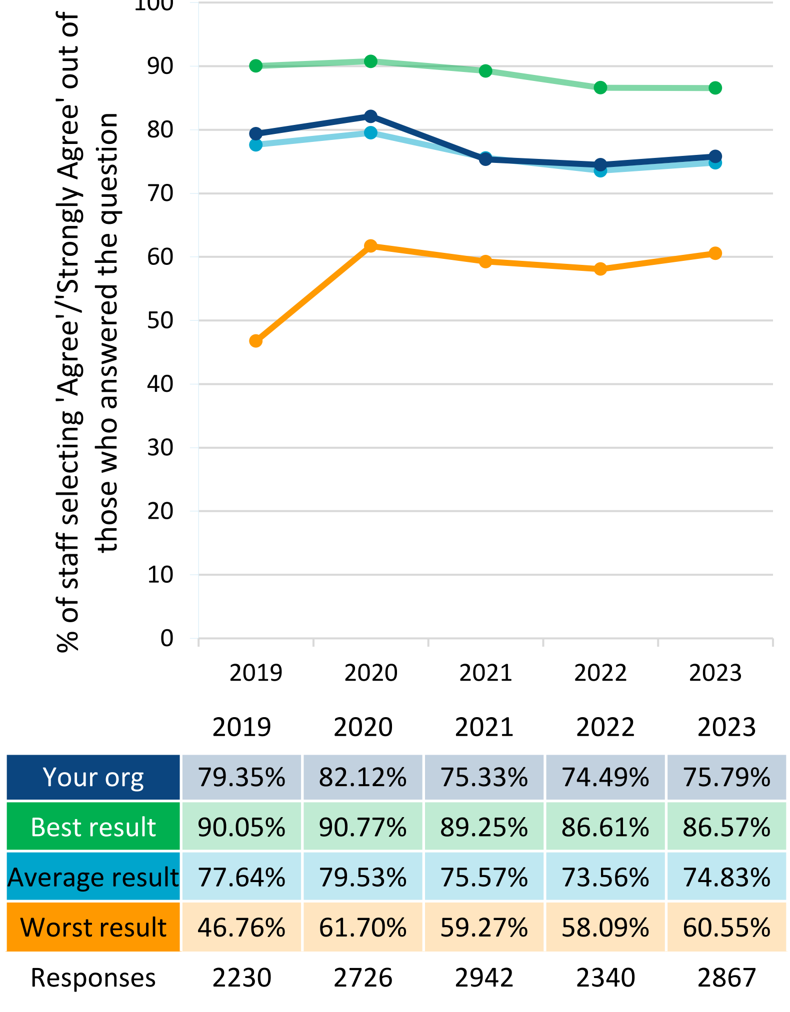


	2019	2020	2021	2022	2023
Your org	79.03%	73.92%	70.68%	73.21%	74.77%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	2274	2727	2944	2350	2876

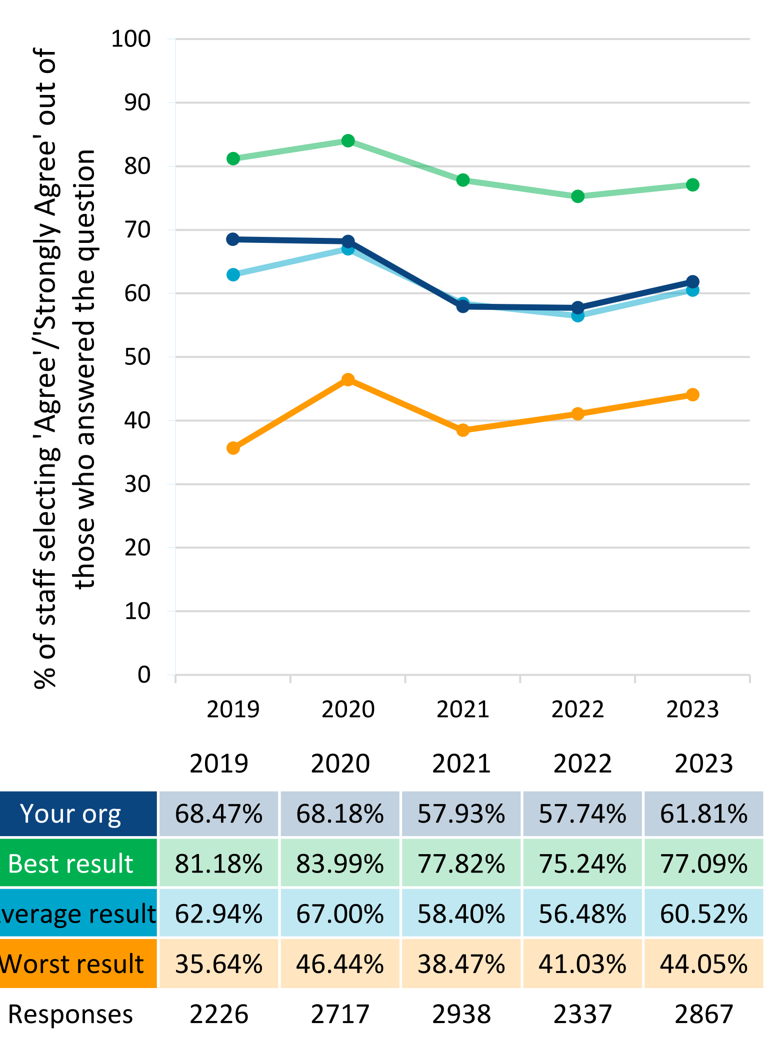


	2019	2020	2021	2022	2023
Your org	60.80%	58.10%	52.33%	56.62%	57.82%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	2258	2709	2937	2346	2872

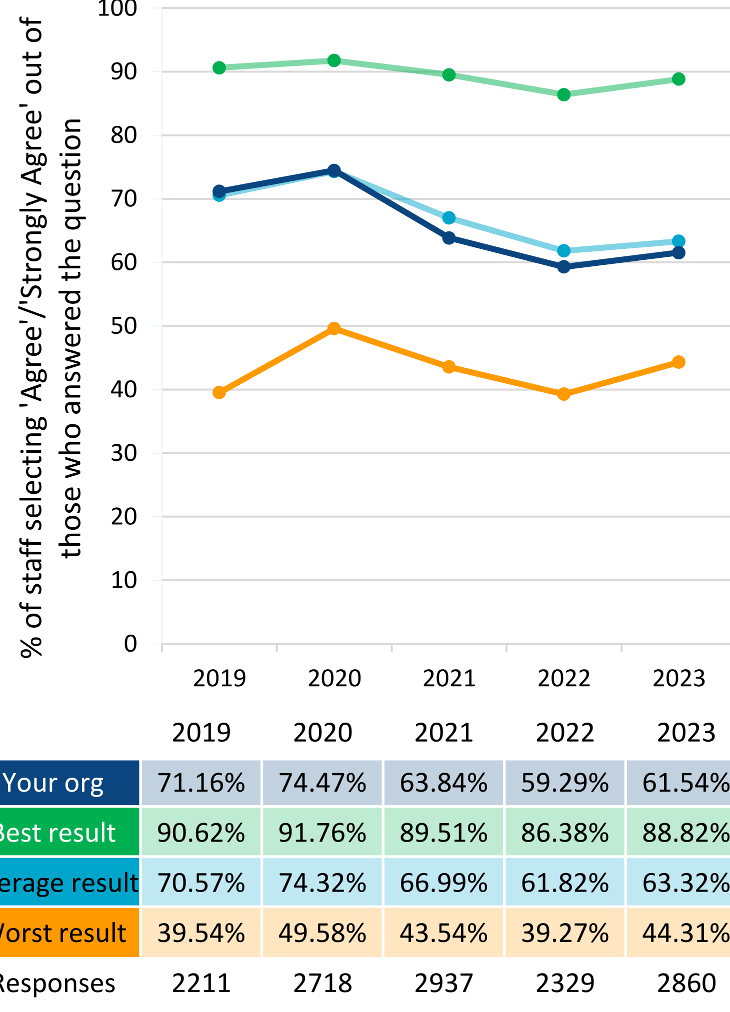
People Promise elements and theme results – Staff engagement: Advocacy



	2019	2020	2021	2022	2023
Your org	79.35%	82.12%	75.33%	74.49%	75.79%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	2230	2726	2942	2340	2867



	2019	2020	2021	2022	2023
Your org	68.47%	68.18%	57.93%	57.74%	61.81%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2226	2717	2938	2337	2867



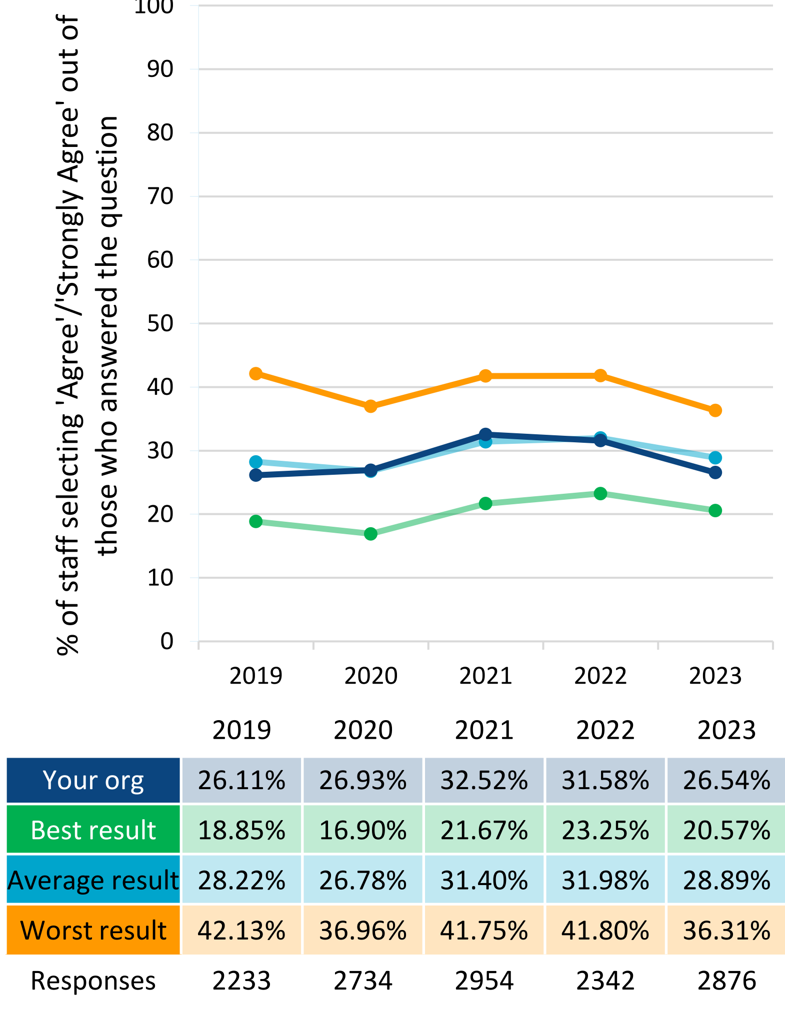
	2019	2020	2021	2022	2023
Your org	71.16%	74.47%	63.84%	59.29%	61.54%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2211	2718	2937	2329	2860

Theme - Morale

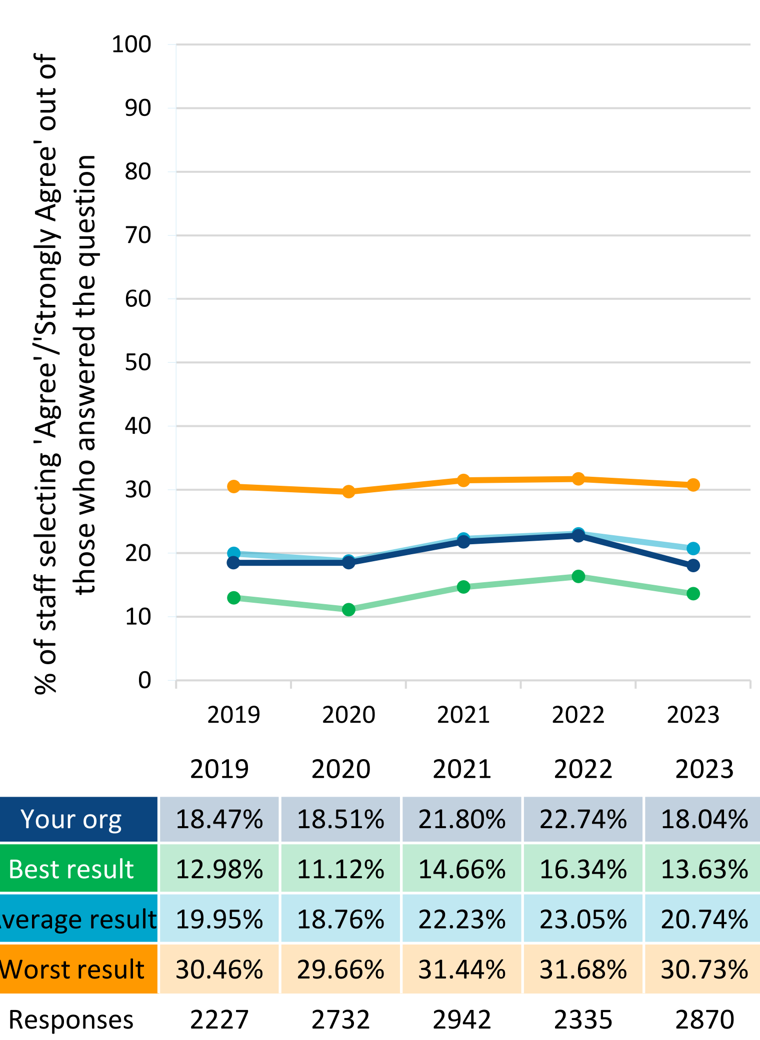
Questions included:
Thinking about leaving – Q26a, Q26b, Q26c
Work pressure – Q3g, Q3h, Q3i
Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

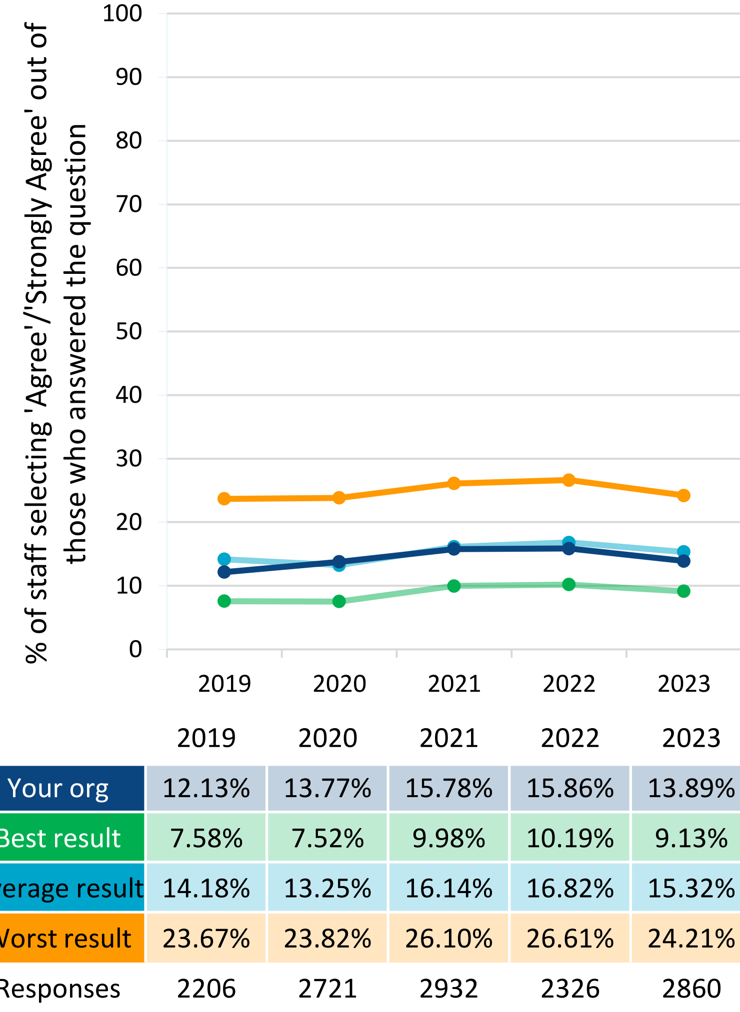
People Promise elements and theme results – Morale: Thinking about leaving



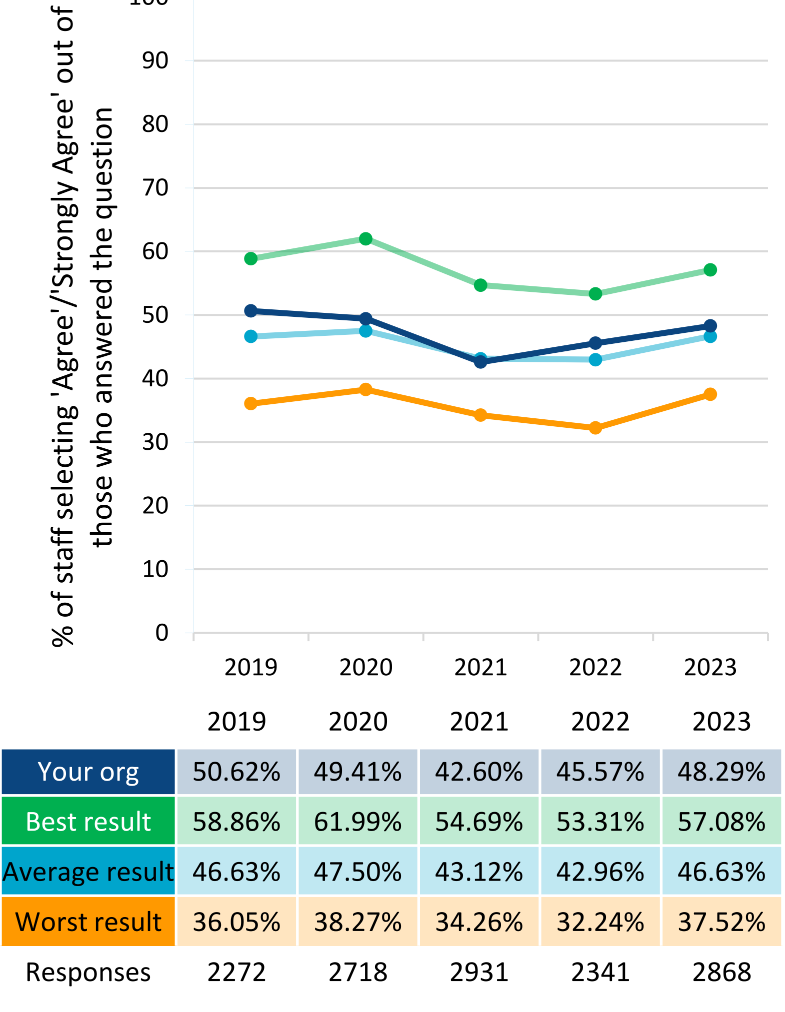
	2019	2020	2021	2022	2023
Your org	26.11%	26.93%	32.52%	31.58%	26.54%
Best result	18.85%	16.90%	21.67%	23.25%	20.57%
Average result	28.22%	26.78%	31.40%	31.98%	28.89%
Worst result	42.13%	36.96%	41.75%	41.80%	36.31%
Responses	2233	2734	2954	2342	2876



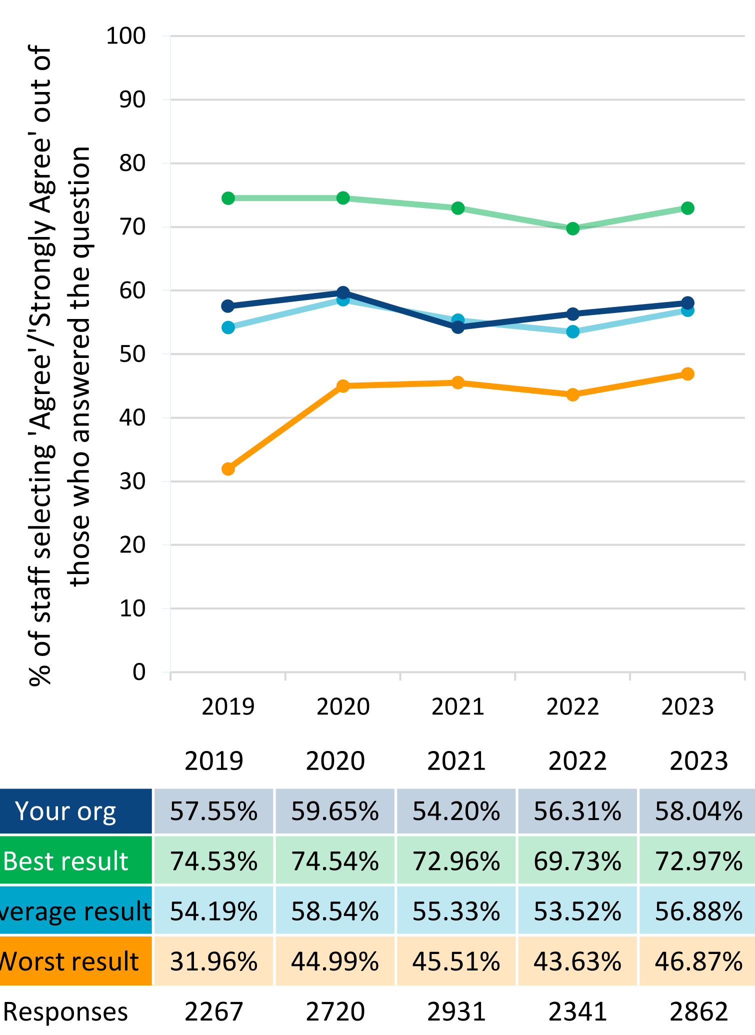
	2019	2020	2021	2022	2023
Your org	18.47%	18.51%	21.80%	22.74%	18.04%
Best result	12.98%	11.12%	14.66%	16.34%	13.63%
Average result	19.95%	18.76%	22.23%	23.05%	20.74%
Worst result	30.46%	29.66%	31.44%	31.68%	30.73%
Responses	2227	2732	2942	2335	2870



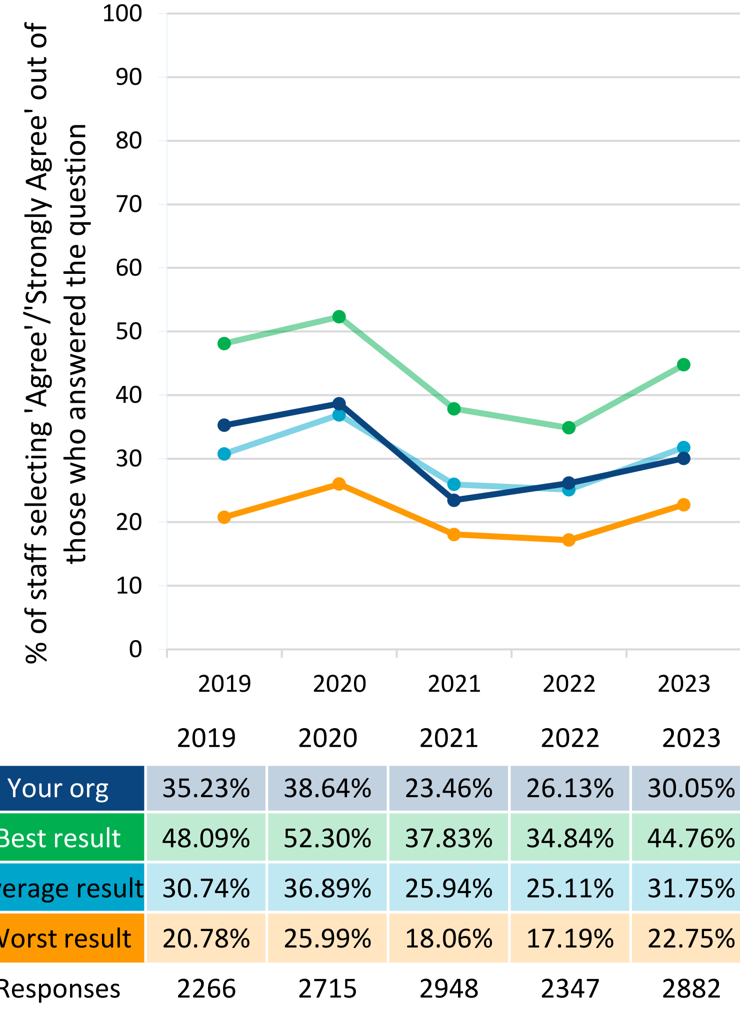
	2019	2020	2021	2022	2023
Your org	12.13%	13.77%	15.78%	15.86%	13.89%
Best result	7.58%	7.52%	9.98%	10.19%	9.13%
Average result	14.18%	13.25%	16.14%	16.82%	15.32%
Worst result	23.67%	23.82%	26.10%	26.61%	24.21%
Responses	2206	2721	2932	2326	2860



	2019	2020	2021	2022	2023
Your org	50.62%	49.41%	42.60%	45.57%	48.29%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	2272	2718	2931	2341	2868

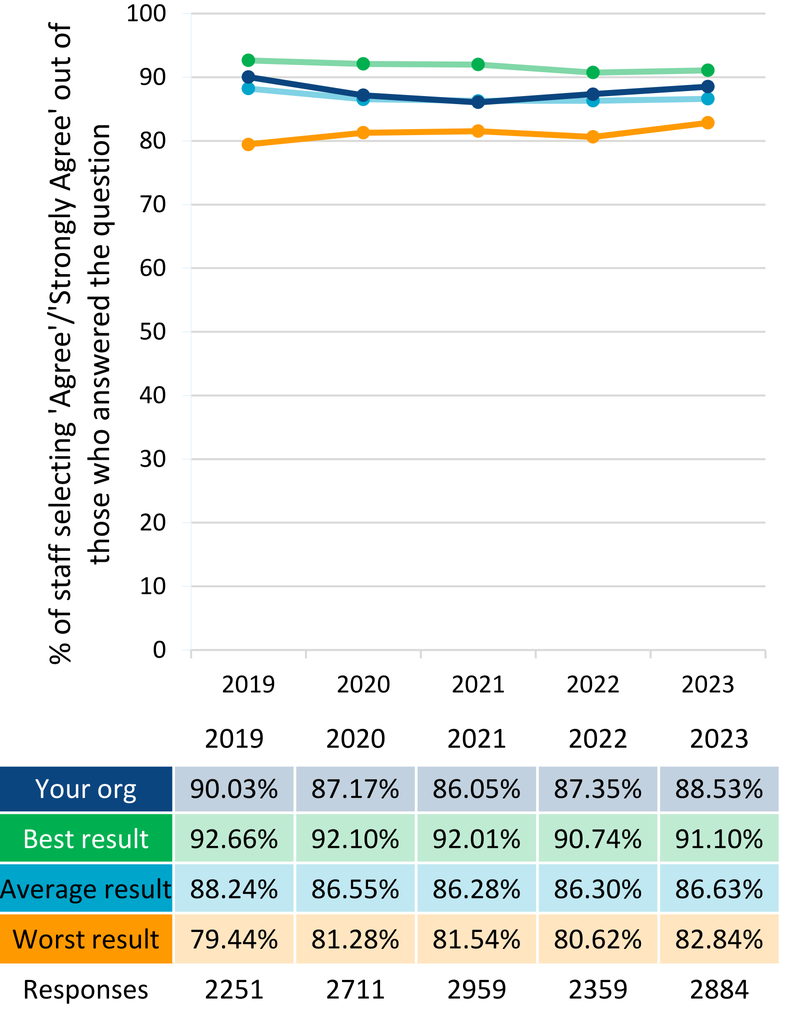


	2019	2020	2021	2022	2023
Your org	57.55%	59.65%	54.20%	56.31%	58.04%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	2267	2720	2931	2341	2862

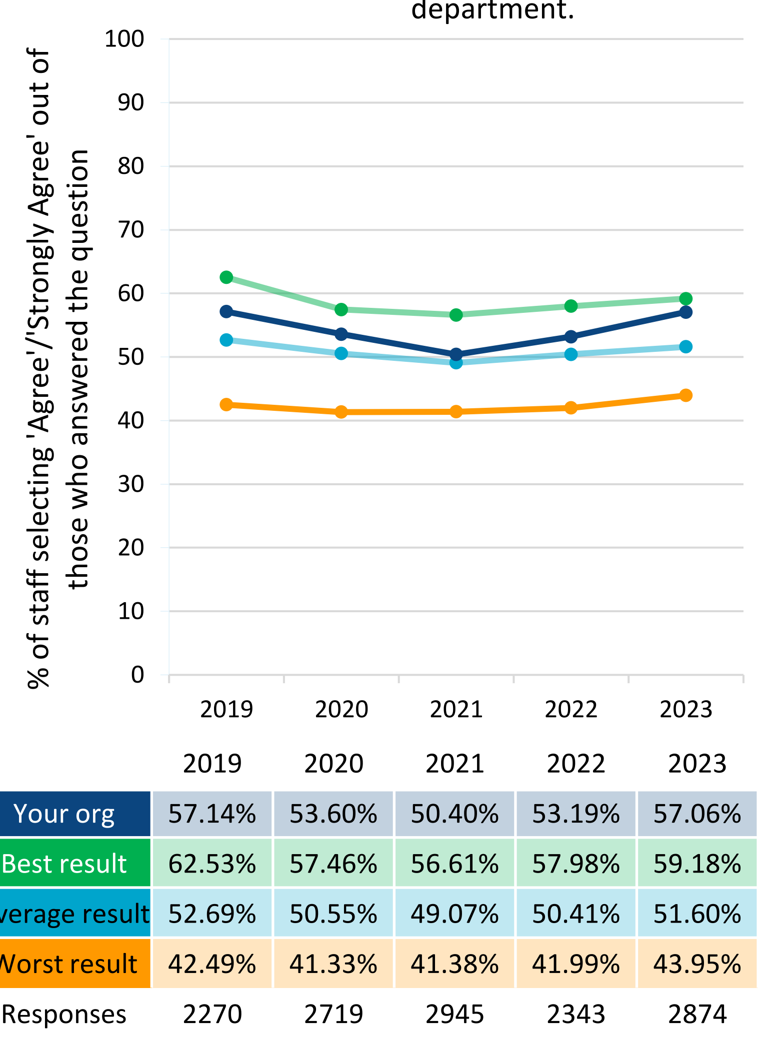


	2019	2020	2021	2022	2023
Your org	35.23%	38.64%	23.46%	26.13%	30.05%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	2266	2715	2948	2347	2882

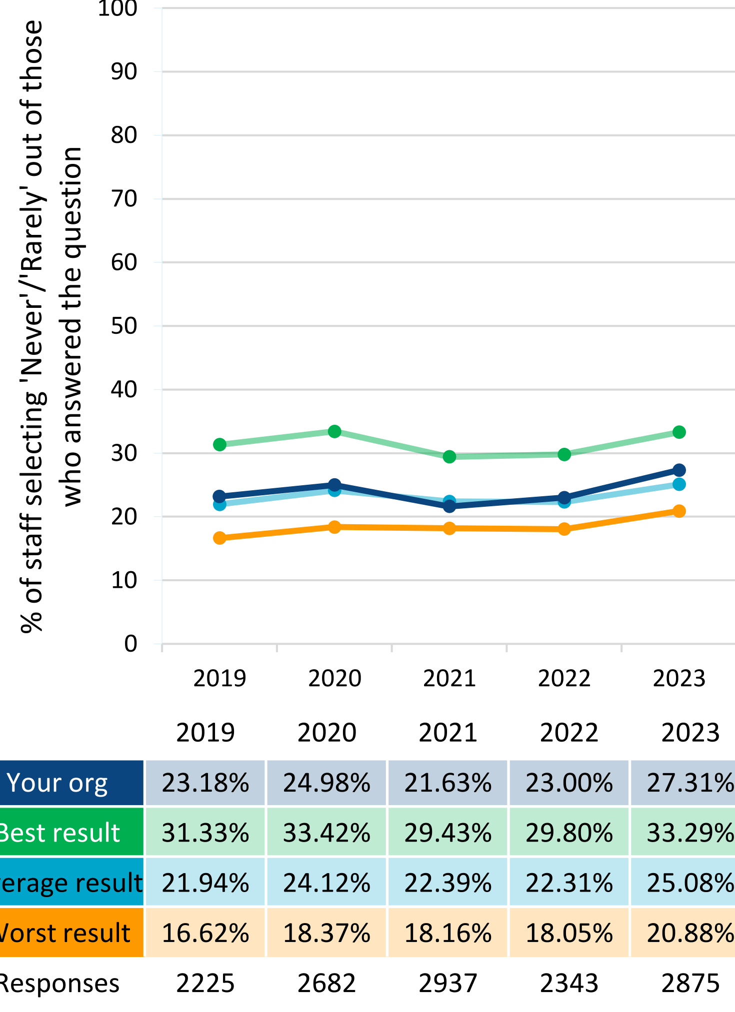
People Promise elements and theme results – Morale: Stressors



	2019	2020	2021	2022	2023
Your org	90.03%	87.17%	86.05%	87.35%	88.53%
Best result	92.66%	92.10%	92.01%	90.74%	91.10%
Average result	88.24%	86.55%	86.28%	86.30%	86.63%
Worst result	79.44%	81.28%	81.54%	80.62%	82.84%
Responses	2251	2711	2959	2359	2884

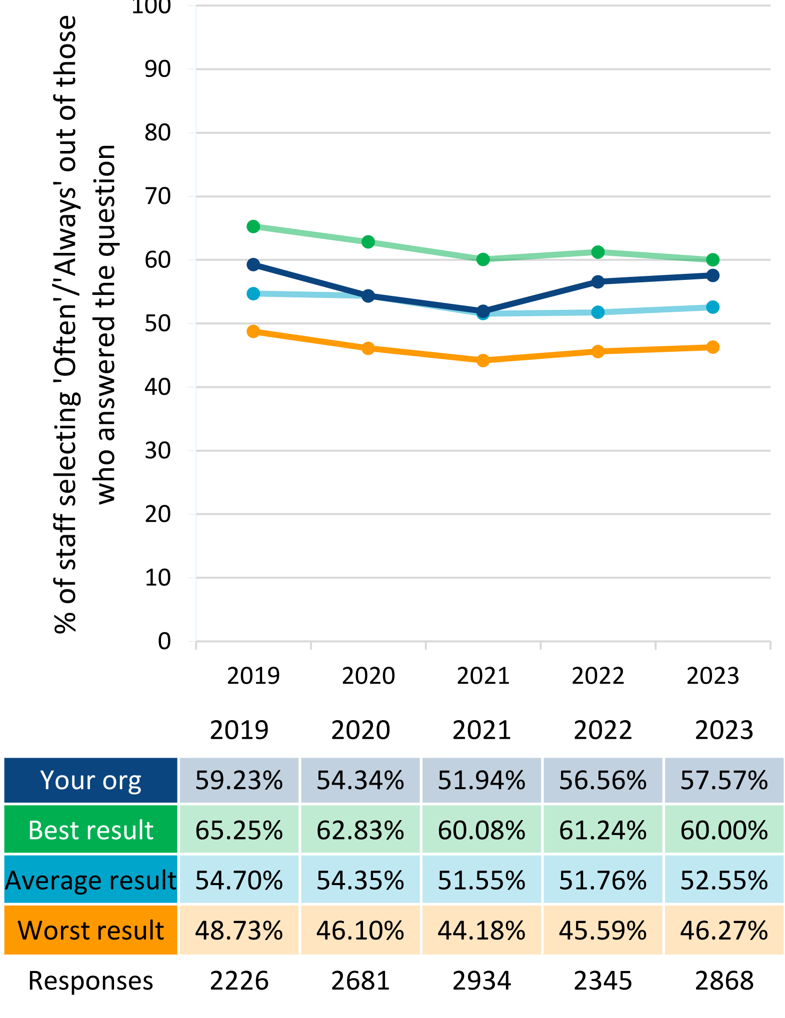


	2019	2020	2021	2022	2023
Your org	57.14%	53.60%	50.40%	53.19%	57.06%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	2270	2719	2945	2343	2874

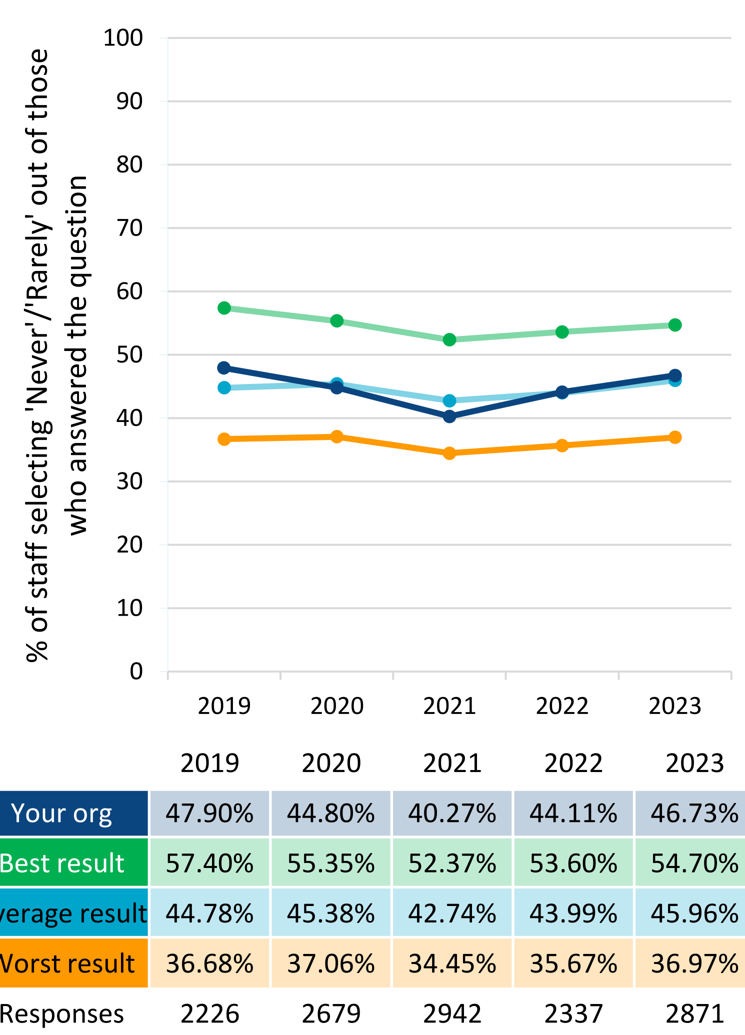


	2019	2020	2021	2022	2023
Your org	23.18%	24.98%	21.63%	23.00%	27.31%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	2225	2682	2937	2343	2875

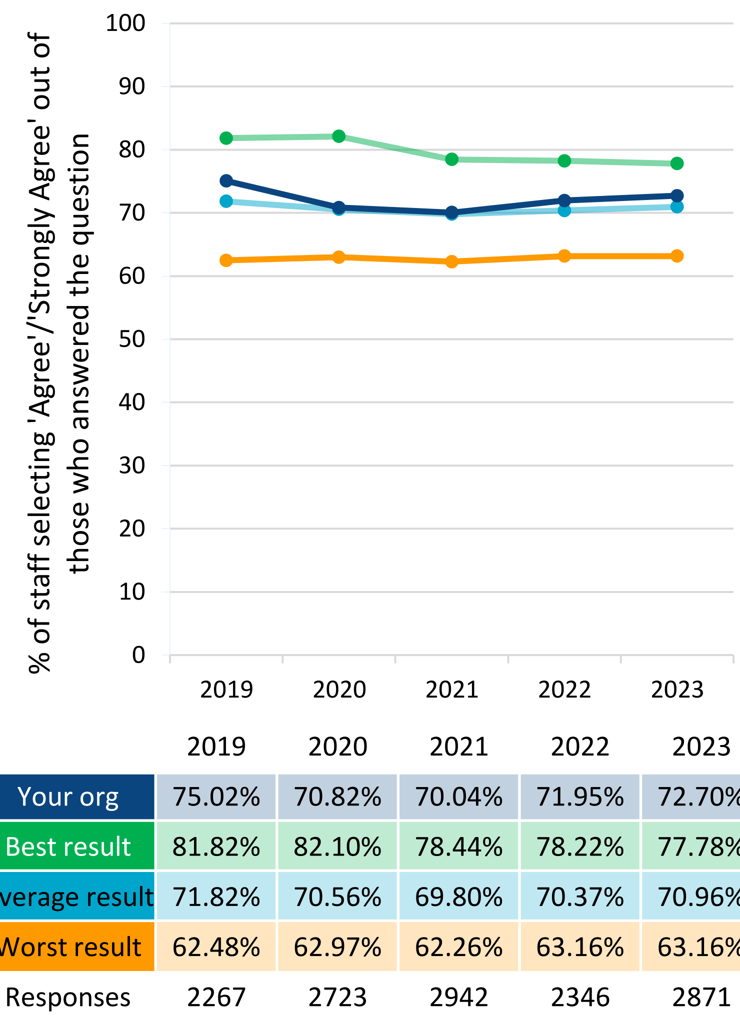
People Promise elements and theme results – Morale: Stressors



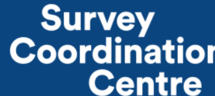
	2019	2020	2021	2022	2023
Your org	59.23%	54.34%	51.94%	56.56%	57.57%
Best result	65.25%	62.83%	60.08%	61.24%	60.00%
Average result	54.70%	54.35%	51.55%	51.76%	52.55%
Worst result	48.73%	46.10%	44.18%	45.59%	46.27%
Responses	2226	2681	2934	2345	2868

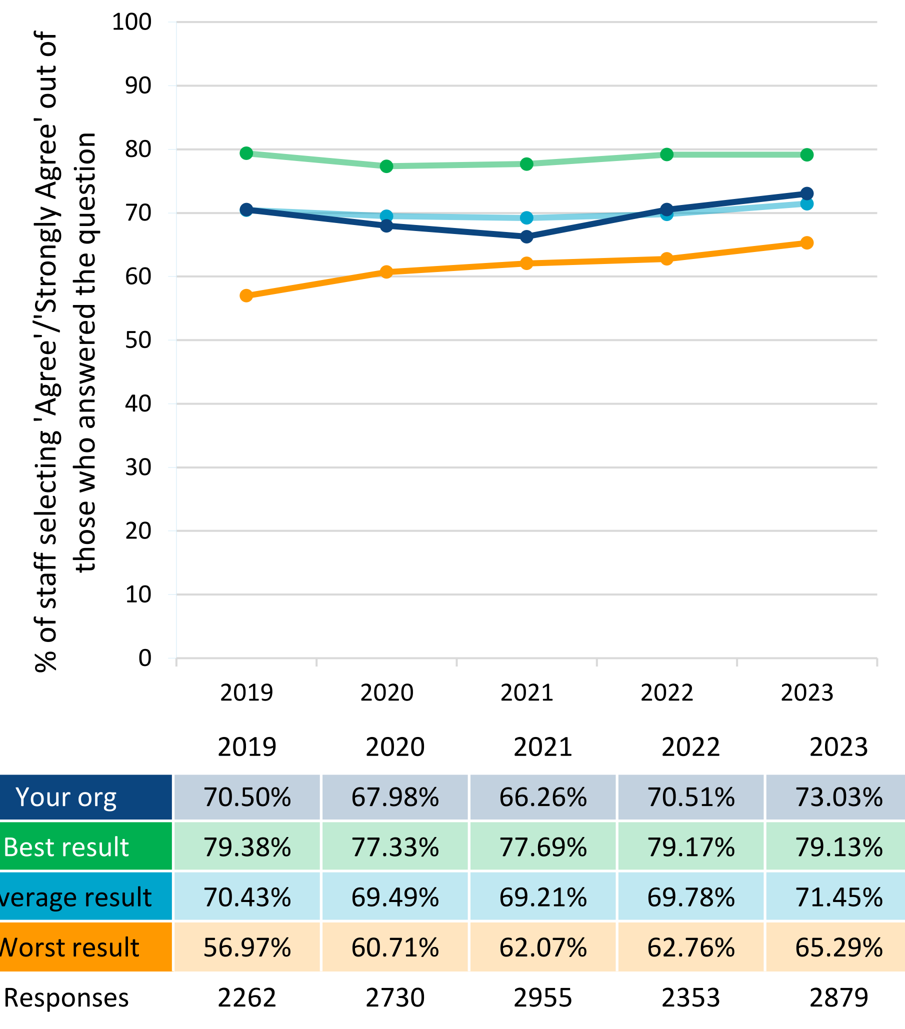


	2019	2020	2021	2022	2023
Your org	47.90%	44.80%	40.27%	44.11%	46.73%
Best result	57.40%	55.35%	52.37%	53.60%	54.70%
Average result	44.78%	45.38%	42.74%	43.99%	45.96%
Worst result	36.68%	37.06%	34.45%	35.67%	36.97%
Responses	2226	2679	2942	2337	2871



	2019	2020	2021	2022	2023
Your org	75.02%	70.82%	70.04%	71.95%	72.70%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	2267	2723	2942	2346	2871





	2019	2020	2021	2022	2023
Your org	70.50%	67.98%	66.26%	70.51%	73.03%
Best result	79.38%	77.33%	77.69%	79.17%	79.13%
Average result	70.43%	69.49%	69.21%	69.78%	71.45%
Worst result	56.97%	60.71%	62.07%	62.76%	65.29%
Responses	2262	2730	2955	2353	2879

Question not linked to People Promise elements or themes

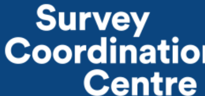
Questions included:*

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q31b, Q26d

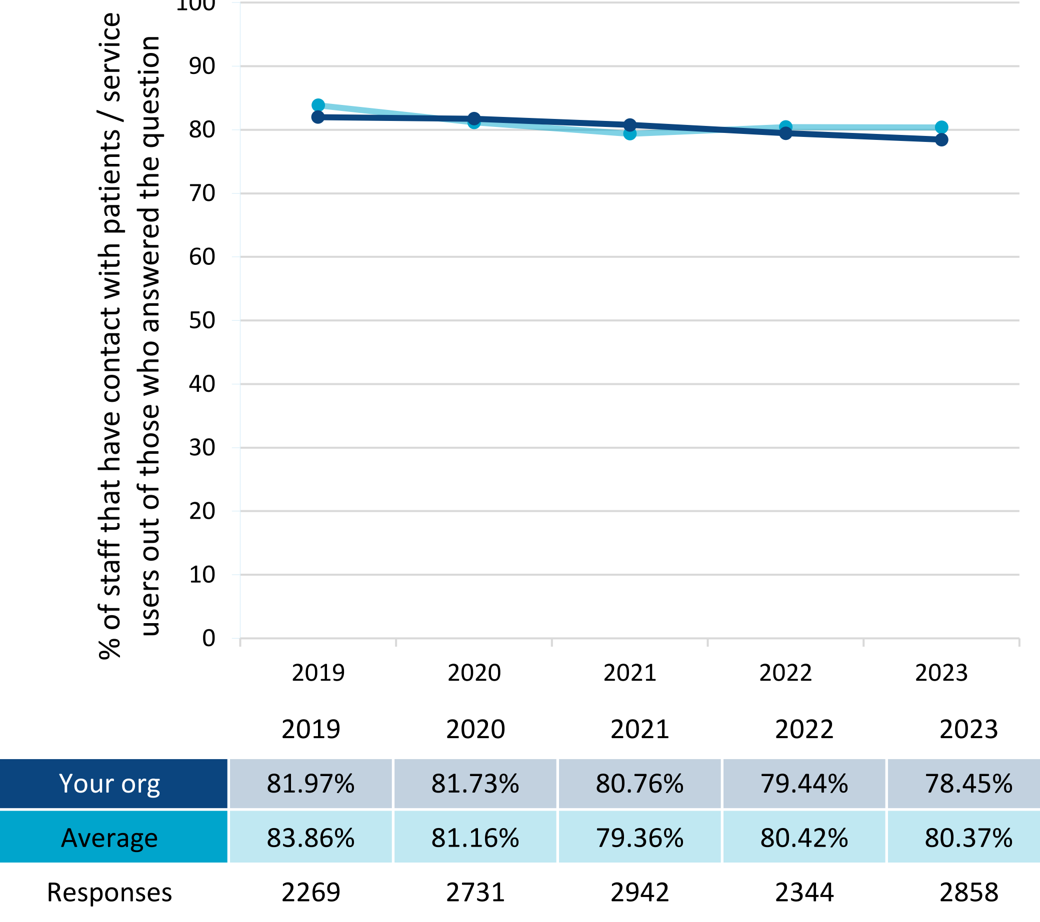
*The results for Q17a, Q17b and Q22 are reported in the section for People Promise element 4: We are safe and healthy. These questions do not contribute to any score or sub-score calculations.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Questions not linked to People Promise elements or themes

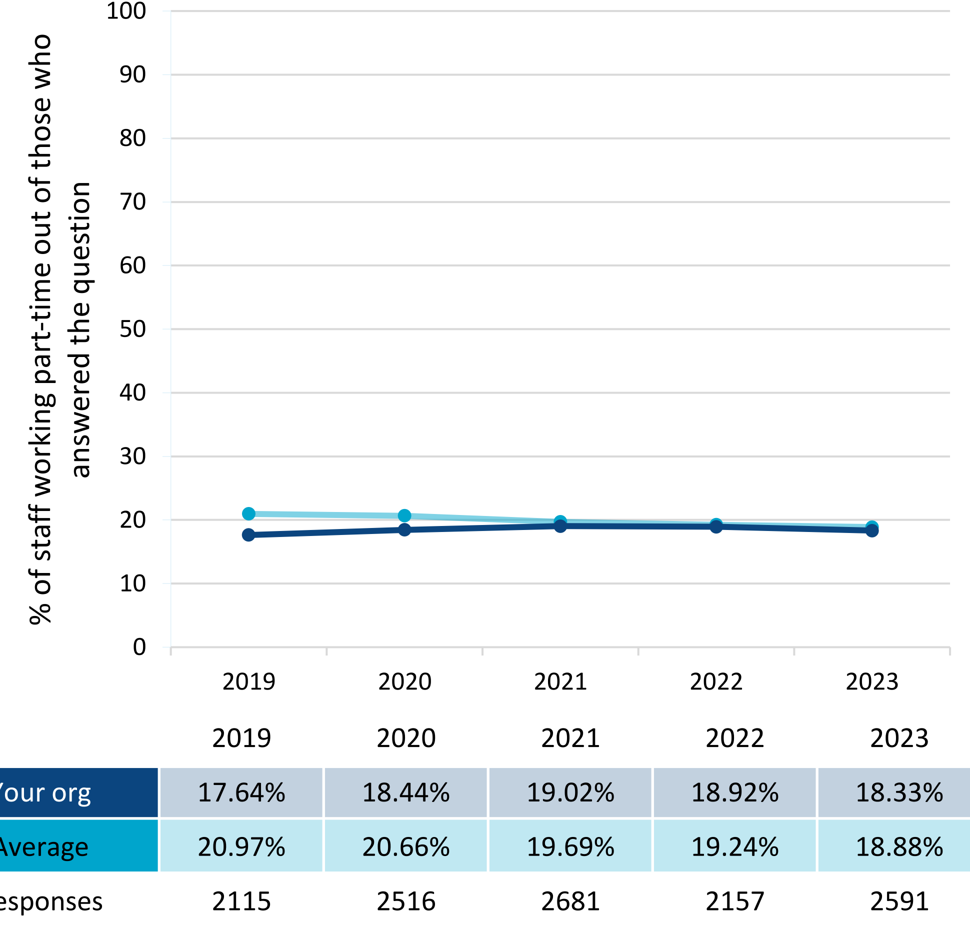


Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?

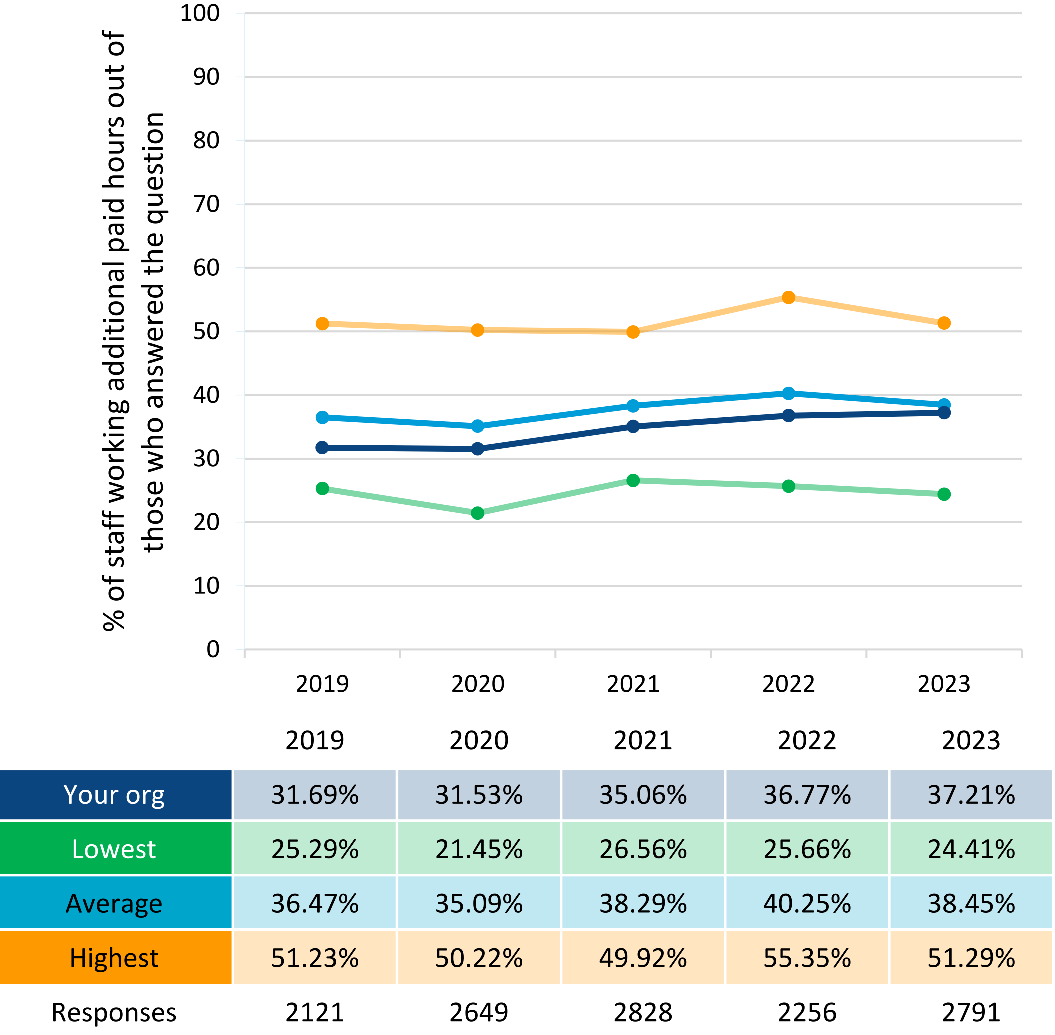


	2019	2020	2021	2022	2023
Your org	81.97%	81.73%	80.76%	79.44%	78.45%
Average	83.86%	81.16%	79.36%	80.42%	80.37%
Responses	2269	2731	2942	2344	2858

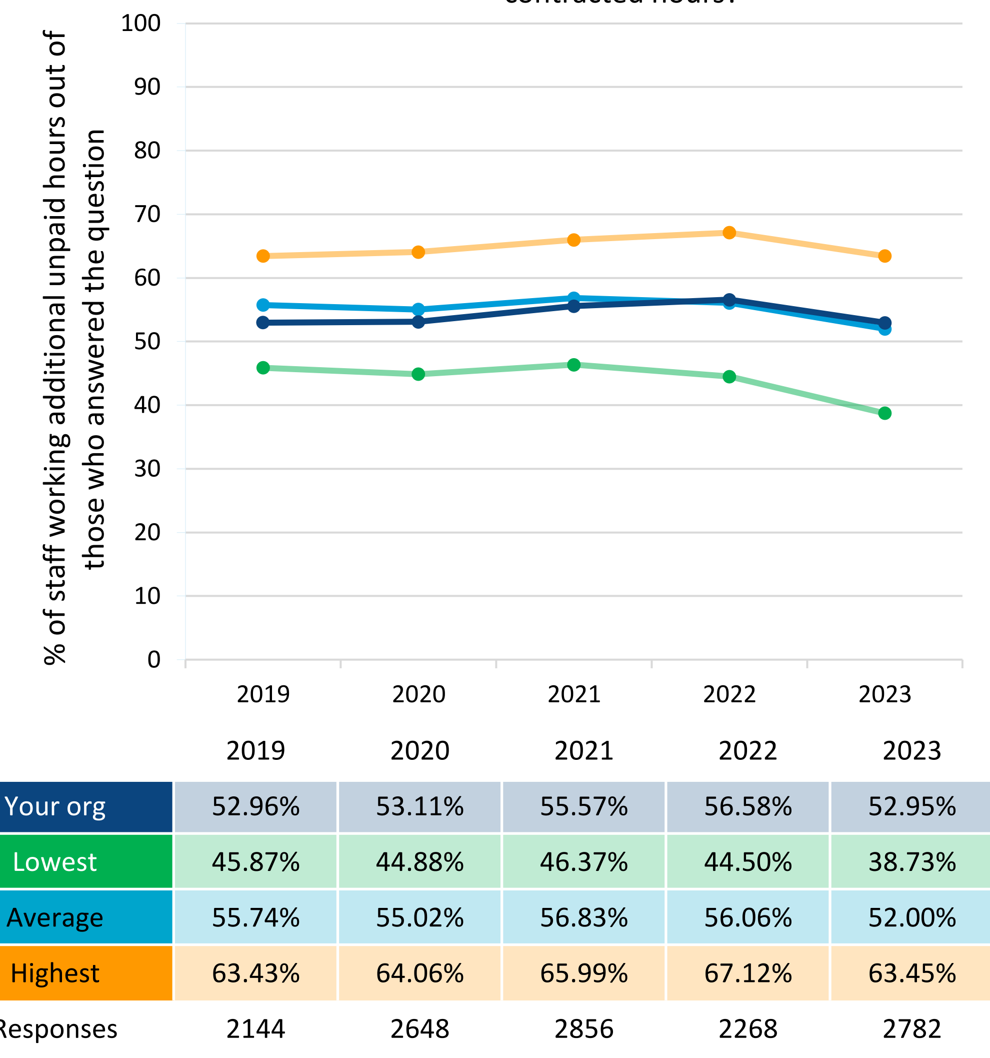
Q10a How many hours a week are you contracted to work?



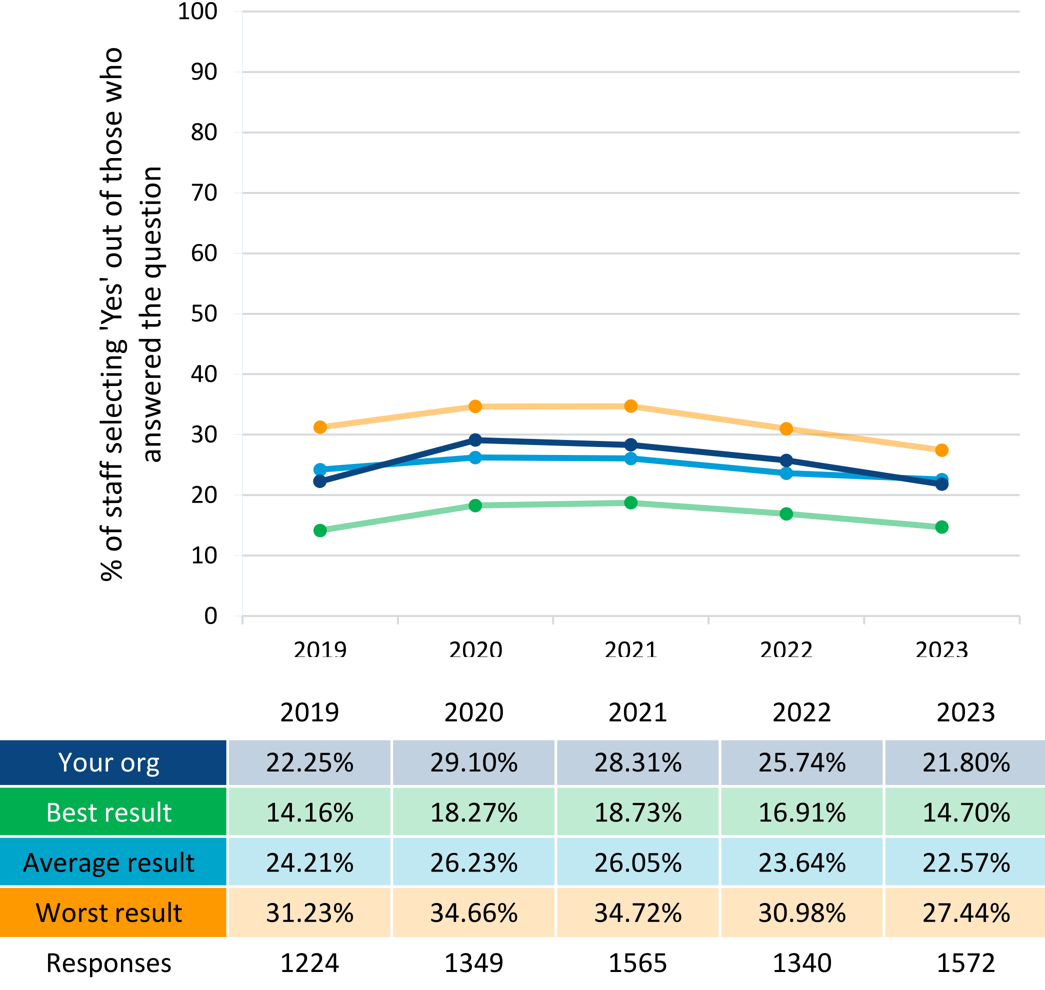
	2019	2020	2021	2022	2023
Your org	17.64%	18.44%	19.02%	18.92%	18.33%
Average	20.97%	20.66%	19.69%	19.24%	18.88%
Responses	2115	2516	2681	2157	2591



	2019	2020	2021	2022	2023
Your org	31.69%	31.53%	35.06%	36.77%	37.21%
Lowest	25.29%	21.45%	26.56%	25.66%	24.41%
Average	36.47%	35.09%	38.29%	40.25%	38.45%
Highest	51.23%	50.22%	49.92%	55.35%	51.29%
Responses	2121	2649	2828	2256	2791

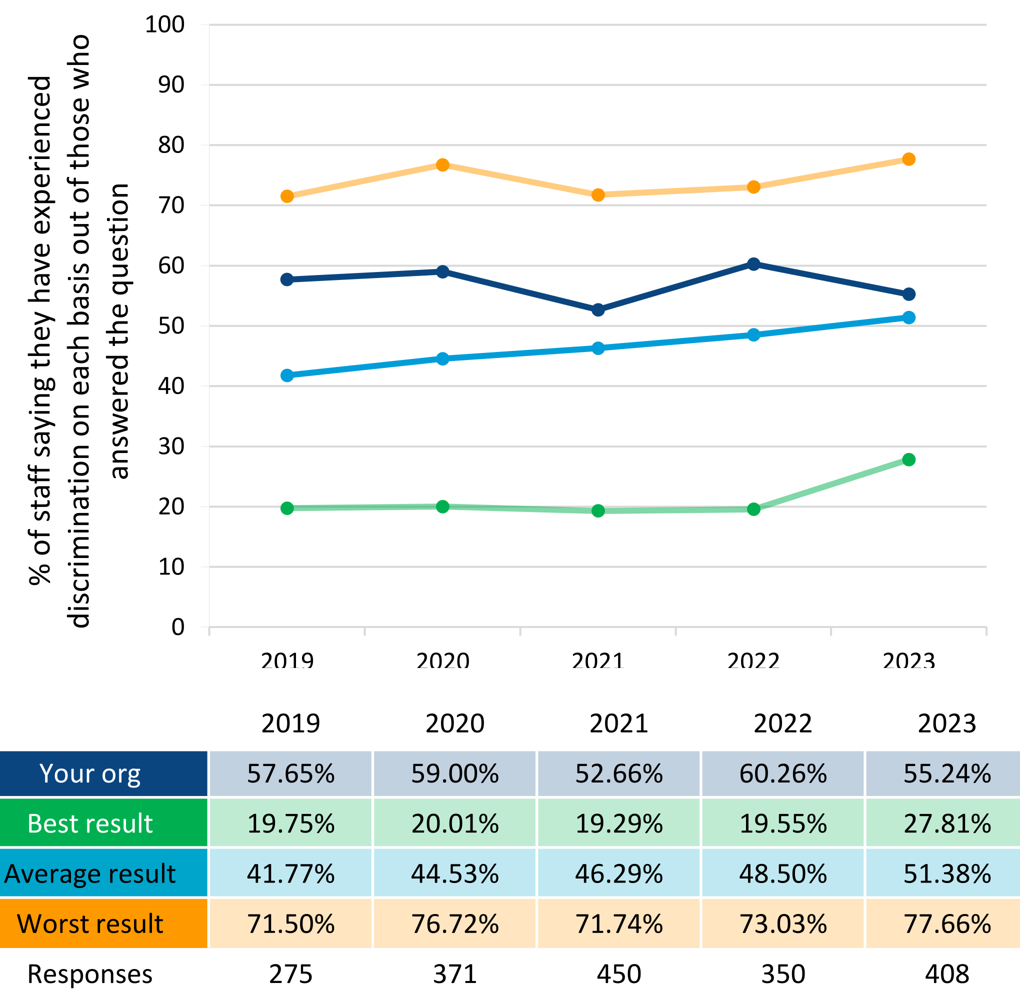


	2019	2020	2021	2022	2023
Your org	52.96%	53.11%	55.57%	56.58%	52.95%
Lowest	45.87%	44.88%	46.37%	44.50%	38.73%
Average	55.74%	55.02%	56.83%	56.06%	52.00%
Highest	63.43%	64.06%	65.99%	67.12%	63.45%
Responses	2144	2648	2856	2268	2782

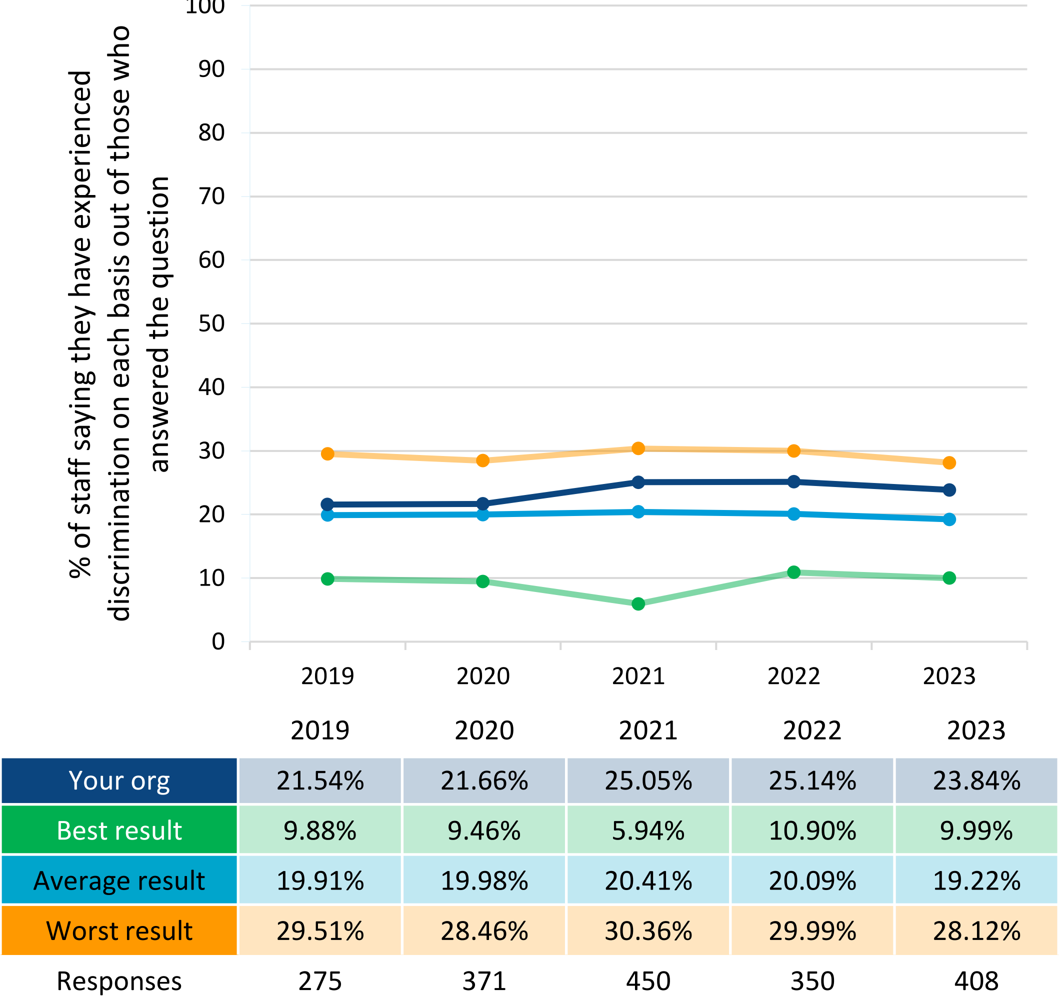


	2019	2020	2021	2022	2023
Your org	22.25%	29.10%	28.31%	25.74%	21.80%
Best result	14.16%	18.27%	18.73%	16.91%	14.70%
Average result	24.21%	26.23%	26.05%	23.64%	22.57%
Worst result	31.23%	34.66%	34.72%	30.98%	27.44%
Responses	1224	1349	1565	1340	1572

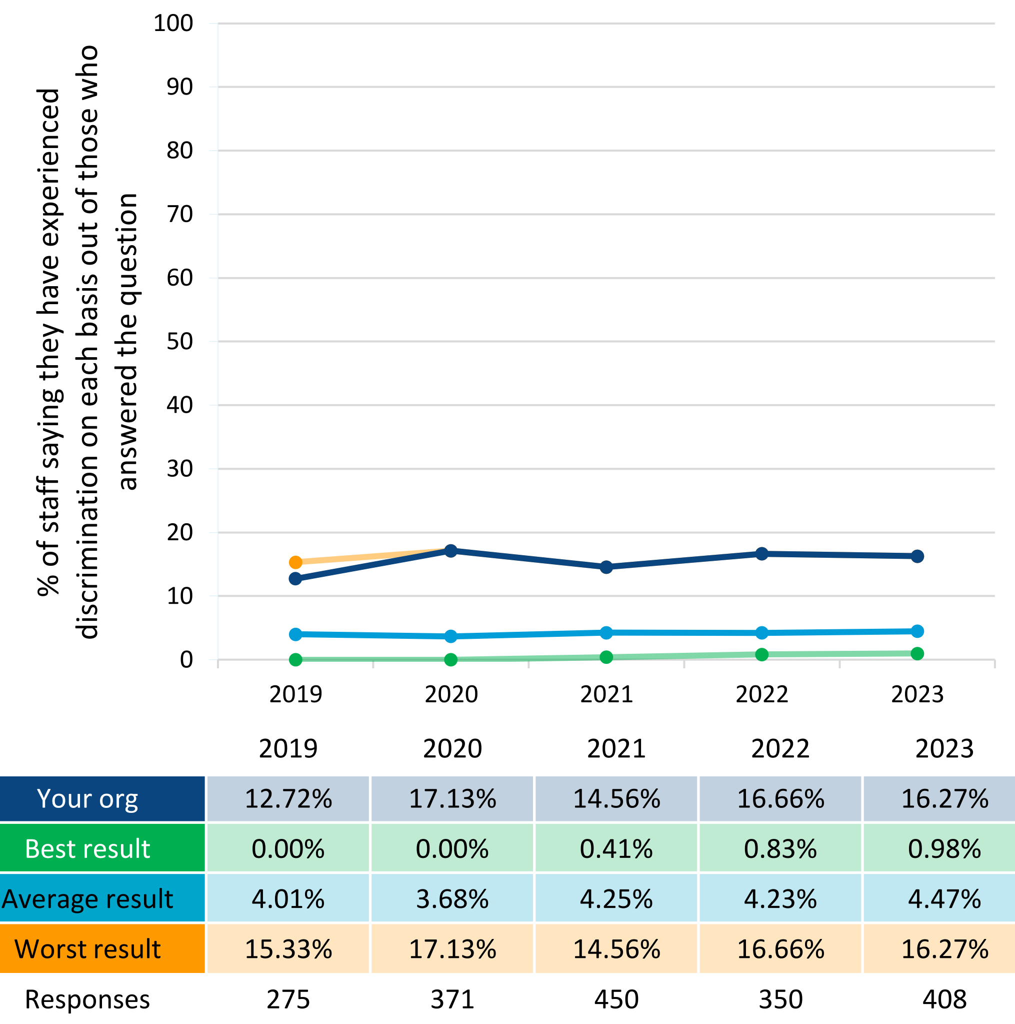
*Q11e is only answered by staff who responded 'Yes' to Q11d.



	2019	2020	2021	2022	2023
Your org	57.65%	59.00%	52.66%	60.26%	55.24%
Best result	19.75%	20.01%	19.29%	19.55%	27.81%
Average result	41.77%	44.53%	46.29%	48.50%	51.38%
Worst result	71.50%	76.72%	71.74%	73.03%	77.66%
Responses	275	371	450	350	408



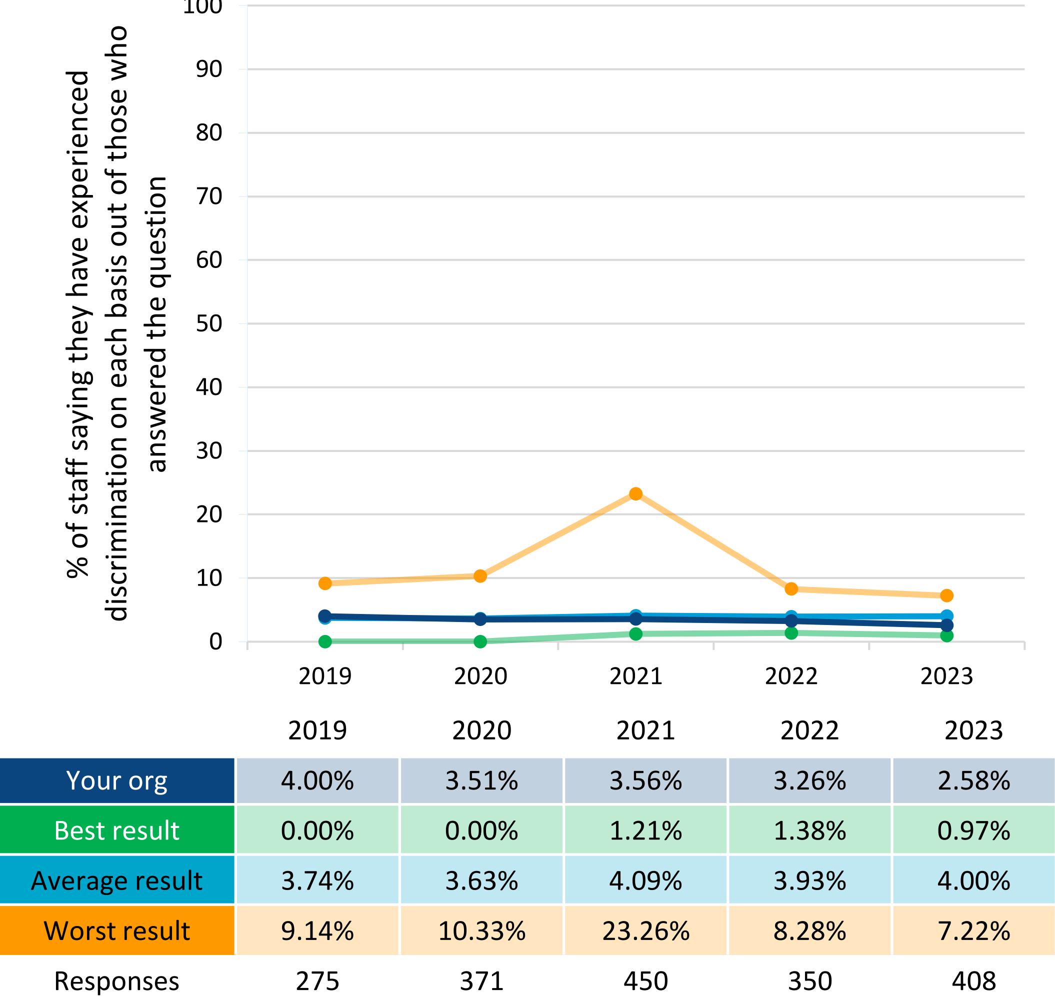
	2019	2020	2021	2022	2023
Your org	21.54%	21.66%	25.05%	25.14%	23.84%
Best result	9.88%	9.46%	5.94%	10.90%	9.99%
Average result	19.91%	19.98%	20.41%	20.09%	19.22%
Worst result	29.51%	28.46%	30.36%	29.99%	28.12%
Responses	275	371	450	350	408



	2019	2020	2021	2022	2023
Your org	12.72%	17.13%	14.56%	16.66%	16.27%
Best result	0.00%	0.00%	0.41%	0.83%	0.98%
Average result	4.01%	3.68%	4.25%	4.23%	4.47%
Worst result	15.33%	17.13%	14.56%	16.66%	16.27%
Responses	275	371	450	350	408

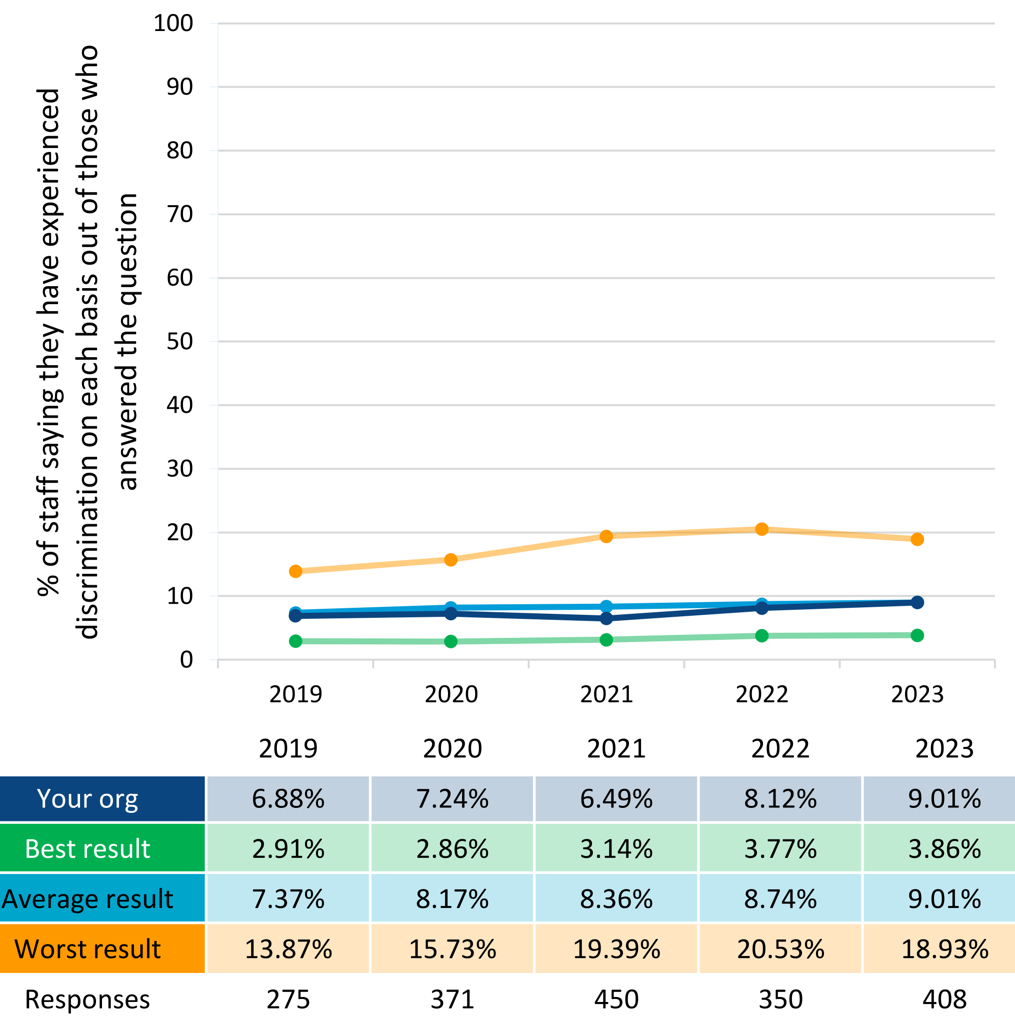
People Promise elements and theme results – Questions not linked to People Promise elements or themes

Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



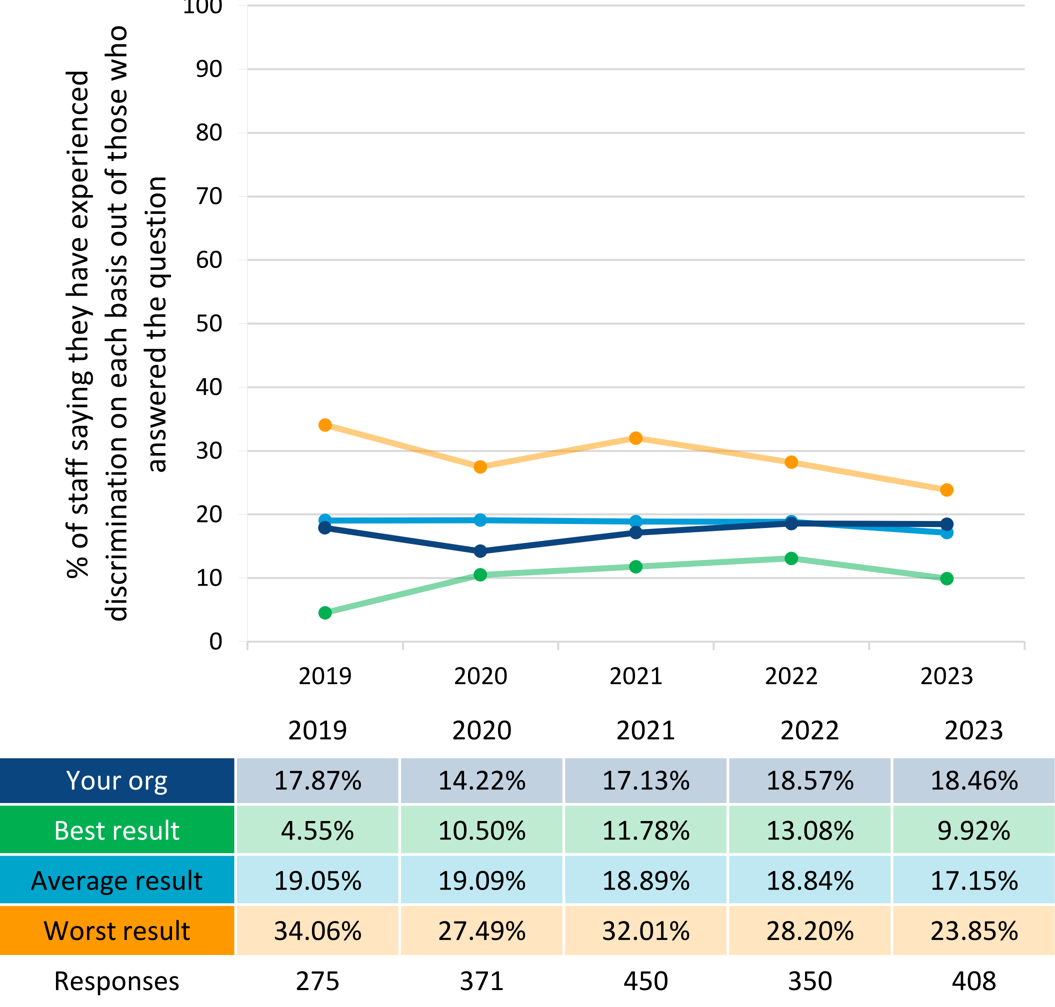
	2019	2020	2021	2022	2023
Your org	4.00%	3.51%	3.56%	3.26%	2.58%
Best result	0.00%	0.00%	1.21%	1.38%	0.97%
Average result	3.74%	3.63%	4.09%	3.93%	4.00%
Worst result	9.14%	10.33%	23.26%	8.28%	7.22%
Responses	275	371	450	350	408

Q16c.5 On what grounds have you experienced discrimination? – Disability.

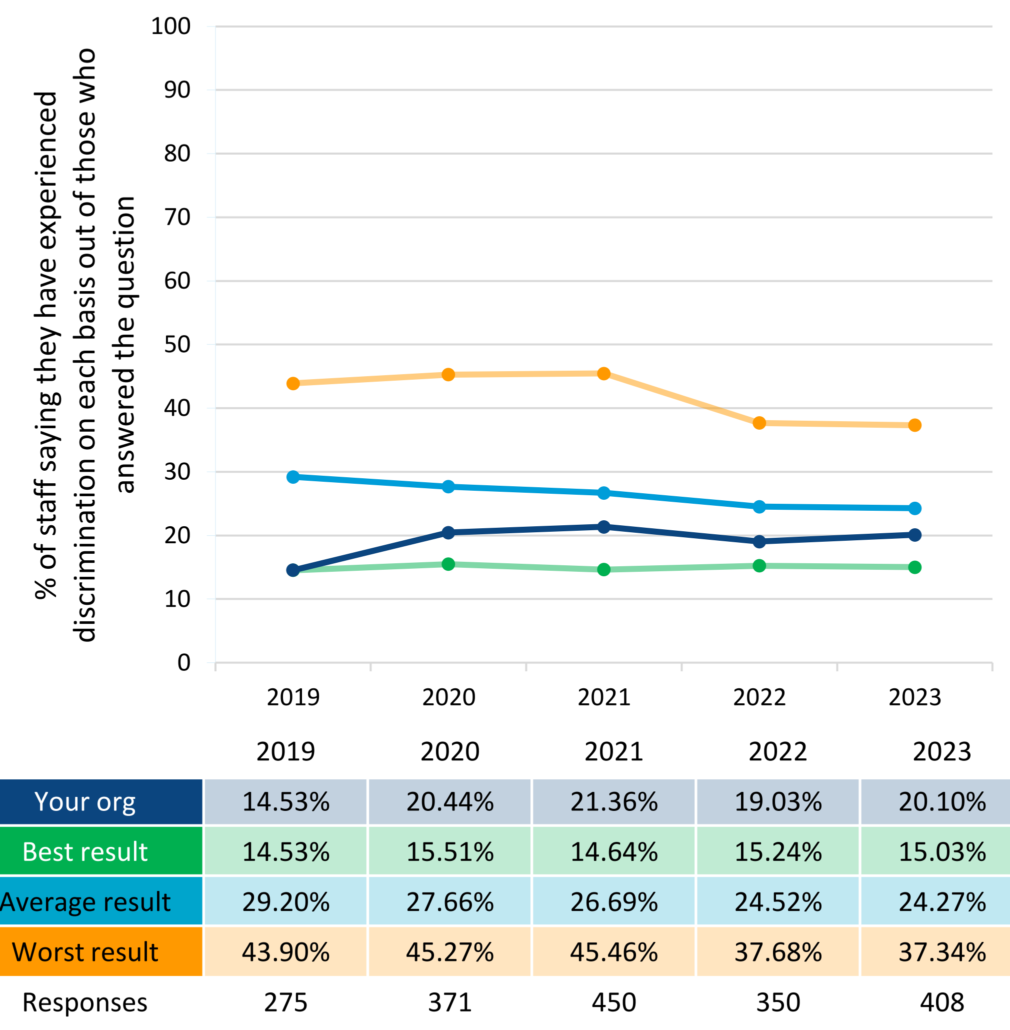


	2019	2020	2021	2022	2023
Your org	6.88%	7.24%	6.49%	8.12%	9.01%
Best result	2.91%	2.86%	3.14%	3.77%	3.86%
Average result	7.37%	8.17%	8.36%	8.74%	9.01%
Worst result	13.87%	15.73%	19.39%	20.53%	18.93%
Responses	275	371	450	350	408

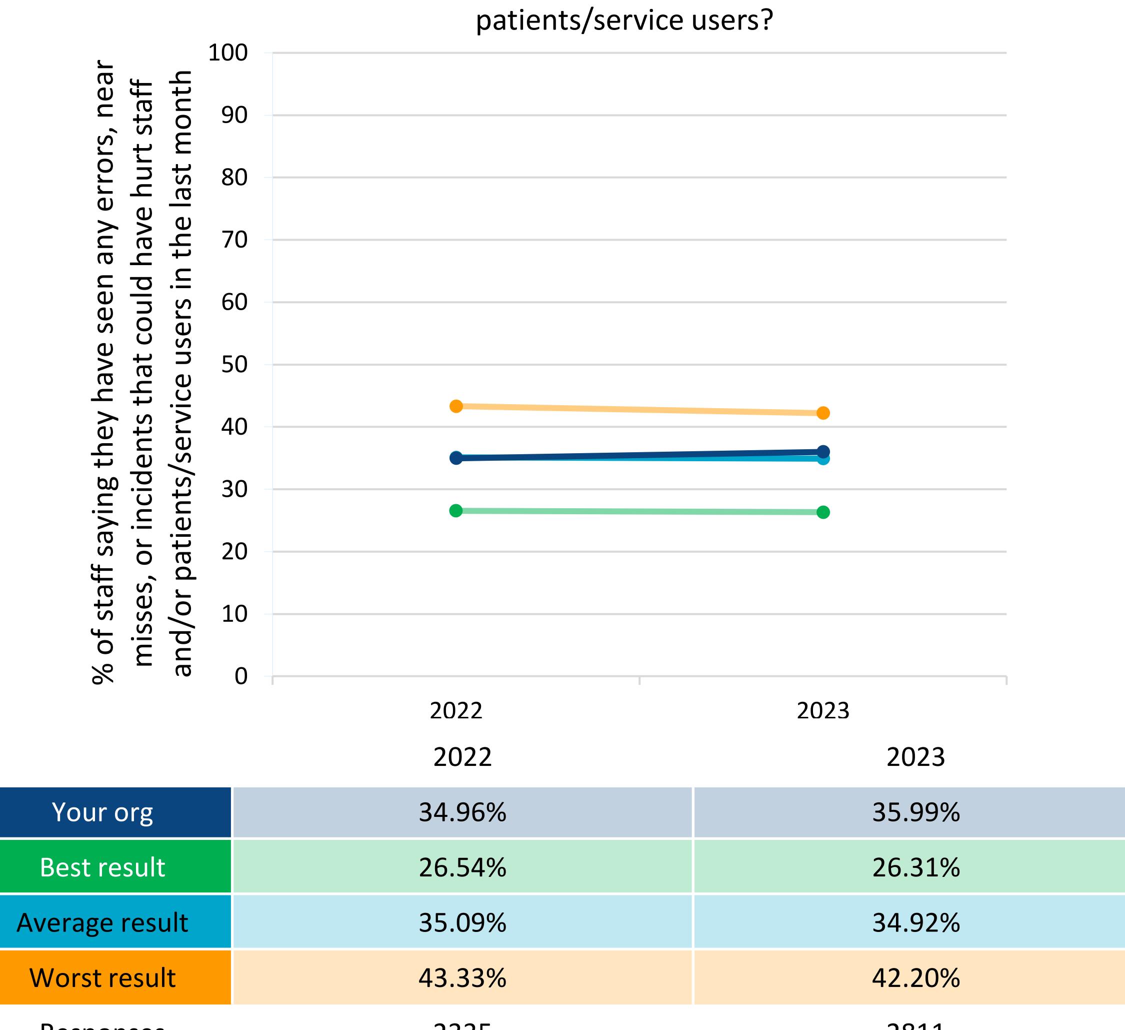
People Promise elements and theme results – Questions not linked to People Promise elements or themes



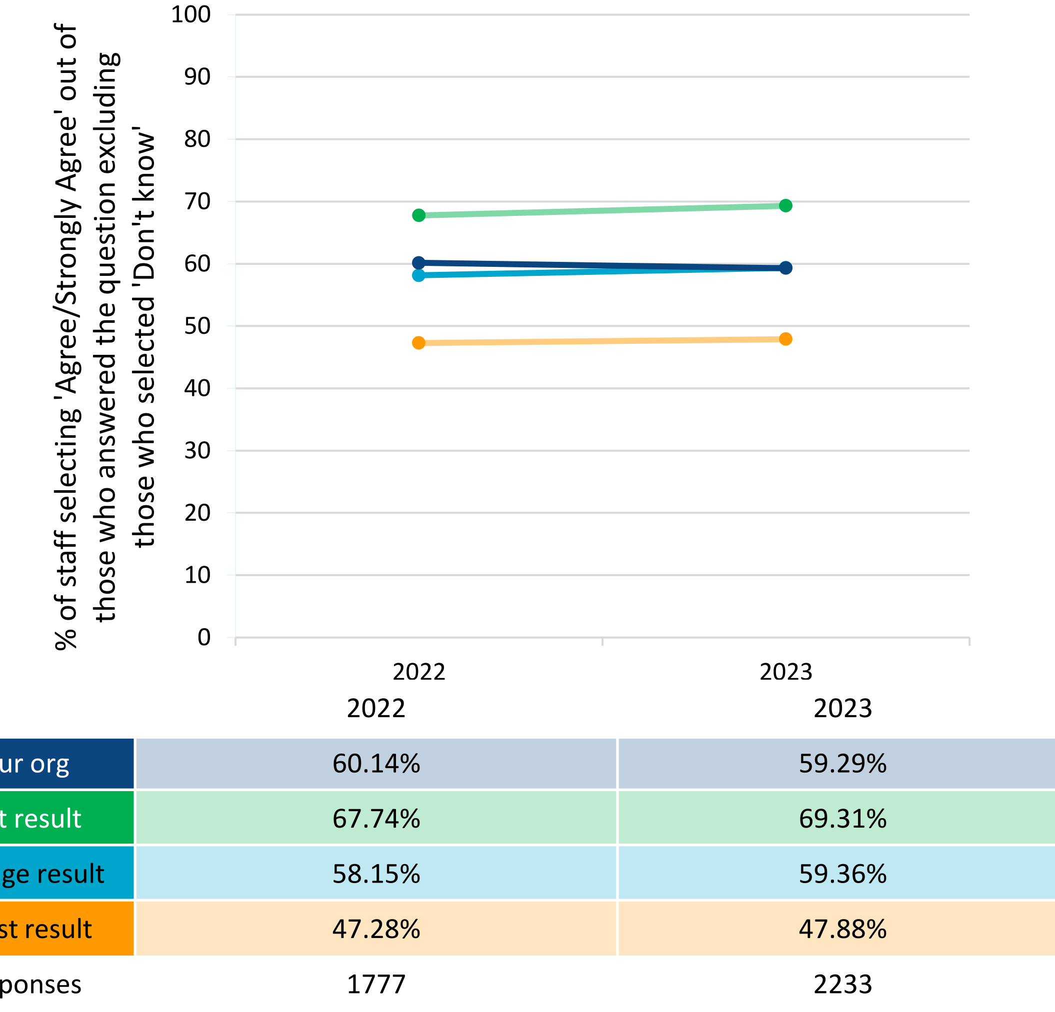
	2019	2020	2021	2022	2023
Your org	17.87%	14.22%	17.13%	18.57%	18.46%
Best result	4.55%	10.50%	11.78%	13.08%	9.92%
Average result	19.05%	19.09%	18.89%	18.84%	17.15%
Worst result	34.06%	27.49%	32.01%	28.20%	23.85%
Responses	275	371	450	350	408



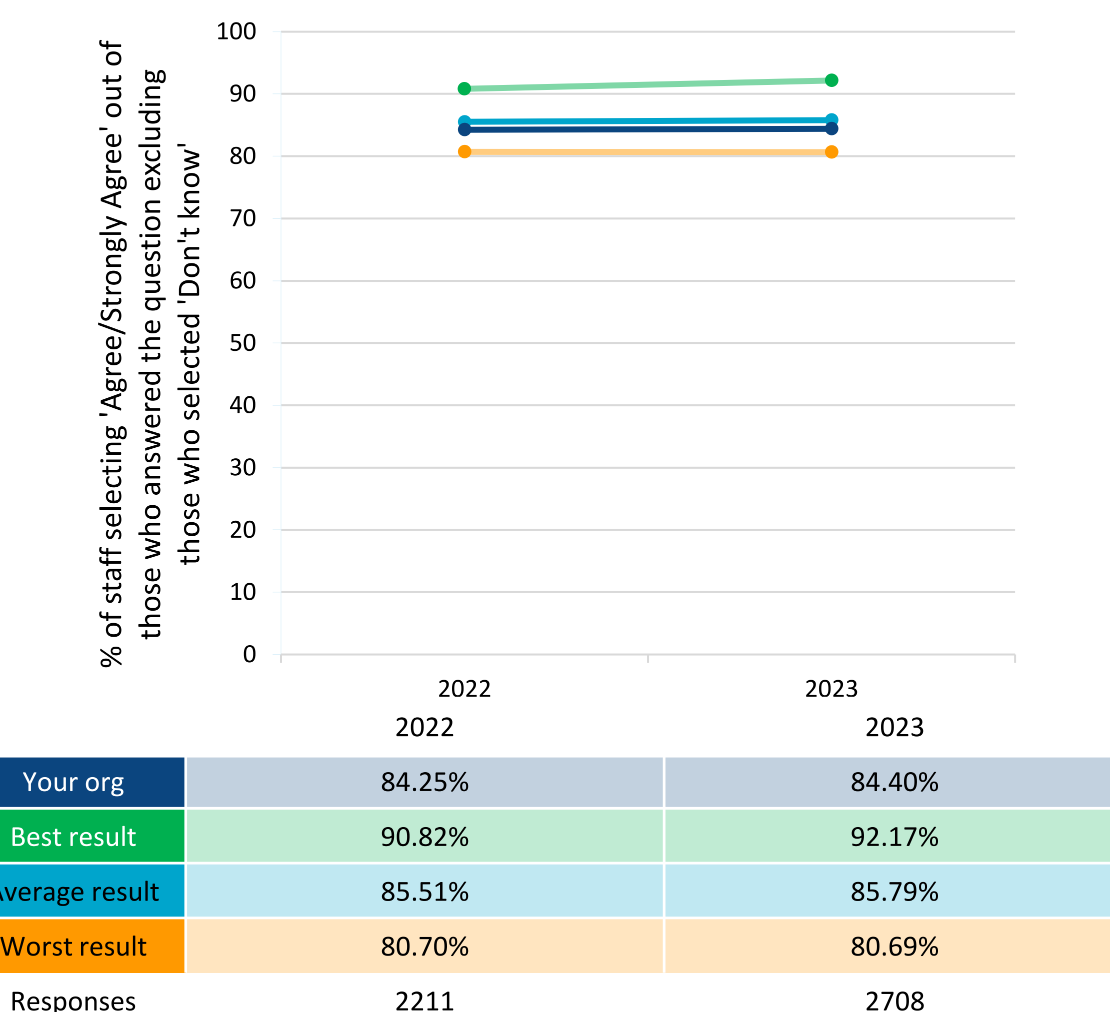
	2019	2020	2021	2022	2023
Your org	14.53%	20.44%	21.36%	19.03%	20.10%
Best result	14.53%	15.51%	14.64%	15.24%	15.03%
Average result	29.20%	27.66%	26.69%	24.52%	24.27%
Worst result	43.90%	45.27%	45.46%	37.68%	37.34%
Responses	275	371	450	350	408



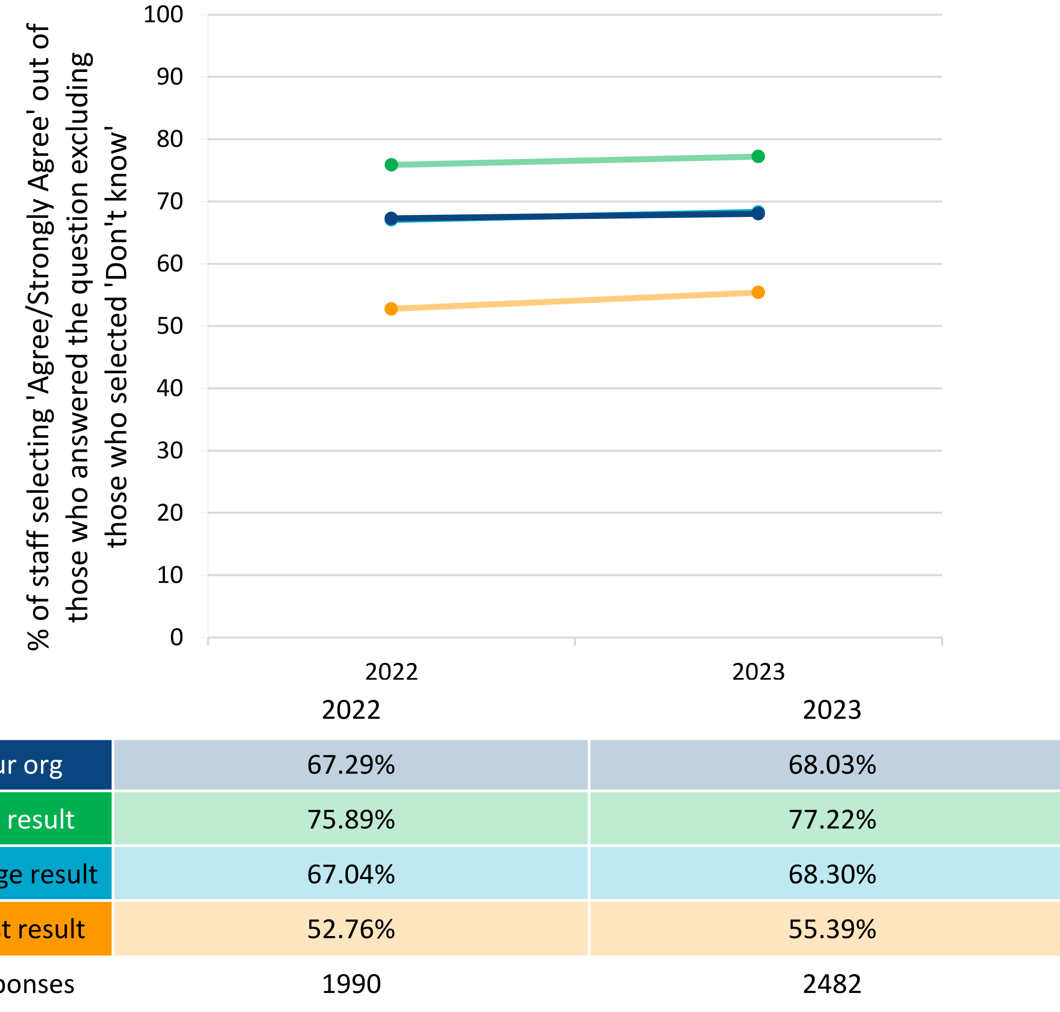
	2022	2023
Your org	34.96%	35.99%
Best result	26.54%	26.31%
Average result	35.09%	34.92%
Worst result	43.33%	42.20%
Responses	2335	2811



	2022	2023
Your org	60.14%	59.29%
Best result	67.74%	69.31%
Average result	58.15%	59.36%
Worst result	47.28%	47.88%
Responses	1777	2233

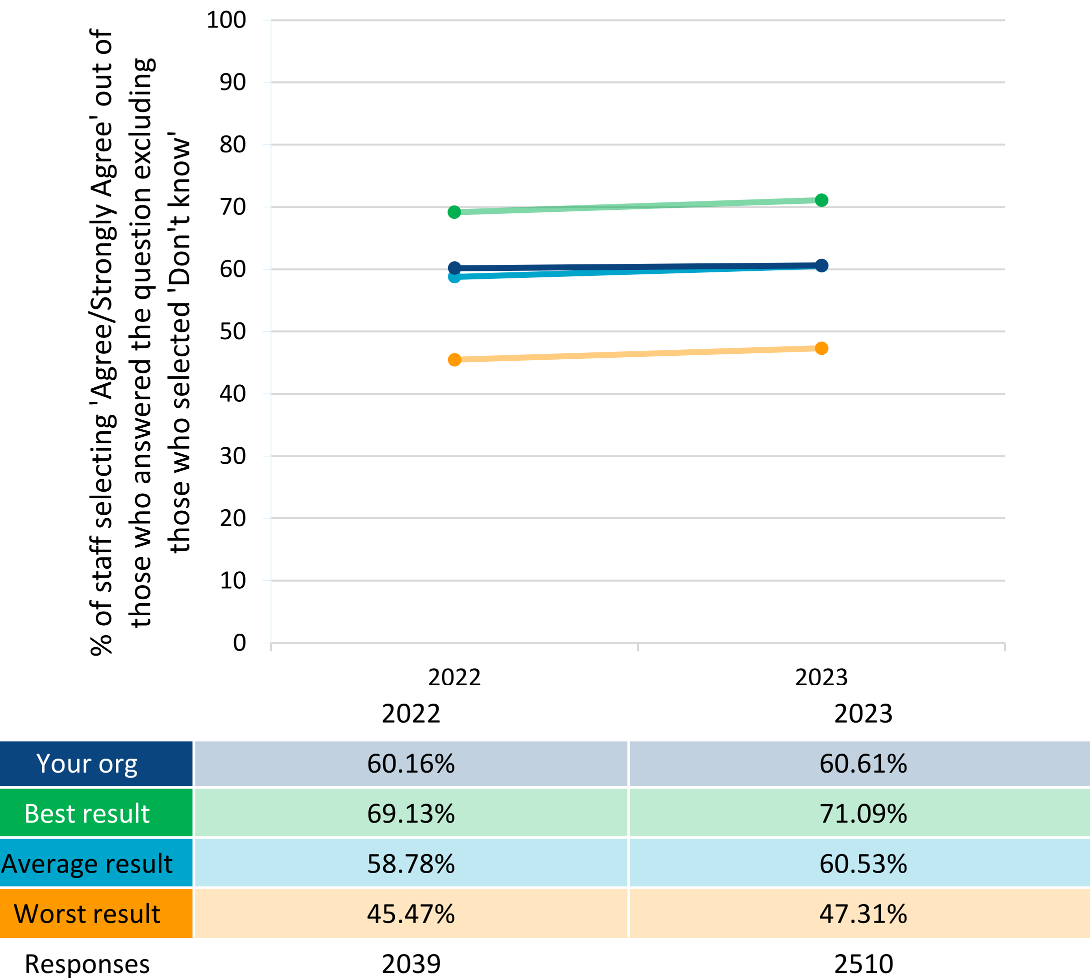


	2022	2023
Your org	84.25%	84.40%
Best result	90.82%	92.17%
Average result	85.51%	85.79%
Worst result	80.70%	80.69%
Responses	2211	2708

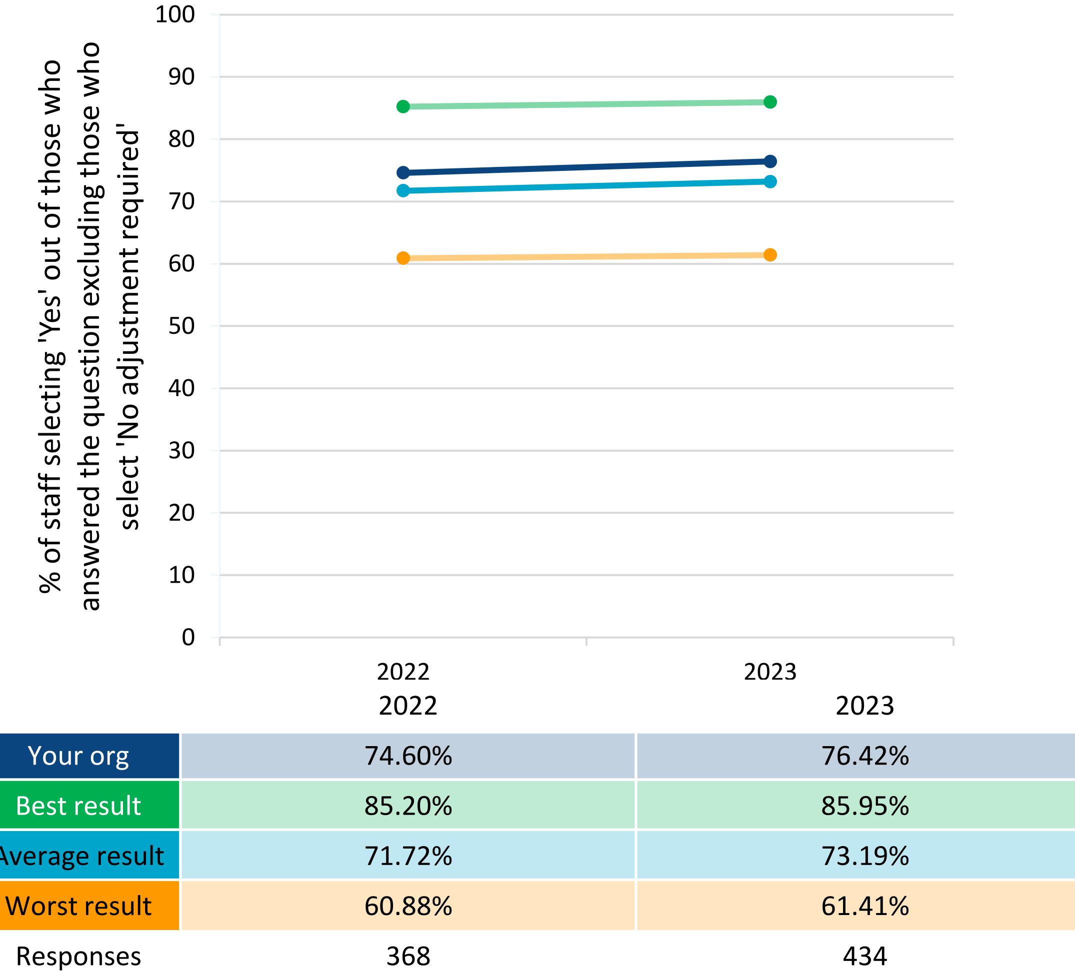


	2022	2023
Your org	67.29%	68.03%
Best result	75.89%	77.22%
Average result	67.04%	68.30%
Worst result	52.76%	55.39%
Responses	1990	2482

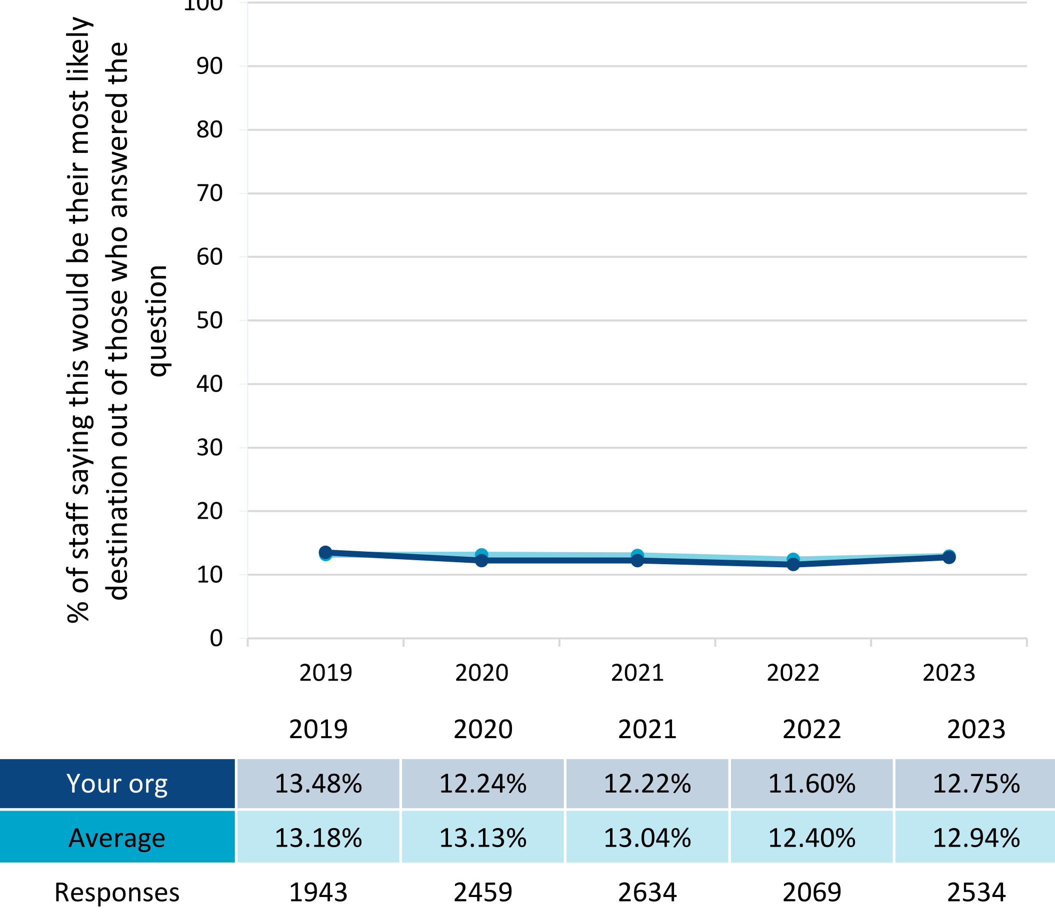
People Promise elements and theme results – Questions not linked to People Promise elements or themes



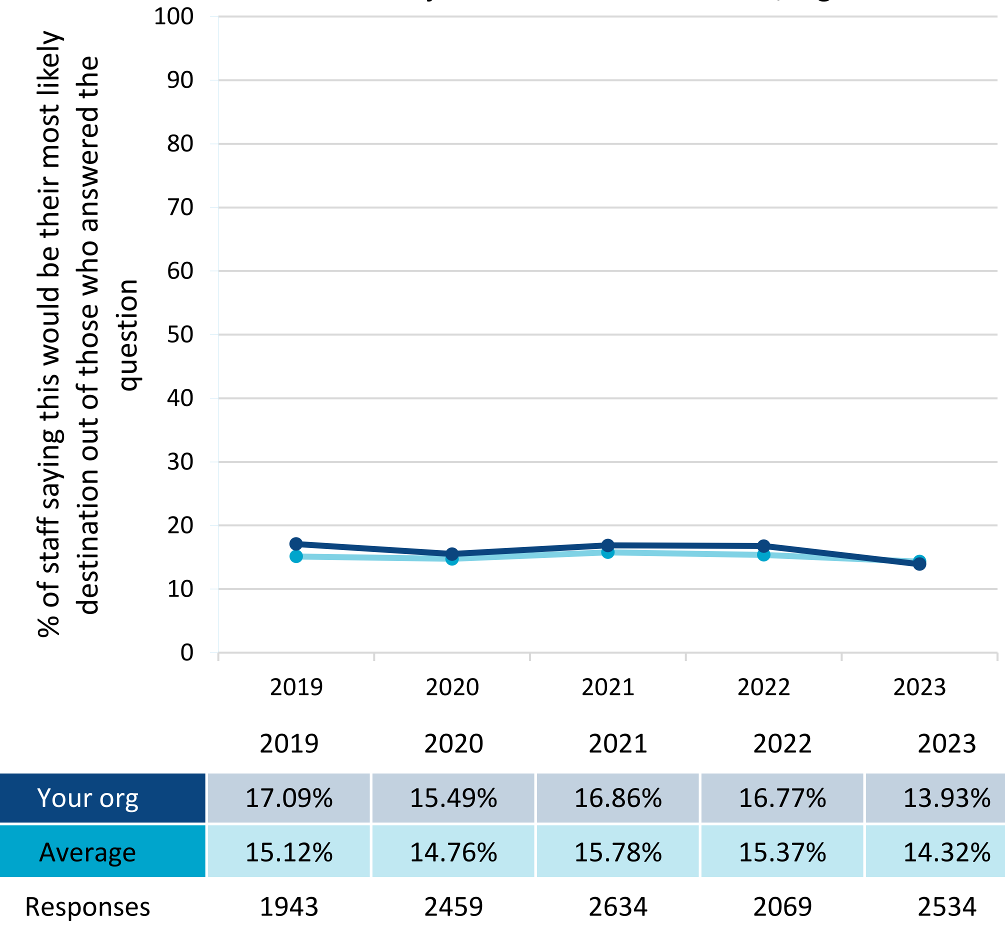
	2022	2023
Your org	60.16%	60.61%
Best result	69.13%	71.09%
Average result	58.78%	60.53%
Worst result	45.47%	47.31%
Responses	2039	2510



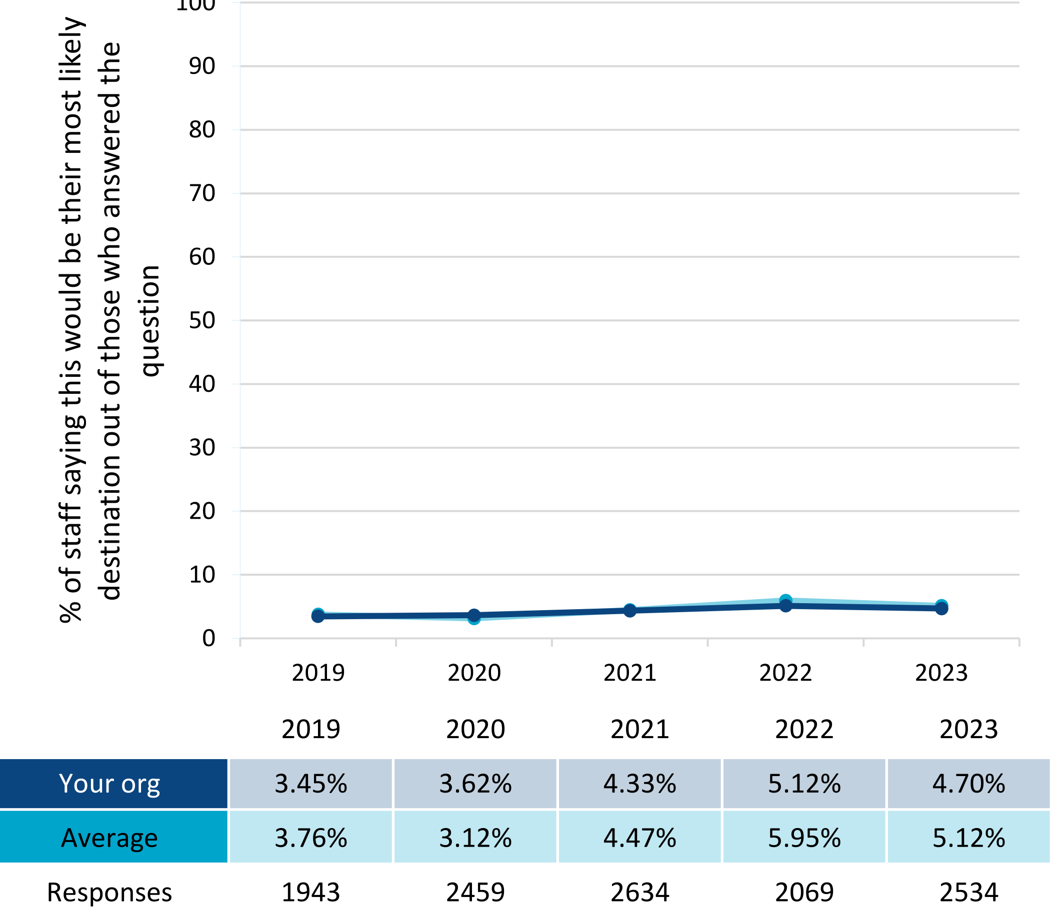
	2022	2023
Your org	74.60%	76.42%
Best result	85.20%	85.95%
Average result	71.72%	73.19%
Worst result	60.88%	61.41%
Responses	368	434



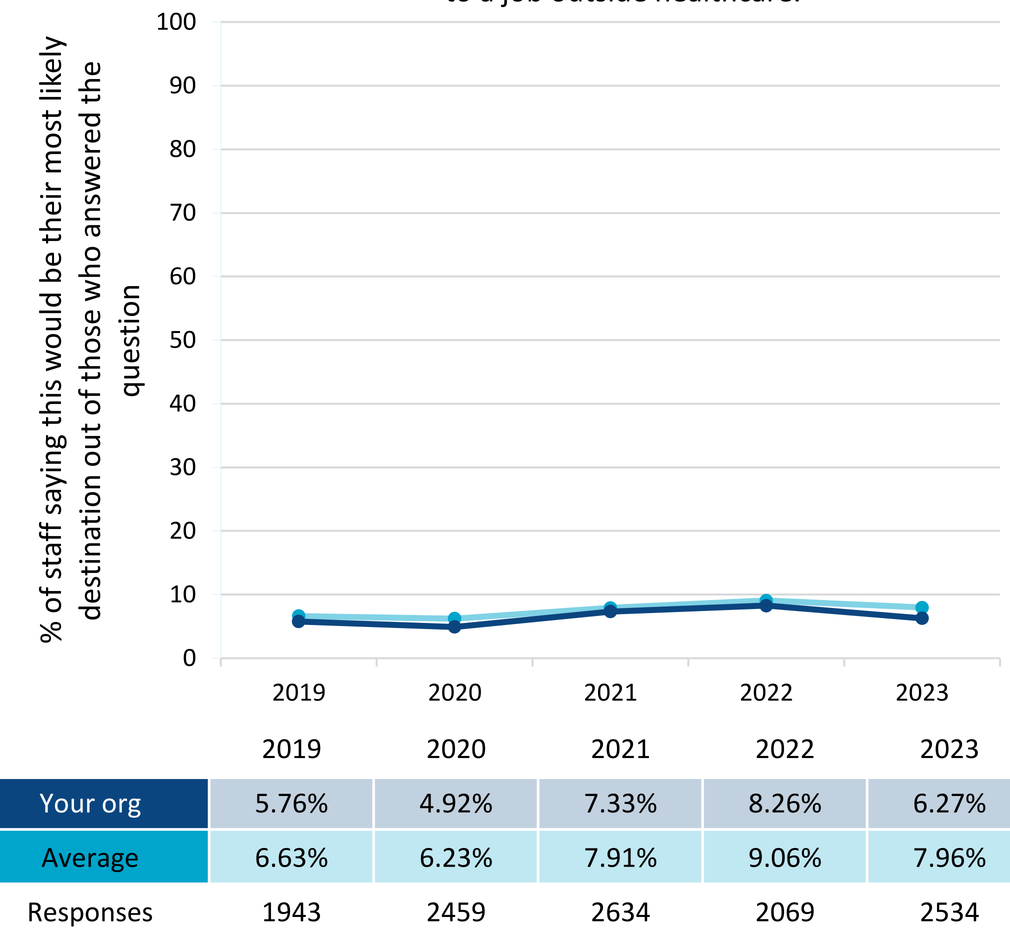
	2019	2020	2021	2022	2023
Your org	13.48%	12.24%	12.22%	11.60%	12.75%
Average	13.18%	13.13%	13.04%	12.40%	12.94%
Responses	1943	2459	2634	2069	2534



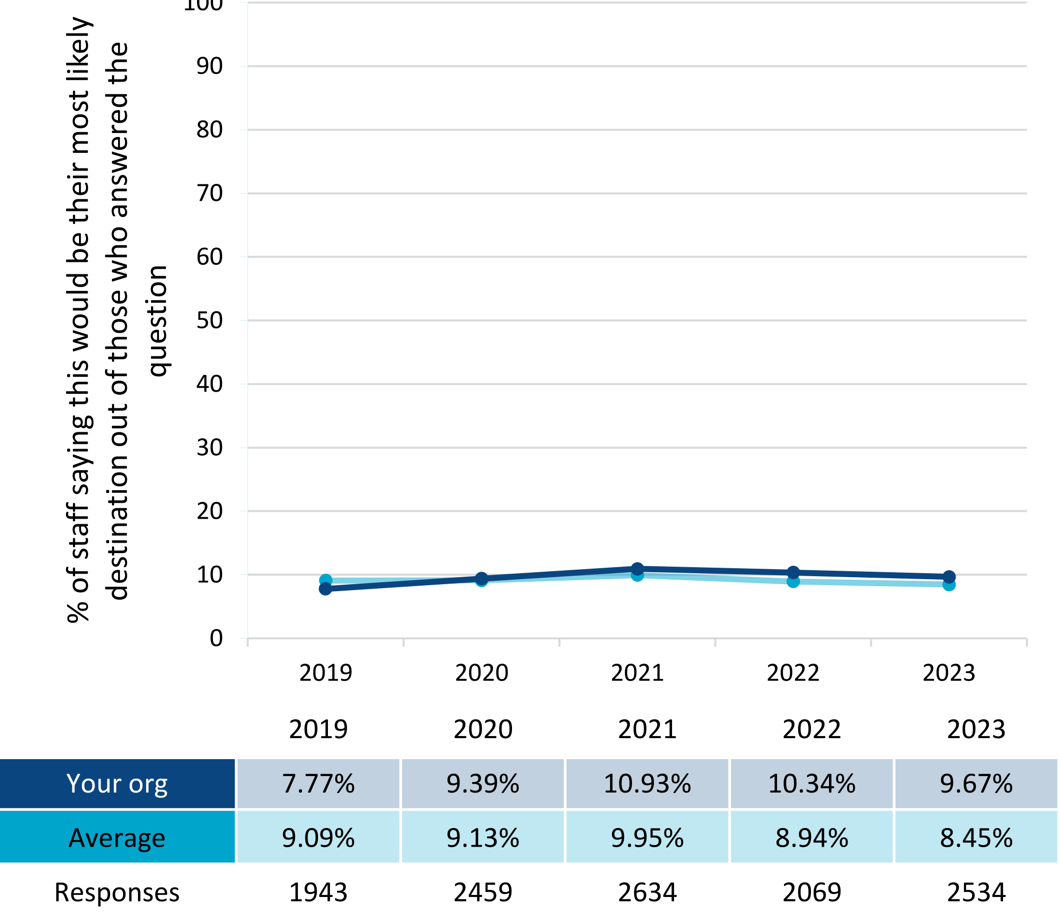
	2019	2020	2021	2022	2023
Your org	17.09%	15.49%	16.86%	16.77%	13.93%
Average	15.12%	14.76%	15.78%	15.37%	14.32%
Responses	1943	2459	2634	2069	2534



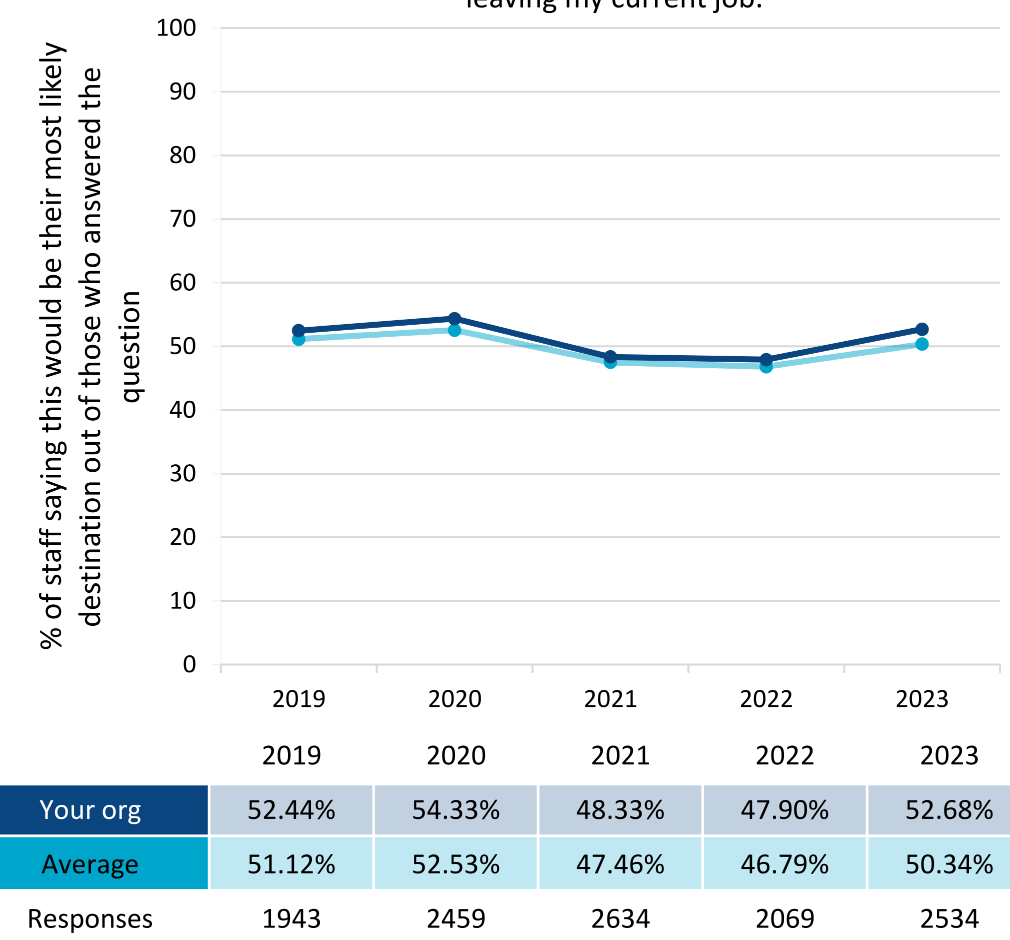
	2019	2020	2021	2022	2023
Your org	3.45%	3.62%	4.33%	5.12%	4.70%
Average	3.76%	3.12%	4.47%	5.95%	5.12%
Responses	1943	2459	2634	2069	2534



	2019	2020	2021	2022	2023
Your org	5.76%	4.92%	7.33%	8.26%	6.27%
Average	6.63%	6.23%	7.91%	9.06%	7.96%
Responses	1943	2459	2634	2069	2534



	2019	2020	2021	2022	2023
Your org	7.77%	9.39%	10.93%	10.34%	9.67%
Average	9.09%	9.13%	9.95%	8.94%	8.45%
Responses	1943	2459	2634	2069	2534



	2019	2020	2021	2022	2023
Your org	52.44%	54.33%	48.33%	47.90%	52.68%
Average	51.12%	52.53%	47.46%	46.79%	50.34%
Responses	1943	2459	2634	2069	2534

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Workforce Equality Standards

Note where there are fewer than 10 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2019-2023 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

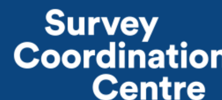
Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2019-2023 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q31b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

In 2022, the text for q31b was updated and the word ‘adequate’ was updated to ‘reasonable’.

The WDES breakdowns are based on the responses to q31a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards



This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
8	Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Indicator	Qu No	Workforce Disability Equality Standard
		For each of the following indicators, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4a	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4b	Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4c	Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4d	Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
6	Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

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Workforce Race Equality Standards (WRES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WRES charts are unweighted.
Averages are calculated as the median for the benchmark group.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months out of those who answered the question

	2019	2020	2021	2022	2023
White staff: Your org	28.09%	29.57%	30.22%	28.81%	25.14%
All other ethnic groups*: Your org	24.47%	30.32%	27.32%	29.68%	23.47%
White staff: Average	27.67%	25.36%	26.47%	26.91%	24.72%
All other ethnic groups*: Average	29.51%	28.01%	28.84%	30.82%	28.11%
White staff: Responses	1652	2019	2194	1708	1973
All other ethnic groups*: Responses	523	653	699	593	848

*Staff from all other ethnic groups combined

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months out of those who answered the question

35
30
25
20
15
10
5
0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
White staff: Your org	20.44%	24.80%	22.20%	24.43%	20.78%
All other ethnic groups*: Your org	24.95%	26.72%	30.47%	28.84%	21.76%
White staff: Average	24.44%	24.37%	23.65%	23.25%	22.37%
All other ethnic groups*: Average	28.39%	29.07%	28.53%	28.81%	26.20%
White staff: Responses	1654	2020	2194	1707	1968
All other ethnic groups*: Responses	525	655	699	593	850

*Staff from all other ethnic groups combined

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

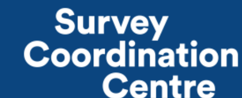
70
60
50
40
30
20
10
0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
White staff: Your org	63.02%	63.00%	63.60%	65.65%	64.97%
All other ethnic groups*: Your org	44.02%	46.66%	43.71%	46.09%	50.60%
White staff: Average	60.00%	59.39%	58.64%	58.65%	58.84%
All other ethnic groups*: Average	46.62%	45.24%	44.56%	47.00%	49.64%
White staff: Responses	1644	2027	2184	1697	1964
All other ethnic groups*: Responses	527	658	700	588	832

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)



Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months out of those who answered the question

20 18 16 14 12 10 8 6 4 2 0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
White staff: Your org	4.88%	4.98%	6.52%	5.69%	6.56%
All other ethnic groups*: Your org	14.37%	15.68%	15.44%	18.27%	12.66%
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
White staff: Responses	1640	2007	2179	1686	1966
All other ethnic groups*: Responses	515	644	693	591	845

*Staff from all other ethnic groups combined

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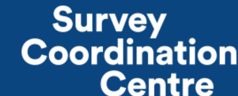
Workforce Disability Equality Standards (WDES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WDES charts are unweighted.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.



Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.

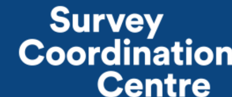
Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question

40
35
30
25
20
15
10
5
0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	33.95%	36.79%	34.91%	34.79%	25.76%
Staff without a LTC or illness: Your org	25.55%	27.71%	27.65%	27.03%	24.27%
Staff with a LTC or illness: Average	33.17%	30.86%	32.43%	32.98%	30.35%
Staff without a LTC or illness: Average	26.45%	24.53%	25.19%	26.16%	23.76%
Staff with a LTC or illness: Responses	433	560	676	572	691
Staff without a LTC or illness: Responses	1773	2129	2217	1746	2122

Workforce Disability Equality Standards

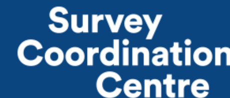


Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months out of those who answered the question

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	16.71%	21.68%	17.74%	19.41%	14.16%
Staff without a LTC or illness: Your org	9.47%	11.55%	11.31%	10.72%	6.77%
Staff with a LTC or illness: Average	18.45%	19.35%	18.00%	17.09%	15.87%
Staff without a LTC or illness: Average	10.76%	10.78%	9.77%	9.88%	8.74%
Staff with a LTC or illness: Responses	431	558	665	572	685
Staff without a LTC or illness: Responses	1764	2112	2202	1735	2113

Workforce Disability Equality Standards



Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

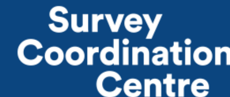
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months out of those who answered the question

30
25
20
15
10
5
0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	25.29%	26.49%	24.29%	27.29%	25.94%
Staff without a LTC or illness: Your org	15.20%	16.89%	16.61%	17.62%	15.04%
Staff with a LTC or illness: Average	27.71%	26.89%	26.60%	26.93%	25.86%
Staff without a LTC or illness: Average	17.51%	17.79%	17.11%	17.67%	16.60%
Staff with a LTC or illness: Responses	431	555	671	568	690
Staff without a LTC or illness: Responses	1757	2102	2186	1720	2108

Workforce Disability Equality Standards



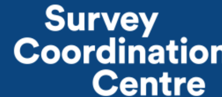
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it out of those who answered the question

60 50 40 30 20 10 0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	51.34%	47.45%	50.99%	53.16%	53.07%
Staff without a LTC or illness: Your org	48.35%	45.10%	47.66%	42.33%	51.58%
Staff with a LTC or illness: Average	46.92%	47.01%	47.03%	48.43%	50.44%
Staff without a LTC or illness: Average	46.07%	45.80%	46.20%	47.30%	49.33%
Staff with a LTC or illness: Responses	187	274	304	269	277
Staff without a LTC or illness: Responses	546	725	747	541	634



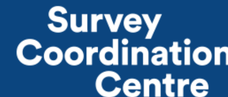
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion out of those who answered the question

70
60
50
40
30
20
10
0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	53.35%	53.91%	55.87%	55.44%	55.22%
Staff without a LTC or illness: Your org	59.22%	59.97%	59.19%	62.09%	62.21%
Staff with a LTC or illness: Average	51.93%	51.61%	51.41%	51.39%	51.54%
Staff without a LTC or illness: Average	58.39%	57.45%	56.84%	57.25%	57.52%
Staff with a LTC or illness: Responses	433	562	673	570	690
Staff without a LTC or illness: Responses	1768	2141	2210	1733	2101

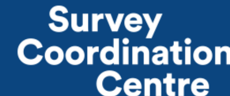


Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties out of those who answered the question

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	32.69%	37.26%	34.33%	29.76%	29.24%
Staff without a LTC or illness: Your org	18.31%	25.10%	24.95%	23.36%	17.90%
Staff with a LTC or illness: Average	32.66%	33.00%	32.18%	29.97%	28.55%
Staff without a LTC or illness: Average	21.84%	23.44%	23.74%	20.80%	19.46%
Staff with a LTC or illness: Responses	312	365	469	410	489
Staff without a LTC or illness: Responses	890	964	1070	912	1056

Workforce Disability Equality Standards

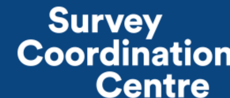


Percentage of staff satisfied with the extent to which their organisation values their work.

Percentage of staff satisfied with the extent to which their organisation values their work out of those who answered the question

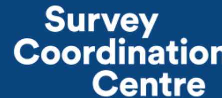
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	41.74%	36.56%	27.93%	33.28%	36.01%
Staff without a LTC or illness: Your org	55.69%	51.36%	43.35%	46.76%	50.21%
Staff with a LTC or illness: Average	38.11%	37.36%	32.62%	32.46%	35.66%
Staff without a LTC or illness: Average	49.92%	49.27%	43.30%	43.56%	47.19%
Staff with a LTC or illness: Responses	436	558	673	574	697
Staff without a LTC or illness: Responses	1767	2126	2203	1743	2123

Workforce Disability Equality Standards



Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.

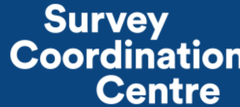
	2022	2023
Staff with a LTC or illness: Your org	74.18%	76.04%
Staff with a LTC or illness: Average	71.76%	73.38%
Staff with a LTC or illness: Responses	368	434



Staff engagement score (0-10)

	2019	2020	2021	2022	2023
Organisation average	7.21	7.09	6.79	6.91	7.02
Staff with a LTC or illness: Your org	6.80	6.57	6.29	6.42	6.63
Staff without a LTC or illness: Your org	7.31	7.23	6.95	7.06	7.17
Staff with a LTC or illness: Average	6.65	6.65	6.42	6.35	6.46
Staff without a LTC or illness: Average	7.13	7.14	6.97	6.92	7.04
Staff with a LTC or illness: Responses	440	562	682	576	699
Staff without a LTC or illness: Responses	1787	2146	2236	1755	2135

Note. Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

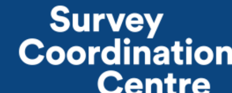


About your respondents

This section shows demographic and other background information for 2023.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Gender

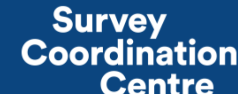


	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	75.96%	21.11%	0.38%	0.17%	2.37%
Average	76.60%	19.78%	0.24%	0.18%	3.22%
Responses	2866	2866	2866	2866	2866

Background details – Is your gender identity the same as the sex you were registered at birth?

	Yes	No	Prefer not to say
Your org	96.83%	0.34%	2.83%
Average	96.62%	0.37%	3.08%
Responses	2682	2682	2682

Background details - Age



	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.81%	15.12%	24.65%	26.97%	31.01%	1.44%
Average	0.55%	15.42%	25.91%	24.51%	31.50%	1.70%
Responses	2844	2844	2844	2844	2844	2844

Background details - Ethnicity

% of staff

	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	69.79%	2.39%	23.85%	2.35%	0.28%	1.33%
Average	78.07%	1.97%	14.15%	3.83%	0.44%	0.84%
Responses	2847	2847	2847	2847	2847	2847

Background details – Sexual orientation

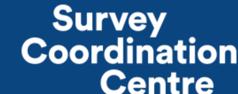
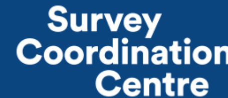


Chart: % of staff (0–100) by category — Heterosexual or straight, Gay or lesbian, Bisexual, Other, Prefer not to say

	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	90.60%	2.04%	1.09%	0.35%	5.93%
Average	89.71%	2.00%	1.84%	0.52%	5.94%
Responses	2850	2850	2850	2850	2850

Background details - Religion

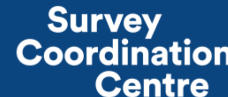
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	35.79%	38.43%	0.25%	1.58%	0.21%	15.77%	0.98%	1.26%	5.73%
Average	38.30%	47.38%	0.65%	2.43%	0.15%	2.93%	0.23%	1.51%	5.80%
Responses	2847	2847	2847	2847	2847	2847	2847	2847	2847



% of staff selecting 'Yes'

100
90
80
70
60
50
40
30
20
10
0

Your org	24.67%
Average	24.33%
Responses	2837

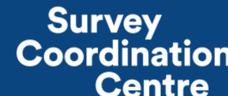


Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age.

% of staff selecting 'Yes'

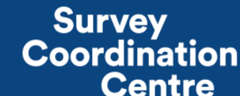
	Do you have any children aged from 0 to 17 living at home with you or who you have regular caring responsibility for?	Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age.
Your org	43.71%	35.06%
Average	40.90%	31.16%
Responses	2853	2818

Background details – How often do you work at/from home?



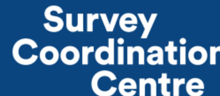
	Never	Rarely	Sometimes	Often	Always
Your org	49.90%	17.06%	18.85%	12.52%	1.68%
Average	56.75%	15.34%	15.41%	10.73%	1.52%
Responses	2860	2860	2860	2860	2860

Background details – Length of service



	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	10.56%	13.00%	17.43%	15.96%	12.27%	30.78%
Average	10.57%	16.18%	18.32%	18.03%	10.71%	25.95%
Responses	2869	2869	2869	2869	2869	2869

Background details – When you joined this organisation were you recruited from outside of the UK?



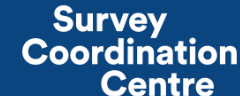
	Yes	No	Prefer not to say
Your org	4.63%	94.55%	0.82%
Average	7.79%	90.98%	1.04%
Responses	2789	2789	2789

Background details – Occupational group

% of staff

	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	27.33%	7.23%	8.98%	13.15%	6.56%	0.07%	1.18%	0.00%	16.29%	6.77%
Average	30.16%	8.01%	8.16%	13.19%	7.17%	0.15%	0.19%	0.07%	15.88%	5.86%
Responses	2806	2806	2806	2806	2806	2806	2806	2806	2806	2806

Background details – Occupational group



% of staff (axis 0–100)

	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	4.92%	2.78%	0.00%	0.00%	0.04%	0.00%	0.00%	0.00%	4.70%
Average	3.76%	2.74%	0.02%	0.00%	0.03%	0.00%	0.00%	0.00%	3.63%
Responses	2806	2806	2806	2806	2806	2806	2806	2806	2806

Survey Coordination Centre

Appendices

Survey Coordination Centre

Appendix A: Response rate

Response rate

	2019	2020	2021	2022	2023
Your org	37.66%	44.05%	47.20%	37.05%	42.85%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	2290	2747	2970	2365	2905

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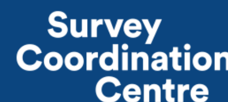
Appendix B: Significance testing 2022 vs 2023

Appendix B: Significance testing – 2022 vs 2023



Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.26	2353	7.37	2878	Significantly higher
We are recognised and rewarded	5.86	2349	6.12	2881	Significantly higher
We each have a voice that counts	6.79	2316	6.87	2838	Not significant
We are safe and healthy	5.92	2333	6.12	2857	Significantly higher
We are always learning	5.58	2236	5.94	2738	Significantly higher
We work flexibly	6.07	2331	6.28	2858	Significantly higher
We are a team	6.70	2347	6.88	2873	Significantly higher
Themes					
Staff Engagement	6.90	2358	7.02	2887	Significantly higher
Morale	5.81	2356	6.06	2884	Significantly higher

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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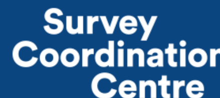
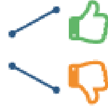
Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

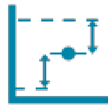


The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users.

Key points to note



The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the results are calculated can be found in the technical document available on the Staff Survey website.

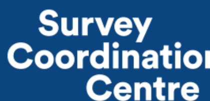


A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single chart.

Note. Historical benchmarking data for 2019 has been revised for the Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trusts benchmarking groups. This is due to a revision in the occupation group weighting to correctly reflect historical benchmarking group changes. Historical data is reweighted each year according to the latest results and so historical figures change with each new year of data; however it is advised to keep the above in mind when viewing historical results released in 2023.

Appendix C: 1. Reviewing People Promise and theme results



When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas of interest which can then be compared to the best, average, and worst result in the benchmarking group.

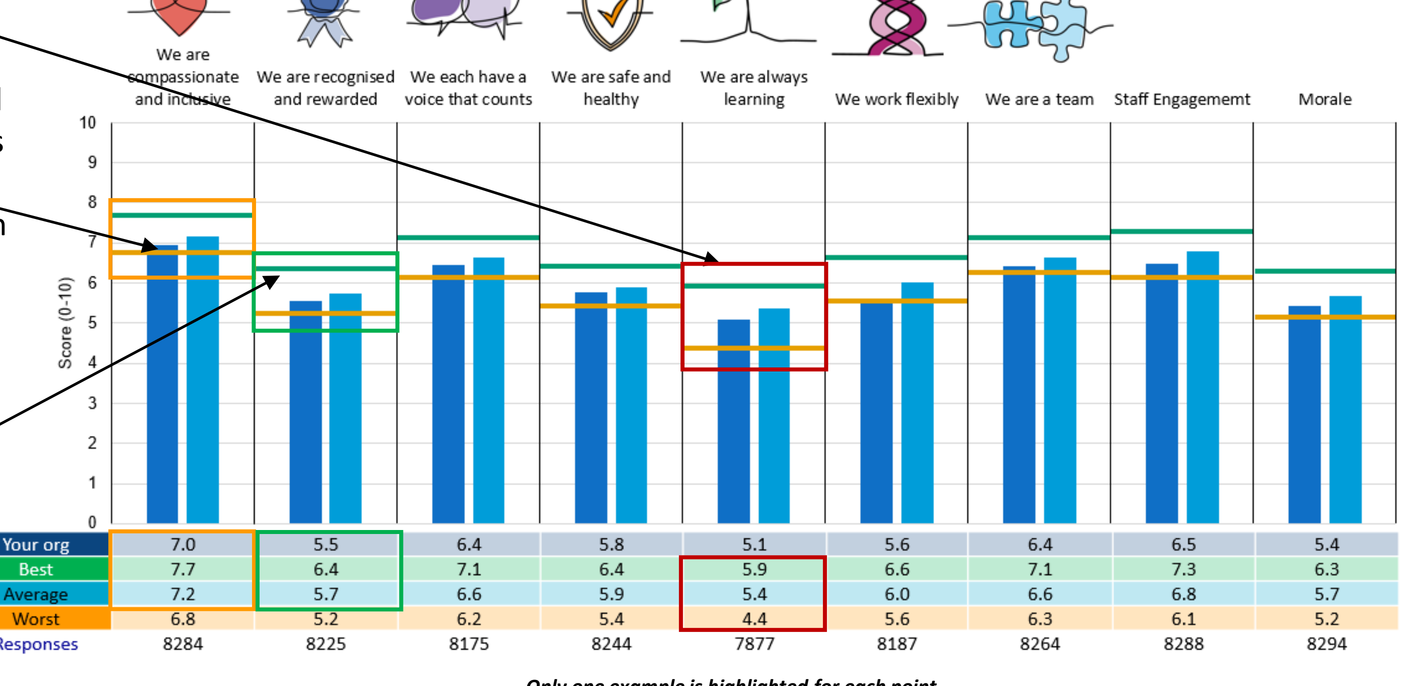
It is important to **consider each result within the range of its benchmarking group 'Best result' and 'Worst result'**, rather than comparing People Promise element and theme results to one another. Comparing organisation results to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average result' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst result'. The closer your organisation's result is to the worst result, the more concerning the result.
- Results where your organisation's result is only marginally better than the 'Average result', but still lags behind the 'Best result' by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' results are distinctly higher than the benchmarking group 'Average result'.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best result'.



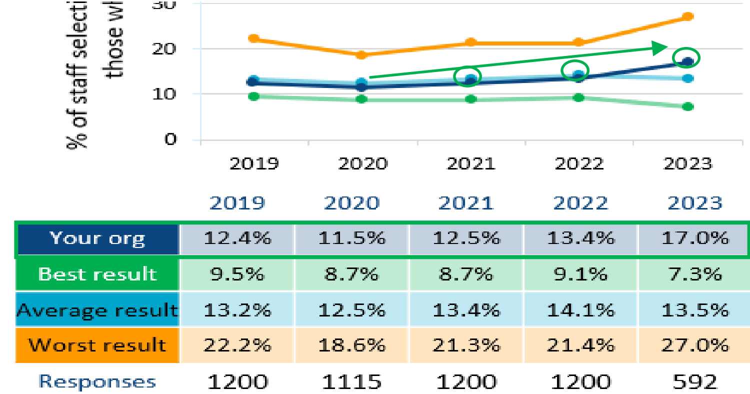
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



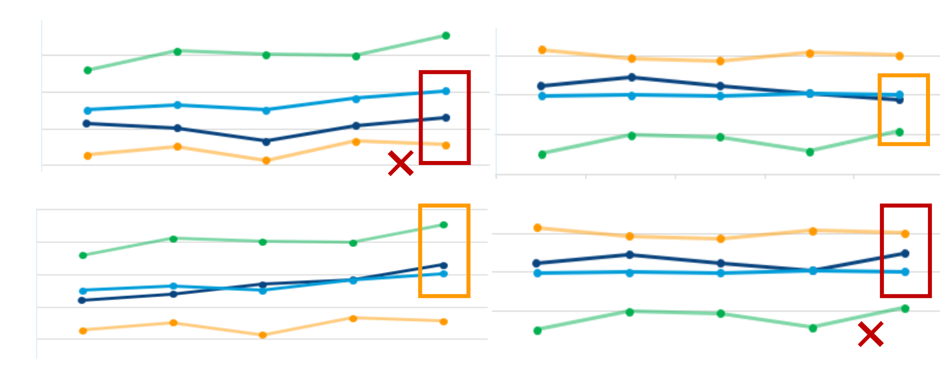
	2019	2020	2021	2022	2023
Your org	12.4%	11.5%	12.5%	13.4%	17.0%
Best result	9.5%	8.7%	8.7%	9.1%	7.3%
Average result	13.2%	12.5%	13.4%	14.1%	13.5%
Worst result	22.2%	18.6%	21.3%	21.4%	27.0%
Responses	1200	1115	1200	1200	592

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

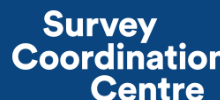
Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme results, you should review the sub-scores and questions feeding into these results. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' results to the benchmarking group 'Average', 'Best' and 'Worst' results for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



Appendix C: 3. Reviewing question results



This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

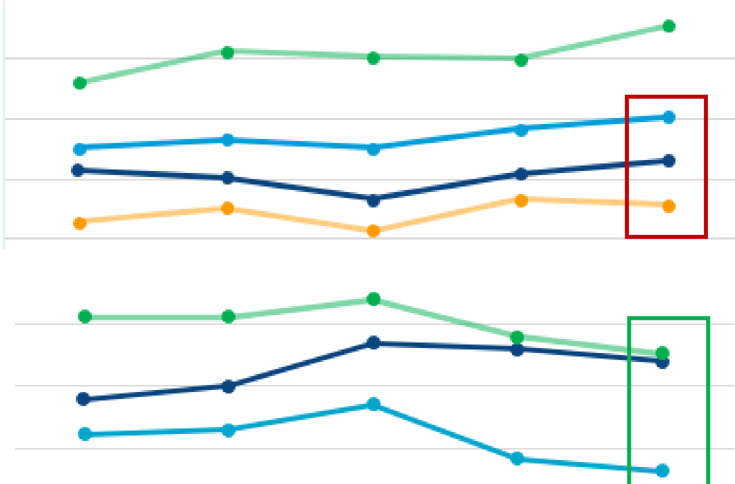
Identifying questions of interest

➢ **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

➢ **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher result always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the ‘Using the report’ page in the ‘Introduction’ section).



➢ **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst result, particularly questions where your organisation result is very close to the worst result. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the organisation has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

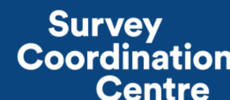
➢ **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

Survey Coordination Centre

Appendix D: Additional reporting outputs

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs



Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other reporting outputs

Online Dashboards: Interactive dashboards containing results for all trusts nationally, each participating organisation (local), and for each region and ICS. Results are shown with trend data for up to five years where possible and show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for Bradford Teaching Hospitals NHS Foundation Trust.

National Briefing Document: Report containing the national results for the People Promise elements, themes and sub-scores. Results are shown with trend data for up to five years where possible.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

Bradford Teaching Hospitals NHS Foundation Trust

2023 NHS Staff Survey

Breakdown report

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This breakdown report for Bradford Teaching Hospitals NHS Foundation Trust contains results by breakdown area for People Promise element and theme results from the 2023 NHS Staff Survey. These results are compared to the unweighted average for your organisation.

Please note: It is possible that there are differences between the 'Your org' scores reported in this breakdown report and those in the benchmark report. This is because the results in the benchmark report are weighted to allow for fair comparisons between organisations of a similar type. However, in this report comparisons are made within your organisation so the unweighted organisation result is a more appropriate point of comparison.

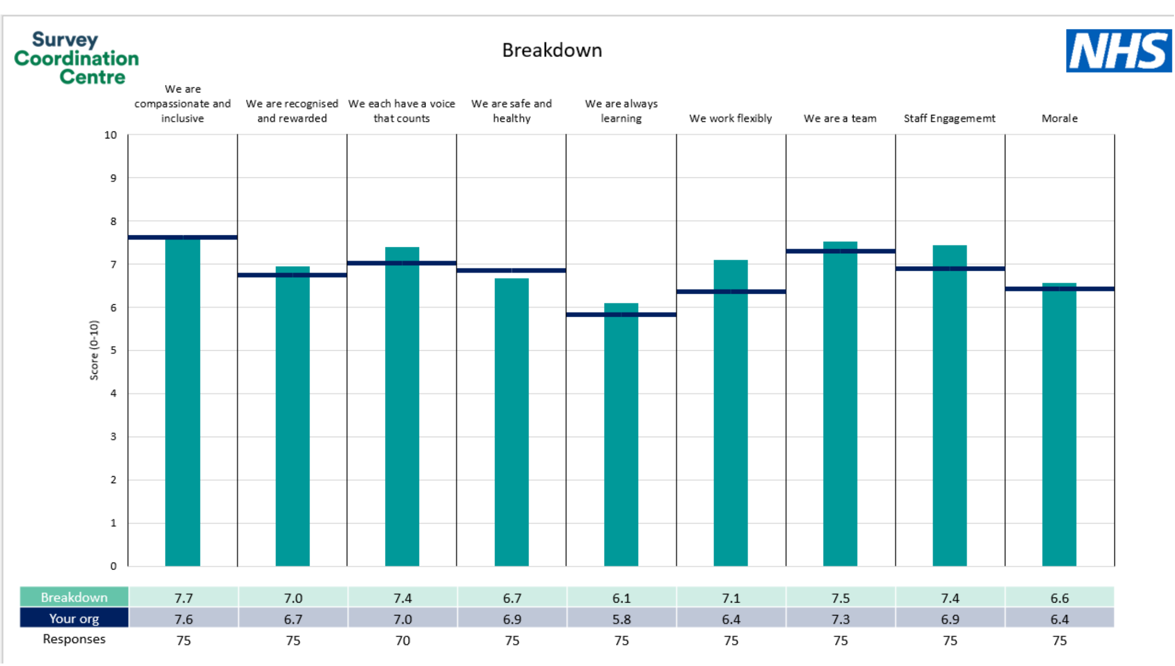
The breakdowns used in this report were provided and defined by Bradford Teaching Hospitals NHS Foundation Trust. Details of how the People Promise element and theme scores were calculated are included in the Technical Document, available to download from our results website.

Key features

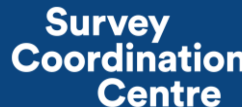
Breakdown type and **breakdown name** are specified in the header.

Breakdown results are presented in the context of the (unweighted) **organisation average ('Your org')**, so it is easy to tell if a breakdown area is performing better or worse than the organisation average. For all People Promise element and theme results, a higher score is a better result than a lower score

The **number of responses** feeding into each measures and sub-scores for the **given breakdown** is specified below the table containing the breakdown and trust scores.



! Note: when there are less than 10 responses in a group, results are suppressed to protect staff confidentiality, for some organisations this could mean that all breakdown results are suppressed.



Breakdowns 1

Bradford Teaching Hospitals NHS Foundation Trust

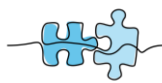
2023 NHS Staff Survey

Corporate Services

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.63	6.70	7.13	6.69	6.05	7.02	7.30	7.24	6.42
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	447	450	445	447	427	447	447	451	449

Score (0-10)

Survey Coordination Centre



Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.13	5.84	6.69	5.96	5.69	6.02	6.53	6.82	5.88
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	590	589	578	585	561	584	589	588	589

Estates & Facilities

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.34	6.45	6.85	6.83	6.06	6.93	6.79	7.37	6.56
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	184	185	175	176	160	181	181	186	185

Planned Services

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.33	5.99	6.76	6.07	5.91	5.95	6.82	6.90	5.97
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	817	818	811	810	787	813	818	818	818

Research Directorate

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.95	7.38	7.36	7.27	6.44	7.83	7.82	7.58	6.96
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	151	150	146	151	146	149	151	151	151

Score (0-10)

Survey Coordination Centre

Unplanned Services

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.36	5.88	6.87	5.64	5.92	5.98	6.81	6.99	5.86
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	689	689	683	688	657	684	687	693	692

Score (0-10): 0 1 2 3 4 5 6 7 8 9 10

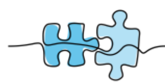
Survey Coordination Centre

Breakdowns 2

Bradford Teaching Hospitals NHS Foundation Trust

2023 NHS Staff Survey

Access



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.30	5.81	6.75	6.28	5.84	5.70	6.67	6.85	6.19
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	108	108	105	107	103	107	108	108	108

Score (0-10)

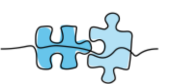
Survey Coordination Centre

Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.96	6.98	7.56	6.58	6.21	7.47	7.75	7.84	6.70
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	54	55	54	54	54	55	54	55	55

Survey Coordination Centre

Chief Operating Officer



Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.31	6.72	7.04	6.76	5.92	7.17	7.09	6.98	6.32
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	58	58	58	58	55	58	57	58	58

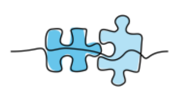
Survey Coordination Centre

Children's Services

Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.70	6.46	7.38	6.36	6.39	6.52	7.05	7.51	6.33
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	146	145	143	146	141	145	146	147	146

Estates



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.53	6.44	7.01	6.77	6.08	7.50	7.09	7.36	6.50
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	56	56	55	56	52	56	56	56	56

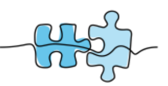
Survey Coordination Centre

Facilities

Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.26	6.45	6.78	6.86	6.05	6.67	6.65	7.38	6.59
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	128	129	120	120	108	125	125	130	129

Finance



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.92	7.06	7.04	6.91	6.71	7.27	7.65	7.37	6.68
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	71	71	71	71	69	70	71	71	71

Score (0-10)

Survey Coordination Centre

Human Resources

Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.70	6.60	7.22	6.51	6.25	6.56	7.18	7.25	6.08
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	68	68	67	68	64	68	68	68	68

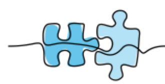
Informatics

Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.52	6.37	6.99	6.80	5.37	7.39	6.93	6.87	6.32
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	79	81	78	79	73	80	81	81	80

Survey Coordination Centre

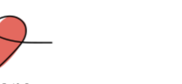
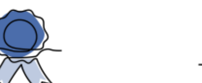
MSK and Therapies

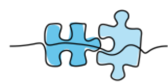


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.54	6.24	6.89	6.06	6.06	6.18	7.10	6.95	5.89
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	304	304	303	302	294	303	303	304	304

Survey Coordination Centre

Medical Directors



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	6.84	6.29	6.53	6.00	5.22	6.05	6.19	6.88	6.05
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	21	21	21	21	19	21	21	21	21

Score (0-10)

Survey Coordination Centre

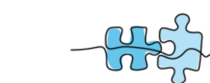
Medicines Management

Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	6.94	5.88	6.52	5.75	5.54	6.16	6.38	6.66	5.32
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	107	107	107	107	102	106	107	107	107

Survey Coordination Centre

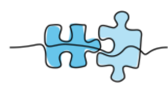
Radiology and Imaging



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.32	5.99	6.85	6.37	5.65	6.26	6.56	6.95	6.28
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	143	143	141	143	133	142	142	143	143

Survey Coordination Centre

Research

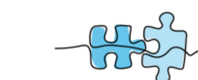


Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.94	7.34	7.34	7.26	6.38	7.82	7.80	7.56	6.93
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	157	156	152	157	152	155	157	157	157

Specialist Medicine

Survey Coordination Centre



Score (0-10)

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.01	5.74	6.64	5.66	5.72	5.94	6.51	6.80	5.74
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	232	231	225	228	223	229	232	230	231

Survey Coordination Centre

Strategy and Integration

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	8.17	7.18	8.23	7.20	6.27	7.29	7.80	7.84	7.02
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	28	28	28	28	26	28	27	29	28

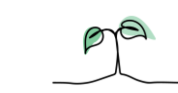
Score (0-10)

Surgery and Digestive Diseases

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.25	5.85	6.67	6.00	5.77	5.61	6.68	6.87	5.99
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	313	314	309	310	297	313	314	314	314

Theatres, Critical Care and Daycase

Survey Coordination Centre



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.11	5.80	6.67	6.17	5.93	6.09	6.58	6.86	6.06
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	194	194	193	192	190	191	195	194	194

Score (0-10)

Survey Coordination Centre

Training & Education

Score (0-10)

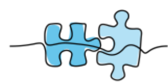
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.47	6.52	6.87	6.56	6.09	6.59	7.50	7.22	6.38
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	73	73	73	73	72	72	73	73	73

Survey Coordination Centre

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.06	5.70	6.57	5.46	5.75	5.80	6.56	6.70	5.71
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	308	308	308	308	293	304	308	310	310

Score (0-10)

Women's Services



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.53	5.73	6.93	5.39	5.82	5.85	6.96	7.02	5.73
Your org	7.37	6.14	6.87	6.15	5.93	6.30	6.88	7.02	6.08
Responses	230	231	227	229	218	230	228	231	231

Score (0-10): 0 1 2 3 4 5 6 7 8 9 10

BO.3.24.18 - LOOKING AFTER OUR PEOPLE

BO.3.24.19 - REPORT FROM THE CHAIR OF THE QUALITY AND PATIENT SAFETY ACADEMY ?JAN & FEB 2024

REFERENCES

Only PDFs are attached

Bo.3.24.19 - Report from the Chair of Quality and Patient Safety Academy - January 2024.pdf

Bo.3.24.19 - Report from the Chair of Quality and Patient Safety Academy - February 2024.pdf

Meeting Title	Board of Directors		
Date	14.3.24	Agenda item	Bo.3.24.19

Committee/Academy Escalation and Assurance Report (AAA)

Report from the Quality and Patient Safety Academy

Date of meeting: 31st January 2024

Key escalation and discussion points from the meeting
Alert:
• The Chair wishes the Board to be alert to the pressures on Midwifery and Neonatal services. In the last two weeks there has been an increase in pressures that has created further unit diverts, and staff are feeling burnt out with low morale. Recognised nationally, a national maternity review has been recommended.
Advise:
• The number of apologies received from Non-Executive Directors was noted and the Academy recognised that its ability to provide necessary challenge might be impaired. • The Trust was at Opel 3, with very high numbers of patients requiring admission from A&E, with a lack of beds resulting in some significantly long stays in A&E. However, performance against A&E targets continues to be one of the strongest in the country. • The report following the NHS Specialised Commissioning visit to the neonatal unit on 7/12/23 showed very high assurance. The report following the independent desktop exercise on governance processes (April 2021 onwards) in relation to serious incidents (SIs) also did not identify any issues around openness, honesty and transparency. Reports to be submitted to the Board. • In relation to perinatal deaths, one surveillance case missed the one-month completion deadline due to an IT issue. EMBRRACE who perform external review of cases and NHS Resolution have been notified. NHS Resolution asked that this be reported to the Board, and advised this will be taken into consideration with regard to full compliance, and that the mitigation being undertaken provides assurance.
Assure:
Serious Incident reporting The Academy report included one maternity obstetric incident reported via the Maternity and Newborn Safety Investigation programme (MNSI) during the reporting period, and the 10 ongoing serious incident investigations. Three Trust investigations have extensions in place with work continuing to close these by the end of February 2024. The MNSI reports will continue, as they are a national priority, with any identified patient safety incident investigations from local or national priorities being reported. The Academy noted the current position provided in the circulated report and appendices,

and confirmed their assurance that the Trust has processes in place to identify, investigate and learn from SIs.

Palliative care annual report covering the period July 2022 to June 2023.
Presented by the Hospital Palliative Care Team who cover BRI and care of the elderly in (St Luke's Hospital) SLH. The team has expanded and now provides seven-day cover, however it does not cover community hospitals. This is included on the Risk Register as NHS England issued an adult service specification in January 2023 stipulating face-to-face assessment should be available for palliative care in all areas. A business case is under discussion to provide resource to support and develop the work within the intermediate care unit.

A new Clinical Nurse Speciality (CNS) role with a special interest and knowledge of South Asian culture and religious needs is currently in the evaluation stage. This role will be able to provide culturally sensitive care at end of life based on the needs of our population.

The Academy noted the report, thanked the Team and assurance was confirmed.

Maternity and neonatal update
The Academy noted:

- The monthly stillbirth position of two. We were advised both were MDT reviewed with no learning identified which could have led to a different outcome in either case
- The reduction in the rate of stillbirths from 6.6 per 1000 in 2022, with an adjusted rate of 5.0 per 1000 births, to 5.1 per 1000 in 2023, with an adjusted rate of 4.2 per 1000 births. There were 27 stillbirths in total in 2023, a reduction on 32 in 2022.
- 1 case of HIE (Hypoxic-ischaemic encephalopathy) reported in December
- 3 neonatal deaths in December
- No maternal deaths in December

The Academy were informed of 5 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level. Two completed MNSI/Internal Serious Incident reports were shared

The Academy noted that there was 1 MNSI reportable case and 0 reportable Serious Incidents (SI) declared in December

The Academy noted the information provided and confirmed its assurance notwithstanding the challenges and difficulties that currently exist and have been noted.

Patient Experience Six- month report
The Academy noted the report and that the Patient Experience and Engagement Strategy is going live within the next month.

A question was raised as to potential bias in groups being chosen for Patient Stories and the need for inclusive selection criteria. Suggestions were proposed including closer links with the Interpreting Service and SPaRC (Spiritual, Pastoral and Religious Care)

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team. It was agreed a review of the SOP for patient stories would be undertaken and an Equality Impact Assessment.

The Academy confirmed agreement with the recommendations detailed in the Patient Experience Bi-Annual Report and thanked the Team for their work.

Learning from Deaths
The crude mortality data in December 2023 was entirely in line with the position two years previously. An in-depth review of all cases found nothing of concern, but learning points have been noted. This includes improving communication and knowledge mobilisation, especially when dealing with complex patients.

The CMO noted that highest ratings of poor care are seen at end-of-life. It was recognised teams need to be proactive in contacting the palliative care team for their assistance, expertise and support, and how improved processes can support this.

Quality Improvement Programme
The Academy were advised the Trust has been invited to participate in the national collaborative 'Worries and Concerns' work around improving timely interventions for deteriorating patents. We are the only Trust representing West Yorkshire and Humber.

Mortality Review Improvement Programme
The cases reviewed are mostly where a concern has been raised and care has been rated overall as poor. Reports and learning continue to be produced. The group needs to focus on appropriate dissemination.

The Academy confirmed they feel assured that the programme will deliver against the strategic objective of providing outstanding care, delivered with kindness.

Outstanding Theatre Programme (OTS)
The Academy noted that 31/01/24 marks the end of the Outstanding Theatre Programme. A presentation of future plans called Moving to Outstanding, which was developed by the CSU, the OTS Programme and others, was provided. The Academy expressed their thanks for the work done so far and recognised that improvement work continues.

The Academy confirmed they have been provided with assurance that the work in the OTS Programme will be sustained going forward.

Patient Safety Response Incident Framework
Transition to the Patient Safety Incident Response Framework (PSIRF) took place on 1st December 2023 and the Trust is therefore compliant. Full implementation has not yet taken place, and plans in place for this quarter, with a roadmap developed for the next financial year were presented. The Integrated Reporting, Learning and Improvement System (IRIS) has now replaced the DATIX system. The transition to IRIS was smooth, though further records and documents are to be transferred. Reporting is now done directly into the NHSE Learning from Patient Safety Events (LFPSE) platform. The IRIS system supports the national Patient Safety Strategy in terms of insight available.

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Further work in relation to extracting material meaningful to staff at all levels is being undertaken.

Thanks to the whole team were conveyed, and the Academy confirmed their assurance from the information provided.

Infection Prevention and Control Quarterly Report
The Academy were advised that Covid-19 cases and hospitalisations due to Covid-19 have increased slightly towards the end of the quarter both regionally and nationally, with numerous Covid-19 variants. Omicron BA.2.86 is dominant at the present time. There was a spike in the number of 'flu cases in December 2023 and January 2024.

Of the six mandatory organisms reported on the Trust has seen a slightly reduced number of MRSA cases. The number of C. diff cases was relatively stable with no cases in October 2023. There was a slight increase in MSSA Bacteraemia cases in the community, something seen regionally. E. coli cases have reduced which may be as a result of the commencement of the hydration project in the care of the elderly.

The Trust was compliant in 51 out of 54 standards of the IPC Board Assurance Framework and partially compliant in the remaining three. Improvements made by the Blood Culture Improvement Group to achieve the aim of blood cultures being taken correctly to avoid contamination and improve bacteria rates were reported

The Academy noted the report and thanked YM for the high level of compliance achieved. The Academy provided their approval of the Quarter 3 report.

High Level Risks
The CMO noted the risk concerning EPR which is past its target mitigation date (no 3468). It has been agreed this can now be closed and a new more contextually accurate risk is to be created.

- One new risk added (3474: Risk to new child patients referred to paediatrics, from a delay in initial diagnosis and initiation of appropriate investigation and therapy)
- Two risks have been closed (3788, 3767)
- Two risks have decreased in score (3530 and 3711)
- Three risks were noted to be beyond their review dates 3696 (Pharmacy aseptic unit), 3877 (operational pressures associated with high demand, Covid backlog and Industrial Action) and 3881(recruiting to pharmacy vacancies).
- An update on 3896 (Gynaecology histopathology delays) was given – a more general HR is required as issues not just associated with gynaecology

The Academy were assured all relevant key risks have been identified, reported and are being managed appropriately.

Report completed by:

Louise Bryant

Academy Co-Chair and Non-Executive Director

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Committee/Academy Escalation and Assurance Report (AAA)

Report from the Quality and Patient Safety Academy

Date of meeting: 28 February 2024

Key escalation and discussion points from the meeting
Alert:
• The Chair wishes the Board to be alert to risk 3309 - 'delays in processing of histopathology samples'. A specific histopathology risk relating to gynaecology score had been reduced to 12, however it was agreed that a reassessment be undertaken as there was a view that it should remain at 16. If following the reassessment it is deemed to be rated 12, it would not be included in future reports to Executives or Academies, as it would be managed locally and as part of risk 3309. The Academy has been advised that 'an intensive and immediate response' was now being put in place in response to the risk – ahead of the timelines included in the Histopathology improvement plan (presented at the F&P Academy).
Advise:
• The number of apologies received from Non-Executive Director members of the Academy was again noted with the Academy recognising that its ability to provide necessary challenge may again be impaired. Julie Lawreniuk, Non-Executive Director joined our meeting this month and was a very welcome addition. • The Junior Doctors industrial action had just concluded on the day of our meeting. Over the strike period the level of turnout varied between 52% and 75%. During one of these days, we also had a record high attendance of 525 in Accident and Emergency. Whilst there was no direct harm to patients on the day, indirect harm may be an experience of those patients whose appointments had to be rescheduled.
Assure:
Quality Oversight and Assurance Profile Two incidents were brought to the attention of the Academy. The first involved a renal transplant patient who was undergoing renal dialysis and had tested positive for Hepatitis B. The second incident related to the use of 'single patient insulin pens' in Accident and Emergency over a period of 12 months. Task and finish groups involving the UKHSA had been established and the Academy noted the actions and recommendations that had been implemented. The Academy noted the move to the new reporting system IRIS. The Quality team was keeping a close eye on the incidents reported through the system.

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<u>Serious Incident reporting.</u>
The Academy noted the 8 Incidents ongoing with 5 having extensions in place - four of these investigations were being led by the Trust and 1 by the Maternity and Newborn Safety Investigation programme (MNSI). The Academy noted the current position provided in the circulated report and appendices, and confirmed their assurance that the Trust has processes in place to identify, investigate and learn from SIs.

<u>Maternity and neonatal update</u>
From the report the Academy noted:

- The monthly still birth position of 4 for January 2024.
- 2 neonatal deaths in January.
- 1 maternal death in January of a Bradford woman at Leeds Teaching Hospitals.
- 3 ongoing maternity SIs/Level 1 investigations, 1 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- There were 3 MNSI reportable cases, 2 of which were rejected, and 0 reportable Serious Incidents (SI) declared in January.
- The 8 occasions in January where the unit was assessed as needing to divert women to other organisations which has impacted on the provision of 1:1 care in labour, delayed induction of labour and the experience of some women.

As well as the discussion related to the histopathology risk as highlighted above under 'Alert;' the Academy also sought assurance with regard to the national patient safety alert issued on the Euroking maternity information system. The issues identified have bene reviewed internally to see what impacts they have and only one issue has been identified. This relates to the off-line solution with Oracle Cerner. Mitigation is being put in place in relation to wi-fi capability however there cannot be a guarantee for 100% coverage. Cerner has been asked for a 'cerner oracle' off-line solution – they have this on their road map however there is no time frame yet for when this will be addressed.

The final report following the NHSE neonatal commissioning assurance visit in December 2023, including the recommendations was noted. The recommendation that the Consultant Neonatologist lead/Head of Department attend Board to directly present a regular report on behalf of the department was discussed. It was agreed that QPSA would receive a quarterly update report with updates and escalation to Board as required.

<u>Independent Inquiry – Maidstone and Tunbridge Wells NHS Trust</u>
Comprehensive presentation received. BTHFT complaint with 16 of the 17 recommendations form the independent inquiry into the Maidstone and Tunbridge wells NHS Trust Mortuary Incidents. CNO, Karen Dawber appointed as Executive with oversight to provide assurance to the Board. HTA inspection undertaken in 2023 found we met the majority of the HTA standards, with two major and one minor shortfall regarding consent training and fridge capacity. Work is ongoing work to rectify the shortfalls.

<u>Equality Delivery System</u>
The quality related elements of the EDS were previously presented and reviewed at Academy in November 2023. Good to hear that the Trust was achieving in all the overall

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scores and in domains 2 and 3 some areas were close to excelling. The key area of further focus required is to better support patients identified as 'neuro diverse.' The Academy approved the publication of the EDS data and recommendations on the Trust website.

15 Steps Assurance programme

The Academy received the update on the latest round of ward visits noting that the structure of the visits was aligned to the CQC standards and regulations. The visiting groups were drawn from a cross-section of staff. The report from this round of visits highlighted two overriding areas of action. Access to interpreting services had been flagged by several staff who reported issues accessing the service on weekends. Assistant Chief Nurse, Karen Bently identified that staff could and should make use of the applications available on the trust intranet however, she would collaborate with her Patient Experience Team to undertake some ward based educational activities to ensure staff were aware of the tools available. The other area highlighted as requiring action was signage. Outcomes from the report have been shared with the Estates and Facilities team to take these actions forward. My thanks to the Moving to Outstanding Lead, Nazzar Butt for this very enjoyable and well written report.

The Chair put her name forward as a NED volunteer for the programme and will recommend that other NED colleagues do the same if they are able.

Quality and Patient Safety Academy Dashboard

Key to note was the discussion held regarding 'coding' and the headway made in getting to the root of the issues that had impacted on the Standardised Hospital Mortality Index (SHMI) score. Issues with SHMI and the data collected have been a focus previously in the Academy. A report will be brought back to the Academy in approximately two months that will provide a clear explanation on the issues and the collective actions to be taken to remedy the position. The paper will also include a focus on November 2022 when the figures for SHMI suddenly suddenly rose, to identify what happened at that time to explain this.

High Level Risks

The Academy noted the new risk added at 3309 related to 'delays in processing of histopathology samples' as noted in the 'Alert' section above. The Academy agreed that it felt assured that all relevant key risks have been identified, reported to the academy, and were being managed appropriately.

Report completed by:

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

12 March 2024

BO.3.24.20 - MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

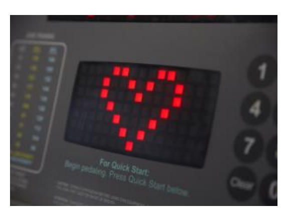
Only PDFs are attached

- Bo.3.24.20 - Maternity and Neonatal Service (presentation).pdf
- Bo.3.24.20 - Maternity and Neonatal Services (cover).pdf
- Bo.3.24.20 - App1.MatandNeoServicesUpdate.(PERINATAL).December 2023 (cover).pdf
- Bo.3.24.20 - App2.MatandNeoServicesUpdate.(PERINATAL).January2024 (cover).pdf
- Bo.3.24.20 - App5.MatandNeoServices.Bradford Neonatal Assurance Commissioning Visit Report - 7.12.23 Final.pdf
- Bo.3.24.20 - App6.MatandNeoServices. WYH LMNS Assurance visit 2023 - Bradford Report.pdf
- Bo.3.24.20 - App7.MatandNeoServices.ANONYMISED.Final.4 - Update BTH Neonatal Serious Incidents 2024.01.19.pdf

Board of Directors
March 2024

Maternity and Neonatal Update
December 2023/January 2024

Sara Hollins, Director of Midwifery



Together, putting patients first

Highlights December/January

- The December and January 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
- Quality Improvement Group (NHSE) concluded significant assurance received in relation to Neonatal services, including review of timeline of reporting, assurance visit and review of Ockenden visit.

Discussion Points - Neonates

- **Positive conclusion following recent external maternity and neonatal assurance visits and reviews.**
  - This key line of enquiry has now been closed by the NHSE Quality Review Group
  - 3 key documents included in bundle: The Assurance Visit Report; Report in relation to the timeline and Ockenden Assurance visit

Discussion Points

- **Positive NHSE Neonatal Assurance visit report and recommendations.**
  - Quality commissioning review found that the neonatal service at BRI is providing safe, high-quality care to its patients, family, and services users. Recommendations for continued improvement which are already in progress were acknowledged by the visiting team.
  - Recommendation that the Consultant Neonatologist lead/Head of Department attend Executive Board to directly present a regular report on behalf of the department.
    - It is suggested that a bi-annual neonatal update report is presented to QPSA with delegated authority of Board, and any concerns/emerging themes are escalated direct to Board.
    - Any issues identified outside of quarterly reporting, would be exception reported via the monthly Maternity and Neonatal Update paper.
  - Board decision required.

Discussion Points – Still Births

- **Reduction in the 2023 stillbirth rate.**
  - 27 stillbirths in total in 2023, a reduction on 32 in 2022.
  - Annual rate of 5.1/1000 births. With an adjusted rate (removing babies with a congenital abnormality) of 4.2/1000 compared to 6.6/1000 and 5.0/1000 adjusted in 2022.
  - National data collection is taken from PMRT who utilise date of birth as opposed to the date death is confirmed. This means there will be a small variance in the eventual published number due to the inclusion of 3 non-viable babies whose deaths occurred before 24 weeks, but who were born after 24 weeks.

Questions?

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MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – DECEMBER 2023 AND JANUARY 2024

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	Identify if the paper is a key control for the Board Assurance Framework	
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	January and February 2024
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 (PMRT) 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 Maternity Incentive Scheme (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 December 2023 and January 2024 activity, was presented and key elements discussed including:

- The number of harms occurring in December and January, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of MNSI and SI cases were discussed.
- 3 completed MNSI and internal investigations/SI reports were discussed at January QPSA and 2 MNSI at February QPSA including learning and progress on actions.
- January QPSA approved the Quarterly PMRT report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme.
- February QPSA was asked to note that the Perinatal Leadership Quad joined the January bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- February Academy approved the Quarter 3 ATAIN report required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme.
- January and February QPSA discussed unit activity and challenges impacting on delayed induction of labour, unit flow and the provision of 1:1 care in labour.
- Reduction in the 2023 stillbirth rate.
- Service pressures due to staffing challenges versus high activity and acuity, particularly impacting on delays in the induction of labour process and the delivery of 1:1 care in labour.
- Positive conclusion following recent external maternity and neonatal assurance visits and reviews including:

- NHS England Neonatal Assurance visit report and recommendations.
- NHS England review of Bradford Teaching Hospitals NHS Foundation Trust. Timeline for the investigation and oversight of three neonatal serious incidents.
- West Yorkshire and Harrogate Local Maternity and Neonatal System assurance visit (Ockenden assurance).

Recommendation

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the December and January 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 December and January 2023/24 and both newly reported and ongoing investigations.
- Trust Board to acknowledge that Appendices 3a, 3b, 3c, 4a and 4b, completed internal incident report and completed MNSI reports, including learning, were shared with January and February QPSA and are available for the attention of Closed Board.
- Trust Board to note that there were 27 stillbirths in total in 2023, a reduction on 32 in 2022.
- Board is asked to note that the eventual nationally published data for 2023 stillbirths will include a further 3 non-viable babies whose deaths occurred before 24 weeks, but who were born after 24 weeks. This is due to data being collected from PMRT who use date of birth as opposed to the date death is confirmed.
- Trust Board to confirm that they are assured that QPSA, as a committee of the Board with delegated authority, have reviewed and approved the Quarterly PMRT report, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5.
- 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 3 ATAIN report and action plan, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, Year 5.
- Trust Board is asked to acknowledge and note Appendices 5, 6 and 7, reports and review findings concluding recent external maternity and neonatal assurance visits and reviews
- Following the NHSE Neonatal Assurance visit and report it was recommended that the Consultant Neonatologist lead/Head of Department attend Executive Board to directly present a regular report on behalf of the department. It is suggested that a bi-annual neonatal update report is presented to QPSA with delegated authority of Board, and any concerns/emerging themes are escalated direct to Board. Any issues identified outside of quarterly reporting, would be exception reported via the monthly Maternity and Neonatal Update paper. This requires a decision from the Board.

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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minima l**	**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 and Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

Meeting Title	Board of Directors		
Date	14.03.14	Agenda item	Bo.3.24.20

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 December 2023 and January 2024 (Appendices 1 and 2):

The December and January updates and associated appendices were respectively discussed at the January and February QPSA.

The key elements of the papers discussed included:

- The number of harms occurring in December and January, 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 3 completed Internal/MNSI reports including learning, shared in January (Appendices 3a, 3b and 3c) and 2 completed MNSI reports including learning, shared in February (Appendices 4a and 4b).
- January QPSA was informed that there were 27 stillbirths in total in 2023, a reduction on the 32 reported in 2022. This equates to an annual rate of 5.1/1000 births. With an adjusted rate (removing babies with a congenital abnormality) of 4.2/1000 compared to 6.6/1000 and 5.0/1000 adjusted in 2022. The reduction reflects the continued commitment towards full implementation of the Saving Babies; Lives Care Bundle Version 3 including the improved identification and management of small for gestational age babies. Board is asked to note that national data collection is from PMRT who utilise date of birth as opposed to the date death is confirmed. This means there will be a small variance in the eventual published number due to the inclusion of 3 non-viable babies whose deaths occurred before 24 weeks, but who were born after 24 weeks. For example, a twin pregnancy where one twin demised at 20 weeks, but who was born at the time of the surviving twins birth at term.
- January QPSA reviewed and approved the Quarterly PMRT report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5.
- February QPSA reviewed and approved the Quarter 3 ATAIN report 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. 2 cases were considered avoidable and learning is now routinely shared at the monthly mandatary Care in Labour training day.
- January QPSA was updated on an improved position regarding 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 increased attempts at diverting services and reduced opportunities to provide 1:1 care in labour. Whilst the position improved in December, further challenge was experienced in January. This remains the same picture across the LMNS and the service continues to work with the 5 neighbouring units, to assess safety at system wide level on a daily basis.

- 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.
- February QPSA was asked to note that the Perinatal Leadership Quad joined the January bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- Appendices 5, 6 and 7 are final reports and review findings concluding a number of externally led maternity and neonatal assurance visits and reviews.
- February QPSA received the NHSE Neonatal Assurance visit final report (appendix 5). The visit was extremely positive and the quality commissioning review found that the neonatal service at BRI is providing safe, high-quality care to its patients, family, and services users. Recommendations for continued improvement which are already in progress were acknowledged by the visiting team. It was recommended that the Consultant Neonatologist lead/Head of Department attend Executive Board to directly present a regular report on behalf of the department. It is suggested that a bi-annual neonatal update report is presented to QPSA with delegated authority of Board, and any concerns/emerging themes are escalated direct to Board. Any issues identified outside of quarterly reporting, would be exception reported via the monthly Maternity and Neonatal Update paper.
- Appendix 6 is the West Yorkshire and Harrogate Local Maternity and Neonatal System, final report following the (Ockenden) assurance visit on 6 November 2023. The visit was positive and there were no immediate safety concerns identified that the trust were not aware of with evidence of the trust providing high quality, safe and personalised care to women and their families. Evidence submitted ahead of the visit was found to be comprehensive and of a high standard. It demonstrated a clear commitment to safety, managing risk, learning, quality improvement and maternity transformation. There were a small number of suggestions as to how the service could be further improved, but no new recommendations or areas of concern.
- NHSE conducted a review and timeline of the investigation and oversight of three neonatal serious incidents references. The review report available as Appendix 7, found that the evidence reviewed to date demonstrates that from the same month, the seriousness of a potential cluster of serious incidents affecting the neonatal unit was recognised and openly shared and reported and that throughout 2021 and later, the information was shared with members of the Board including the Chair in formal, minuted meetings. January and February 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 December and January Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Including all Appendices 1 related to harms and MIS submissions.
- Board is asked to note that the further reduction in still birth rates.
- Receive positive assurance in relation to Neonates following external scrutiny.
- Consultant Neonatologist to attend Board on a Bi-annual basis to focus on neonates.

4	Appendices

- Appendix 1 - Maternity and Neonatal Services Update Paper, December 2023.
- Appendix 2 - Maternity and Neonatal Services Update Paper, January 2024.
- Appendix 3, 3a, 3b and 3c - Closed Board Harms December 2023 and completed MNSI and Internal Investigation reports.
- Appendix 4, 4a and 4b - Closed Board Harms January 2024 and completed MNSI and Internal Investigation reports.
- Appendix 5 - Bradford Teaching Hospitals NHS Foundation Trust Neonatal Unit Visit Report Commissioning Quality Assurance Review Neonatal Visit December 7th, 2023.
- Appendix 6 - West Yorkshire and Harrogate Local Maternity and Neonatal System Assurance Visit 2023 - Trust report Bradford Teaching Hospitals NHS Trust 6th November 2023.
- Appendix 7 – NHS England Bradford Teaching Hospitals NHS Foundation Trust. Timeline for the investigation and oversight of three neonatal serious incidents references.

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MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE DECEMBER 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 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.

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Recommendation
• Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, December 2023. • 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 informed that there were 27 stillbirths in total in 2023, a reduction on 32 in 2022. • Academy is asked to note that there was 1 case of HIE reported in December. • There were 3 neonatal deaths in December. • Academy is informed that there were no maternal deaths in December. • There are 5 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level. • Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs. • There are 2 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for December. • Quality and Patient Safety Academy is asked to note that there was 1 MNSI reportable case and 0 reportable Serious Incidents (SI) declared in December. • QPSA is asked to note appendices 2 and 2a, the final Perinatal Mortality Review Tool reports, required to support compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5 submission. Academy is asked to note the mitigation regarding 1 missed surveillance case, and support the recommendation that full compliance is declared. • Academy to note that there were 3 occasions in December 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 that the increased unit pressures experienced in November has resolved to a level of expected activity.

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					g	

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shared goals						
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)
☐	☒	☐	☐

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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.

- 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.

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 completed 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 focused 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, the 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 2024 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, followed by a series of individual action learning sets and a number of other group days.

The programme culminated with the completion of the SCORE culture survey.

High level feedback included:

- 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.

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 early 2024.

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 in October 2023 and Board in November, as an appendix to the overarching Nursing and Midwifery staffing paper.

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.

The next bi-annual paper will be presented to April 2024 People Academy followed by May Board. This paper will include the analysis from the November 2023 Birth Rate Plus full review, which is based on data collected between 1 November 2023 to 01 February 2024.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 8.38 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 33.8 WTE.

Newly qualified midwives have now completed their supernumerary period and are counted in the establishment numbers. Further new starters are expected to join the service in the early New Year.

Registered Nurses with gynaecology and surgical nursing skills are supporting the ward establishments where midwifery shifts remain unfilled. This is proving to be successful and allowing midwifery staff to focus on midwifery specific roles and responsibilities.

Vacancy approval has been granted to go out to advert for 5 registered nurses to undertake a fully funded Midwifery MSc shortened programme. This is a welcomed step to grow the Bradford midwifery workforce.

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.

A daily system wide safety huddle to assess the need for mutual aid and support across the 6 West Yorkshire and Harrogate Local Maternity and Neonatal System, remains in place.

Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week. A detailed update will be provided in the next monthly update paper.

Neonatal Staffing

There is a new Consultant starting in March and a colleague has been appointed as a permanent Speciality Dr (Tier 2) who has previously been on a temporary contract. The unit has also successfully applied for £50-60k of recurrent funding from NHSE (via the Neonatal network) to assist with junior doctor staffing.

Nursing update:

Currently have out to advert:

- 1.13 Band 7 Senior Sister – No applicants at present.
- 1 WTE Band 7 Governance Nurse (ODN funded) - 3rd time of advertising – no applicants at present.
- 2.857 Band 6 Sister – 2nd time of advertising - No applicants at present. Had meetings with senior band 5 work force and consulted Kez Hyatt regarding encouraging our overseas workforce to apply.
- 6.15 WTE Band 5 Staff Nurse – 35 candidates – 33 of which overseas and will all be rejected and signposted to overseas recruitment agency.
- 1.07 WTE Band 4 RNA – None of the current candidates hold the correct qualifications.

There are current challenges recruiting senior roles at present. We have an incredibly junior workforce so many of the nurses cite that they do not feel ready to step up. We do offer support and career conversations to encourage progress and development.

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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 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. The next update will be provided in February.

Induction of Labour Delays:

During November the service 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. This position continued into the beginning of December, but we are pleased to report that activity, particularly the number of women requiring induction, has returned to a manageable level.

Ongoing improvement plans, described in the November update paper, are in place to prevent a similar situation arising again.

Stillbirth Position

There were 2 stillbirths in December. 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)
November	2	25	1	1 (Internal SI)
December	2	27	0	0

The annual stillbirth total for 2023 was 27 babies. This is a reduction on the 32 babies who were stillborn in 2022. The final birth rate for the year has not yet been calculated but is anticipated to be slightly increased on 2022.

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby diagnosed with HIE in December. This case was referred to MNSI and is in the triage process.

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 was 1 MNSI reportable case occurring in December, and 0 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.
A further case will be removed from the tracker having been rejected by MNSI and not meeting SI criteria. This is referenced in appendix 1.

There are 5 ongoing maternity SIs/Level 1 investigations, 3 HSIB and 2 Trust level.

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

Neonatal Deaths (NND)

There were 3 neonatal deaths in December within the first 28 days of life.

- 1 baby born alive at 18+3, following medical termination for fetal abnormality.
- 1 baby born at 23 weeks, died at 3 days due to extreme prematurity.
- 1 baby born alive at 22 weeks, following medical termination for fetal abnormality.

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
December	3	34	3	0

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Perinatal Mortality Review Tool (PMRT) Quarterly Report

Appendices 2 and 2a are the final PMRT reports required for QPSA/Board attention and to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme Year 5.

The service has met the required Safety Action standard, with the exception of 1 surveillance case which missed the one month completion deadline due to the temporary loss of the master spread sheet. This resulted in 97% compliance against the 100% standard.

NHSR and MBRRACE have been informed of the mitigating circumstances around not achieving this case, and have advised that if full compliance is declared the mitigating circumstances must be included in the self-declaration action plan section. It is highly likely that full compliance will be supported following external verification, but there is a small possibility that it will be challenged and mitigating evidence will need to be provided.

The service is in a position to readily provide an email trail between the service and Information Technology colleagues, who were able to rapidly recover the missing data base.

Importantly, this was a surveillance only case due to the early gestation and serves as a data collection requirement. It has therefore not adversely impacted on the experience, expectations, or wellbeing of the parents.

This information has been presented to January Trust Board as part of the final sign off process.

Maternal Deaths

There were 0 Maternal Deaths in December.

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 was 1 case meeting the MNSI referral criteria in December.

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 December.

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

There were no planned meetings in December and nothing escalated to the Safety Champions outside of the meeting.

Monthly staff feedback from Safety Champions and walk-rounds

There was no attendance at the planned meeting on 1 December due to unit activity.

Maternity Unit Diverts

There were 2 partial/attempted units diverts/escalations in December recorded on the closure log. This is a significant improvement on the 11 cases reported in November and supports the improved activity position reported earlier.

0 women were diverted to a neighbouring organisation for care during the partial diverts, due to no suitable women for transfer on 1 occasion, and no neighbouring units accepting on the 2nd. This meant that the service continued to accept and admit women who impacted on the ability to provide 1:1 care in labour, delays in triage and delays to women waiting for induction of labour.

Table 3:

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
DECEMBER	0	0	2	0
Total	0	25	13	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. Appendix 3 is a copy of the dashboard up until October 2023. A small number of October fields are incomplete awaiting validation.

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.

Achieving 1:1 care in labour remains the key metric of concern. Appendix 4 is a copy of the risk register entry, including actions to mitigate and improve. This is required as part of the Maternity Incentive Scheme, Year 5 submissions to support compliance with Safety Action 5.

Training Compliance

Appendix 5 is a copy of November 2023 maternity training compliance.

Of most significance, the report demonstrates that 90% of all relevant staff groups were compliant with PROMPT emergency training, as verbally reported in the November update to December QPSA, making the service compliant with Safety Action 8 of the Maternity Incentive Scheme.

The service is expecting to see a gradual improvement in FIT test compliance over the coming months, as 2 daily slots are being actively managed with staff released to attend.

The December report was not available for submission at the time of writing, due to the festive period and annual leave.

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

The Main MNVP, final meeting of the year was held on 6 December, with representation from the service. An update on service changes, celebrations and challenges was shared with the group.

MNVP leads have been contacted to arrange to co-produce the action plan in response to the 2023 Annual CQC Maternity Survey.

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 LMNS.

5 RISK ASSESSMENT

1:1 Care in Labour, 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, December 2023.
- 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 informed that there were 27 stillbirths in total in 2023, a reduction on 32 in 2022.
- Academy is asked to note that there was 1 case of HIE reported in December.
- There were 3 neonatal deaths in December.
- Academy is informed that there were no maternal deaths in December.
- There are 5 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 2 completed MNSI/Internal Serious Incident reports to share with QPSA/Closed Board for December.
- Quality and Patient Safety Academy is asked to note that there was 1 MNSI reportable case and 0 reportable Serious Incidents (SI) declared in December.
- QPSA is asked to note appendices 2 and 2a, the final Perinatal Mortality Review Tool reports, required to support compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5 submission. Academy is asked to note the mitigation regarding 1 missed surveillance case, and support the recommendation that full compliance is declared.
- Academy to note that there were 3 occasions in December 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 that the increased unit pressures experienced in November has resolved to a level of expected activity.

Meeting Title	Quality and Patient Safety Academy		
Date	31.01.24	Agenda item	QA.1.24.7

7	Appendices

- Appendix 1, 1a and 1b - Maternity and Neonatal Harms December 2023 and completed MNSI reports.
- Appendix 2 and 2a - Final PMRT quarterly Board reports.
- Appendix 3 - Maternity Dashboard up to October 2023.
- Appendix 4 - 1:1 Care in Labour Risk Assessment.
- Appendix 5 - Maternity Training Compliance, November 2023.
- Appendix 6 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	28.02.24	Agenda item	QA.2.24.10

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE JANUARY 2024

Presented by	Sara Hollins, Director of Midwifery/ Carly Stott, Associate Deputy 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 Newborn 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 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.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
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Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, January 2024.
- Academy is informed that following January Trust Board approval, the Maternity Incentive Scheme, Year 5 Board Declaration form was submitted on 31 January 2024, declaring full compliance with the 10 safety actions.
- Quality and Patient Safety Academy is asked to acknowledge appendix 2, the final report following the NHSE neonatal commissioning assurance visit in December 2023, including the recommendations. Particularly the recommendation that the Consultant Neonatologist lead/Head of Department attend Board to directly present a regular report on behalf of the department. Suggest that QPSA receive a quarterly update report with escalation to Board as required
- 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 was 1 case of HIE reported in January
- There were 2 neonatal deaths in January.
- Academy is informed that there was 1 maternal death in January of a Bradford woman at Leeds Teaching Hospitals.
- There are 3 ongoing maternity SIs/Level 1 investigations, 1 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 3 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for January.
- Quality and Patient Safety Academy is asked to note that there were 3 MNSI reportable cases, 2 of which were rejected and 0 reportable Serious Incidents (SI) declared in January.
- Academy to note Appendix 2, Quarter 3 Avoiding Term Admissions into Neonatal Unit (ATAIN) and Transitional Care Unit (TCU) report and action plan.
- Academy to note that there were 8 occasions in January 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.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
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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

Meeting Title	Quality and Patient Safety Academy (QPSA)		
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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	Quality and Patient Safety Academy (QPSA)		
Date	28.02.24	Agenda item	QA.2.24.10

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 LMNS, 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.

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.

- 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 pilot is expected to be rolled out to a second team in the next few weeks, following initial evaluation.

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 completed 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 focused 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, the 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 2024 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, followed by a series of individual action learning sets and a number of other group days.

The programme culminated with the completion of the SCORE culture survey.

High level feedback included:

- 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.

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 early 2024. Given the time elapsed since the SCORE survey completion, further engagement and co-produced action plans will include the results and feedback from the 2023 Staff Survey.

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 in October 2023 and Board in November, as an appendix to the overarching Nursing and Midwifery staffing paper.

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.

The next bi-annual paper will be presented to April 2024 People Academy followed by May Board. This paper will include the analysis from the November 2023 Birth Rate Plus full review, which is based on data collected between 1 November 2023 to 31 January 2024. The imminent Birth Rate Plus report will provide an up to date calculation of the number of midwives required to provide the service, factoring in the increased number of mandatary training days per midwife.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 6.88 WTE which includes the agreed uplift for maternity leave. The majority of vacancy is sitting within the labour ward establishment, which combined with a vacancy of 2 WTE and 2 WTE long term sicknesses within the maternity theatre scrub team, is compromising safe staffing levels in that area, as midwifery staff are required to provide emergency scrub cover.

In addition, although other clinical areas are fully established in the main, any short term sickness and absence not picked up by bank, is backfilled by labour ward in order to maintain minimum safe staffing levels. Despite the small vacancy rate against the safe staffing establishment, the service continues to feel staffing pressure on a regular basis.

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 32.3 WTE.

Maternity leave is currently 12.66 WTE.

A small number of newly qualified midwives joined the service in January and are currently in their supernumerary period.

5 BTHFT registered nurses have been offered places to undertake a fully funded Midwifery MSc shortened programme. The programme commences in March and is 2 years in duration.

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.

A daily system wide safety huddle to assess the need for mutual aid and support across the 6 West Yorkshire and Harrogate Local Maternity and Neonatal System, remains in place.

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 2 Gaps, one for short term sickness and one for maternity with an anticipated additional Gap from July 2024 .

1 Fully funded Obstetric only consultant post gap– previously advertised and not recruited to. We have advertised for a locum Obstetric and Gynaecology consultant for 12 months and a locum consultant colleague started in post on 12/2/2024 . We plan to re advertise the Obstetric post in a substantive capacity when suitable senior trainees are available and become eligible to apply.

A cost neutral combined obstetrics and gynaecology post is approved and we anticipate the advert to come out this week with a provisional date for interview on 9/4/2024.

There are currently significant areas of extra strain on the consultant body at the present time summarised on the local risk register:
- The volume of extra clinical sessions covered by colleagues. In view of average job plans equalling 11.75 PA 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 1.5 full time gaps in the middle grade rota. This is due to maternity and less than full time training arrangements. This is expected to become 2.5 gaps as of the end of March 2024 due to out of programme fellowship post. We have advertised 2 fellow posts to cover for maternity leave and out of training post. We are in the process of shortlisting.

As part of our aim to meet the CQC must do ask of covering maternity triage, we have interviewed and offered 3 fix term 12 month SAS doctor posts. Escalated rates to cover the gaps have been continued and agreed by HR until end of March 2024.

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

<u>Neonatal Staffing</u>

<u>Nursing:</u>

- Recruitment and retention both continue to be strong on NICU.

- Sickness and absence rates persist around 6.4% for the last few months. Work on going to try reducing this further. It had been 11.5 % last year so we have made progress but want to go further.
- Approximately. 5 WTE band 5 available to recruit to – Job for NQN's to be advertised soon. Will no longer need to recruit adult nurses and can focus on recruitment of children's nurses as demand is now beginning to out strip job availability.
- Available senior posts mostly now filled. Further interviews on 16th February.
- QIS nursing continues to be one of our biggest challenges as 80% of the workforce need to be QIS to meet BAPM standards. We expect to be just over 40% in the coming weeks as 2 more of our staff qualify. We have 10 nurses starting the access course (NFP) in March and a further 4 Nurses on the QIS course currently – expect to meet 70-80% QIS by late 2025 should we be able to continue to retain staff and grow our own.
- External QIS recruitment remains incredibly difficult as the staff simply do not exist in the network. Despite our shortfall of QIS network data suggests that we do out perform some of the other regional NICU's for staffing vs BAPM standard.

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 2023 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', was returned to the CQC and presented to May QPSA, July Board and progress is monitored through 'Women's Core Governance Group' and QPSA.

The Improvement plan was updated in November 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 which has now been approved. The next update will be provided in the February paper. The improvement plan is currently subject to internal audit review.

Maternity Incentive Scheme Year 5 Submission

The final position and recommendation to declare full compliance with all 10 safety actions, was presented to January 2024 Trust Board and approved. This enabled the Chief Executive and the Accountable Officer for the Integrated Care System, to sign the Board Declaration form prior to submission on 31 January 2024.

The Board Declaration form included mitigation regarding Safety Action 1, as recommended by NHS Resolution, in relation to a surveillance only case which exceeded the 4 week completion timeframe due to an information technology issue.

NHS Resolution confirmed receipt of the submission and the service awaits the outcome following review.

Neonatal Unit Assurance Visit Report:

NHSE undertook a neonatal commissioning assurance visit on 7 December 2023. Appendix 2 is a copy of the final report received in January.

Overall summary of the visit:

The visit was extremely positive and the quality commissioning review found that the neonatal service at BRI is providing safe, high-quality care to its patients, family, and services users.

Recommendations for continued improvement which are already in progress were acknowledged by the visiting team and included:

- To continue with plans to implement Electronic Patient Records (EPR) to enhance communication, joined up service delivery and avoidance of duplication.
- To continue with plans to their parent accommodation to improve patient and family experience.
- We acknowledge that there is a process in place for rapid safety and safeguarding escalations into the Executive Board, including the Consultant Neonatologist/Head of Department presenting at Board to represent the overarching view of the department.
- We recommend that Consultant Neonatologist lead/Head of Department continue to attend Exec Board to directly present a regular report on behalf of the department.

It is suggested that a quarterly neonatal update report is presented to QPSA with delegated authority of Board, and any concerns/emerging themes are escalated direct to Board. Any issues identified outside of quarterly reporting, would be exception reported via this paper.

Induction of Labour Delays:

During November the service 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.
This position improved during December, but has escalated again during January for the same reasons described in November

This position is not unique to Bradford and is seen both at LMNS and Regional level, and has also been acknowledged by the Chief Midwifery Officer for the United Kingdom as a national issue.

Ongoing improvement plans, described in the November update paper, are in place to manage and minimise risk as much as possible, including the daily LMNS safety huddle and escalation processes.

Stillbirth Position

There were 4 stillbirths in January. Details are included in Appendix 1. In addition, we are aware of a further intrauterine death in a Bradford mother who required specialist care in Leeds. The service will contribute to the Perinatal Mortality Review Tool (PMRT) for this case and any other investigation commenced by Leeds.

Table 1 is the running total of stillbirths in 2024, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Table 1:

Stillbirths 2024			Expected deaths within total number	Further detailed investigation
Month	**Number of babies**	**Running total**	**Butterfly babies/Congenital abnormalities**	**Number of cases**
January	4	4	1	0

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby diagnosed with HIE in January who sadly died, details in appendix 1. This case was referred to MNSI but will not progress due to the family declining to consent. The case will go back to QUOC for a decision on the level of investigation required.

A 2nd baby was referred to MNSI with a significant brain injury as a result of kernicterus. This was not an HIE case and was not accepted for investigation but does meet the criteria for a Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF) and will be investigated as such.

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 January, 2 declined as described, and 0 internal SIs. Level of investigation for the 2 declined cases will be updated next month when agreed by QUOC.

Safety Action 9 of the Maternity Incentive Scheme, Year 5, 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 6 publication.

Ongoing Maternity SIs:
Appendix 1 includes a position summary of ongoing maternity SIs. There are 3 completed reports (appendices 1a-c) for the attention of Quality and Patient Safety Academy and Closed Board this month including learning and recommendations.

There are 3 ongoing maternity PSIIs/Level 1 investigations, 1 MNSI and 2 Trust level.

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

Neonatal Deaths (NND)

There were 2 neonatal deaths in January.

- 1 Butterfly baby died at 6 days
- 1 baby born with HIE grade 3 died at 2 days (appendix 1)

Please see Table 2 below:

Table 2:

NND 2024			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	2	2	1	1 (MNSI)

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	28.02.24	Agenda item	QA.2.24.10

ATAIN and TCU Quarterly Report

Appendix 3 is a copy of the quarter 3 ATAIN and TCU report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme. Details of the report were discussed at the January Bi-monthly Perinatal Safety Champion meeting.

Q3 data included 39 admissions with a rate of 3.16%, which continues to be consistently below the 5% national target.

2 cases were considered avoidable:

- Maternal pulse mistaken for the baby's and steroids not discussed prior to elective section. This case will be used as an example in the fetal monitoring training day.
- A TCU baby was avoidably admitted to neonatal unit due to a lack of TCU cots.

Opportunities for learning from reviews have improved following the inclusion of ATAIN cases on the mandatory Care in Labour training day.

Maternal Deaths

There was 1 Maternal Deaths in January of a Bradford woman who died in Leeds Details are included in appendix 1 available to QPSA and Closed Board. The case was referred to MNSI by the Leeds team.

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 January. 1 case referred by Leeds and accepted, 2 others declined as previously mentioned.

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 January.

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 Perinatal Safety Champions and Perinatal Quad Leadership team, met on 25 January. Meeting chaired by Deputy Chief Nurse, Joanne Hilton. The group discussed the harms occurring in December and January. The ATAIN Q3 report was briefly discussed. There were no escalations from the Perinatal Quad Leadership team requiring Board support.

Monthly staff feedback from Safety Champions and walk-rounds

The Deputy Chief Nurse chaired the January ward to Board Safety Champion meeting. Positive feedback from the recent Neonatal assurance visit was briefly discussed.

The outstanding action from 2023 regarding staff concerns about car parking safety was raised and carried forward onto the 2024 action log. No new safety concerns were discussed.

Maternity Unit Diverts

There were 8 partial/attempted units diverts/escalations in January recorded on the closure log. 3 women were diverted to a neighbouring organisation for care during the 3 partial diverts, with 1 woman returning to BTHFT to give birth.

5 occasions when the service declared the need to divert services, but no other neighbouring units were able to accept due to similar pressures and challenges. This meant that the service continued to accept and admit women who impacted on the ability to provide 1:1 care in labour, delays in triage and delays to women waiting for induction of labour, and likely negative experience for some women using the service. There is no evidence of physical harm to mother’s or babies as a result of the service pressures.

Table 3:

MONTH	Full Divert	Partial divert	Attempted Divert	Number of women diverted
JANUARY	0	3	5	3 (1 returned to BTHFT to birth)
Total	0	3	5	3

Midwifery Continuity of Carer (MCoC) Action plan

An update on the action plan will be included in the February paper.

Maternity Dashboard

Appendix 4 is a copy of the maternity dashboard, populated up to December 2023.

- 1:1 care in labour saw a slight improvement in December to 90% and remains a key metric for attention. The Birth Rate Plus acuity app has been demonstrated and a finance conversation with a view to purchasing is planned
- Booking below 10 weeks gestation continues to improve and suggests that the importance of accessing early maternity care is becoming more recognised by the local population

Training Compliance

Appendix 5 is a copy of January 2024 maternity training compliance.

FIT training is being actively managed by the Maternity Matrons, who are allocating daily slots to members of the team.

Blood competency training remains a challenge. However 12 members of staff have now been trained as assessors and a plan to operationalise is in progress.

Unfortunately the Professional Development Midwife is off for an extended period therefore an update on PROMPT and Fetal monitoring training will be provided in the next report.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	28.02.24	Agenda item	QA.2.24.10

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 has not been an MNVP meeting in January. Next main meeting planned for March.
The service has received the embargoed results of the annual Maternity CQC Survey, and had a productive meeting with the MNVP leads in late January to review the findings and formulate a co-produced action plan. A detailed update will be provided in the February update paper.

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 LMNS.

5 RISK ASSESSMENT

1:1 Care in Labour, 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, January 2024.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	28.02.24	Agenda item	QA.2.24.10

- Academy is informed that following January Trust Board approval, the Maternity Incentive Scheme, Year 5 Board Declaration form was submitted on 31 January 2024, declaring full compliance with the 10 safety actions.
  Quality and Patient Safety Academy is asked to acknowledge appendix 2, the final report following the NHSE neonatal commissioning assurance visit in December 2023, including the recommendations. Particularly the recommendation that the Consultant Neonatologist lead/Head of Department attend Board to directly present a regular report on behalf of the department. Suggest that QPSA receive a quarterly update report with escalation to Board as required
- 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 was 1 case of HIE reported in January
- There were 2 neonatal deaths in January.
- Academy is informed that there was 1 maternal death in January of a Bradford woman at Leeds Teaching Hospitals.
- There are 3 ongoing maternity SIs/Level 1 investigations, 1 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 3 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for January.
- Quality and Patient Safety Academy is asked to note that there were 3 MNSI reportable cases, 2 of which were rejected and 0 reportable Serious Incidents (SI) declared in January.
- Academy to note Appendix 2, Quarter 3 Avoiding Term Admissions into Neonatal Unit (ATAIN) and Transitional Care Unit (TCU) report and action plan.
- Academy to note that there were 8 occasions in January 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.

7 Appendices

- Appendix 1, 1a, 1b and 1c - Maternity and Neonatal Harms January 2024 and completed MNSI reports.
- Appendix 2 - NHSE Neonatal Commissioning Assurance Visit Report.
- Appendix 3 - ATAIN Quarter 3 report.
- Appendix 4 - Maternity Dashboard up to December 2023.
- Appendix 5 - Maternity Training Compliance, January 2024.
- Appendix 6 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.

Bradford Teaching Hospitals NHS Foundation Trust Neonatal Unit Visit Report

Commissioning Quality Assurance Review

Neonatal Visit

December 7th 2023

Report Author:

Annesha Archyangelio (Chair), Regional Director of Nursing Direct Commissioning, NHS England (NHSE), Northeast and Yorkshire (NEY).

Report Contributors:

Beverly Geary, Director of Nursing West Yorkshire, NHS West Yorkshire Integrated Care Board (ICB).

James Thomas, Medical Director, NHS West Yorkshire ICB.

Emma Green, Service Specialist Specialised Commissioning NHSE, NEY.

Helen Brown, Yorkshire & Humber (Y&H) Neonatal Operational Delivery Network (ODN) Director.

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1. Introduction:

A commissioning quality assurance review visit was undertaken at the Neonatal Unit at the Bradford Royal Infirmary (BRI) on Thursday 7th December 2023 8am to 12.30pm. The review visit was chaired by Annesha Archyangelio, Regional Director of Nursing Direct and Specialised Commissioning, NHS England (NHSE), Northeast and Yorkshire (NEY).

1.1 The reviewing and visit team included:

Annesha Archyangelio (Chair), Regional Director of Nursing Direct Commissioning NHS England (NHSE), Northeast and Yorkshire (NEY)

Beverly Geary, Director of Nursing West Yorkshire NHS West Yorkshire Integrated Care Board (ICB).

James Thomas, Medical Director, NHS West Yorkshire ICB.

Emma Green, Service Specialist Specialised Commissioning NHSE, NEY.

Helen Brown, Yorkshire & Humber (Y&H) Neonatal Operational Delivery Network (ODN) Director.

1.2 Summary of visit findings:

The visiting review team were warmly welcomed by Trust Executive members and multidisciplinary team (MDT) members of the 'Neonatal Family', an expression that was echoed throughout the day. The trust presentation given by the Consultant Neonatologist lead / Head of Department, portrayed an enthusiastic and passionate team that was open, honest, and cohesive, all of which was later evidenced in both the focus groups and the neonatal unit walk-around. Questions and queries were welcomed, with staff being eager to share their work, and responses showed high levels of insight into the strategic direction, as well as the day-to-day operational challenges faced by the unit, and the Trust.

1.3 Observations by the visiting team:

There was an excellent presentation led by the Consultant Neonatologist lead /Head of Department with contribution from many members of the trust team. There is clear investment by the Trust in the neonatal service, through its MDT, which included specialist roles, Allied Health Professions (AHPs), advanced clinical practitioners (ACPs), registered nurses (RN), Occupational therapist (OT), and other roles. There was a clear vision for the service with a plan of how they would achieve their goals, supported by strong governance. Staff were able to describe the journey of improvement over the past few years, in the trust presentation, in service level teams in the department, and through visual demonstration on the neonatal unit. Staff's pride in the service is evident, and are very enthusiastic, patient and family focussed. This is despite the impact this process had on them, and the 'neonatal family' was cited as very been supportive. Consultants cited specific examples of the Trust executive support and input in the service, including the Chief Nurse offering to work clinically to support the service.

1.4 Safety culture:

There was a clear process for escalation from ward to board, staff at all levels were able to articulate this, and they described several ways in which they communicate this more widely, including communication through a closed Facebook group, meetings, and other methods. The visit team witnessed the 'Nursing Children's Neonatal-wide Safety Huddle' meeting, which was conducted through Teams at 8.15 am, and the face-to-face multi-disciplinary morning huddle at 9am. Here staff highlighted risks, staffing gaps (there were none), levels of staff (Qualified in Speciality (QIS), or RN), any safeguarding issues, planned activity on the labour ward and other items. The morning huddles was well-attended and was led by the Nurse in Charge. SI investigations, indicative of candour, demonstrated early learning, the action and review, demonstrated responsiveness.

1.5 The Neonatal Excellence Project (appendix 1) focussed upon:

- Workforce Qualified in Speciality (QIS) and new roles such as ACPs, clinical educators and other roles. Staff have been proactive in planning for the future to ensure resilience in the workforce. This also has a focus on retention, with significant achievements in the last 12 months the (nursing) attrition rate been less than 1%, this work has been shared with the network because of its success.
- Streamlining services
- Family experiences, describing them as partners in care (including teams) are invited to ward rounds, they talked about the butterfly work and the expected outcomes.
- Building that is fit for the future, including a scheme for family accommodation.
- Going digital, Electronic Patient Record (EPR) (Neonatal Unit Going Digital Project Charter-appendix 2) that works for the service.

MDT working was highly evident, the staff can articulate the previous issues, the journey and the actions taken to achieve the results they have enjoyed. Matron articulated the detail of the actions taken with the nursing workforce and staff developments as a result. The Bradford Neonatal Service Workbook (appendix 3) designed in-house, used for staff induction, was taken away by the visit team as an example of best practice. The neonatal team at all levels could clearly identify the challenges that they faced, have a proactive plan to address them and articulated the impact of the changes they had already made.

2. The agenda for the day (**appendix 4**) **covered various items**, **including**:

- Pre-meet for visiting team.
- Welcome and introductions and purpose of visit including with the CEO and CNO.
- Nursing Children's Neonatal-wide Safety Huddle via Teams attendance.
- Neonatal Unit handover /Ward Huddle attendance
- Trust update.
- Key lines of enquiry (KLOEs).
- Focus groups with visiting team and trust team split into two teams.
- Roadshow/ quality showcase/ clinical visit/ meet the staff and patients with their families.
- Further visits to clinical areas not yet seen/ additional focus groups with clinical teams.
- Questions for families, relatives, and carers who are with patients.
- Questions for staff.
- Review of patients' records.
- Time for visiting team to debrief.
- Feedback to trusts including the Chief Executive Officer (CEO) and the Chief Nurse (CNO).
- Closing remarks and next steps with lunch provided by the trust.

3. Purpose of the visit: commissioner quality and safety review guidance:

NHS England's Specialised Commissioning Quality Team, with West Yorkshire Integrated Care Board (ICB), were asked to undertake a joint quality commissioning review visit to the neonatal unit at the Bradford Royal Infirmary (BRI). The purpose was to undertake a joint quality commissioning review using an appreciative approach, conducted in a constructive, open, and honest manner. The visit was to provide a source of contemporaneous commissioner assurance, following concerns that were raised by the former Trust Chair in relation to the management of three serious incidents (SIs) which occurred in 2021. The concerns raised were not about the services, but regarding the governance and escalation of the incidents. The intention of this quality commissioning review was to clarify whether the neonatal service is providing safe, high-quality care presently. This is separate to the review of governance of the SIs that is being undertaken as a separate desk top exercise. When visiting the clinical areas, the visiting team made observations and talked with staff and patients about their experience, where appropriate. To support this, members of trust staff met and escorted the review team during the visit. Verbal feedback was provided at the end of the visit to the trust team hosting the visit on the day, and this formal written report outlining the visit findings is shared with the trust within four weeks of the visit.

3.1 Safe and high-quality care:

The reviewing team met with staff and patients on the neonatal unit to understand their experience of the care provided and to appreciate the work of the trust, including ongoing quality improvements (QI). The reviewing team break the review down into key lines of enquiry (KLOEs), as described in section 7 of this report. This assurance visit focused on KLOEs from the Safe domain and Well-led domain.

3.2 Which areas were visited:

The review visit took place in Bradford Royal Infirmary (BRI) neonatal unit informed by the KLOEs noted above. The visit chair and team remained on site and met with the on-site staff during the visit. The staff contact on the day for the neonatal unit/services was the Associate Director of Nursing for Children and Neonatal Services. The visit team was based at the Maternity Unit, BRI, on the day of the visit.

3.3 The format of the visit was conducted as follows:

- The Chair briefed the review team, clarified responsibilities, and reiterated the scheduled plan for the day.
- The Chair also ensure that team members were clear on the key lines of enquiry (KLOE) and navigation around the trust site, was responsible for time management during the day, and led the group feedback session at the end of the review.
- The review team conducted visits to the designated area and then regroup to agree key points for feedback.
- All comments and notes are retained. Therefore, the visit team were asked to retain documentation and any paperwork used on the day.
- The Chair provide high-level verbal feedback from the review team to the Trust's staff and identified point of contact for the oversight visit.
- This formal report will follow within four weeks of completion of the visit.

3.4 Recording of the visit findings:

Documentation was included in the visit pack to record all findings during the visit, which was collated to provide feedback and used to produce the final report. Members of the reviewing team were given responsibility for leading on the recording of parts of the visit.

3.5 Code of Conduct:

Patients/families and staff were treated with dignity and respect, and the views of all members of the team are equally valid.

3.6 Roles of the visit team members:

- To focus on the quality of patient care throughout the review.
- Treat all ward and departmental staff as you would wish to be treated.
- Be supportive and helpful, but also provide constructive challenge, if appropriate.
- Use individual expertise to help improve the quality of care.
- Take ownership for obtaining evidence and recording the findings.
- Maintain confidentiality. Do not share the findings outside the agreed communication route.
- Adhere to 'bare below the elbows' and hand hygiene/infection prevention and control (IPC) practices when in clinical areas.
- Any significant concerns identified during the visit, to be escalated immediately to the Chair; reviewers should not attempt to resolve any issues.

3.7 What happens after the review took place:

The review chair and team collated and gave initial feedback to the clinical/service manager prior to leaving the neonatal unit and service. There were no concerns or issues which required urgent attention identified during this visit. The review team feedback session then took place, during

which each reviewer provides a summary of their findings; this included several key points relating to areas of good practice and 3 areas for continued improvement and recommendations. Recognising good practice and identifying improvement opportunities are key during this review process. Giving measured feedback ensures the process has credibility and is delivered in a professional and supportive manner.

3.8. Participant feedback about the effectiveness of the review was provided (appendix 5):

The participant feedback form (appendix 5) was used to provide comments by staff who took part and contributed to the review, which will be used to develop, and improve future visits and events. The areas which staff were asked to feedback on included:

1. Event co-ordination, including paperwork, briefing and timings.
2. Opportunity to contribute, observe/interview appropriately, and provide input into their teams.
3. The overall effectiveness of the review and the level of insight and assurance it provided.
4. Any additional feedback.

3.9 Patient Confidentiality: Code of Practice (appendix 6):

All patients and staff have the right to expect that any information held by Bradford Teaching Hospitals NHS Foundation Trust (BTHT) is treated in a confidential manner and is used for the care of that patient or employment of its staff. They also have the right to expect that information regarding their personal circumstances or treatment is only passed on to those involved in their care or employment. Visit team to the Trust abided by the same code of conduct as its employees, in line with the confidentiality declaration form in appendix 6.

4. Nursing Children's Neonatal-wide Safety Huddle via Teams (**8.15 am**) **meeting** on the day of the visit:

Table 1: **Trust staff who attended this safety huddle included**:	
Associate Director of Nursing (Chair).	Quality and Patient Safety Facilitator.
Matron for Neonatal Services.	Ward Sister (2).
Ward Manager (1).	Neonatal Outreach and Transitional Care Unit (TCU) sister.
Neonatal Unit Sister.	Matron for Children's Community Services.

4.1 Items discussed at Paediatric and Neonatal-wide Safety Huddle:

The staffing SitRep review was presented which outlined that there were 3 staff for children's beds, total of 14 which were being validated. There were 27 inpatients on the unit, including 7 level one and 7 level two, with OPEL 4. There were 7 registered nurse (RN) and 1 healthcare assistant (HCA) on the day shift and 8 RNs and 1 HCA on the night shift. The patient categories on the unit included 1 blue (Trauma), 2 reds, 1 CAMHS patients, 1/12 CP plan and patients in triage. There was discussion of the staffing levels for all the areas/wards and the staffing numbers were safe on day and night shifts. The community service had 7 staff, which was okay, there were training planed for some staff and there were no issues escalated. There was no support with 121 needed on the inpatient ward form community, as it was felt that staffing was okay.

Maternity: there were a 34-week woman who was transferred, and a 26-week woman who from ward to intensive care unit (ICU) for urinary tract infection (UTI) and possible sepsis for management.

Staffing levels: There were 13 RNs and 13 QIS staff on the day shift, and 12 RN and 6 QIS on the night shift, the staffing was appropriate the day and night shifts.

There was 1 twin, where family could not visit, due to safeguarding being in place. There was an ICO and adopted parents visited. There was IPC isolation measures in place for the babies in the side room (orange room), with a Gentamycin resistant organism colonisation which was sent for microbiological typing in no datix the laboratory. There was 1 patient awaiting repatriation to another facility. There were no new risks or incidents reported through datix or otherwise in the last 24 hours.

Transitional Care Unit (**TCU**) had transitional care patients, including 7 babies, 2 empty beds, 1 patient waiting to be discharged, and 1 patient with safeguarding issues on child protection plan and has been followed up.

5. Neonatal Unit handover /Ward Huddle attendance (**table 2**):

Table 2: **Trust staff attendees of the 9am huddle included**:		
Meeting lead by the Neonatal Nurse Co-ordinator (chair). Consultant Neonatologist lead/head of department. Neonatal Service Consultant. Support Consultant. Ward Manager. Infant Feeding sister.	Perinatal Palliative Care Co-ordinator. Neonatal Service Matron. Senior ANNP. Ward Clerk. Outreach Nurse Discharge Co-ordinator Sister.	Clinical Psychologist. Senior Registrar. Registrar X 4. Tier 1 Doctor X 3. Trainee ANNP.

5.1 Items discussed at the Neonatal Unit handover / Ward Huddle included:

Items were discussed as per the section 4.1 on the Neonatal-wide Safety Huddle, including the number of babies on the unit, discharges planned, and staffing levels were good. Medical staffing was appropriate, with covers for day and night, including 2 consultant, 4 registrar, 3 low dependency doctors, ANPs.

Transfers: there was liaison with 'embrace' regarding patients who were safe for transfer. There were safeguarding plans in place for 6 families, and there were maternal support plans in place. There were some babies with same name, and staff were reminded to be careful with ID checks.

Breast feeding support is in place. One patient 24 weeks, and patient 34 weeks awaiting delivery. There was one patient who was 23 weeks plus 2 weeks who went home.

5.3 The various huddles and MDTs for neonatal which takes across the trust as detailed below:

• A huddle at 8:15 which the Neonatal Service Matron and Associate Director of Nursing attends.

• A whole unit huddle including maternity, at 9am and 9pm, attended by members of the visit team.

• The Neonatal service consultant also attends the maternity huddle at 12:30 each day.

• Various MDTs are in place across the department.

• There are clinical MDTs including weekly MDT between Neonates/Peadiatrics/Child Development service to manage transition of patients between areas and to discuss complex patients.

The unit also have MDTs to link in with Specialty services, including Cardiac, Genetic, and Surgery as required.

• From a governance perspective, there are several meetings across the Pediatrics Clinical Service Unit (CSU), including:

A monthly Core Group meeting which deals with the business of governance.

A monthly Specialty Quality and Safety meeting, which shares learning and Quality Improvement (QI) work.

To link in with maternity, there is a monthly shared Perinatal forum and a twice-yearly Specialty Quality and Safety meeting.

Maternity and Neonatal monthly safety champions meetings with the Executive Lead.

Maternity and Neonatal bimonthly meeting with the Quadrumvirate, Executive Lead and NED Safety Champion.

The unit also present at and attend various other governance and QI meetings across the trust.

• **For operational / business issues**:

MDTs are in place which covers physio, breast feeding, and psychologist support on the ward round, which are staff who help to support the duties on the ward. These staff are making important discharge planning decisions for the babies. This work is supported by the NHS Perinatal culture and Leadership Programme work (Bradford Neonatal unit (NNU) Score Culture Survey Feedback) in appendix 7.

The monthly Neonatal Operative Group (NOG) is held where the neonatal MDT and management meet to discuss specific operational issues.

There is a monthly meeting between Associate Director of Nursing (Chair), Matron for Neonatal Services, Consultant Neonatologist lead / Head of Department, and the Paediatric CSU Triumvirate (Clinical Director, Associate head of nursing, and Manager). There is also a monthly business meeting and a CSU: Executive meeting which the Paediatric CSU Triumvirate attends.

6. Trust update:

The trust team feedback, presented by the Consultant Neonatologist lead/head of department, regarding what has been going well and what can be undertaken better, as detailed below.

6.1 BRI neonatal service update on activities over the last 5 years, looking at what the neonatal unit aims to achieve, **including**:

- To deliver outstanding care for patients.
- Continued learning.
- Be the Best NHS Employer to work in the NHS.
- Be sustainable.

6.1.1 Means of achieving these aims include:

- Neonatal Critical Care Review (NCCR) and Getting It Right First Time (GIRFT).
- Framework and Resource of What Good Looks Like (WGLL).
- Receiving additional resources from ODN.

6.1.2 Continued learning:

The department outlined that they have strong governance process, which includes continued learning and has developed over many years including for peadiatrics and maternity. The serious incidents (SIs) in 2021 was used as an opportunity to explore the governance process, and

strengthen it, including using Duty of Candour (DoC) through being open with family, implementing agreed actions, and supporting staff through the process.

6.1.3 Be the Best NHS Employer to work in the NHS: **Neonatal Intensive Care** (**NIC**):

One of the benchmarks for NIC is to have 2000 care days per year that is sustainable. Other criteria benchmark for the unit is being over the numbers of very low birthday weight babies and they aim to do this better, with various plans in place. There is a focus on quality of care, including IPC outbreak management. Staff development and retention, moving from low dependency to high dependency is a focus, aiming to be a happy unit where staff enjoys working at, and there was evidence of this in place.

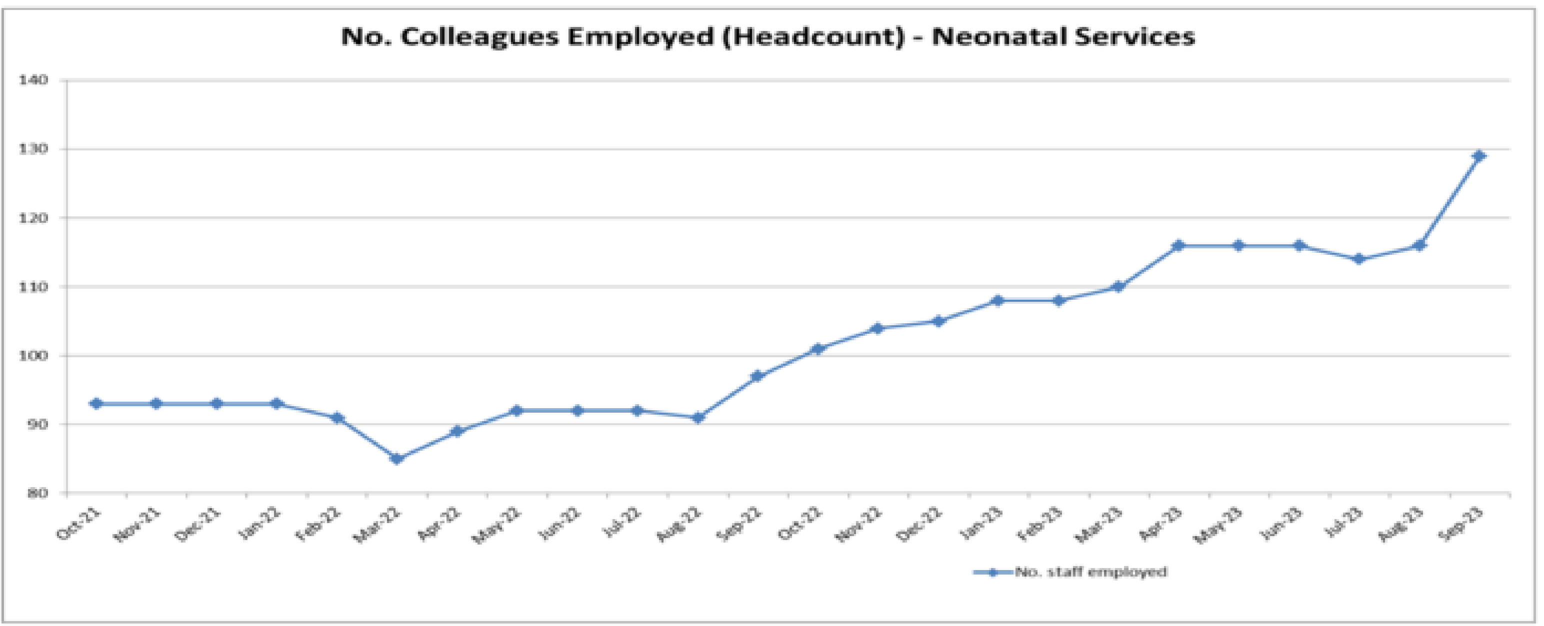
6.1.4 Be sustainable: the unit recognized that in the past they have been '*doing too much with too little', which has* pushed staff, and was not sustainable. At that time there was not as good recruitment and retention (R&R) and sickness absence was high, this was in the middle of the pandemic, which impacted on staffing across all areas. However, the unit did self-critique, looking at and addressing the challenges, to have a sustainable service, including how access mutual aid. They had a stock take in 2021 on being able to deliver outstanding care and this process continues. There is now a focus on key areas, including to 'grow the service' from a stronger base, including what does outstanding and excellence look like. There is now better awareness and nuance to manage these, and the unit has done a lot to address the challenges, know what need doing and how to do it, including balancing to 'build back better', focusing on NCCR and GIRFT as a framework. The unit undertook CCU review of what good looks like, through the Neonatal Excellence Project, including the mirroring and integrating with maternity; workforce; better outcomes for families; maternity integration; and going digital through EPR implementation, for which a business case is written.

6.2. Investment and support funding is being used to allow R&R in the various areas, including NHSE funding for nursing, AHPs, medical, and other roles; and Trust Support for NEP co-ordinator, organizational development (OD) team and service development time and workstream leadership.

6.3 Workforce work includes recruitment, with specific strategies for different areas such as retention, with focus on leadership and culture (appendix 7), professional development, supportive learning, and flexible learning; and creating a real MDT focusing on having a substantive AHP pool as part of the staffing models and new roles, and different perspectives. The progress with recruitment for nursing, is outlined in figure 1 below, indicating the ongoing significant increase in nursing recruitment.

Figure 1: recruitment for nursing:

Are we winning?
What does our data say?



The **Bradford Neonatal Unit Nursing Establishment Whole Time Equivalent** (**WTE**) **Staffing data** in **table 3** below.

Table 3: **Bradford Neonatal Unit Nursing Establishment WTE data**:	
140 staff in post on the unit.	7 Senior Sister 6.4 WTE.
8a Matron 1 WTE.	6 Sister 13.93 WTE.
7 Ward Manager 1 WTE.	5 Staff Nurse 59.17 WTE.
8a ANNP 2 WTE.	4 RNA/NN 7.93 WTE.
7 Trainee ANNP 4 WTE.	3 IFSW/HCSW 7.67 WTE.
7 Perinatal Palliative care practitioner 1 WTE.	2 Housekeeper 2.39 WTE.
7 Governance nurse 1 WTE (vacant).	7 Psychologist 1 WTE.
7 Senior Educator 1.16 WTE.	7 SALT 0.5 WTE.
6 Clinical Educator 1.8 WTE.	7 Physio 0.9 WTE.
6 Infant Feeding Sister 0.92 WTE.	7 OT 0.6 WTE.

6.4 Nursing currently 4 WTE being filled, and 6 waiting to start in the trust. Recruiting QIS nurses have been the main issue in Bradford, like other Neonatal Intensive Care (NICs). The neonatal ODN are supporting this with wider access to their Neonatal ODN Foundation Programme.

6.5 Medical staffing: The aim is for recruitment of new consultant to be fully compliant with the full specification by 2025. Team aims not to rely on trainees to fill medical posts and is also looking at and fulfilling the training needs of doctors. The unit has been impacted by the pressure regarding the challenges from Junior doctor regarding staffing and other elements and is undertaking various steps to address these. Junior doctors staffing is mitigated with junior doctors being recruited from oversees; junior doctors working with ODN; advanced Neonatal Nurse practitioner (ANPs); and fellows. There is also, pediatrics plus training and use of maternity incentive scheme for funding.

6.6 Junior doctors staffing data summary includes:

8 Consultants.

Tier 1 Medical rota.

Tier 2 Medical rota.

8 WTE medical rota, consisting of training and non-training grade doctors, and advanced Neonatal Nurse practitioner.

7 WTE medical rota, consisting of training and non-training grade doctors, and advanced Neonatal Nurse practitioners.

1 Consultant vacancy at present (appointed from April 24).

There are no junior gaps at present, but this fluctuates according to trainee allocation, usually at least 1-2 WTE.

6.7 Recruitment and retention: there is support for staff through training to work to the top of their license, with additional educators to support training and development to move from low to high dependency areas in the units. There are 2 educators in post in the unit and 1 is being recruited. The unit has a model to release people for training. Career and development conversations with staff is in place to provide support, and the discharge coordinator role is being used to check in with staff. These help with reducing vacancies and steady the workforce in the department. There is now a monthly staff turnover of less than 1 %. The matron has time-out session to speak to staff and has physical visibility and is accessible on the unit to provide support. The matrons' office is based on the unit, as well consultant team, open and welcoming to staff. To support retention, for recruitment of new staff, the Neonatal Intensive Care (NIC) Nurse job description (JD) is updated to talk about what staff roles and duties as a NIC nurse, including the foundation programme, newborn foundation course, Equality Impact Assessment (EQIA), and QIS. This has been successful, with a large cohort of staff from unit taking up the QIS training in September 2023. The ODN and the unit does the foundation course together, ODN work with unit to scope out the neonatal training, which is a model the unit aims to keep. The ODN network runs NSP (state full name) to fill the gap. The neonatal unit has a good Neonatal Service Workbook (appendix 3), used to induct, develop, and train staff, as part of the R&R programme.

6.8 Streamlining and escalation of services: is delivered through a perinatal team to deliver the NHSE 3-year plan and saving babies lives care bundles. This is supported by the Neonatal Safety Champions, through shared governance; Perinatal Services meeting through QI and service development on Preterm group, Perinatal Optimisation, Avoiding Term Admissions into Neonatal units (ATAIN); staff undertaking Perinatal Mortality Review Tool (PMRT)/Mortality review; and working with the Local maternity and neonatal system (LMNS) on data collaboration.

There is also support for low dependency care, including discharge coordinator, MDT ward rounds, and working with community to support discharge.

6.9 Family experience: the unit uses family centred care to support staff and deal with any potentially difficult cases, in line with high level of congenital anomaly in Bradford. This includes focusing on the Butterfly pathway; Baby-Friendly Initiative (BFI) re-accreditation; Parental Partnership event; Network Family Care Team; Virtual ward rounds; and the Padlet project where families can see the progress of their babies.

6.10 A Building Fit for the Future: the building of a new parent accommodation and facilities is being planned, which includes Neonatal End of Life Care (EoLC) and outdoor space. This has stage 1 sign-off and is going into stage 2 project. This is being funded in collaboration with the Hospital Charity and the Sick Children's Trust.

6.11 Ongoing learning from SI regarding power outage: the department is undertaking 'uninterruptible power supply' (UPS) work to address this risk, including fire and flood prevention. There is work on the fire alarms and undertaking evacuation simulation plan of how to evacuate the unit, working with emergency preparedness, resilience, and response (EPRR), and using action cards, with testing being completed 13 minutes.

6.12 The department is going digital, with planned implementation of EPR, as currently, systems fail at boundary level, as staff are writing on paper, where information can get loss. The department aims to integrate Badgernet, with Cerner (which is used in the Trust), with EPR,

maternity and ODNs systems. EPR is already implemented in maternity. The visit chair has connected Consultant Neonatologist lead/Head of Department with the regional/national EPR digital lead for any available resource to support EPR implementation.

6.13 The department is aware of its outcomes and challenges, including National Neonatal Audit Programme (NNAP) covering 2-year follow up, deferred cord clamping, necrotizing enterocolitis (NEC) versus bronchopulmonary dysplasia (BPD), thermoregulation, and infection; with action plans regarding Local and ODN activities; qualified staffing in speciality; and delivery / getting babies born in the right place. There are various processes in place to address these including the NNAP neonatal audit project, neonatal dashboard, quarterly data collection and review, infection prevention and control (IPC) measures (appendix 8) use along with IPC dashboard with case mix data that is adjusted, and monthly meeting by matrons to monitor compliance with IPC. The department aims to use QIS to meet the service needs. There is further work planned between the medical director in the ICB, linking with NHSE/HEE to support training of junior doctors to help address the medical staffing challenges in Bradford.

7. Key lines of enquiry (KLOEs):

7.1 Focus groups with visiting teams and trust teams were split into two teams to review the KLOEs, as detailed below in table 4.

Table 4: Focus groups with visiting teams and trust teams:	
Focus Group 1: Visit team 1: **Annesha Archyangelio, James Thomas, and Helen Brown.**	**Focus Group 2: Visit team 2:** **Beverly Geary and Emma Green**
Trust team staff group 1: Quality and safety assurance against the KLOE part 1 discussion: Consultant Neonatologist (1) lead/ Head of Department. Clinical Director Children's Services, Consultant Paediatrician. General Manager, Children's Services. Quality and Patient Safety Facilitator. Quality and Patient Support Officer.	**Trust team staff group 2: Quality and safety assurance against the KLOE part 2 discussion:** Director of Midwifery. Consultant Neonatologist (2). Associate Director of Nursing for Children and Neonatal Services. Matron for Neonatal Services. Named Nurse Safeguarding Children. Perinatal Palliative Care Co-ordinator, NNU.

The focus group discussion finding summary relating to the specific KLOEs from the review of BRI Neonatal Unit are detailed below.

7.2 Safeguarding systems, processes, and practices used to keep people safe:

This visit examined how the safety and safeguarding systems, processes and practices were developed, implemented, and communicated to staff to keep people safe. There is a clear high-reporting safety culture regarding safeguarding process and understanding or support, the unit are very responsive, they promote reporting and learning from incidents. Safeguarding nurses provide and use a unit specific "think family" process. Datix and rapid clinical reviews are employed for safeguarding incidents and events when needed, and the safeguarding team works includes neonates. The Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) safeguarding team compromises of named doctors (2), named nurses, and a safeguarding midwife that are all well-known to the unit and this team participates in daily huddles and datix incidents reporting and review meetings. This ensured that senior team knows about incident in as early as 2 hours following occurrence. Safeguarding training is provided for all staff at the appropriate levels throughout each month, including level 3 for senior staff. Links with external agencies are well established, for example, the Domestic Violence Unit and participation in a weekly safeguarding meeting on the unit to discuss key items. There are monthly Internal Senior Safeguarding meetings and an external Safeguarding Steering Group chaired by the Trust's named safeguarding nurses, which fosters the appropriate linkages between Ward, Board and External Agencies. There is interface and alignment between the Local Authority (LA) Safeguarding Team and BTHFT Safeguarding Team, and staff knows where to go for help with safeguarding issues. There is good links with Social Care and the trust, to gain support, although places to discharge patients to, and places of safety can be difficult to obtain. There is weekly safeguarding meeting on unity to discuss key items and notes are added to Badgernet. This includes planning and preparation for discharge. The trust is working on improving communication lines with Social Care, including supporting foster care, and monthly peer review of cases. There is an inter-agency safeguarding board being set up, comprising of the named doctor supporting interaction

with Social Care. These meetings and processes are used for safeguarding reporting up through the governance process, structures, and routes through to the Board.

7.3 Safety systems, **processes**, **and practices**:

All relevant staff, services, partner organisations and people who use the services are involved in reviews and investigations. Staff described how they feed into Quality and Safety and the local and system governance structure, through teams, weekly learning huddles/meetings every Friday and to network, as well as through mandatory study days. There is a patient safety lead in place, and staff can seek verbal response from ward-based staff and ask for support with recent incidents.

7.3.1 Staff understanding of their roles and responsibilities:

Interface with Patient Safety indicates that staff understand their responsibilities, including why and when to raise concerns. The importance of recording safety incidents, concerns and near misses was clear to see at all levels, staff demonstrated that they understand their roles and responsibilities to report incidents internally and externally, and the importance of learning from these mistakes.

The safety ethos and culture were clear to see across all levels, with a strong focus on sharing learning, including with the safeguarding lead, who provide support daily informally and formally to the team as necessary. The unit have people to go to for advice for staff who are supernumerary. Staff reported that they have a zero tolerance for medication error. There is a good incident reporting culture, and all staff are encouraged to report these for learning. The unit report they normally get 1-2 datixs per day and see this as real learning opportunity, to use QI

tools. Currently, a neonatal clinician presents at the trust board as required for any safety items and a separate clinician present on safeguarding to the trust board.

7.3.2 Process from a system perspective in sharing learning within wards, services, and the wider Trust:

There are detailed processes from a system perspective in sharing learning within wards, services, and the wider Trust. This includes the governance structure, which is wrapped around this, including how it flows from Ward to Board. There are several meetings that are held to look at incidents, such as local / business unit meetings, executive safety champion meeting, Quality of Care (QoC), SEG, Neonatal operational group meeting, and perinatal meetings.

The multi-disciplinary team help to develop weekly learning posters for presentation which includes the learning from the units' incidents, which is shared with the team. There is a folder within the staff room that the team reads showing any changes that they need to be aware of. The trust has implemented conversation cafes with staff which enables co-production with staff involvement. Perinatal meetings are held looking at challenges, admission rates, themes, and trends, which this involves the LMNS. Neonatal operational group meeting is held once a month, with the consultants, senior nurses, and other members of the team. There are time-out sessions with the matron with staff and parents. There is also a matron's restorative clinical supervision de-brief with both doctors and nurses to support each other. There is the undertaking of Professional nurse advocate (PNA) training to support staff health and wellbeing, as part of the post-incident management process. Staff discussed secondary victim and how they addressed this. There is compliance with the Network Quality Standards and the unit meet with the ODN network regularly,

share learning and audits takes place to check that the lessons have been learnt. The safeguarding team are looking at training across the MDT with learning included relating to the specific training needs are required for neonates.

7.3.3 Information disseminated to ward level, and **monitoring of action plans**:

Safety: There is a named NED and Executive Trust Maternity and Neonatal Safety Champion who are both members of the Board. A exec safety champion meeting is held monthly, which is extended to all members of the team, and includes a hybrid option to increase attendance. There is a set agenda, looking at themes and trends, HIE (state full name), stillbirths, datix. Any datix that is at a higher level this is taken to the risk meeting and escalated accordingly. If the datix is a possible serious incident, then a rapid clinical review is requested, and this is taken to Senior Executive Group (SEG) to review and confirm if this is a SI. There is a weekly Quality of Care (QoC) exec group, which is held every Monday, discusses whether incidents are SI or not and make decision regarding the level of investigation that will be undertaken, and any items that is identified from the SEG. There is a closed board report where the SI's are reviewed, and this is an opportunity to challenge any SI's that are not closed/actioned. The unit presents a perinatal paper to board which includes the neonatal harms. There is a child over death review group that is held every quarter. The pre-birth assessment is links in with social care at the time of booking which can help to identify safeguarding concerns so plans can be put in place to help mitigate this.

Staff participate in, attend relevant reviews or panels, and learn from reviews and investigations by other services and organisations. Information is escalated to the quality committee with dates of occurrences, where they can be challenges by internal and external staff including NEDs. Neonatal information is included in midwifery report, including EBT, so that this can be presented with along with the Director of Midwifery report, as dual leadership as role. Staff stated they feel safe, and that the cultural element of this work in this setting makes it easy to learn from others.

It gives a chance to "press pause" and to provide support to others and give assurance. The involvement of staff in these activities is at very significant level.

7.3.4 Lessons learned and improvements made when things go wrong:

Information sharing and lessons learned are shared to make sure that action is taken to improve safety. Lessons learnt are demonstrated by the weekly learning events to feedback, which includes all disciplinaries, and involves key things that have happened on the unit, medication errors, any issues with labelling, any changes in practice and positive information to share with the team. This information is developed by the medical team so that they can incorporate any learning points. A poster is placed on the door, presented on the computer screen.

Staff are encouraged to report incidents through the datix system, which goes through to senior staff in the trust, and incidents are also reported at huddles as a failsafe. Potential SIs are escalated to the Safety Event Group using SBAR, where the group agree the level of incidents investigation. MDT is trained on SBAR to support rapid and appropriate escalation. From Friday 1st December 2023, the trust is transitioning from the SI process to using Patient Safety Incident Response Framework (PSIRF). The department has a PSIRF plan, as part of the wider trust plan which includes training on PSIRF (incident management) and this is being distributed to all trust staff, to undertake the training offered. There is also external PSIRF training available to staff, to undertake.

There is a unit MDT Perinatal Forum which includes AHPs, pharmacy, psychology and other staff focuses on the Quality Improvement (QIs). Escalation to the Trust Safety Event Group is undertaken using SBAR (Situation, Background, Assessment, Recommendation). SIs on the unit is declared through the Trust Quality of Care Panel and live processes are in place to support rapid escalation immediately to Execs if required, through the Exec daily calls and this not limited by when formal scheduled meetings or wait to go through the formal the process.

There is discussion with the educational leads on the unit, who highlighted different routes of disseminating learning including through the safeguarding and SI processes. Information is fed into the mandatory days where the educator is involved. The neonatal unit staff also uses daily huddles, training sessions, videos, and a closed Facebook group to share information and lessons learned in the nursing team, wider unit, and other services. There is also a communal board, and a 'Friday Grand Round' discussion where appropriate, to disseminate learning and issues. SI's are feedback to the Neonatal ODN network so that this learning can be shared across the network. There is a team brief folder which details incidents, and staff example of concerns raised, and how staff escalated to region. This provides evidence that lessons are learnt, themes identified, action taken following investigations and improvements are made when things go wrong, including through clinical reviews which goes external if needed. Learning points shared and specifically pointed out and any changes to guidelines very explicit. Action plans sits with the Clinical Business Unit (CBU), with individual focus groups, which feeds into risk meetings.

Other evidence of learning from incidents on the units includes examples where the unit showed that they learnt from the rapid review for the umbilical cord bleed case, with more emphasis on observation to 'watch' more carefully. It was recognised that incidents like these have significant impact on staff, as well as relatives and families. Therefore, staff have explained how much emphasis is placed on focusing on the factual, supportive, and debriefing elements following the incidents.

Staff can access support from psychologists, as required, as described in the psychology programme on the Neonatal Unit Psychology Board in appendix 9.

A hot briefing has been implemented by the psychologist in the unit to share learning, where an incident occurred, and the team are called together to debrief about the incident; the focus is on staff support. The Psychologist has worked on a debrief later, called press pause and this is where the senior team and consultant are given guidance on how to structure a debrief to individual staff members and the team as required.

The neonatal risk team meets regularly to discuss and communicate learning from risks and incidents which are reported, including rapid response 72 hours review, SI reporting regarding Duty of Candour (DoC), using letters designed locally for personalisation, followed by the right investigation, development, and implementation of action plan. DoC – the neonatal unit produce a personalised, decision-making document and shared with families. The personalised nature gives the team the ability to understand and consider differences in culture and the expectation of families.

Risk management and **assurance**: this feeds out to speciality meeting across the Clinical Service Unit (CSU) to share learning. This enables staff to co-design learning from incidents, including through QI, perinatal and Healthcare Safety Investigation Branch (HSIB) work. Setting up Monthly Perinatal Service meeting, where some of this work can be reported into. There are weekly scheduled meetings with the maternity governance lead to discuss neonatal risk and other items to support rapid learning and feedback.

The unit has various safety champions, including a joint Maternity and Neonatal safety champion, leads who have conversations up to the Board level, including the discussion of neonatal morbidity and mortality (M&M) rate. The Consultant Neonatologist lead who is a safety champion attend Board directly and presenting their papers directly. Items are escalated through the trust safety panel to the board.

There are effective arrangements in place to respond to relevant external safety alerts, recalls, inquiries, investigations, or reviews. The Network (and others) alerts the matron, for example regarding feeding, which are reviewed at neonatal risk meeting and governance meetings and shared. The Neonatal Group also review these with safety champion. Matron runs family's clinic to discuss all aspects of care.
The safety alerts process both internally and externally includes reporting locally and up through Quality Committee to the board, as well as through safeguarding meeting and processes. Pre-birth assessments are undertaken to identify risk and put plans in place head of delivery. The

Mat/Neo teams work together, including through maternity safety events to review both services, including Post Har actions, observations, looking at models of care, and cleaning. The team gave a great example of a recent alert that they had received about a kit they used, the matron had received this alert from several contacts, and they looked at the kit, wrote a risk assessment and implemented the changes. This was then reviewed at the neonatal risk meeting and governance meeting, and then shared with the relevant parties.

Safety is monitored through a range of sources, including datix, SI's, audits, sickness and workforce levels, family feedback. The trust demonstrated that in 2021 sickness was 11%, this has been reduced to zero and less than 1%. There are monthly meetings with IPC to look at what they can do to improve IPC and compliance. The number of QIS staff is monitored and the number of QIS staff in the different areas on the units are split up to ensure QIS is present in each area.

Staff survey for May 2023: part of perinatal culture development programme shows areas of strength such as improvement readiness, safety climate, a statement that scored high on was '*culture here makes it easy to learn from others*?'. Safety is also monitored through the PMRT process, where the medical examiners process independently asks families for feedback and input. There is feedback from Junior Doctors regarding learning from incidents and datix. MDT for safeguarding is to commence to improve learning, looking at specific neonatal training, and staff articulated impact of this. The unit used 'You said We did' (appendix 10) to indicate how they acted on what staff said.

7.3.5 Training provided to staff regarding incident reporting, **SIs**, **and RCA**:

Staff receive effective training in safety systems, processes, and practices, and, also about culture (appendix 7). Staff training on PSIRF (replacing datix) is being formally rolled out across the Trust by an external company. There is PSIRF training taking place across the trust for all staff,

including drop-in sessions, online training, and some external training for ward sister level and above. There are some concerns about non-casual learning (staff don't know the cause of the incident) that may come from PSIRF and trainers will build this into the formal training being progressed.

7.3.6 Training records for **SI reporting**:

All staff have mandatory training on being open non-blame culture and Freedom to Speak Up (FTSU) and this links with the medical examiner. There are induction and mandatory training records covering incident reporting. Some people had Structured Judgement Review (SJR) training as required for their role and any staff undertaking a SI has support from Trust Risk team, who have been trained on this process. Additionally, with the introduction of the new PSIRF system and In-Phase process to replace datix, the Trust have been undertaken PSIRF training trust-wide. The training undertaken covers elements related to families.

7.4 The **matron**'**s office** has an open-door policy and is located on the unit to ensure access to families and staff who are encouraged to 'drop in'. Staff offices: all staff offices on the unit that were in use that day either had their doors open or had notices inviting staff to enter, '*which I felt promoted the 'neonatal family' ethos and eroded any hierarchical barriers that can usually exist'*.

7.5 Other good practices were noted: there were several people that the team could approach if they have any concerns, or issues, including:

- Discharge coordinator who was supernumerary.
- Ward manager who is accessible Monday to Friday.

• There were 2 clinical educators who were on the 'shop floor' to help the team as necessary.

7.6 Security team works with **clinicians** to **ensure safety**:

There are no CCTV in place, but any blind spots are well managed. The unit has secured door, and nurses who monitors regularly. Accessibility versus security is a challenge in any unit, but BTHFT view families not as visitors but as partners in care and are aware of the limitations of the unit at present. Fingerprint ID access and admission options are being considered and plans are well underway for the provision of family accommodation to meet the standard 'within dressing gown distance'.

7.7 Visiting policy:

There are defined strict numbers of visitors per family allowed on the ward. Immediate family/children are allowed to enable a balance between visiting and meeting department and service user needs. The unit has a list of people who can and cannot access to the unit to limit cross infection and overcrowding. There is disability access to the unit and a reception where there is observation of entry and exit to the ward.

7.8 Design, **maintenance** and **use of facilities** and **premises keep people safe**:

The key priority environment work for the trust, which they are working to address are fixing UPS, learning from previous power outage, fire safety is being addressed as fire alarms are undergoing a refit and the building of the new of their new parent accommodation.

Environment/equipment: there are housekeepers, Medical Engineers (EBME) and ward managers located within the unit to ensure all checks and maintenance are undertaken and there is understanding of the needs of the neonates and the provision of responsive and efficient service. There are hand soap dispensers and other handwashing facilities in place on the unit (appendix 8).

Risks to people are assessed, and their safety monitored and managed, so that they are supported to stay safe, using risk assessment tools to identify, mitigate, and reduce risk. Rehearsal of alarm calls/fire drills and abduction action cards are undertaken on a regular scheduled basis and alarm bells are in place if required. Patient call bells in bays and side rooms are in working order for staff and patient relatives to use if required or wanted. The unit have well tested Abduction Policy and Lock Down Plans as well as an Emergency Evacuation Planning (with EPRR) in progress with simulation exercises included. Trust representative visits the department and undertake checks and training and provider information to staff.

It was demonstrated that staff have the information they need to deliver safe care and treatment to people, and individual care records, including written clinical data, are managed in a way that keeps people safe, and care records used different systems, including paper. Patient records medical and nursing notes are kept on the cot side. If there are any safeguarding issues identifying the notes are put on Badgernet. The team felt that it was important that the notes are kept at the cot side as the family are key partners in the care. **Documentation** varies between team member, any issues identified is feedback to that team member. The **discharge** coordinator has developed a care plan proforma which is implemented on the unit.

7.9 Staffing levels and skill mix:

Staffing levels and skill mix are planned and reviewed so that patients receive safe care and treatment. Vacant posts are recruited to provide full complement to ensure staff do not work excessive hours to cover staffing gaps, as detailed in the actual and planned staffing levels in table 3 on the Neonatal Unit's Nursing Establishment WTE data and figure 1 on the recruitment levels for nursing.

Safer staffing levels and information are provided at multiple points daily, in various huddles and forums, where cover for any staff absence is reviewed and provided to ensure the unit is safe. There is use of bank/TNR internal staff or familiar agency staff only if there are no other options. Various staffing reports were shared with the group and there appeared a wide understanding of the related issues. Recent investment in nursing and AHP roles has had a positive impact and recruitment continues to move at pace. There is recognition that this inexperienced workforce requires development of their skills to undertake their roles competently and the unit is well engaged with the ODNs Education Programme (Foundation and QIS). BTHFT have positively contributed to the development of the region wide education strategy. The unit also considers the requirements of long-term support of its staff to ensure well-being and retention including the offer of psychological support and drop-in sessions with the matron.

Junior medical staffing, especially trainees, remains challenging and will require some innovative plans and the courage to 'think outside the box'. A BTHFT neonatologist is working with the ODN to progress some options including overseas recruitment.

Arrangements are in place for using bank, agency, and locum staff to ensure patients are kept safe, through comprehensive induction of agency staff to the unit and using familiar or regular bank or agency staff on the unit. There is also good handover process to support this.

There were arrangements for handovers and shift changes to ensure that people are safe, including twice daily huddles with all team present. Members of the review team attended morning huddle and witnessed the team huddle and agenda was comprehensive.

8. Neonatal Unit walk round: **clinical visit by the review team, escorted by trust staff**:

The clinical visit included roadshow, quality showcase, and meeting the staff and patients with their families. There was further discussion in focus groups with clinical teams regarding additional clinical areas which were not accessible such as mum's expressing rooms and isolation rooms as they were in use.

The **clinical visit by the review team to the neonatal unit identified several areas of good practices** as described below.

Overall impression: Entry to the unit was in line with the 15-steps approach, the whole atmosphere was welcoming, upbeat and clean. On entering the unit, we were met with very visible attention to hygiene and cleanliness with excellent hand washing facilities provided, including clinical hand-washing sinks on entry with mandatory hand washing prior to entering the units. The hand-washing sink was of high quality and in good working condition. There was also an instructional video screen in use over the sink to help families and visitors to correctly wash their hands. This is quickly followed by friendly smiling welcomes from the ward clerks sitting on reception. After talking with the ward clerk, it was evident that they feel part of the team and are part of the 'neonatal family'. Staff were friendly and whilst there was a ward round in progress and the unit invariably busy you weren't made to feel as though you were in the way. In fact, all team members were eager to share their enthusiasm for the work they did, and it was clear how proud they were of the unit.

There was additional hand wash and hand gel facilities at appropriately designated areas throughout the unit. The unit is newly refurbished, with new and improved features and facilities including mum expressing room, sterile room, and milk room with milk fridge and bottle cleaner. The units had various facilities, including, but not limited to; parents' room where staff can have discussion with parents and relatives, including providing end of life care (EoLC) services and support. The 'testing room' on the unit was clean, tidy and in good condition. There were good controls on entering the bays, with anyone entering asked to both wash and gel their hands to eliminate a maximum of number of organisms. Individuals entering the bays are asked to be hand-free (not touch anything) unless that is an essential part of their purpose and duties in the bay. The bed spaces in the bays are self-contained, which exclude individuals who does not need to be in the bed space. These practices reduce traffic, with the aim of reducing the risk of overcrowding and cross-contamination. There was additional 'scrub sinks' in the bays for staff to use prior to clinical care and aseptic procedure. There was water on these sinks to filter out organisms such as pseudomonas aeruginosa, which presents high risk patients, particularly babies.

The visiting team met the staff lead for the 'Butterfly pathway', which supports families and babies with life-limiting pathways. This includes the provision of EoLC support and services, with a 'memory focus'. The visiting team observed ward-rounds which were in progress, which ensured MDT review of the babies. The bay areas have locked separate controlled drugs (CD) and emergency cupboard, and the keys are kept by the nurse in charge.

There is one side room which is available for single-baby isolation or other procedures, and 3 rooms/bays which can be used for co-horting for infection. There are photographs of a selection of signage used in the unit to ensure compliance with IPC in appendix 8. These includes posters on the 10 steps for hand washing, Aseptic Non-Touch Technique (ANTT), 'contacting the nurse before touching the incubator', disposable apron

and curtain use, don't visit the unit if you are unwell, entrance/in-unit/bay hand washings/sink signage, unit entry hand washing sink and signage, gloves use signs, hand soap and gel signage, IPC boards, IPC signage on walls, and standards for IPC signs in NNU and at the nurses station.

There is a high dependency (HDU) room on the unit, which had MDT ward round in progress. There was also a low dependency room, to suit the relevant age-group, and had a 2-year-old ambulant child, who was up and about. There were various types of sinks in this bay, such as areas to wash the patient, plus separate hand-washing sink. Educators on the unit share some of the various plans in place to support newly recruited nurses to work to the top of their license in the neonatal unit. This is supported by the neonatal workbook pictured in appendix 3.

We also met an OT who shared how happy she was working on the unit and has been involved innovative work since joining. We also me the Baby Friendly Initiative (BFI) lead, who runs the accreditation for the unit, including undertaking regular audits, with the current training compliance rate at 97%. The unit has recently successfully completed their accreditation and is now working towards the gold-standard of accreditation. We met the ‘Excellence Project Coordinator’, who supports all staff and programmes to achieve excellence in the unit.

9. Questions regarding KLOEs to obtain feedback from families, relatives, and carers who are with patients:

The responses and comments from service users and relatives who were spoken with are detailed here. Five patients’ relatives, and carers were asked the following questions based on the KLOEs to gain their feedback on the quality of care their relative are receiving and regarding their experience of care.

Relatives feedback that staff listen and respond to any specific needs or concerns they may have. There is also drop-in clinic for parents, held by the matron. The OND picks up themes previously, which has been worked on to meet the needs of parents and patient.

Patient relative (dad) who were spoken to said, yes, staff listen and respond to any specific needs or concerns had. For example, on ward rounds, the patient said they asked many questions, as their baby was very small and in isolation. They advised that staff responded with great support and was not rushed.

Families present on the day were also willing to share their views. '*I personally spoke with a mother present with a sibling, her baby was in Special Care Unit (SCU) and she was feeding baby (EBM) whilst her elder child played with toys provided by the unit'*. Mum admitted that her 2-year-old got bored easily and could become a bit of a nuisance but felt her being able to see and touch her sibling was fabulous.

A dad was at the cot side in ITU and as English wasn't his first language it was a bit more challenging to get an accurate perspective from him. Having said that it was obvious by his smiling relaxed demeanour that he was not feeling uncomfortable or particularly stressed under the circumstances.

Patient relative (dad) noted that they never had to request to be put in contact with any external agencies, but asked about the process for registering the birth locally as they were out-of-area and they were well supported and provided with the information needed. Patient dad said, he felt that the facilities/ward areas and equipment are safe and well looked after, added that he found no issues. In the isolation room, he needed a longer tube for one of the machines, which was provided straight away. He broadly felt there are enough staff to meet the needs of patients on the unit, including that broadly there is one-to-one care being provided in ICU and the isolation area. He noted that there is a good 'regiment' in place for when staff goes on breaks, with good handover, cover, and systems in place for early and late lunches. He stated that he saw good

communications regarding feeding, and changing their baby as part of the handover, prior to going on breaks. He said there was never a time when he was unable to access help the help needed from nor there was no time when the appropriate help was not provided. He had Been able to access any information they needed and noted that staff spent time to explain things to him. He said he had at least twice daily involvement in the care delivery or being informed about the completion of care and treatment plan and had no need to raise a complaint or concerns even though he was the type of person who would do so if found a need to.

9.1 Additional comments and information regarding the care patients, families/relatives, and carers received are detailed below:

The member of the team was asked to talk about what it was like working on the unit, and whether they felt supported and listened to, and the response are detailed below.

One person feedback that "*over the last 5-10 years the leadership has got stronger, and the culture is better, which is a positive storey, and people know where to go to for help. The unit have a special care coordinator, a discharge coordinator, and psychology and speech therapy and therapists in place, which provides great support. The unit do have peaks and troughs in morale, some nurses to leave to go to other units, as it is fast-paced on this unit, hence, we do support each other as a neonatal family. It feels supportive, open, and honest. Regarding the Datix, it is used as learning, we are all human, no one is perfect and the Datix is about learning*."

Person 2 was asked a quick question as visiting the different sections of the unit, what is it like working here and they "*I enjoy it*."

We did not interview a patient (neonates) but from the unit walk around it was clear that patient's parents were interacting with staff. We also heard about the use of digital methods to ensure family could not be present at/attend ward rounds.

10. Questions regarding KLOEs to obtain feedback from staff:

Staff were asked questions based on the KLOEs to gain their feedback on the quality of care delivered, and their experience of working in the unit. The responses and comments from staff who were spoken with are detailed here and staff indicated that they:

- Are aware of the safeguarding and SI systems and processes and any changes are communicated to them.
- Can describe the training they receive around safeguarding and SIs, including the systems and processes used.
- Can describe how they would identify and report someone at risk of harm and how they would work with other agencies to help them.
- Can describe the processes for raising concerns and reporting incidents.
- Felt that the working environment is safe.
- Ensure equipment are well maintained and they feel competent in its use, including reporting faults for rectification.
- Consider staffing levels and skill mix to be safe.
- Experiences of working with agency or locum staff in managing staffing shortages managed is good, and the neonatal unit only use familiar and set agency staff, where there are no other options.
- Use checklist for agency staff and planning to update it.
- Can you describe the patient/shift handover processes.
- Can describe how patients with deteriorating or challenging conditions are managed and senior staff support with this.
- Ensure that patient's care records completed, managed, and stored appropriately.
- Can you easily access all the information they need to deliver safe care and are planning to implement EPR.

- Ensure that patient care information is shared with others when needed, for example when patients are discharged or transferred.
- Are involved in an incident review, either internally or externally.
- Learning is shared with staff following investigations and incident reviews.

10.1 Additional comments and information regarding the staff experienced are detailed below:

Four staff members were interviewed, they were clearly motivated and passionate about their work and the unit's ability to respond to the patient's and family's needs. All interviewed were patient focused, enthusiastic, compassionate, and supportive of patient, families, and staff.

There was good awareness of processes on ward with sharing feedback, and good practices were seen and heard about including:

- **Psychological support** to staff following any event. Dedicated ward psychologist to support families and staff. Training staff to support each other especially straight after any significant event- worth sharing module of learning that they have developed to others.
- **Palliative care arrangements**- wrap around support offered and in unit and home. Links with primary care and local palliative care services. Starts early pre-birth to support family and supports families throughout and if transition to other services. Excellent practice ensuring integrated approach with other services.
- **Education** – excellent arrangements to ensure sharing of learning via private Facebook group, ward notice board, daily huddles, grand round sessions, departmental sessions etc. Educators expanding.

10.2 Additional comments (**questions from staff**):

NIC: unit coordinator today. Beenhere 22 years but last 2-3 years see head of nursing and senior team. Matron visible "positive tea trolley". Ward manager supernumerary Monday - Friday. Significant change in culture for the better. In AHPs including psychological support for families and staff. Speech and language. True multi-disciplinary education team V strong foundation programme. QIS smooth "open and honest" good reporting culture to focus on learning. Articulated 2nd victim syndrome – and how they teach things to new members of staff.

11. Question for KLOE: **Review of patients' records**:

There was review of patients' records, as detailed below.

Patient records: these were situated at cot side where they remained throughout the babies stay. The records were contained in wipeable plastic binders and all 3 sets that I reviewed were up to date with entries/observations. Daily checklists also included a section on family questions/concerns and relatives were encouraged to complete in preparation for the ward round – especially if they were unable to be personally in attendance for it. BTHFT recognised that having records in several places (paper and systems) was challenging but very clear that any future EPR solution should not diminish the culture of openness and transparency that currently existed but only serve to support and enhance it.

There is training for recording on all patient record systems, and some staff have completed training on this, including:

Two WTE B7, two B6 are always on shop floor, and the discharge coordinator – quite a few supervisory.

The review of patients' records identified the following:

- Any concerns or risks of harm are flagged in the record, is done appropriately and the information is easily visible.
- Patient care and risk assessments been completed, are comprehensive and include a management plan.
- Records are complete, legible, and stored appropriately, and contain the expected information. Daily care plan formulated to focus on plan for that day, with additional information on Badgernet.
- Key information relating to care and treatment is easily accessible and in the record.
- Parents have access to own notes by the bedside, confidential and safeguarding records are also kept separately and notes on Badgernet.
- Handover information (internal or external) was recorded in an appropriate place.
- Both paper and electronic records are in use, and EPR is being planned to be implemented to ensure they are linked/easily accessible.

12. Review findings and feedback summary:

Following debrief by the visiting team, a summary of feedback to trusts including CEO/CNO is detailed below.

Participant feedback:

'*I enjoyed this experience, the team were passionate about the unit, being a 'family' shone through-it was a great to be part of such a review*'.

12.1 Overall summary of visit:

- The review visit went well.
- There was clear safety culture demonstrated.
- The team were responsive to incidents, there was clear governance structure in place, the team were focused on learning, the ethos was about learning and a no blame culture.
- The team were enthusiastic, and passionate about the care and the unit.
- They were aware of the challenges and were addressing them.

12.2 Areas of good practice:

- We found lots of **good practices**, from what we have seen, heard from staff, and read, including:
- The unit was **clean**, tidy, and welcoming.
- Staff were **enthusiastic**, **patient** and **family** focused.
- Really clear **safety culture**, from ward to board.
- Staff can **escalate things**.
- Evidence of **learning from incidents**, clear processes up to the board.
- The **Bradford Neonatal Service Workbook/induction booklet** (appendix 3) developed locally.
- Several evidence of provision of a good service and patient care, which can be shared wider.

- The unit held a **fire prevention/preparation drill exercise** – the unit felt this was a beneficial exercise, (it took 13 mins to evaluate the unit). They are looking at holding another one.
- **Conversation cafes** with the team – active involvement with the team to **support co-production**. There is a student visual board which includes names and photos of new starters so that everyone knows who the new starters are.
- The **Matron is supportive**, and it certainly comes across that we care for his team, he is passionate about the unit. He starts an early shift so that he can spend some time with the night staff so that they can see him and reach out if necessary. Good leadership in place.
- **Looking at different staffing workforce models** due to the challenges with the workforce and the difficulties faced with the medical staffing junior doctors.
- **Psychological support**: to staff following any event. Dedicated ward psychologist to support families and staff. Training staff to support each other especially straight after any significant event- worth sharing **module of learning** that they have developed to others.
- **Palliative care arrangements**: wrap around support offered and in unit and, home. Links with primary care and local palliative care services. Starts early pre-birth to support family and supports families throughout and if transition to other services. Excellent practice ensuring integrated approach with other services.
- **Education**: excellent arrangements to ensure sharing of learning via private Facebook group, ward notice board, daily huddles, grand round sessions, departmental sessions etc. Educators expanding.

12.3 Recommendation for continued improvement:

We recognized the challenges they have, which they are addressing. The areas for improvement and recommendations which the trust is already addressing include:

- To continue with plans to implement Electronic Patient Records (EPR) to enhance communication, joined up service delivery and avoidance of duplication.
- To continue with plans to their parent accommodation to improve patient and family experience.
- We acknowledge that there is a process in place for rapid safety and safeguarding escalations into the Executive Board, including the Consultant Neonatologist/Head of Department presenting at Board to represent the overarching view of the department. We recommend that Consultant Neonatologist lead/Head of Department continue to attend Exec Board to directly present a regular report on behalf of the department.

12.5 Findings and outcomes from this visit:

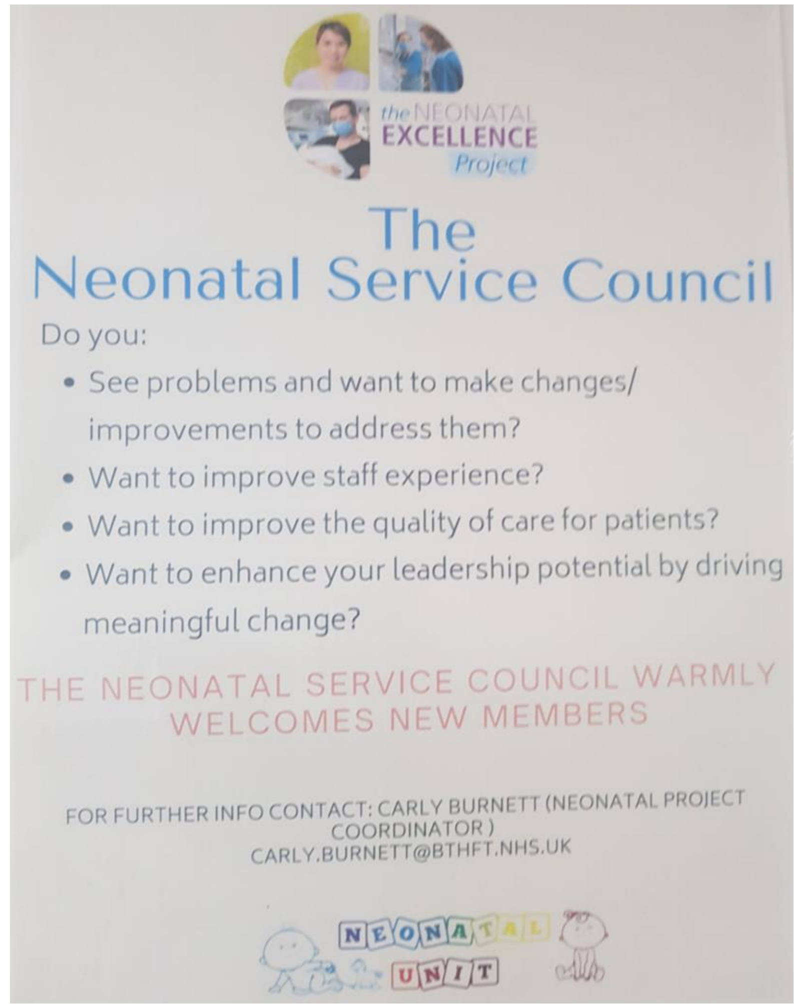
This quality commissioning review found that the neonatal service at BRI is providing safe, high-quality care to its patients, family, and services users.

12.6 Next steps:

This report has been factually checked by the Trust. This report then go through NHSE internal senior management team, regional leadership group and commissioning committee. Then, the Bradford QIG, and regional Quality Assurance Group (QAG), where the KLOEs are discussed.

13. Appendices:

Appendix 1: **The Neonatal Excellence Project**:



Appendix 2: Neonatal Unit Going Digital Project Charter:

Project Charter – Going Digital | **Neonatal Excellence Project**

Executive Sponsor: Karen Dawber	Workstream Lead: Laura Dalton	Project Coordinator: Carly Burnett

Background

The Neonatal service requires an electronic patient record (EPR) to replace existing paper records and paper based prescribing, which should be viewable both at the bedside and remotely. The EPR solution should have capabilities that allow it to become a single point of access to most clinical information, to ensure safe, effective, and efficient clinical care delivery. It should be either specifically designed for neonatal care, or at least highly customisable to meet the needs of our service. It will need to integrate with the current systems used in the Trust (primarily Cerner) and across the UK Neonatal network (Badgernet).
The removal of paper notes from the neonatal unit environment also has the potential benefit of reducing risk of infectious contamination from patient to notes and vice versa. This is a real concern on the neonatal unit where we have high rates of bloodstream infection locally and a population of patients who are particularly vulnerable to infection.
The use of an EPR system will also reduce the current risks that exist with paper notes around illegibility and therefore poor understanding of written assessments and plans, missing notes, and the ability to access notes at critical times.

There is also a requirement to improve our conferencing facilities on the Neonatal Unit to support communication across the network and offering flexibility to all staff to attend meetings virtually. The equipment currently being used on the unit has been condemned and is impacting on the deliverance of virtual meetings, medical grand round and general training where the computer needs to be used as a central resource.

Project Objectives

- Efficient and streamlined EPR system that supports neonatal intensive care to replace the current use of written paper notes and paper prescribing.
- Single point of access to clinical information, viewable both at the bedside and remotely
- Efficient and contemporaneous recording of clinical information
- EPR system that links with already utilized electronic equipment and integrates with current EPR systems (Cerner and Badgernet)
- Real- time oversight of observations and identification of patient deterioration
- Implement fit for purpose conferencing facilities on the unit
- Update and modernise external website and trust intranet site to reflect current information

Delivery Approach

The workstream group will meet monthly and consider all feasible options, engage stakeholders, establish recommendations and develop a business case. We will work with the Informatics Team to make sure we have the best system to support both local and regional needs. Implementation of the agreed EPR / prescribing solution will require planning and risk assessment prior to implementation.

Scope In	Scope Out
Electronic system that replaces paper notes and prescribing	Additional clinical systems
Electronic system that is used locally and regionally	
Conferencing facilities to suit departmental needs	

Initial Risks, Issues & Dependencies

Dependency: Successful business case
Dependency: Clinical requirements being met by the product
Issues: The changes do not impede clinical work
Issues: The changes do not impact on patient care

Project Delivery Milestones	Target Completion Date
EPR local and clinical priorities paper to be completed	June 2023
Business Case	October 2023
Conferencing Facilities for Seminar Room	September 2023

Quality / Financial Impacts

- Improved working efficiency and reduce risk of patient harm due to clerical and prescribing errors
- Reduced infection risk
- Improved regional communication with other hospitals and ensure safe transfer of patients and clinical information.

Governance

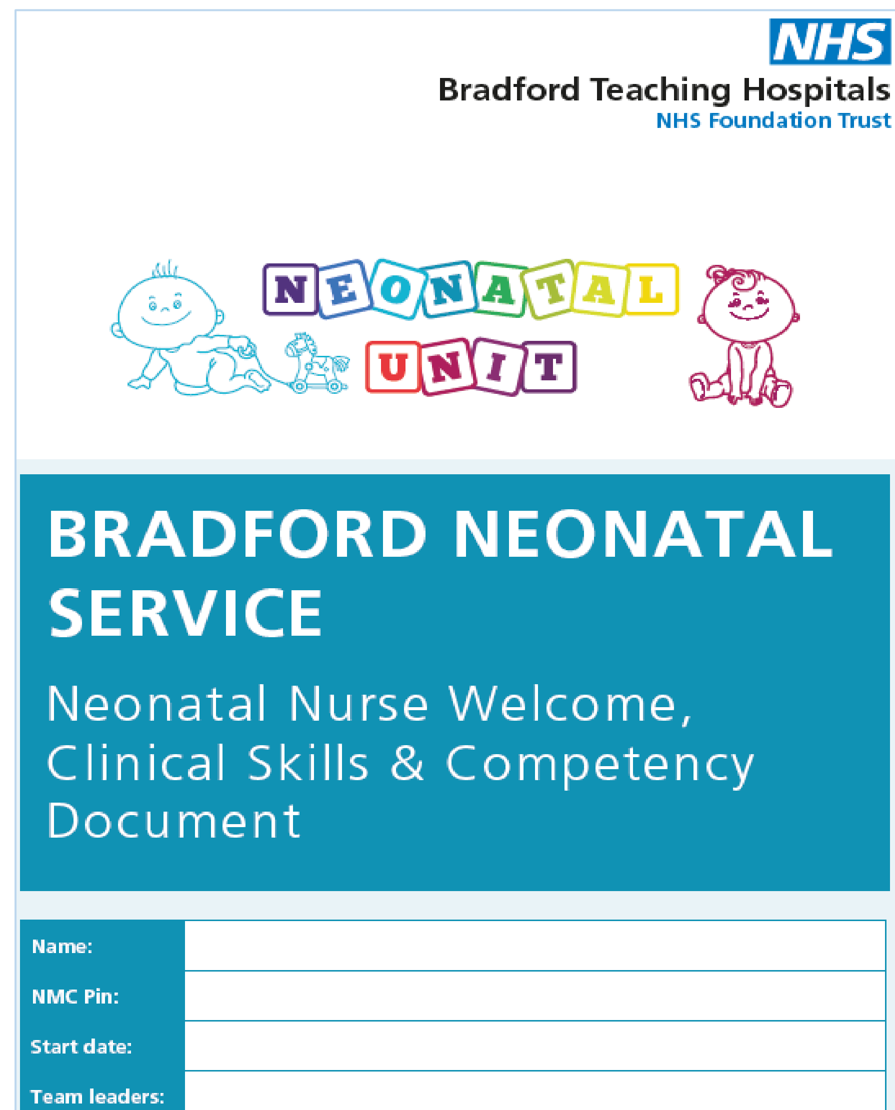
Workstream group to meet monthly.
The NNU Project Group will report quarterly to the sponsor via the CSU to Exec meeting.

Workstream Group

Consultant: Laura Dalton
Consultant: Sam Oddie
Programme Director Informatics: Glyn Bigmore
Assistant Chief Nurse-Informatics: Kay Pagan
Deputy General Manager: Anne Pinkney
Neonatal Project Coordinator: Carly Burnet

Executive Sponsor: Karen Dawber	Signed: [signature]	Date: 24.11.23
Workstream Lead: Laura Dalton	Signed: [signature]	Date: 14.09.2023

Appendix 3: Bradford Neonatal Service Workbook:



Appendix 4: **agenda for the day**:

AGENDA **Commissioner Assurance Visit Neonatal Unit visit Bradford Royal Infirmary** **Thursday 7th December 2023 8.00-12.30pm.** **Venue**: The Maternity Conference Room, Maternity Unit, Bradford Royal Infirmary (BRI), Bradford, BD9 6RJ (Separate discussion room available: Kay Rushforth's office, Maternity Unit, BRI)		
Time	Details	Lead
08.00	Visit chair – Annesha Archyangelio (AA)	AA
08.00	Pre meet for visiting team – Pastries/tea/coffee	AA
08:30	Welcome & introductions (CEO/CN attended) Purpose of visit	AA
9:00	Visit team to attend the Neonatal Unit handover /Ward Huddle at 9 am. There will also be an earlier 8.15 am Nursing Children's Neonatal-wide Safety Huddle via Teams meeting on the day of the visit.	Visit Team

	NB: possible that half of the team attend each huddle.		
9.30	Trust update / feedback on what's gone well and what can done better. Sam Willis.		Trust
Focus groups – visiting teams split into two teams			
09.50	Quality and safety assurance against the KLOE part 1 discussion: Team 1 Staff group composition: Dr Sam Wallis, Consultant Neonatologist Dr Helen Jepps, Clinical Director Children's Services, Consultant Paediatrician Louise Lacy, General Manager, Children's Services Denise Stewart, Quality and Patient Safety Facilitator Kath Wilkinson, Quality and Patient Support Officer	Quality and safety assurance against the KLOE part 2 discussion: Team 2 Staff group composition: Sara Hollins, Director of Midwifery Dr Catriona Firth, Consultant Neonatologist Kay Rushforth, Associate Director of Nursing for Children and Neonatal Services Jamie Steele, Matron for Neonatal Services Liz Ward, Named Nurse Safeguarding Children Vicky Jones, Perinatal Palliative Care Co-ordinator, Neonatal Unit	Visit team/ Trust staff
10:40	Refreshment break		

10:45	Roadshow/ Quality showcase/ Clinical visit/ Meet the staff and patients with their families. Further visits to clinical areas not yet seen / additional focus groups with clinical teams.	Visit team/Trust
12.00	Time for visiting team to debrief.	AA
12.15	Feedback to trusts (CEO/CNO attended).	AA
12.30	Closing remarks and next steps with lunch	Visit team/Trust

Appendix 5: **Participant feedback form**:

Thanks for taking part in the review, your contribution is very much appreciated. Any feedback you can provide will be welcomed and will be used to develop and improve future events.

Area of feedback	Score*	Comments
1. Event co-ordination, including paperwork, briefing and timings.		
2. Your opportunity to contribute, observe/interview appropriately, and provide input into your team.		
3. The overall effectiveness of the review and the level of insight and assurance it provided.		
4. Any additional feedback.		
***Scoring**: 5 = very good. 4 = good. 3 = average. 2 = poor. 1= very poor		

Appendix 6:

Code of Practice:

All patients and staff have the right to expect that any information held by BTHT will be treated in a confidential manner and will not be used for any purpose other than for the care of that patient or employment of its staff. Patients and staff also have the right to expect that information regarding their personal circumstances or treatment will only be passed on to those involved in their care or employment. As a visitor to the Trust, you are expected to abide by the same code of conduct as its employees.

Staff were asked to respond to the following:

- You may hear and see privileged information regarding patients or staff, and you are expected to maintain confidentially; you must not divulge this information to anyone else.
- You are not permitted to use the Trust's computer systems unless you have been given a password, have been trained, given specific access, and are accompanied by a Trust staff member.
- You must always wear a visitor's identification badge whilst on the hospital site.
- You are expected to report any breaches of confidentiality that you may come across to a senior manager for action.
- Any breach of confidentiality will be treated very seriously and dealt with by the Trust.

Declaration

I agree not to divulge to any person, whether employed by the Trust or otherwise, any information I may obtain about the social, physical or medical condition of any patient or member of staff, other than that required for the performance of my duties as a visitor/contractor of the Trust. I accept the rights of patients and staff to confidentiality and the Trust's code of practice for the security of Health Records and information systems. This undertaking binds me during my time in the Trust and when I terminate that visit.

Signed: Print name: Date:

Appendix 7: **Bradford NNU SCORE Culture Survey Feedback**:

Appendix 8a: **Sample IPC signage used in the neonatal unit to ensure compliance**:

Appendix 8b: **Sample IPC signage used in the neonatal unit to ensure compliance**:

Appendix 9: **Neonatal Unit Psychology Board**:

Appendix 10: **Neonatal Unit You Said We Did Board**:

YOU SAID WE DID

Morale

You Said	We Did
• Morale is low • You indicated you would like alternative ways of rostering examining	• Fixed staffing problems which was contributing to staff feeling overworked and under supported • Enrolled on NHS England improvement programme which may result in self rostering in the summer • Encouraged flexible working • Addressed education concerns and recruited educators
Successes	**Limitations**
• Active engagement clinics, to have your voice heard • Staffing numbers consistency averaging 13 nurses per shift able to take a work load	• Requires reassessment - "SCORE Survey"

Leadership

You Said	[illegible]
• Sisters not supported to do their role • Staff being asked to do things outside their role • Leadership needed in Special Care • Loss of cohesion with no direction • Concerns over future of the unit	• [illegible] Special Care Coordinators [illegible] focus • Reinstated Band 7 roles that were due to be downgraded and enhanced further • Recruited to all vacancies
Successes	**Limitations**
• Leadership away day to remotivate Senior team and provided an open forum to discuss challenges • Multiple staff members have completed the Leadership Pathways available within the trust.	• Still not completely consistent in application of coordination but improving • Leadership will be easier when new roles are established (Special Care Coordinator)

Safe Staffing

You Said	We Did
• Lots of vacancies • Staff voting with their feet (leaving the unit) • High turnover of staff • High sickness • Concerns around flexibility	• Significant time spent on recruitment • Created family friendly roles (Special Care Coordinator and TCU Coordinator) • Recruited AHPs to support the nursing team • Encouraged and approved flexible working requests
Successes	**Limitations**
• Growing our own QiS staff • 25+ flexible working requests agreed • Actively engaged overseas recruitment • Received skill mix monies to create RNA • Made education offer attractive to encourage staff to want to work on our NICU	• High sickness still remains, although improving

Communication

You Said	We Did
• Staff members were out of the loop and didn't know what was going on within the unit • There was a closed door feeling when trying to reach the Senior Team	• Set up regular team meetings for all levels of staff • Matron now sends monthly round up to all staff sharing key developments • Arranged Senior Nursing 1:1 clinics for all staff
Successes	**Limitations**
• Implemented Matron "Hype, Gripe & Idea's" Clinic • Highlights key areas that require further support • The feedback received in relation to new staff clinics has been extremely positive	• Some consistency challenges with coordination and day to day management of the unit • Not all colleagues access emails on a day to day basis

Education

You Said	We Did
• Staff not supported with their education • Pathways not clear	• Creation of infant feeding sister post, special care coordinator and education roles
Successes	**Limitations**
• Staff feel more supported which goes on to support our families • Improved training package due to go to print April '23 • Training pathways for new starters • Staff applying for Foundation Course within 6 months and QiS within 18 months	• Senior staff do not currently have a training pathway

Improving Special Care

You Said	We Did
• Junior staff consistently being placed in special care • Special care staff not feeling the same support as ICU staff • Inconsistent Nurse led ward rounds	• Not in numbers roles created (Special Care Coordinators) • Full review of Nurse led ward rounds planned • Coordinators will provide learning opportunities for junior staff on ICU
Successes	**Limitations**
• Successfully employed 2 Special Care Coordinators (Start 6th May) • Employed 2 Educators now in post active on the unit	• Occasionally junior staff will be put on special care • There will be times when Special Care Coordinators will need to be included in the numbers

West Yorkshire & Harrogate Local Maternity & Neonatal System

Assurance Visit 2023 - Trust report

Bradford Teaching Hospitals NHS Trust

6th November 2023

Visiting team:

- Karen Poole, Associate Director, Maternity Transformation Programme, NHS West Yorkshire ICB
- Debi Gibson, Senior Midwife, West Yorkshire & Harrogate Local Maternity & Neonatal System
- Emma Brown, Admin Support Officer, West Yorkshire & Harrogate LMNS
- Sonya Ainley, Project Manager, West Yorkshire & Harrogate LMNS
- Claire Keegan, Deputy Chief Midwife, NHS England North East & Yorkshire
- Sarah Wall Regional MVP Representative, North East & Yorkshire
- Ruth Shaw, Senior head of integration & change (Women and Children), Bradford District & Craven HCP/West Yorkshire ICB
- Rebecca Musgrave, Head of Midwifery/Nursing Leeds Teaching Hospitals NHS Trust
- Emma Nunez, Executive Director for Nursing, Midwifery & Allied Health Professionals.
  Acting Deputy Chief Executive, Harrogate & District NHS Foundation Trust.
- Nasrin Ali, MVP Lead

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2 INTRODUCTION

The Ockenden Report (2020 and 2022), and the Reading the Signals report (Kirkup 2022) identified that trusts were not implementing sustained change in response to independent enquiries and recommendations. Prior to the Ockenden reports trusts had consistently self-assessed as being compliant with recommendations for earlier reports including the Morecambe Bay Investigation report (Kirkup 2015). The findings of the subsequent reports suggested that not all trusts were as compliant as assessed.

In response to this, assurance and support visits were carried out during 2022 in each trust to assess and confirm progress towards the implementation of the 7 immediate and essential actions of the Ockenden interim Report 2020. These visits were led by NHS England regional maternity teams, supported by the local maternity & neonatal system (LMNS) team.

Further assurance visits are being undertaken in 2023, led by the LMNS with support from ICB PLACE leads, Chief Nurses and Directors of Midwifery from neighbouring trusts providing peer review, members of the NHSE regional maternity team and, most importantly, supported by the voice of local service users via maternity voices partnership (MVP) leads.

2.1 AIMS AND OBJECTIVES OF THE VISIT:

Aim

To gain insight and assurance of safe, effective and responsive Maternity & Neonatal services, identifying and sharing innovative practice.

Objectives

- To triangulate information and evidence in relation to implementation and embedding of the initial 7 Immediate and essential actions, from the interim Ockenden report (December 2020).
- To understand and learn how the 3 year delivery plan is being implemented across the service.
- To gain knowledge on the Trusts response to their recent CQC inspections and reports.
- To celebrate successes and for staff to gain greater awareness of the work of the LMNS, clinical networks and MatNeoSIP.
- Enable identification of priorities for system transformation.

2.2 Process

The trust were asked to provide evidence in advance of the visit which was reviewed by the LMNS team. In addition, information already submitted to the LMNS through perinatal quality surveillance was reviewed.

On the day the visiting team met with trust staff in focus groups and visited clinical areas, speaking to staff and service users where possible. An open questioning technique was used to probe the key lines of enquiry.

Initial findings were discussed in an open forum with members of the maternity senior leadership present. High level feedback was given to the maternity and neonatal team.

3 Findings

3.1 Overall impression

The evidence submitted in advance was comprehensive and of a high standard. It demonstrated a clear commitment to safety, managing risk, learning, quality improvement and maternity transformation.

Staff were extremely passionate about their service and the care they gave to women and their families. They were proud to work at Bradford and shared multiple examples of how they were working hard to ensure services were the best they could be for the communities they serve.

There was clear commitment to team working and mutual respect, within the maternity services and neonates. There was a commitment to learning and improving and ensuring staff and service users were at the forefront of any change. All staff used kind and considerate language and clearly articulated a woman and family centred approach.

3.2 Feedback on the day

High level feedback was given on the day using the bullet points below:

Key Headline

- Positive staff, enthusiastic about service
- Visible leadership
- Commitment from the board and staff fully aware of chief nurse and their role
- Women positive about their experience
- Personalised care for whole family, plan to trial new digital tool
- Staff working across different areas
- MDT working
- Décor on labour ward and AN/PN ward, birth centre, positive and welcoming
- Staff involved in quality improvement and working out solutions
- Clear vision for the future and ongoing quality improvements
- Focus on inequalities throughout

- Localised training that is valued by staff

Even Better If

- Capacity of MNVP improved and role embedded,
- Informed choice offer to be clearly evaluated
- The birth centre could be available whenever needed by women

3.3 Implementation and Embedding of the 7 IEA's of the Interim Ockenden Report

The evidence submitted in advance demonstrated review of the current position against the 7 immediate and essential actions. The trust is not currently able to audit compliance with personalised care and support plans and are commencing a trial of an online app based tool which will support this. The trust are compliant in all other areas.

The trust opened the day by sharing a presentation on their current position and actions taken following the Ockenden assurance visit in June 2022. A summary is presented in the table below.

June 2022 recommendations	Current progress
Continue to develop the fetal wellbeing programme	The fetal wellbeing programme continues to evolve
Consider sending women who have chosen to give birth in the birth centre there directly to support them to have the best experience and ensure they get their choice of place of birth	This sits outside of the BSOTS approach and at the current time is not a consideration due to ongoing staffing challenges, but will be reconsidered when safe to do so
Keeping the Birth Centre open (if staffing allows) will help spread footprint to ensure capacity available for women experiencing pre-term birth, ensuring babies born in the right place with right facilities.	As above. Every effort is made to support low risk women to birth on the Birth Centre. We have no evidence to suggest that Birth Centre closures have impacted on pre-term birth place of birth
Consider adding the role of Consultant Midwife	Prioritising appointment of a HOM
Consider recommencing the clinical live skills drills	Re-commenced ad hoc
Consider how to capture informed consent with the MVP	Changes to the MNVP have not enabled us to progress this
The MDT ward round appears embedded, but there is no record of this. Consider how the service has assurance of this practice (safety huddle practice is captured, can you do the same?)	Excel spreadsheet populated at 2 of the 4 MDT ward rounds with a view to increase this to all 4.
Consider cultural competency training	SCORE survey completed to inform approach
Involve MVP in guideline & information leaflet development from the beginning	Changes to the MNVP have not enabled us to progress this

3.4 PROGRESS TOWARDS IMPLEMENTATION OF THE 3 YEAR DELIVERY PLAN

The trust submitted a clear plan to implement the 3 year delivery plan. The outstanding maternity service (OMS) programme will support the implementation. There was a clear commitment to addressing inequalities with discussion on how additional data collection may be of benefit. There was a commitment to continue to develop the working relationship between neonatal and maternity services.

3.5 RESPONSE TO THE TRUST CQC REPORT

The trust submitted their improvement plan in response their latest CQC report. The trust presentation at the start of the day gave further narrative of the actions being taken and progress made. Additional narrative on improvements in the antenatal clinical area were demonstrated during the clinical area walkaround. Monthly assurance audits are in place which includes review of medicine management practice; medical reviews in triage were being prioritised and there is a plan for implement a 2 tier rota which will enable senior registrar cover in triage.

The trust have utilised external funding to procure the Language Line Carts following a successful trial period. These now form part of the options to increase access to language support 24/7, where and when needed.

The trust has ongoing staffing concerns and has implemented several strategies to try to address these. The trust engage with the LMNS workforce steering group and committed to delivering the LMNS workforce strategy.

3.6 TRIANGULATION AND EMBEDDING LEARNING FROM INCIDENTS, CLAIMS AND COMPLAINTS AS WELL AS NATIONAL REPORTS, GUIDANCE AND RECOMMENDATIONS

There was good evidence of commitment to quality improvement, listening to staff and service users, learning, implementing and embedding change where needed. The OMS programme was viewed positively across the service and is enabling quality improvements that are facilitated by staff and coproduced by service users. There are 5 key workstreams:

Priority 1: Investing in our workforce
Priority 2: A building fit for the future
Priority 3: Moving to digital
Priority 4: The women's journey and clinical excellence
Priority 5: Linking learning through the quality of our information

The trust shared examples of how learning from data, feedback and incidents or events was incorporated into staff training, learning memos' staff feedback forums, and these were viewed positively by staff. Representatives from the trust legal team attend maternity governance meetings to support learning from claims. Where new practice was implemented, there were clear processes to test success through the OMS programme. The trust shared how local and national reports were benchmarked and how action plans were developed and continued to be reassessed.

The trust is committed to delivering high quality training to staff and prioritise staff attendance on mandatory training days. At the time of the visit there was a PROMPT training day underway and it was evident that removing staff from training to fill clinical gaps was a last resort. Management of non-attendance at training was closely monitored and

addressed by the professional development lead midwife. Staff shared that they valued the training programme and information they received to share learning and reported a positive culture towards learning.

The trust are progressing their implementation of the patient safety incident response framework (PSIRF).

3.7 PERINATAL CLINICAL QUALITY SURVEILLANCE MODEL IN PRACTICE

The maternity service has clear communication to trust board and open transparent relationships were evident. The Director of Midwifery attends trust board and maternity papers are presented. Clinical staff were aware of the floor to board reporting framework and could name the chief nurse, advising that she attends the clinical areas regularly and engages with staff. There have been gaps in non-executive director engagement with the MVP and attendance at safety champions meetings.

The maternity service has monthly perinatal quality surveillance meetings with Airedale as part of the Bradford District & Craven Health Care Partnership. The meeting is attended by the PLACE based ICB leads and LMNS leads and chaired by the Director of Nursing for Bradford District Care NHS Foundation Trust as part of a distributed leadership model. The terms of reference of this meeting have recently been updated and the meeting format has become more structured and is evolving.

The trust engages well with the WY&H LMNS and the Yorkshire & Humber Clinical Network.

3.8 MNVP ENGAGEMENT AND COPRODUCTION

The trust had good examples of working with local service users to codesign services, through the OMS project and through communication via specialist midwifery roles. There was a clear commitment to tailoring services to meet the needs of the local population and ensuring care is personalised.

There have been gaps in the lead MVP role but good progress has been made since recruited to earlier this year. The MVP is one part of a broader approach to engagement across the Bradford District and Craven Health and Care Partnership. The Partnership are currently working to ensure all maternity and neonatal focused engagement is overseen by the recently renamed MNVP. This work includes a review of the capacity of the MNVP leads, other MNVP members and the commissioned VCS support to deliver their workplan whilst providing the expected engagement with services and the ICB.

The MVP lead attended the assurance visit and was clearly well engaged with the service with plans to further develop the role. The MVP meet bi-monthly with other leads across the LMNS and the Yorkshire & Humber Neonatal family liaison lead.

The trust shared that they recently started utilising the Maternity & Newborn Safety Investigations Programme (MNSI) family inclusivity toolkit to support engagement during investigations.

The Parent Education Team seek to provide a personalised service wherever possible. There were several different class groups available and individual sessions are provided where needed.

3.9 Staff engagement, communication, implementing and embedding change

Specific examples of staff engagement were shared including roadshows, tea trolley sessions, you said we did and band 6 leadership roles. Staff were encouraged to join weekly review meetings to discuss learning from incidents and complaints with their contributions being viewed as valuable.

Staff were keen to share information about their services and there was clear evidence of all staff being offered the opportunity to engage with quality improvement and learning initiatives. The OMS programme is valued by staff across the service and was seen as a key driver of quality improvements. The neonatal team shared the Neonatal Excellence Project with a focus on quality services and improving provision for families. The introduction of the butterfly pathway for families who choose expectant management for babies with conditions not compatible with life was admirable and demonstrated a further commitment to tailoring services to the needs of the local population.

3.10 Examples of external funding allocations and expenditure

The trust shared examples of the utilisation of external funding for enhanced continuity of care, by providing administrative and maternity support worker roles to support the teams; uplifting the midwifery and obstetric workforce; access to interpreting services for women and purchase of smart phones for the parent education leads to enable them to upload educational content to social media platforms and improve communication of the services they provide.

3.11 Assessment of service risk and mitigation

The trust submitted their risk register to the LMNS in advance of the visit. Their highest risks were identified as midwifery & obstetric staffing levels; the antenatal clinic waiting area; lone working in community; ultrasound scan department capacity. Mitigations and controls were evident and key workstreams in response to some of these risks are detailed earlier in the report.

The service escalates risks to trust board and the LMNS as appropriate. Recently additional support has been sought from the LMNS with regard acute staffing shortages and the management of workload. Daily huddles have been instigated and a SitRep is completed. The trust have valued the support from other trusts across the system when this is available, but unfortunately help is not always possible. The ongoing risks and issues are escalated to the ICB and NHSE regional maternity team.

3.12 Addressing inequalities

The trust are committed to addressing inequalities across the service. The trust has very high levels of deprivation and high numbers of families whose first language is not English. Poverty was identified as a theme from incident reviews and have taken steps to address specific findings as a result. The trust work with local voluntary services and other NHS services to provide additional support where possible. Examples of innovations include providing food parcels when women attend maternity appointments; providing interpreting services through different methods; providing parent education in different languages; providing written information in different languages and producing videos in different languages on key health topics. The director of midwifery chairs the LMNS Addressing Health Inequalities Steering Group. This group provides a forum through which equity &

equality issues can be identified, solutions agreed and implementation of improvements overseen as a system.

The trust provide midwifery continuity of care to women with some focus on vulnerable groups. The trust plans to further roll out continuity models when staffing allows.

3.13 Working collaboratively with the wider system and network

The trust engage well with the LMNS and their contribution to improving system wide learning and support is valued. The trust ensures attendance at working groups and representatives chair some groups. The trust also engages with the Yorkshire & Humber clinical network.

The trust links with Leeds maternity services to provide peer review of perinatal mortality review tool cases, which they have found beneficial, enabling a fresh eyes approach to care delivery.

The trust has a referral pathway for the maternal medicine centre and is working towards fully implementing this. They have a maternal medicine network lead midwife in post. It was acknowledged that the trust are used to managing many complex pregnancies themselves without additional referral and are working to develop their processes. It was noted that some women find travelling to the maternal medicine centre in Leeds for care a challenge and will continue to provide personalised care for women with support from the maternal medicine centre.

The trust asked for support from the LMNS in sharing of good practice where this has been evident in other trusts. It was also suggested that a. In addition, support was requested in:

- Development of digital processes to improve communication for women being transferred between trusts and those who are receive cross boundary care
- Networking for bereavement midwives
- Alignment of pathways where possible with particular reference to – induction of labour; management of the small for gestational age fetus; maternity service escalation and implementation of maternity PSIRF plans

3.14 Recommendations

The visit was positive and there were no immediate safety concerns identified that the trust were not aware of. The current staffing gaps and high activity levels were acknowledged as a current and ongoing risk. There was evidence of the trust providing high quality, safe and personalised care to women and their families.

Some areas that could be considered to further improve:

The role of the MVP could be improved by increasing their capacity. This would enable them to engage more with local service users, the trust and neonatal services, to identify areas of good practice and areas of improvement, which could then be coproduced. The trust is committed to this and the ICB and LMNS are working together to drive this forward and identify funding. MVP engagement with the non-executive director should also be increased when this is possible.

The trust is committed to providing informed choice and should continue to develop initiatives to evaluate their offer. The LMNS look forward to hearing of the trial of personalised care and support plans.

The significant staffing challenges have been acknowledged throughout which has impacted the trusts' ability to staff the birth centre. This was disappointing as this reduces choice of place of birth for women and can reduce intervention. The demographics of the population were also acknowledged, with high numbers of women being identified as higher risk and therefore not automatically appropriate for birth centre care. We recommend the trust keep the birth centre service provision under constant review to maximise its availability for women.

4 APPENDIX:

4.1 AGENDA

AGENDA			
Time	**Details**		**Lead**
09:15	**Pre meet for visiting team**		**DG**
09:30	**Welcome & Introductions**		**Trust**
09:40	**LMNS purpose of visit including roadshow element** Roadshow stalls available from 0930		**KP**
Focus groups – visiting teams split into two teams			
	Team 1 led by Karen Poole	**Team 2** led by Debi Gibson	
09:50	**Quadrumvirate**	**Governance Leads and Professional Development Leads (Midwifery, Obstetric & Neonatal)**	
10:40	**Refreshment break**		
10:45	**Safety Champions and NED** This meeting will likely finish earlier than 11:45, team 1 will likely commence clinical visits earlier	**Clinical teams - Including Specialist Midwives (e.g. Public Health, Bereavement, Digital, Training, Infant Feeding) Clinical Managers, Community Midwives, MSW's, Other Support Staff, Doctors in training, Student Midwives and Neonatal staff**	
11:45	**Visiting clinical areas small groups from visiting teams of 2 or 3** Labour ward, Birth centre, Triage, ANC, Ward areas (AN/PN/TC/NNU), Community Midwives,		
12:45	**Lunch**		
13:30	**Further visits to clinical areas not yet seen / additional focus groups with clinical teams**		
14:30	**Time for visiting team to debrief (DoM's/CDs welcome to attend this)**		
15:30	**Feedback to trusts (CEO / CN attendance expected)**		KP

	• What is going well • Areas to consider for further development • Any potential gaps and support requirements	
16:00	**Closing remarks and next steps**	

PERSONAL IDENTIFIABLE INFORMATION REDACTED

Bradford Teaching Hospitals NHS Foundation Trust. Timeline for the investigation and oversight of three neonatal serious incidents references: 2021 9379; 2021 8864 and 2021 9386: Progress report

Over 80 documents have been provided mainly by Bradford Teaching Hospitals, some with embedded papers. All papers have now been reviewed; there are a very few remaining gaps, and these papers will be requested from the Trust for completeness.

All reviewed papers have been tagged and placed in a folder of evidence and detailed in a chronological timeline.

It is clear and has been from the early stages of the review, that these three serious incidents have been openly discussed within the Trust and reported to expected stakeholders throughout.

Key points to note:

1 Recognition of a serious incident:

Date	Detail
11 April 2021	Serious Incident 1 (osteomyelitis): incident occurred
14 April 2021	Serious Incident 2 (umbilical bleed): incident occurred, and decision taken to identify this as a serious incident
17 April 2021	Serious Incident 3, (Klebsiella Meningitis): incident occurred
22 April 2021	Serious Incident 1 (osteomyelitis): decision taken to identify this as a serious incident
24 April 2021	Serious Incident 3 (klebsiella meningitis): decision taken to identify this as a serious incident
26 April 2021	Serious Incident 2 (umbilical bleed) serious incident logged on STEIS reference 2021_8864
4 May 2021	Serious Incident 1 (osteomyelitis): serious incident logged on STEIS reference 2021_9379
4 May 2021	Serious Incident 3 (klebsiella meningitis) serious incident logged on STEIS reference 2021_9386

Creating a STEIS entry automatically sends a notification to NHS England, to a wide circulation of nursing and quality staff who have access rights, and to the former NHS Bradford District and Craven Clinical Commissioning Group. Therefore, by 4 May 2021, the three serious incidents were notified to a wide range of people external to the Trust.

2 Duty of candour

20 April 2021	Initial duty of candour letter sent to parents of Serious Incident 2
21 April 2021	Initial duty of candour letter sent to parents of Serious Incident 3
23 April 2021	Initial duty of candour letter sent to parents of Serious Incident 1

Within the same month as the incidents occurring, all three sets of parents had been notified by the Trust that an incident had occurred, and an investigation would be taking place.

Whilst it is not part of this review to comment on the quality or appropriateness of any actions, the opening paragraph of the letter sent to the parents of Serious Incident 2 was felt to be particularly thoughtful and compassionate, aiming to provide the parents with comfort at a very difficult time.

3 Recognition of potential cluster of serious incidents

27 April 2021	By 27 April 2021, there were already documented discussions within the Trust acknowledging the cluster of incidents, albeit seemingly unrelated, and the need for an external review.
28 April 2021	At the Quality Academy meeting on 28 April at which three non-executive directors were present, a verbal update was given on the serious incidents in the neonatal unit.
6 May 2021	There is an email from the Trust to Liverpool Women's Hospital discussing an independent review of the three serious incidents
23 September 2021	At the open Board meeting chaired by Dr Maxwell Mclean, all three serious incidents were discussed. Contextually and not specific to these incidents, the minutes also note staffing difficulties due national shortage of midwives; increased staff absence due to ongoing pandemic; significant bereavement and sickness leave, impacting on ability to carry out clinical reviews within 72 hours.

There are multiple documents which provide evidence that the serious incidents were considered at numerous meetings from April 2021 onwards. Between recognition of the three serious incidents in April 2021 until closure of the last in June 2022, no meetings note any significant concerns by members of the Board.

4 Summary

The main purpose of this review was to determine whether there was evidence of colleagues within Bradford Teaching Hospitals failing to be open and transparent in relation to the three serious incidents that occurred in April 2021.

All the evidence reviewed to date demonstrates that from the same month, the seriousness of a potential cluster of serious incidents affecting the neonatal unit was recognised and openly shared and reported.

Throughout 2021 and later, the information was shared with members of the Board including the Chair in formal, minuted meetings.

5 Further work

The output of this review aimed to provide the Trust with a robust, chronological, and evidenced timeline to support any assurance necessary now and in the future. There are,

as noted earlier, a very small number of gaps in documentation which will be addressed for completeness.

It was initially proposed that the relevant terms of reference for meetings and policies would also be reviewed and included within the review. Given the volume of documents already provided, and with clear evidence of the Trusts openness and transparency throughout, it is suggested that collating this additional information is unnecessary.

6 The Quality Improvement Group is asked to:

a. Note the work so far and the assurance provided,

b. Advise if it agrees with the recommendation to not include terms of reference for meetings and internal policies,

c. Recognise the significant work on the part of colleagues in the Trust to find and share the volume of documents, and for their open and helpful cooperation with the review to date.

Kerry Warhurst
Deputy Director of Nursing
NHS England (NE and Yorkshire)
19 January 2024

BO.3.24.21 - REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE - FEB 2024

REFERENCES

Only PDFs are attached

Bo.3.24.21- Report from the Chair of the Audit Committee - February 24.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.21

AUDIT COMMITTEE REPORT TO BOARD

Presented by	Bryan Machin, Non-Executive Director and Audit Committee Chair	
Author	Bryan Machin, Non-Executive Director and Audit Committee Chair	
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 February 2024**	
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	14 March 2024	Agenda item	Bo.3.24.21

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)
☒	☒	☒	☐

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.21

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 February 2024.

2 BACKGROUND/CONTEXT

The agenda of the meeting was driven by and derived from the 2023/24 Audit Committee Annual Workplan.

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	14 March 2024	Agenda item	Bo.3.24.21

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 February 2024.

2. Key Matters discussed

- **External Audit Annual Plan**
  The Committee noted that there were no concerns at this stage of planning for the external audit work.

- **Charitable Funds Accounts and Report Submission**
  The Committee received the Charitable Fund 2022/23 Annual Accounts and Report for the Bradford Hospitals Charity and the associated ISA260 audit report and letter of representation. The previous review history through the Audit Committee and Charitable Fund Committee and approvals post audit obtained from those committees and the Board prior to submission was noted.

- **Internal Audit progress report**
  Internal Audit reported that good progress was being made in executing the 2023/24 Audit Plan and that there was no risk to obtaining a Head of Internal Audit Opinion due to insufficient audit coverage.

  Audit Yorkshire reported that management had requested five amendments to the previously agreed audit plan. After considerable discussion of the rationale for these amendments, the Committee approved the changes with audits carried forward into the 2023/24 plan where it was only timing that was the reason for the amendment.

  Internal Audit reported that 8 audit reviews had been completed since the Audit Committee meeting in November:

  - 1 High Assurance
  - 6 Significant Assurance
  - 1 Limited Assurance

  The limited assurance rating was given to an IT Systems and Software Management Follow Up Report. The Chief Digital and Information Officer was in attendance to explain the reasons for the limited assurance, namely that insufficient progress had been made on a couple of recommendations, one being a major priority concerning management of contracts. The Committee heard that whilst some success had been had in sourcing the detail of some of the contracts there remained further work to do on some longstanding contracts. The Chief Digital and Information Officer advised the Committee that a new Chief Technology officer was now in post and making a positive impact in progressing the outstanding work and providing the assurances required. The Committee requested a further update at its meeting on 21 May 2024.

- **Follow up on Internal Audit Recommendations**
  The Audit Committee had a detailed discussion on this issue.

  The Committee remains concerned about the lack of action and or responses from management on progress on actioning agreed internal audit recommendations. The Director of Finance said that discussions on this did take place with each Executive Director and at Executive team meetings. He undertook to express the Committee's concern with Directors whose teams, on this occasion, had not given the actions or the responses the priority that the Audit Committee would expect.

  The Committee then went on to discuss the process of signing off completion of agreed internal audit actions and the extent of assurance that the Committee, on behalf of the Board could take. The Committee could not, based on the discussion in the meeting, take full assurance from the current process. After the meeting, Committee members discussed their concerns about the evidencing of the current process and a possible lack of clarity of the roles of management and internal audit in evidencing completion of actions. The Director of Finance and Internal Audit manager have been asked to clarify the process and the assurances that can be taken at the next meeting of the Audit Committee.

- **Annual Salary Overpayments benchmarking report**
  The Committee noted the Trust performed well compared to other Trusts in the report but with room for further improvement. A payroll audit is current underway which will provide further information on assurance levels in this area.

- **Internal Audit effectiveness review**
  The Committee noted the generally positive views of Audit Yorkshire as the Trust's internal audit provider as expressed in a recent survey of Trust Executive Directors.

- **Counter Fraud progress report**
  Counter Fraud provided a report on progress since the last Audit Committee meeting which the Committee noted.

- **Financial Governance**
  The Committee received reports on high value expenditure approvals under the scheme of delegation, the schedule of losses and special payments and single source tenders. All were noted and assurance taken over the associated controls.

- **Assurance regarding compliance with the Risk Management Strategy**
  The Associate Director of Corporate Governance/Board Secretary and the Associate Director of Quality provided background and information to support the Committee's bi-annual review of compliance with the Risk Management Strategy. Positive information was provided about the introduction of the new Integrated reporting, learning and Improvement System (IRIS). Whilst it was good to hear of the level of maturity of some CSUs in their governance discussions this was not embedded consistently across all CSUs and work would continue to develop their approaches.

In assessing the assurance that could be taken the Committee noted the high assurance rating given to the internal audit in 2022/23 and the good work described at the meeting. Further assurance was taken from the work some CSUs were undertaking.

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.

- **Audit Committee Annual Self-Assessment**
  The Committee had previously 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. The Associate Director of Corporate Governance/Board Secretary said that she was now in possession of a draft of the new handbook. It was agreed that the Chair and the Associate Director of Corporate Governance/Board Secretary would consider how to take this forward, considering the approach taken by the academies to self-assessment.

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.

Bryan Machin
Audit Committee Chair

7 March 2024

BO.3.24.22 - REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE ? MARCH 2024

REFERENCES

Only PDFs are attached

Bo.3.24.22 - Report from the Chair of the Charitable Funds Committee.pdf

Board of Directors			
Date	14 March 2024	Agenda item:	Bo.3.24.22

Report from the Chair of the Charitable Funds Committee

Presented by	Altaf Sadique, Deputy Chair of the Charitable Funds Committee	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Sajid Azeb, Chief Operating Officer (Executive Lead)	
Purpose of the paper	To provide a summary of the discussions and outcomes from the Charitable Funds Committee meeting held on 7 March 2024.	
Meeting attendees	Members: • Altaf Sadique, Non-Executive Director (meeting Chair) • Sarah Jones, BTHFT Chair • Julie Lawreniuk, Non-Executive Director • Karen Walker, Non-Executive Director • Sajid Azeb, Executive Lead for Charitable Funds In attendance: • Michael Quinlan, Deputy Director of Finance • Laura Parsons, Associate Director of Corporate Governance/Board Secretary • Sharon Milner, Charity Director • Jacqui Maurice, Head of Corporate Governance Apologies were received from: • Mel Pickup, Chief Executive • Mohammed Hussain, Non-Executive Director	
Action required	For assurance	
Previously discussed at/ informed by	*N/A*	
Previously approved at:	*N/A*	**Date**

Key Matters Discussed

The Committee last met on 7 March 2024. Summaries of the key items discussed are presented below. The next meeting is scheduled for 30 April 2024.

Summary of key items discussed.

1. 2023/24 Finance report

The budget received was initially approved in March 2022 and it was noted that an updated budget paper will be provided in April. From this report, income was low in comparison to previous years however, it was noted that this had been an exceptional year in terms of change. The NNU appeal had been scrutinised and a great deal of work had been undertaken on revising the initial costs. The focus of the last year had also been on infrastructure rebuilding, rebranding, and the implementation of a new database. The Charity Team had also been subject to delays in progressing recruitment as well as other internal staffing disruptions resulting from sickness in the team – the impact of this had been significant. The greatest challenge at present however seemed to be the time scales in making progress and the impact on the Charity of the wider competing priorities of the wider Trust. Despite all this the team had done great work in laying the foundations and building the case for Independence and, there was a high level of confidence amongst the Committee, based on the experience of other

Trusts who had moved to independence, that there would be more positive outcomes in the future.

2. (Rathbones) Investment report

The last three months, up to 31 January, saw growth of 3.6% against benchmarking of 3.2%. Since the inception of the investment portfolio in January 2020 the fund grew by 20.6% compared to the predicted 8.5% and so overall it is performing reasonably well. However, the Committee will review this against performance of another smaller fund which was doing quite well - in line with a recommendation made in the ISA 260 for 2022/23.

3. Bradford Hospitals Charity Annual Report & Accounts/ISA 260

The annual report and accounts were approved by the Committee and subsequently the Board in early January (via email). In the interests of good governance, the Committee received at its meeting the final reports. It was good to note that they had been submitted to the Charities Commission as required by the end of January 2024. The timing of the appointment of the External Auditor was the key factor in the later then planned submission of the annual report and accounts.

4. Case for Independence

The Committee had a full discussion on the case for independence which was also referred to under other items discussed at this meeting. The Committee agreed to recommend the case for approval by the Board and it is presented under item Bo.3.24.23 on today's agenda.

5. NNU Parental Accommodation Business Case

The Committee was unanimously supportive of the business case which covered the provision of living accommodation for parents with babies on the NNU. The proposal was for the creation of five rooms in purpose built accommodation on the BRI site. Provision of this accommodation would help to alleviate additional financial burdens on parents, help address health inequalities and, bring the Trust in line with practice in place nationally. Initial funding plans had been reviewed and were now down to £3m which makes for a more manageable fundraising campaign, with the ability to develop a more defined and realistic strategy for potential funders. This also provides the opportunity to access £1.5m from the Sick Children's Trust.

The Committee approved the business case and noted that this is the main fundraising project which will launched as part of Bradford Hospitals Charity strategy.

6. Charity Operational Committee report

A great deal of assurance and reassurance was derived from this summary report on the activities of the work covered by the Operational Committee. In particular the Committee noted the positive outcomes from the recent '100 club' event providing the ability for donors to see first-hand the workings of the Da Vinci Robot which had been set up on the concourse at BRI. Four surgical specialties were present to share what this investment has meant in providing improved outcomes for patients. The event was hugely successful, and the Charity team will be seeking to schedule in more activities such as this.

7. Charity Operational Committee Terms of Reference

The Charitable Funds Committee reviewed the minor amends presented and approved the Terms of Reference for the Operational Committee.

8. Charitable Funds Committee Work Plan

This would be kept under review considering the planned 'move to independence' and the approval of outcomes from NNU business case.

9. Committee effectiveness review

Committee members participated in the on-line real time survey; the results of which would be presented back at the next Committee meeting.

10. Any other business

The Committee noted that the Charity Director would shortly be leaving the Trust and a replacement will be recruited. The Committee placed on record that it was highly appreciative of the substantial body of work delivered by Sharon Milner during her time as the Charity Director to prepare the Charity for its move to independence.

Matters escalated to the Board

There were no matters to escalate to the Board of Directors.

New/emerging risks

There were no new or emerging risks identified.

Recommendation

The Board of Directors is requested to note the discussions and outcomes from the Charitable Funds Committee meeting held on 7 March 2024.

BO.3.24.23 - BRADFORD HOSPITALS CHARITY ? CASE FOR INDEPENDENCE

REFERENCES

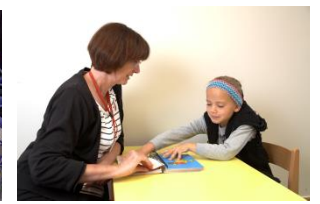
Only PDFs are attached

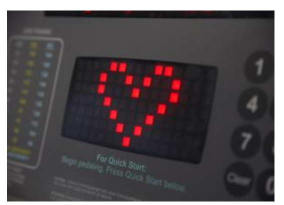
- Bo.3.24.23 - Case for independence - presentation slides.pdf
- Bo.3.24.23 - Independent Charity Business Case(cover).pdf
- Bo.3.24.23 - Appendix 1 - BHC Outline Business Case v15 03 Jan 2024.pdf
- Bo.3.24.23 - Appendix A - Independent Charity Policy Requirement.pdf
- Bo.3.24.23 - Appendix B - Risk Log.pdf
- Bo.3.24.23 - Appendix C - Independence Outline Project Plan.pdf

NHS Charity Conversion to Independent Charity

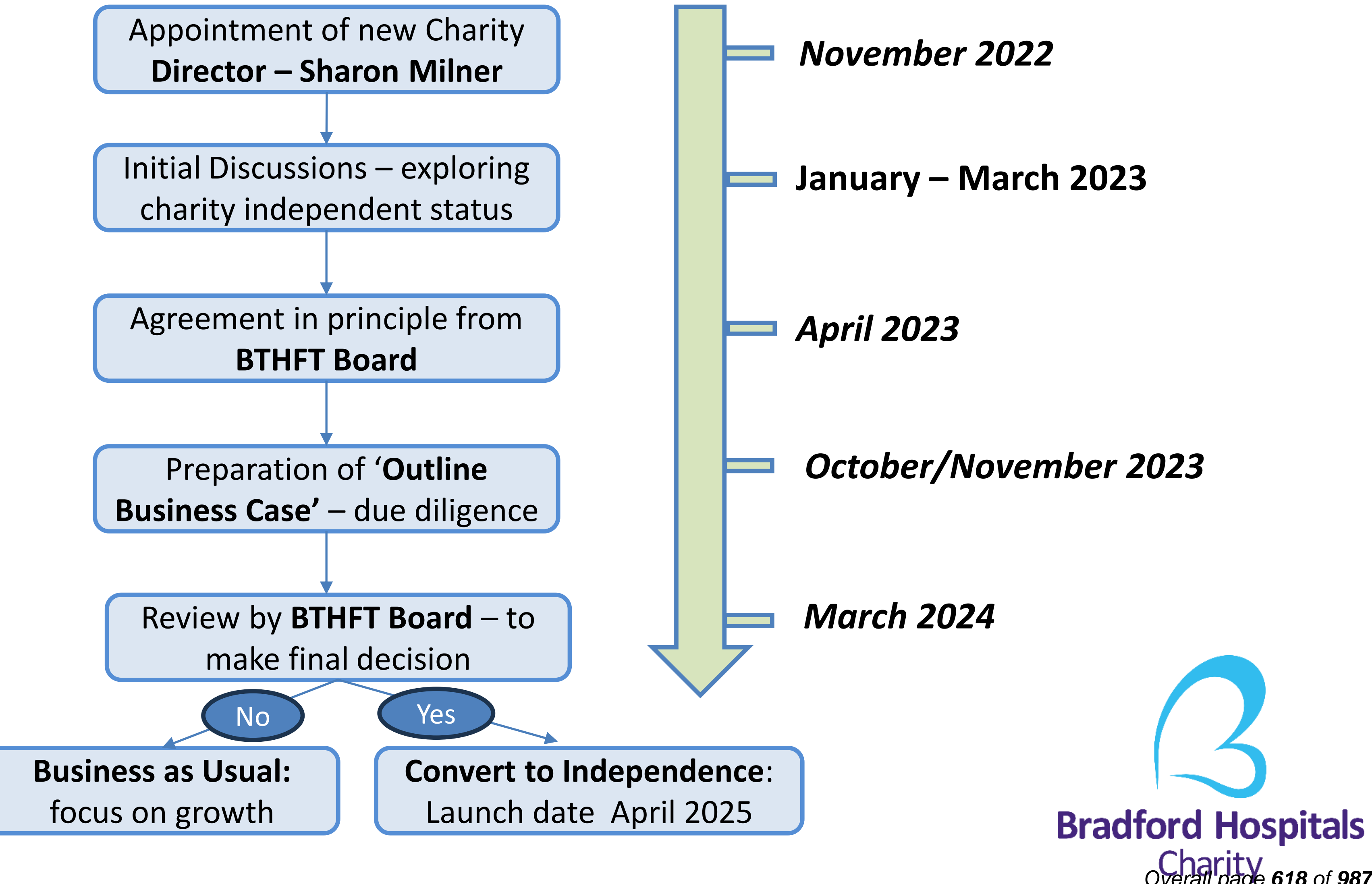
Outline Business Case

Board of Directors – 14 March 2024





Proposal Timeline



The Case for Change

The key **non-financial benefits (operational)** of independence are as follows:

1. **Autonomy:** to focus solely on the needs of the beneficiaries and to be released from Department of Health oversight/authority
2. **Governance:** work to a legal framework aligned to the Charity Commission, supported by an independent Board of Trustees
3. **Fundraising:** access to a wider range of funding streams and fundraising activities.
4. **Workforce:** agile and fit for purpose for fundraising activities, not bound to Agenda for Change; market-aligned T&Cs
5. **Agile and focussed:** released from the demands of hospital operations/performance, can adapt quickly to charitable needs

Bradford Hospitals Charity

Legal Frameworks

Corporate Trustee Model (NHS Charities)

- Charity Trustees are comprised of all members of the Trust Board
- Requirement to adhere to all NHS Trust policies, including Agenda for Change
- Charity funds and reserves are incorporated within the Trusts financial accounts
- Potential overlaps and blurred lines re; spending decisions for charity monies

Charitable Incorporated Organisation (CIO)

- Ideal structure for smaller, start-up charities, with lower regulatory burden
- Registered and regulated by Charity Commission only
- Is an independent legal entity, can hold property, assets and independent contracts
- Board of Trustees are responsible for managing activities and operations of the charity

Charitable Company Limited by Guarantee (CLG)

- Well established model, adopted by all NHS charities who have converted to date
- Non-profit organisation, run within a business framework
- Registered and regulated by both Charity Commission and Companies House
- Board of Trustees, appointed to oversee all fundraising & expenditure
- Articles of Association (statutory document) to define all objects, aims & principles

Bradford Hospitals
Charity

Financial Implications

Base Model Financial Summary (Corporate Trustee)

Description	2022 /23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Pay Costs	(220)	(312)	(459)	(598)	(598)	(598)
Non-Pay Costs	(80)	(120)	(122)	(122)	(122)	(122)
Charitable Activities	(751)	(200)	(200)	(1,700)	(200)	(200)
Income *	1,062	390	1,230	2,225	1,405	1,405
Income / (Expenditure) before investments	**11**	**(242)**	**449**	**(195)**	**485**	**485**
Net gains / (Losses) on investments	(91)	0	0	0	0	0
Net Movement in Funds	**(80)**	**(242)**	**449**	**(195)**	**485**	**485**

Independent Charity Model Financial Summary

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Pay Costs	(220)	(312)	(459)	(574)	(574)	(574)
Non-Pay Costs	(80)	(120)	(236)	(193)	(193)	(193)
Charitable Activities	(751)	(200)	(200)	(1,700)	(200)	(200)
Income	1,062	390	1,230	2,584	1,910	1,1910
Income / (Expenditure) before investments	**11**	**(242)**	**334**	**117**	**943**	**943**
Net gains / (Losses) on investments	(91)	0	0	0	0	0
Net Movement in Funds	**(80)**	**(242)**	**334**	**117**	**943**	**943**

Financial Implications

Return on Investment for each £1 spent on fundraising

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Corporate Trustee	6.35	1.47	2.96	4.02	2.54	2.54
Independent	6.35	1.47	2.86	4.31	3.19	3.19
Variance	0	0	(0.10)	0.3	0.65	0.65

* The return of £6.35 in 2022/23 was due to a one-off donation from Sovereign Healthcare of £500k and receipt of legacies of £180k.

Benefits of *Autonomy*….

Examples of current operational issues include:

1. HR & Recruitment:

- Requirement to seek approval for Charity roles to be aligned to NHS AfC
- Lengthy NHS recruitment and on-boarding process for new staff
- Results in significant delays (by several months) in recruitment process

2. Financial:

- Annual budget approval linked to Trust timetables, can be delayed
- Impact on the Charity's ability to book events, pay invoices, place orders for merchandise and branded stationery etc.
- Approval for key equipment (tap to pay device) to be approved via NHS SOPs
- Issues re: obstacles for standard charitable activities, such as low-level hospitality costs for donors and fundraising events.
- Finance staff not reporting to Charity Director can cause conflict of priorities

3. Decision making:

- Decisions relating to charitable expenditure can be reactive rather than proactive, due to varying Trust/Charity priorities

Bradford Hospitals Charity

Unspoken questions…

What if the charity decides to 'go rogue' and behaves badly?

But what about our reputation?

Will the Trust lose out as a beneficiary?

How is this going to be funded. Can we afford it?

I feel that we might lose control – what then?

How can we ensure that our future working relationships are fair and reasonable?

What if it just doesn't work?!

Bradford Hospitals Charity

Summary & Recommendation

Key Benefits:

- Independence provides a 'freedom to act' with joined up working
- Wider range of fundraising opportunities
- Significant financial benefit for both the Charity and the Trust
- Ability to work within a separate but robust legal framework

Recommendation:

To request that the Board approves the conversion of Bradford Hospital Charity to an independent charity

Stage 3 : Next Steps

If approval granted by BTHFT Board at the March 2024 meeting:

1. **Develop project plan – timeframe for transfer 9-12 months**
   – Engage legal firm to draft legal documents, action legal registrations

2. **Commence recruitment for Chair & Trustees (form Shadow Board)**

3. **Agree key objects and principles with the Trust Execs**
   – Develop a Memorandum of Understanding, to be approved by Trust Board

4. **Undertake all due diligence processes**
   – TUPE and HR processes
   – Third party providers, contracts, financial regulations etc

5. **Monthly progress review (with key Trust Execs) to assess progress and risks/concerns**

6. ***GO LIVE – potentially 1st April 2025.***

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.23

Bradford Hospitals Charity – Outline Business Case for Independence

Presented by	Sajid Azeb, Chief Operating Officer (COO)	
Author	Sharon Milner, Bradford Hospitals Charity Director/Jennifer Lindsay Project Manager Bradford Hospital Charity	
Lead Director	Sajid Azeb, Chief Operating Officer (COO)/Matthew Horner, Director of Finance	
Purpose of the paper	This paper puts forward an outline Business Case for the consideration to transfer the Bradford Hospital Charity from its current corporate trustee model to an Independent Charity. The case presented provides an in-depth overview of the risks and benefits of each option.	
Key control	Not applicable	
Action required	For approval	
Previously discussed at/ informed by	ETM – 19th Dec 2022, Charitable Funds Committee – 12th Jan 2023 Trust Board – approval in principle to undertake due diligence – April 2023 ETM- 11th Dec 2023, no objections, agreement to move forward with some additional information requested within the Business Case, now completed. Charity Operational Committee – 20 February 2024 – no objections. Charitable Funds Committee – 7 March 2024 – agreed to recommend the case for approval by the Board.	
Previously approved at:	**Meeting:**	**Date:**
	N/A	

Key Options, Issues and Risks

The Trust Board have previously agreed in principle to support further work to identify the potential for Bradford Hospital Charity (currently operating within a Corporate Trustee model) to convert to be an Independent Hospital Charity. To inform this decision, the Charity Director, Sharon Milner, was asked to complete stage 2 of the process, in the form of an Outline Business Case, incorporating financial modelling, legal and governance considerations and risks/mitigations. The Executive team requested that the Business Case was constructed within the '5 case model' to ensure that all aspects of the decision were considered (Strategic, Commercial, Economic, Financial & Management). Incorporated within this Business Case are comparative financial models, which assess the financial impact of both remaining as a corporate trustee charity compared to working as an Independent Charity; specifically reviewing the difference between fundraising (income) and expenditure, in addition to detailing financial risks and assessing Return on Investment for both models.

The Outline Business Case is attached for review and describes the Legal implications of the various charity structures, as well as working through the benefits, disadvantages and potential risks of conversion to an independent organisation. All aspects of the impact of transfer have been considered.

Analysis

The key element of analysis required for this Business Case, is the financial analysis. Whilst there are a range of impacts of moving to independence, the fundamental element which must be defined to provide assurance to the Executive Team and Trust Board is that the transfer is a) affordable b) that the fundraising income will increase and c) that the Trust (and the beneficiaries) will continue to benefit in line with increased funds raised. The finance team have completed the analysis, detailed within Section E of the Business Case.

Recommendation

On the basis of both the financial and non-financial benefits described above and the recognition of risks and commitment to their mitigation, the Board is asked to **approve the conversion of Bradford Hospitals Charity to an independent charity**.

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.23

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: Corporate Services, Procurement, Estates & Facilities	
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	14 March 2024	Agenda item	Bo.3.24.23

1	PURPOSE/ AIM

This paper puts forward an outline Business Case for the consideration to transfer Bradford Hospitals Charity from its current corporate trustee model to an Independent Charity. The case presented provides and in-depth overview of the risks and benefits of each option.

Following the consideration of the Business Case, the Charitable Funds Committee is asked to support the recommendation to move from the current Trustee model to an Independent Hospital Charity.

If an approval to progress to an independent charity is provided, we will move to Stage 3 of the process, with the development of a detailed and robust project plan for the transition to the new status.

2	BACKGROUND/CONTEXT

The main concern expressed by Board members is the risk/impact from a financial perspective, if the Charity converts to independence. Therefore, incorporated within this Business Case are comparative financial models, which assess the financial impact of both remaining as a corporate trustee charity compared to working as an Independent Charity; specifically reviewing the difference between fundraising (income) and expenditure, in addition to detailing financial risks and assessing Return on Investment for both models. The conclusion from the financial section, is that the proposal for conversion to independence is affordable and that there are significant potential financial benefits from independence.

3	PROPOSAL

Approval is sought for independence, subject to the relevant approvals being provided, it is hoped to adhere to the following timetable:

1. Approval by BTHFT Trust Board — March 2024
2. Development of Project Plan — March/April 2024
3. Approval/agreement of plan at ETM — April 2024
4. Appointment Project Manager, legal team — March/April 2024
5. Commence conversion activities — April 2024
6. Sign off MOU by ETM — October 2024
7. Finalise sign off by BTHFT Board — March 2025
8. Launch of Independent Charity — April 2025.

4	BENCHMARKING IMPLICATIONS

There are no specific benchmarking standards to review in the context of this submission, however within the document are details estimating the Return on Investment (£ raised per £1 spent), which is shown for a 5 year plan for both the Corporate Trustee model and the independent model, as well as comparisons to other hospital charities across the North of England.

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.23

5	RISK ASSESSMENT

Throughout the document, references are made to potential risks and issues for consideration, which are listed at the end of each section. In addition, the summary of high level risks are listed (with mitigations) in Section 6, page 18 of the Business Case. Finally, a risk log is included as Appendix B. A range of risks are listed with mitigations.

6	RECOMMENDATIONS

On the basis of both the financial and non-financial benefits described above and the recognition of risks and commitment to their mitigation, the Board is asked to **approve the conversion of Bradford Hospitals Charity to an independent charity**.

7	Appendices

The Outline Business Case document (and appendices) is included with this summary sheet for review and approval.

NHS Charity Conversion to Independent Charity

Outline Business Case

January 2024

Version Control:
Outline Business Plan v15 – 03 January 2024

Contents:

a) **Introduction and context** .... Page 3

b) **Strategic case;** is this change needed? .... Page 5

c) Commercial case; is this viable? .... Page 7

d) Economic case; will this deliver value for money? .... Page 9

e) Financial Case; is this affordable? .... Page 11

f) **Management Case;** is this achievable and deliverable? .... Page 17

g) **Risks and Issues;** addressing key concerns .... Page 20

h) **Summary & recommendations** .... Page 21

i) **Appendices** .... Page 21

a. Appendix A (attached) - Independent Charity Policy List
b. Appendix B (attached) – Risk Log
c. Appendix C (attached) – Independence Outline Project Plan

j) **References** .... Page 21

a) ***Department of Health;*** Review of the regulation and governance of NHS Charities; Summary Report, October 2012

b) ***Department of Health and Social Care;*** NHS Charities conversion to Independent Status; February 2020

c) ***Charity Commission Guidance:*** Charity Commission guidance - GOV.UK (www.gov.uk)
Full information on the regulations and requirements required from legal and good practice requirements in establishing, reporting and operating an independent charity.

Rationale and Proposal for Bradford Hospital Charity Independence Status:

Introduction and Context:

Following a review by the Board in April 2023, it was agreed that Bradford Hospital Charity (BHC) should complete an Outline Business Case, to further develop the 'Case for Change' paper to allow for objective decision making as to whether we would seek to move the charity function to an independent status. The Case for Change' document defines the rationale and request to convert Bradford Hospital Charity from an **NHS charity** to an **Independent Hospital Charity,** which would be established and function under charity law.

Background Information:

NHS Charities are linked directly to NHS organisations. The default position is that NHS Charities function within a **Corporate Trustee** model, with the Board Executive Directors and Non-Exec Directors acting as accountable Trustees of the charity. This model is well established within the NHS (under the legislation of the National Health Service Act 2006) but does not exist within mainstream charity sector; who would typically function as an independent organisation, in the form of a Charitable Company Limited by Guarantee (CLG). (Note: since 2015, thirty NHS hospital charities have converted to independent charities, all of which have opted for the CLG model)

Current NHS Organisation Charity Structure:

Corporate Trustee Model: Whilst this model fits within NHS ways of working, it should be noted that NHS Charities which exist within the Corporate Trustee model, do so under the Secretary of State for Health, who has legislative authority to transfer or access funds and assets of the charity. Although commonly adopted by hospital charities, the Corporate Trustee model is not entirely without risk, as the Trustees must be able to demonstrate that they act independently in managing both the charity and expenditure of their funds, which should be solely in the interests and needs of the beneficiaries. Issues can arise, potentially resulting in a breach of legal duty if charity funds are spent solely within the Trust, aligned to the operational needs of the hospital, rather than aligned to the strategic plans of the charity. This can lead to an additional burden of due diligence and process, to demonstrate good practice and appropriate expenditure. In the mainstream charity sector, the Corporate Trustee model is allowed, but rare. Alternative legal entities, commonly the CIO or CLG model (detailed below) are adopted, in order to address the key requirement of the Charity Commission, as regulator, to demonstrate independence.

Options for Structure of Independent Hospital Charity:

Charitable Company Limited by Guarantee (CLG): this is the model under which the majority of mainstream charities operate and is approved by the Charity Commission. This model is used primarily by charities, social enterprises and other non-profit organisations. The organisation does not have any shares or shareholders, but a Company Limited by Guarantee, is in the ownership of guarantors who pay an agreed amount of money towards the company assets. This sum, usually set at a minimal value, is the entire legal accountability for any debts incurred. As a non-profit organisation, all excess business earnings are used to realise the charitable aims of the organisation, for the welfare of defined beneficiaries. The charity must appoint at least one director to run its regular business operations and financial investments. In addition, Companies Limited by Guarantee must be registered both with Companies House and the Charity Commission.

Charitable Incorporated Organisation (CIO): this is a legal structure available for charities or charitable groups who wish to be incorporated. It can be used instead of registering as both a charity and a company, therefore reducing the regulatory burden. CIOs are aimed specifically at smaller charitable groups who do not need to adhere to the additional regulations of registering with and reporting to Companies House. A CIO would have its own legal personality and can enter into contracts in its own right. Trustees therefore have limited liability.

Trustees are responsible for managing and providing governance for the organisation. CIOs can own land, hold property and borrow money, to enable the charity to occupying premises and their own offices. The aim of CIO is to provide an appealing legal structure for small to medium sized charities, as this structure reduces the administrative burden and can be established without having any current income. Therefore, it is an ideal legal framework to facilitate start-up charities.

Key Differences:

Current NHS Charity (Corporate Trustee Model)	**Independent Hospital Charity (CLG or CIO)**
NHS charities function under the legislation of the ***National Health Service Act 2006.*** The Secretary of State for Health has statutory powers, above Trustee level to transfer funds out of the charity, in specific circumstances.	Secretary of State has no power within the charity. Independent charities operate under a stand-alone written governing document, specific to the aims and objects of the charity
NHS Charities do not have own legal personality; and therefore, bring theoretical risks re: unlimited liability for Trustees and the need to have processes in place demonstrate exclude issues relating to conflict of interest.	Trustees are appointed by the charity (within defined governance structure) and can be NHS employees or individuals with external expertise. The Charity operates within a legal framework (CLG or CIO) and trustees hold limited liability – within either model.
All NHS Charities accounts are consolidated into Department of Health & Social Care resource account and therefore within the NHS Trust accounts and financial statements.	Individual accounting responsibilities, standalone accounts. Accountability and responsibility to spend, invest and to transfer funds, within defined, agreed limits. Financial accounts to be audited and filed with Companies House and/or The Charity Commission (CLG both, CIO one)
NHS Charities have limited autonomy. They are unable to adapt governance arrangements, review or update their objects, or work to policies which are different from their host NHS organisation. This primarily impacts ways of working within HR and Finance functions.	Independent charities can review and amend their governing instrument, working practices, define the criteria for selection of Trustees and determine their staff recruitment processes, in response to changes in beneficiary needs or the external environment.

In Summary:

NHS charities have relatively restricted autonomy, unlike independent charities, who have greater scope to define their purpose and to access a wider range of funding streams. NHS charity Trustees, as Trust Board members have a huge portfolio of responsibilities, including Trust operational and performance issues, meaning that the needs of the charity are a small part of that much broader agenda. Hospital charities are somewhat restricted in the activities they undertake, due to the limitations of the statutory roles of the Secretary of State and DHSC.

However, Independent charity Trustees are supported by a legal framework, which provides autonomy to set the criteria to appoint individuals who are solely focussed on the needs of the charity, its objects and its beneficiaries. The financial accounts of an independent hospital charity are entirely separate from those of the Trust and would not be included within the Trust's financial statements. The independent charity would be registered with the Charity Commission and Companies House (depending on CIO or CLG) and would be bound by the relevant laws and regulations.

1. Strategic Case: *Is this change needed and does it align with BTHFT strategy?*

Currently, **Bradford Hospital Charity** (BHC) operates within a Corporate Trustee model, governed by Trustees who are the members of the Board at Bradford Teaching Hospitals NHS Trust; delivering funding and projects for the benefits of staff, patients and their families. BHC fund projects and equipment which are beyond the scope of government funding, to enhance hospital care and the patient environment and invest in the development and wellbeing of staff.

The attraction of the Corporate Trustee model is that the charity continues to report to the Trust Board, who are focussed on the priorities and needs of the Trust; however, there are opportunities as an independent hospital charity to adopt a more innovative approach. Independence provides a greater degree of autonomy as well as opportunities to access new fundraising activities, alternative funding streams and provide a more focussed approach from an appointed Board of Trustees, on fundraising, investment and expenditure.

The ***continuing benefits*** to remaining as an NHS Charity;

a) Minimise/remove the need for workload and potential additional expenditure to undertake the transition; particularly at a time when BHC is working to consolidate a number of recruitment and internal support functions and at a time when charitable giving may be compromised due to the cost-of-living crisis.

b) Having a such a defined link to an NHS organisation, facilitates BHC to meet their primary objective of supporting the welfare of NHS patients. As such, there is some potential merit to remaining within BTHFT, ensuring that activities of the charity are aligned to the needs of the Trust, with the oversight of Board Directors (Trustees)

c) Working within BTHFT also facilitates a cost-effective use funds and a sense of belonging within a wider organisation. Currently 'back-office' functions are provided by the Trust, with minimal or no cost to the charity from a range of departments such as HR, procurement and estates; (although these working arrangements may be changed moving forward)

d) A period of stability, consolidation and growth of BHC could be of benefit, as 'business as usual' enhancements and new ways of working are established. A focus on the new ***Charity Strategy*** (in development) would provide a sound foundation to raise awareness and work with the Trust to identify specific appeals, which would attract additional giving and income. Focusing on incremental growth over the next 5 years.

However, there are ***a number of advantages*** to transition to an Independent Hospital Charity model, which have been presented and agreed within the previous Case for Change paper. These include:

a) The principle (identified and supported by the Department of Health and Social Services) that a transfer to independent status would enable the new, independent NHS-focussed charities the opportunity to work more autonomously; defining their mission and vision, developing partnerships and working more flexibly, within their own governance and regulatory framework.

b) Independence facilitates the ability to access (or enhanced access) to funding streams, such as Foundations & Trusts, who currently have concerns or exclusion criteria, in relation to donating to charities within the Corporate Trustee model.

c) As an independent, the charity would have the freedom to be more proactive, developing a broader strategy to access new income streams, looking at innovative potential options such as retail or lotteries.

d) Ability to appoint Trustees with the appropriate mix of charity and business experience (rather than only NHS Directors) as well as hospital patients, Execs/managers and senior clinicians.

e) The charity can develop job descriptions and pay-grades outside Agenda for Change, facilitating a faster recruitment process, attracting people with fundraising experience, well versed with working to annual fundraising targets, linked to their performance measures.

f) Removes the risk inherent with the Corporate Trustee model, releasing the Trustees from any potential conflict of interest and avoiding the challenge of the same individuals making decisions for both Exchequer and Charity fund expenditure. The move to a separate, appointed Board of Trustees would facilitate independent decision making and remove the potential for conflicts of interest.

An independent Hospital Charity model would provide the freedom to access new funding streams but could still retain alignment to the current beneficiaries of the Charity; Bradford Hospital patients, their families, service users, volunteers and employees of BTHFT.

Under this model, the Trust Board would be able to work in conjunction with the Charity as it moves towards independence, to ensure that the aims and vision of the charity remained aligned to the strategic objectives, vision and values of the Trust. These principles would be enshrined within the ***Memorandum of Understanding*** with BTHFT and ***Articles of Association***, within the governing framework of the Charity Commission.

Risks/Issues for Consideration:

Changes to the current hospital charity model, will have implications for the ways of working between the two organisations, which are not risks as such, but may have impact on either or both organisations and would need to be considered and incorporated in any transition planning:

- Both organisations will need to agree new ways of working, when the Trust requests/applies for monies from the charity, either as individual departments or by the Execs for the benefit of Trust wide staff. This would require agreeing an application process, approval levels and timelines for any such requests.

- The charity will need to recognise that there may be elements of support and communication, currently provided by a range of service departments across the Trust, which will need to be more formally scheduled or requested. This could include liaising with Estates and Procurement in relation to equipment purchasing, installation etc.

- There could be some potential impact on Trust finances, potentially with loss of income, equivalent for the members of the Trust finance team, allocated to and paid for by the charity. However, there would need to be agreement between both organisations, in the form of an SLA or MOU, defining costs associated with the use of Trust services and facilities.

2. Commercial Case: *Is this viable in the short and longer term?*

Currently, Bradford Hospitals Charity operates as a relatively small NHS charity. BHC income levels are shown below, which shows relatively static annual incomes, except the year of Covid-19, which resulted in a spike in public giving.

Income/Expenditure	31/03/2018	31/03/2019	31/03/2020	31/03/2021	31/03/2022
Total Gross Income	£272.49k	£346.00k	£435.92k	£957.00k	£302.25k

The charity currently has plans in development to increase levels of income, through a range of initiatives to build awareness of the charity, expand the numbers of fundraisers employed and to manage donor relationships more effectively. However, there is an understanding that operating as a Corporate Trustee, could serve to restrict potential expansion.

The fundamental premise behind the transfer to an independent model, is that of the fundraising opportunities which the change can bring. A range of commercial opportunities can be accessed, which either cannot be (legal restrictions) or are more challenging to access, under the current Corporate Trustee model.

These include:

- **Trusts & Foundations**; currently these organisations will scrutinise and set defined criteria for selection of which charities they will support and to whom they will distribute funds. Many of these larger Trusts & Foundations will not engage with charities with the Corporate Trustee model and a number have defined exclusion criteria within their funding application bid process. Recently, a funding application from BHC to ***The Leeds and Bradford Community Foundation*** was rejected due to its Corporate Trustee model.

- **High net worth individual donors**; similarly, these individuals are often seeking organisations with a commercial legal structure, rather than a corporate model.

- **Lotteries*;*** as an independent charity, it would be possible to run a public, wide scale lottery, selling tickets to members of the general public, who may not otherwise have interaction with the hospital. An expansion of the lottery concept could include scratch-cards, in due course. This public lottery could be run in addition to the current in-house staff lottery, both of which could be managed by a specific lottery fund raising member of staff.

- **Door-to-door giving*;*** another opportunity for fund raising could be to make direct approaches to the local community collecting donations; selling lottery tickets, raising donations by direct-debit, or engaging individuals with the concept of legacy giving. Currently, within BTHFT, this form of fund raising could be seen as inappropriate and create challenges for the Trust relating to applications for required trading licences. However, a Trustee Board, with different experiences and outlook may wish to explore these options and have the legal framework to support the necessary contracts & registrations.

It is important to note, that the funding streams above can all enhance the opportunity to raise **unrestricted funds**, facilitating the opportunity for larger scale expenditure on more significant projects aligned to the needs of BTHFT and the strategic expenditure plans of BHC. Bradford Hospitals Charity is in a good position to appeal to a wide range of Bradford residents, as the hospital provides healthcare from a broad range of specialities, which everyone in Bradford (and their loved ones) will access at some point in their journey from cradle to grave.

Market Factors: Charities in the UK have faced some difficult years due to the pandemic, with disruptions to service delivery, fundraising and volunteering. The charity market is now dealing with challenges from rapidly rising inflation and the devastating impact of global humanitarian crises, all of which are impacting financial concerns amongst the population.

However, the UKs charitable giving 'market' remains reasonably stable, with a UK total of £12.7 billion in 2022, showing steady growth year on year from 2019. Within Yorkshire & Humber, total charitable giving was close

to £800 million in 2022. Despite economic difficulties, charitable audits suggest that philanthropic giving, from both individuals and successful businesses, is relatively unimpacted by economic factors, such as recession.

Purely for context, the figures below illustrate the annual income per head of population (in the year 2021/22) for three independent hospital charities and three corporate model charities, from across the North of England. Note: that these figures are for comparison and information only, with no suggestion that acquiring independence is the reason for the scale of income for Leeds, Nottingham and Sheffield. These organisations were clearly thriving and successful organisations prior to independence, however this does highlight that significant growth in fundraising income can be achieved when given to access different, more innovative fundraising activities and investments.

Hospital Charity	Income (2021/22)	Population	£ per Head of Population	Return on Investment (£ raised per £1 spent)
Leeds Hospitals Charity*	£7.1 million	900,000	£7.80	£2.29
Nottingham Hospitals Charity*	£4.4 million	800,000	£5.50	£5.50
Sheffield Hospitals Charity*	£4.3 million	585, 000	£7.35	£5.35
Airedale Hospital Charity	£429,000	200,000	£2.24	£3.23
Calderdale Hospitals Charity	£434,000	478,000	£0.90	£3.49
Bradford Hospitals Charity	£302,000	535,000	£0.56	£1.43
* Independent Hospital Charities				

Note: there are significant variations in terms of financial reserves and investment income; however, the independent charities have moved towards a higher level of active fundraising and voluntary income (donations and legacies)

Risks/Issues for Consideration:

- Economic environment: although national data suggests that philanthropic giving is relatively unaffected by recession, the situation in Bradford specifically could impact new fundraising activities, due to Bradford being an area of relative deprivation. There could be a risk of adding costs to the charity, without generating the necessary uplift to deliver acceptable return on investment.

- Board Trustees could adopt a conservative/ risk averse approach to fundraising: although the independent charity model provides the autonomy to appoint innovative, entrepreneurial and experienced Trustees, there is a risk that it is not possible to do this in Bradford, or that it takes some time to recruit such individuals. This could result in a fundraising approach which is very similar to the status-quo.

- **Note:** a number of colleagues have raised the question about why an NHS Charity is unable to undertake those fundraising activities listed above. Since a Corporate Trustee organisation is not a legal entity, it cannot hold licences, leases or contracts. Therefore, although activities such as a public lottery or door-to-door fundraising are theoretically possible within the NHS structure, the barriers in place make this practically impossible. The Trust would require both a gambling licence and a canvassing licence, which is standard practice for an independent charity; but an NHS charity would require permission from the Department of Health & Social Care, which is extremely unlikely to be approved. No English hospital charity has achieved this to date and when approached on the topic, the DHSC recommends a transfer to independence.

3. Economic Case: Will this proposal deliver value for money?

A key consideration for the preferred operational model is that it must deliver ***value*** for all stakeholders of the charity. Value can be measured in both financial terms and in the form of ***intangible benefits***, which should not be underestimated. Independence would facilitate a range of different ways of working, which will allow the charity to be more agile in its decision making, recruit a broader range of staff and Trustees, work to a more tailored set of Governance standards and function within a different legal framework; all of which in turn have the potential to improve the commercial, governance and financial arrangements of the charity.

Intangible benefits and value of working differently:

- A significant difference, with a positive impact for an independent charity, is that of its Governance structure. Since the charity is no longer a small part of a large organisation but would be structured to focus solely on the business and charitable purpose; decision making becomes more rapid. Regular Board and committee meetings, with focus on specific issues can facilitate decisions being made and actioned rapidly.

- Independence allows the appointment of a different type of Trustee, from a wider range of backgrounds, which can be very different from the NHS. This can bring alternative skills, such as commercial, marketing and media experience; which can result in a more innovative approach. Trustees bring with them a range of contacts and business leaders, who are keen to support health projects. In addition, Trustees can bring valuable investment portfolio experience, helping to maximise assets. Fundamentally, the Trustees within the independent model are free to focus solely on the needs of the charity, without having to manage the ongoing challenges of the operational and financial performance of a complex NHS Foundations Trust.

- Key issues such as staff recruitment, management and retention would become significantly more straightforward, once independent. The charity would no longer be restrained by the current HR policies of the Trust, including Agenda for Change. This would enable the Charity Director to recruit experienced fundraisers, at salary levels aligned to the charity market, with appropriate T&Cs. A more streamlined recruitment and pre-employment process would improve efficiency and reduce delays, therefore increasing the speed of recruitment and reducing issues with staff retention.

- The charity would also be able to compile specific policies and procedures, aligned to the needs of the business and which would be more in keeping with ways of working within the wider charity sector. This could include recruitment processes and more flexible T&Cs; as agreed by the Trustees.

Financial benefits: 'freedom of action' to source funding:

There has been much deliberation about the range of activities which can or cannot be undertaken by an independent charity as opposed to a Corporate Trustee model. The situation is not completely clear cut; however, it is the case that although some fundraising activities are possible under the umbrella of an NHS Foundation Trust, the logistics and legal and financial risks associated with these activities make them almost impossible to implement. It is clear, that an Independent Charity (either as a CLG or CIO) does have a freedom of action to source different and potentially innovative funding streams.

- **Trusts and Foundations:** these valuable funding sources have an application process for charities to apply for funding and grants, which are given to organisations aligned to their own values and purpose. However, it is common that charitable Trusts & Foundations often have exclusion criteria, which de-select applicants working under a Corporate Trustee model. This exclusion does not apply to all Trusts & Foundations, but it is widely adopted. The reasons are varied, but often this is due to the perceived lack of independence, potential conflict of interest and that this is simply donating to services which they feel should fall within NHS funding remits.

- **Partnerships with commercial organisations:** an independent charity can demonstrate its independence and can provide reassurance to large corporate donors, that funds will be used over and above NHS

provision. Large corporate organisations (including Pharmaceutical and national businesses) could enter into a sponsorship arrangement for larger capital purchases, or to fund Research & Development.

- **Lotteries and door-to-door activities:** whilst these activities are theoretically possible under the current structure, in practice they are challenging. Since a Corporate Trustee charity is not a legal entity in its own right, it cannot hold licences, leases or contracts. Therefore, to run a public charitable lottery, the NHS Trust would have to apply for a Gambling Commission Licence and a Canvassing Licence; both of which would require permission from DHSC which is unlikely to be granted.

- **Retail opportunities:** similarly, the opportunities to establish charity retail outlets would be difficult within the Trust, as this would require a Trading Licence, property lease, VAT registration etc, all of which the Trust would have to apply for and seek DHSC approval. Independent charities, as a separate legal entity can hold these licences and undertake retail activity.

Risks/Issues for Consideration:

- Short term benefits: The intangible/value benefits, could be realised in the very short term, following the transfer date to an independent charity. From day one, Trustee meetings can be held, within their new governance and decision making framework. In addition, the Charity Director would have immediate benefit of working to the charities own policies, HR processes etc. **Note:** for the purposes of assurance, the plan would be to utilise and adapt policies from exiting independent hospital charities, which they are generously happy to share. In addition, the Charity would recruit a third party HR provider, with considerable experience in the sector to advice on HR policies, with legal oversight. In addition, the Trust, throughout the process of transition, will be able to review/audit/assess everything that the Charity produce and only when the members of the Trust Board are satisfied will they 'sign-off' the final move to independence.

- Longer term issues: the opportunities to access new funding streams may prove to be an expensive option from an up-front cost of recruitment, applying for licences etc. It may take some time for the charity to feel confident enough or established sufficiently to move towards these more innovative activities.

- **Note:** in reference to the charity holding a gambling licence, as required to run a public lottery, it is important to clarify the implications of this. Although there are appropriate concerns around the hospital and its charity being seen to endorse the activities associated with large gambling organisations, in this case the holding of a gambling licence would specifically be for the delivery of a public lottery with relatively inexpensive tickets, to directly support the hospital and its beneficiaries. This would be in line with other independent health and hospital charities who run public lotteries as a standard activity. (Leeds Hospitals Charity have a successful public lottery)

4. Financial Case: *Is this affordable?*

There are financial implications to a transfer to an independent charity. There will be additional costs, which include one off set-up/transfer costs, in addition to increased operational and running costs, aligned to the running of an independent organisation. However, there are potential additional income streams, which independence can bring.

Financial Evaluation and Implications:

1. **Approach**
   The financial implications of the Charity becoming independent has been assessed by comparing the next 5 years of operating costs and income under a corporate trustee model against an independent charity.

2. **Base Model – Corporate Trustee**
   The base model for the case for change is based on the several underlying assumptions:

Corporate Trustee

The model assumes the current Corporate Trustee management model remains in place through the period considered by the case for change. This includes the current management arrangements being continued including management support by the Deputy Director of Finance, Assistant Director of Finance and Senior Finance Manager which are recharged to the Charity.

Fundraising Staff

In addition to the existing Fundraising team additional posts have been included in the establishment from April 2024 and April 2025. A summary of the assumed staffing included in the model is set out below.

Post	WTE	Assumption
Charity Director	1.0	Existing post
Head of Fundraising	1.0	Existing post
Community Fundraiser	2.0	2 new posts starting in April '24 and April '25
Corporate Fundraiser	1.0	1 new post to start in April '24
Trusts Fundraiser	1.0	1 new post to start in April '24
Legacy Fundraiser	1.0	1 new post to start April '25
Communications Officer	0.8	Existing post
Admin Support	1.0	Existing post
Digital Fundraising Officer	1.0	1 new post to start April '25

NNU Appeal

It has been assumed that the NNU appeal will proceed with a total fundraising target of £3m to be raised by the Charity across the 2024/25 and 2025/26 financial years. The total fundraising target is expected to be split with £1.5m to be raised by the Charity and a further £1.5 m to be raised by the Sick Children's Trust. The financial models presented here only include the £1.5m to be directly raised and spent by the Charity. It has been assumed that the £1,500k raised will be paid to the Trust in 2025/26 and is included in the Charitable activity costs.

Charitable Activities

To aid comparability, charitable activity has been set at £200k a year with the exception of 2025/26 which includes an additional £1,500k for the NNU appeal. This is based on the budgeted charitable activities for the financial year 2023/24. Charitable activity is often higher than £200k, however this represented a budgeted breakeven position when balanced against forecast income and running costs.
In practice the extra net income generated by expanding the fundraising team will lead to a direct increase in Charitable activity provided back to the Trust with the aim of net nil income and expenditure for the charity.

Income
The expanded fundraising team will be able to generate more income on an ongoing basis. All the staff will require a bedding in period in their first year with less forecast income generated than subsequent years. Income growth through the case for change model is set out below. Excluding NNU income is projected to increase from £400k in 2023/24 to £1,400k in 2027/28. The NNU appeal will help the fundraising team raise significantly more income in 2024/25 and 2025/26. This demonstrates the importance of the Trust working with the Charity to identify fundraising appeals to maximise the overall income generation and charitable activities provided to the Trust.

Table A – Base Model Income

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Fundraising	74	160	235	460	510	510
Donations	712	70	170	420	520	520
Legacies	180	60	60	80	110	110
Grants	0	0	165	165	165	165
Staff Lottery	40	50	50	50	50	50
Investment Income	56	50	50	50	50	50
Sub-Total	**1,062**	**390**	**730**	**1,225**	**1,405**	**1,405**
Trusts and Grants (NNU)	0	0	500	1,000	0	0
Total	**1,062**	**390**	**1,230**	**2,225**	**1,405**	**1,405**

(2022/23 Donations includes £500k donation from Sovereign to the purchase of a new DaVinci robot)

Table B – Base Model Financial Summary

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Pay Costs	(220)	(312)	(459)	(598)	(598)	(598)
Non-Pay Costs	(80)	(120)	(122)	(122)	(122)	(122)
Charitable Activities	(751)	(200)	(200)	(1,700)	(200)	(200)
Income *	1,062	390	1,230	2,225	1,405	1,405
Income / (Expenditure) before investments	**11**	**(242)**	**449**	**(195)**	**485**	**485**
Net gains / (Losses) on investments	(91)	0	0	0	0	0
Net Movement in Funds	**(80)**	**(242)**	**449**	**(195)**	**485**	**485**

Note: * *Income excludes the £1.5m to be raised by the Sick Childrens Trust on the assumption that this will be paid directly to the Trust to fund the NNU development. Further work is needed to establish if this donation will be shown in the Charity accounts.*

Base Model Summary
The base case demonstrates that the growth of the fundraising team will take the Charity from a net loss of £0.2m in 2023/24 to a surplus of £500k in 2026/27 and 2027/28. Delivery of the NNU appeal will allow a surplus to be reported in 2024/25 but the additional Charitable activities delivered in 2025/26 will lead to an in year loss. The NNU appeal has a net nil impact to the model overall.

3. <u>Independent Charity</u>
The financial impact of the Charity becoming independent is based on the same assumptions as the base model with amendments for the changes to an independent model. The model assumes the Trust becomes independent in April 2025 and as such will follow the existing Corporate Trustee model until that date. It has been assumed that the Trust would expect any goods or services provided to support the Charity would be done so on a commercial basis. Should the Board approve the case for independence then any such charges would be agreed during the implementation phase.

Pay Costs
Pay costs of the fundraising team would remain the same as under the Corporate Trustee model. This assumes that the Charity will continue to pay under Agenda for Change terms and conditions.
The Charity will generate a £24k saving on pay costs on management support costs from the Finance team as the Charity would retain a finance function that would report directly into the Charity Director. Finance support would comprise an Accountant (Band 6) with support from a Finance Officer (band 3). Additional finance support would be sought to prepare and audit annual accounts.

Implementation Costs
In total it is estimated that there will be a one-off cost of £115k for the move to independence. This will include professional fees to support the legal change to an independent body, recruitment of Trustee's, project management, other professional fees and purchase of IT equipment.

Table C – Implementation Costs

Description	Amount £000
Trustee Recruitment and Selection	20
Legal Fees	30
Other Professional Servies	20
Project Management	30
IT Equipment Purchase	15
Total	**115**

Support Services
As an independent entity the Charity would need to directly procure a range of support services. In total additional support costs are estimated to cost £36k per annum and increase of £16k.

Table D – Support Service Costs

Description	Amount £000
Accountancy – Preparing and Audit of Accounts	10
Human Resources	2
Informatics	7
Insurance	2
Legal	5
Payroll	9
Trustee Expenses	1
Total	**36**

Retained Services
The model assumes that the Trust will retain the Trusts Cashier and cash collection service which will mean the existing Cashiers recharge of £2k (+VAT) per annum will be retained. It is also assumed that the Charity will continue to use office space provided by the Trust. An estimate for rent and service costs of £2k per month has been included in the model (£29k per annum including VAT). The final list of services to be retained and the proposed charges will be negotiated should the decision be made for the Charity to become independent. It should be noted that any services charged by the Trust to the Charity will be subject to VAT charges which the Charity will be unable to recover. As such this is an additional tax charge that isn't levied on the current recharges.

Optimism Bias
An optimism bias of £25k per annum from April 2025 has been included in the model to represent the risk that costs in the model could be understated.

Income

Total additional income of £1,369k has been included above the base case model. The Charity Director has confirmed that this is a realistic forecast of the income that can be achieved under an independent structure. This is largely due to higher income expectations for the bid writer who will submit Trust and Grant applications. The Charity has found that not all grant giving organisations will work with Corporate Trustee charities. BHC was unable to submit a grant application to Leeds & Bradford Community Foundation due to its current status. Additional income has also been applied across the remainder of the fundraising team. This reflects a 4.6 times uplift in the cost of the fundraising team (excluding the Charity Director and Bid Writer) to the overall income generated.

Table E – Additional Income for Independent Charity

Description	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000
Trusts and Grants	0	0	292	335	335
General Income Uplift	0	0	67	170	170
Total	**0**	**0**	**359**	**505**	**505**

Independent Charity Summary

After an initial investment in 2024/25 of £115k additional income of £312k will be generated in 2025/26 and then £458k per annum going forward. This is a total benefit of £1,113k over the life of the financial model.

Table F – Independent Charity Model Financial Summary

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Pay Costs	(220)	(312)	(459)	(574)	(574)	(574)
Non-Pay Costs	(80)	(120)	(236)	(193)	(193)	(193)
Charitable Activities	(751)	(200)	(200)	(1,700)	(200)	(200)
Income	1,062	390	1,230	2,584	1,910	1,1910
Income / (Expenditure) before investments	**11**	**(242)**	**334**	**117**	**943**	**943**
Net gains / (Losses) on investments	(91)	0	0	0	0	0
Net Movement in Funds	**(80)**	**(242)**	**334**	**117**	**943**	**943**

Table G – Summary of Changes

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Pay Costs	0	0	0	24	24	24
Non-Pay Costs	0	0	(115)	(71)	(71)	(71)
Charitable Activities	0	0	0	0	0	0
Income	0	0	0	359	505	505
Income / (Expenditure) before investments	**0**	**0**	**(115)**	**312**	**458**	**458**
Net gains / (Losses) on investments	0	0	0	0	0	0
Net Movement in Funds	**0**	**0**	**(115)**	**312**	**458**	**458**

4. **Analysis:**

Return on Investment

The Charity seeks to achieve a return on investment of £4 being generate for each £1 spent on fundraising. The return on investment calculation compares all the costs deemed to relate to fundraising against income earned by the Charity. Costs include fundraising team salaries, non-pay fundraising costs

such as marketing materials and an element of running costs such as HR support. The move to independence would see an improvement on the return on investment from 2025/26 onwards although it would still be below the overall target of £4 generated for each £1 spent. The target is exceeded in 2025/26 due to the impact of fundraising for the NNU appeal.

It is the view of the Charity Director that it will be possible to achieve the £4 rate of return with strong campaigns. This is reflected in the forecast for 2025/26 where the additional NNU appeal fundraising leads to a rate return over £4 for both the Independent and Corporate Trustee model. The income figures presented in this case are considered realistic for the charity based on the proposed structure. To achieve the £4 target in 2027/27 and 2027/28 would require an additional £468k per annum. Fundraising for compelling appeals will help to generate larger sums needed to achieve the target.

Table H – Return on Investment for each £1 spend on fundraising

Description	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Corporate Trustee	6.35	1.47	2.96	4.02	2.54	2.54
Independent	6.35	1.47	2.86	4.31	3.19	3.19
Variance	0	0	(0.10)	0.3	0.65	0.65

*The return of £6.35 in 2022/23 was due to a one-off donation from Sovereign Healthcare of £500k and receipt of legacies of £180k

Pay Back Period

An overall investment of £115k will be required to fund the move to independence. This is to be funded by donations into the Charity and as such needs to be demonstrated that the initial investment will be returned. The finance model predicts a financial benefit of £312k the following year which would see the initial investment paid back within the first 5 months of the move to independence.

Sensitivity Analysis

The key risk included in the finance model is the income projects which show substantial growth from the forecast performance for the current year. The sensitivity analysis compares the proportion of overall income that would need to fall to cancel the financial benefit of moving to an independent charity. This shows that should income be lower than projected in 25/26 by more than 12.1% or in 2026/27 or 2027/28 by more than 24.0% the financial benefits of becoming independent will not be achieved.

Table I – Sensitivity Analysis

Description	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000
Financial Benefit of Independence	**0**	**(115)**	**312**	**458**	**458**
Adjustment to Income to breakeven	-	-	(312)	(458)	(458)
Total Income	390	1,230	2,584	1,910	1,910
% of Total Income	-	-	12.1%	24.0%	24.0%

Financial Impact to the Trust

The move to independence in April 2025 will have a direct impact on the Trust finances. Under the Corporate Trustee model, the Charity pays the Trust £29k for management support from the Finance team and to access the Trusts cashier's service. This income would largely be lost with the move to independence. The final charges would be subject to negotiation; however, the proposed model assumes that following the move to independence the Charity would pay the Trust £26k a year for rental and a cashier's service, representing a net loss of £3k per year to the Trust. The Trust will directly benefit from the growth in charitable activities to be funded by the move to independence. When this growth is considered, the Trust is generating a net benefit of £309k in 2025/26 and £455k per annum thereafter, on the basis that this will be spent within the Trust.

Table J – Financial Impact to the Trust

Description	2025/26 £	2026/27 £	2027/28 £
Lost Finance Income	29	29	29
Cashier Service	(2)	(2)	(2)
Office Rental Charge	(24)	(24)	(24)
Net (Income) / Expenditure	**3**	**3**	**3**
Charitable Activity Growth	(312)	(458)	(458)
Overall Trust Impact	**(309)**	**(455)**	**(455)**

5. Summary and Conclusion

The move to independence will lead to a net benefit of £1,113k being generated by April 2028. An initial investment of £115k will be recovered in the first full year of operations under an independent charity model when an additional net income of £312k will be generated. From 2026/27 onwards an additional net income of £458k is forecasted to be generated. An independent charity will also return a higher return on investment than the Corporate Trustee model. The sensitivity analysis shows that total income would need to fall by 24% to erode the financial benefits of independence. This gives a degree of assurance that a financial benefit will be realised should the forecast income included in the model not be delivered in full.

5. Management Case: *Is this achievable, deliverable and within good governance?*

Should the case for change be agreed by BTHFT Board, the process for transfer to charitable status is well defined and is clearly set out in a document, published by the Department of Health & Social Care; ***NHS Charities- Conversion to Independent Status,*** February 2020.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/868598/NHS_Charities-guidance-update_Feb_2020.pdf

This ***implementation document*** provides a complete description of the stages and required actions for the transfer to an independent charity, including sequence of actions, contact details, process flowcharts, MOU suggested content, financial and legal requirements and full project plan template. All of the required actions are well defined and are straightforward, however there may be a requirement for some Project Management support to implement the changes, reporting to and managed by Charity Director.

In addition, there are regulatory and legal implications to the transfer/implementation process, which would require external specialist legal support. The external legal specialist would complete the actions relating to requesting transfer from the Department of Health & Social Care and the re-registration with the Charity Commission, as well as registration with HMRC. Legal advice would also be required to ensure that due diligence has been completed correctly and that all governance structures are robust, in place and meet all statutory regulations.

Timing: the process of transfer and implementation will be determined by the complexity of the NHS Hospital Charity assets and the speed/progress of negotiations over future working arrangements with BTHFT. However, the estimate is that the process will take a minimum of 9 months to complete, with a recommendation of 12 months. The timing of the transfer process should be considered, with 31st March seen as a convenient date to align to a complete financial year, facilitating the transfer of funds and any in-year tax/cost liabilities.

Independent Charity Governance Arrangements:

The main advantage of an independent charity is having a dedicated board of Trustees who have time, skills and knowledge to be solely focussed in driving forward the growth of the charity. However, this form of organisation will require robust governance arrangements, separate from and yet aligned to BTHFT.

The Board of Trustees would be structured as follows:

<table>
<tr><th>Board of Trustees:</th><th>Key Legal & Governance Requirements:</th></tr>
<tr><td>1. Chair of the Board
2. Vice Chair of the Board
3. Treasurer
4. Company Secretary
5. Trustee with NHS experience – clinical
6. Trustee with NHS experience – managerial
7. Trustee with Governance responsibilities
8. Trustee with Marketing & PR responsibilities
9. Trustee with HR & Diversity responsibilities
10. Trustee-at-large: Public Figure</td><td>• Board Meetings – min 4 times per year
• Articles of Association (governing document)
• Formation of Committees
  ○ Finance & performance Committee
  ○ Fundraising Committee (income)
  ○ Funding Committee (expenditure)
  ○ Research & Innovation Committee
  ○ Audit, Governance & Risk Committee
• Annual General Meeting</td></tr>
<tr><th colspan="2">General responsibilities for all Trustees:</th></tr>
<tr><td colspan="2">• Act in the best interest of the charity and its beneficiaries.
• Attend and actively participate in Board meetings and relevant committees.
• Disclose conflicts of interest and act with transparency and integrity.
• Be familiar with and adhere to the charity’s governing documents.
• Promote the charity’s mission, values and ethical standards.
• Stay informed about relevant laws, regulations and sector trends.</td></tr>
</table>

Governing Instrument:

An independent charity requires a new overarching governing document. Depending on the structure of the new charity this would be:

- **Articles of Association** if the new charity is a **Company Limited by Guarantee** (CLG)
  These outline the structure of the Board of Trustees, including the roles and responsibilities and the procedures for decision making. This also includes provision for the for the appointment and removal of Trustees. The Articles of Association must be registered with the relevant government authority and are subject to the laws and regulations applicable to companies. Articles of Association are public records.

- **Constitution** if the new charity is to be a **Charitable Incorporated Organisation** (CIO)
  This a legal document which sets out the charitable aims and purpose, defined as it's 'objects'. It sets out the structure of the Board, how Trustees are appointed and who can be a member. It also defines what the charity is permitted to do, such as owning land and borrowing money, it's 'powers'

Statutory Regulations:

Legal Entity	Legal Requirements
Company Limited by Guarantee (CLG)	Regulated by both company law and charity law. CLGs are required to file financial reports with both Companies House and the Charity Commission
Charitable Incorporated Organisation (CIO)	Regulated primarily under charity law. CIOs report to and file financial reports to the Charity Commission

Additional Governance Arrangements:

These will need to encompass all elements of the organisations functions and are required to be separate from BTHFT policies. These should include all aspects of employment and HR (including remuneration and pension), mandatory training, financial regulation and management, adherence to codes of practice including GDPR and the Code of Fundraising Practice.

Memorandum of Understanding:

This is the key document which will define the ways of working between BTHFT and Bradford Hospitals Charity, should it become independent. This would be agreed and negotiated between the two organisations and would incorporate the following scope:

- Overarching description of the relationship between both organisations
- Formal agreements relating to the transfer of existing and any defined future funds.
- Definition and agreements for transfer of NHS assets to the charity.
- Scope of the charity objects and how these will be aligned to the requirements and benefits of BTHFT patients and staff.
- Future consultation between both organisations and if relevant, dispute resolution mechanism.
- Any issues relating to intellectual property rights.
- Agreed use of any of BTHFT property, facilities, maintenance, support staff of 'back-office' functions; aligned to agreed monthly fees payable and payment terms.

Implementation Project Plan and Process Towards Conversion:

If the BTHFT Board agree to the transition to an independent charity, the next step will need to be to establish if the charity is in a position to commence and undertake the transition process. There are key criteria, as defined by the Department for Health and Social Care

Defined prerequisites for transition – organisational readiness:

a) Have written plans for transition, which are scalable and straightforward to implement; without overly costly or onerous workload, taking into account all legal and other issues for current NHS staff who may be required to transfer.
b) Have a defined agreement to protect charitable income streams and an agreed policy to enable the charity to continue to receive donations/legacies previously donated to the Trust.
c) Maintain or enhance donor confidence, with shared messaging, PR and stakeholder engagement.

Process and Implementation Plan for Transfer:

The next step will be the development of a Project Plan and to identify a nominated Project Lead. The plan will need to be fully details, with identified associated costs, actions and deadlines. However, for the sake of completeness and reassurance, the topics which need to be addressed are outlined below:

Category	Actions Required
Legal	• Define the legal entity to be adopted by the independent charity • Complete any outstanding due diligence issues re: contracts held, specific Trust funds etc. • Define any assets and liabilities and agree process for novation • Implement all statutory requirements for insurance, inc. public liability, trustee indemnity etc.
Governance	• Development of Articles of Association and Memorandum of Understanding • Definition of Charity structure, including Board of Trustees composition and committees • Define vision, purpose and mission • Notification of staff, donors and any relevant third parties of date of independence/transfer • Compiling full list of policies to cover all aspects of business process (approx. 70-80 policies) *
Regulatory	• Registration with Companies House and the Charity Commission • Align transfer actions to the Charity Commission guidelines (see link below) • Engage and consult with the Department of Health and Social Care • Identify any issues in relation to GDPR and transfer restrictions for data held by the Trust • Notification of all regulatory bodies of the date of independence/transfer • Define reporting requirements, timescales and specific submission dates
Financial	• Agree process for transfer of assets from the Trust to the charity (criteria and timescales) • Costs to be paid by charity to Trust; rent, utilities, support services, kit & equipment etc • Establish separate Bank Account for independent charity • Register with and consult with HMRC • Agree and define VAT registration and required payments • Appoint financial support, internal or external, management accountants and auditors
Human Resources	• TUPE for staff, including consultation and identification of costs • Identify any outstanding HR issues or unresolved concerns • Register for new pension scheme arrangements for any new employees post transfer • Define recruitment criteria for Trustees, selection procedures and remuneration • Staffing recruitment policies and define employment T&Cs (salary, pension, benefits)
Other:	• Implementing changes to IT, links to Trust network (or not) and server access • Making changes to web site, branding or social media • Establishing separate emails and IT accounts for charity staff and Trustees • Defining any interim arrangements for the transition period, handover documents etc • Full 'go-live' action plan with mitigations and count down actions.

A **full list of policies** (above *) is listed in ***Appendix A***

6. Risks and Issues:

Addressing potential key concerns:

A key issue to address with BTHFT Board is the relationship between the hospital and their associated charity. There may be some concerns that the move to independence could risk weakening their status as the principal beneficiary of the funds, there may also be some concern around the risk of change, into unfamiliar territory and the associated financial risks.

Key Concern:	Mitigation:
Financial Sustainability; concerns relating to insufficient reserves, potential to not break even or additional costs and tax burdens which may be damaging to potential charitable activity	• Financial modelling for both Corporate Trustee model in comparison to Independent Charity have highlighted that the cash reserves required are available and that the risk is minimal. • The financial models have been based on realistic assumptions of increase in fundraising opportunities and activities, based on feedback from other hospital charities. Targets have been set to recognise that growth will take time to build following the recruitment of additional fundraising staff. • The costs of the process of transfer to independence are realistic and have been checked and agreed by other charity colleagues who are also in the process of moving to independence • The burden of additional tax (VAT) has been assessed by the financial team and has been incorporated into the financial models.
The process of transition to an independent charity could be time consuming, be an onerous workload and divert attention from business-as-usual activities	• There is a clear road map, produced by the DHSC, to outline the process, governance and legal requirements for a transfer to independence. • There are a number of other NHS Hospital charities, already converted to independence (including Leeds Hospitals Charity), who have formed an informal support network to advise as required. • Local solicitors (Wrigley's) are now familiar with the requirements of transition and can advise on any gaps or specific areas of risk. • DHSC advise that the full end-to-end process takes 9-12 months, but that much of that time is awaiting responses from registration applications etc. • There may be some requirement for Project Management support, as well as some one-off costs relating to the transition process. However, these can be built into the cost benefit summary model for the Independent Charity, to inform the final Board decision.
Concerns re: future relationship between BTHFT Board and an independent BHC – potential 'loss of control'	• Both BTHFT and the charity can negotiate and agree the terms within the written governance documents, purpose and objects within the ***Articles of Association.*** • BTHFT will be able to agree formal representation of their employees within the membership of the Board of Trustees of the charity. • Future working arrangements, including use of premises, access to BTHFT support services, utilities, would be agreed and defined within a ***Memorandum of Understanding*** or ***Service Level Agreement***. • BTHFT Board would be responsible for enacting the initial transfer of funds to the charity; which would not take place until the Trust Board are satisfied with the governance structure, legal framework, due diligence and future working arrangements have been completed and approved.

Risk Log: In addition to the key concerns above, a list of risks and mitigations is included as ***Appendix B***

Summary & Recommendations:

Key Benefits:

a) Becoming an independent charity will provide a 'freedom to act' more innovatively and at pace, with a sole focus on delivering the most impactful support and care for its beneficiaries. Independence will also facilitate joined up working, with Finance, Marketing and Fundraising activities, all functioning within one organisation and all under the management and oversight of the Charity Director.

b) As an independent charity a wider range of fundraising opportunities can be accessed. Well established fundraising routes such as applications from Trusts & Foundations will become more accessible as an independent charity and in time, more innovative activities can be launched, such as retail and lotteries.

c) The move to independence will lead to a significant financial benefit to the Charity and in its turn to BTHFT. Larger projects can be planned and fundraised for, in line with Trust plans and strategic developments.

d) The Charity, as an independent will be able to operate under a well-defined, robust and legally regulated assurance framework. This will facilitate making choices which are separate from the Trust, but will benefit the Trust and are supported within statutory governance arrangements.

Recommendation:

On the basis of both the financial and non-financial benefits described above and the recognition of risks and commitment to their mitigation, there is a recommendation to Charity Operations Group, Charitable Funds Committee, the Executive Team and the Trust Board **to approve the conversion of Bradford Hospitals Charity to an independent charity**, subject to the further approval of a robust transfer plan.

Appendices:

Appendix A: List of policies required for Independent Hospital Charity

Appendix B: Risk Log; including mitigations

Appendix C: Independence Outline Project Plan

References:

1. ***Department of Health;*** Review of the regulation and governance of NHS Charities; Summary Report, October 2012

2. ***Department of Health and Social Care;*** NHS Charities conversion to Independent Status; February 2020

3. ***Charity Commission Guidance:*** Charity Commission guidance - GOV.UK (www.gov.uk)
Full information on the regulations and requirements required from legal and good practice requirements in establishing, reporting and operating an independent charity.

Appendix A: List of Policies - required for an Independent Bradford Hospitals Charity

#	Policy Title	Purpose	Type	Regulatory Requirement
1	**Staff Handbook**			
	Expenses Policy & Procedure	Set out arrangements for BT and Expenses	Policy	No
	Company Credit Card Policy	Sets out arrangement for Charity Credit Card use.	Policy	Yes – Charity Commission
	Redundancy	To set out the Charity's policy and procedures in this area.	Policy	Yes – Employment Law
	Parental Leave and Pay Policy	Including time off, paternity leave, maternity leave	Policy	Yes – Employment Law
	Remote Working/Home Working	To set out the Charity's policy and procedures in this area.	Policy	No
	Adoption leave and Pay	To set out the policy and procedures for adoption leave and pay.	Policy	Yes – Employment Law
	Shared Parental Leave and Pay	To set out the Charitys commitments in this area.	Policy	Yes – Employment Law
	Parental Bereavement Leave Policy	To set out the Charitys commitments in this area.	Policy	Yes – Employment Law
	Employee Training & Development Policy	Sets out the Charity's commitment to train and develop employees including professional qualifications, training courses, study leave and funding.	Policy	No
	Pregnancy and Maternity Rights	To set out the Charitys commitments in this area.	Policy	Yes – Employment Law
	Pay	Remuneration and employment terms and conditions	Policy	No
	Equality, Diversity and Inclusion Policy	Statement also needed for annual report	Policy	Yes - Equality Act 2010
	Sickness Absence	Includes access to medical records and occupational health support	Policy	Yes – Employment Law
	Holiday Policy	Sets out annual leave arrangements and entitlements	Policy	Yes – Employment Law
	Positive Work Environment	Includes bullying and harassment procedure	Policy	No
	Flexible Working Policy	To set out the Charitys commitments in this area.	Policy	Yes - Employment Law
	Time Keeping and Time Off Statement	Includes special leave, bereavement leave, adverse weather, jury service,	Policy	No
	Code of Conduct (Employees)	To set out the Charitys commitments in this area.	Policy	No
	Recruitment and Selection Policy	To set out the Charitys commitments in this area.	Policy	No
	DBS Policy Statement	To set out the policy with regards to the Charity's DBS requirements.	Statement	Yes - Other - Police Act 1997
	Alcohol and Substance Abuse	To set out the Charitys commitments in this area.	Policy	No
	Lone Working Policy	Highlights risks presented by lone working, to identify the responsibilities each person has in this situation.	Policy	No
	Complaints Policy and Procedure	To set out the policy and procedures for raising a complaint or grievance at work	Policy	No
2	Social Media Policy	To cover personal use of social media.	Policy	No
3	Media Policy	To ensure that media enquiries are dealt with appropriately.	Policy	No
4	Anti-Money Laundering Policy & Procedures	Responsibilities and guidance in relation to the prevention, detection and reporting of money laundering	Policy	Yes - Other - Money Laundering, Terrorist Financing and Transfer of Funds (FCA)
5	Policy on Investment Management	Sets parameters to be issued to our investment managers around investing decisions, including Ethical Social & Governance (ESG) for the portfolio.	Policy	Yes - Charity Commission
6	Anti-facilitation of Tax Evasion	Responsibilities and guidance in relation to the prevention, detection and reporting of anti-facilitation of Tax Evasion.	Policy	No
7	Intellectual Property	Sets out our approach to IP in the context of funding awarded and opportunity for the organisation to benefit from IP.	Policy	Yes - Other - Association of Medical Research Charities
8	Adult and Child Safeguarding Policy	To set out the policy and procedures for managing safeguarding.	Policy	Yes – Charity Commission
9	Standards	Dress code, wastage,	Policy	No
10	IT & Communications Systems (Handbook)	Describes the standards required by staff when using systems.	Policy	No
11	IT AUP (Acceptable Use Policy)	Describes the standards required by staff when using systems.	Policy	No
12	Bring your own device (BYOD) Policy	Describes the standards required by staff when using systems.	Policy	No
13	User Security and Access Control	Describes the standards required by staff when using systems.	Policy	No
14	IT Security Policy	Describes the standards required by staff when using systems.	Policy	No
15	Remote Access	Describes the standards required by staff when using systems.	Policy	No
16	Internet Usage Policy	Describes the standards required by staff when using systems.	Policy	No
17	IT Email Usage Policy	Describes the standards required by staff when using systems.	Policy	No
18	Mobile Device Policy	Describes the standards required by staff when using systems.	Policy	No

19	Password Policy	Describes the standards required by staff when using systems.	Policy	No
20	Volunteer Involvement Policy	Sets out the principles by which the Charity works with our volunteers.	Policy	No
21	Volunteer Expenses Policy	Sets out clear guidelines for any volunteer working with the Charity and the reimbursement of out-of-pocket expenses.	Policy	No
22	Young Volunteers Policy	Sets out our commitments to supporting young volunteers safely (under 18s).	Policy	No
23	Policy on use of charitable funds for educational activities	Sets out the criteria for using charitable funds to underwrite the delivery of educational activities.	Policy	No
24	Reserves Policy	Sets out the Charity's approach to reserves.	Policy	Yes - Charity Commission
25	Fundraising Policy	To include grant funding from external charities / bodies Policy.	Policy	Yes – Fundraising Regulator
26	Corporate Partnerships Policy	Provides a clear framework for the charity to enter into partnership arrangements.	Policy	Yes – Fundraising Regulator
27	Our Fundraising Promise	To articulate to our supporters what they can expect from the charity in relation to the handling of their donation.	Policy	Yes – Fundraising Regulator
28	Fair and Transparent Terms of Practice	Compliance with gambling Act. Preventing gambling from being a source of/associated with crime/disorder, or to support crime. Ensuring gambling is conducted in fair/open way. Protecting children/vulnerable persons from harm/exploitation by gambling.	Policy	Yes – Gambling Act 2005
29	Self-exclusion	Compliance with gambling regulations, demonstrates we up-hold the Acts objectives. Require a self-exclusion policy.	Policy	Yes – Gambling Act 2005
30	Technical Standards	Compliance with gambling regulations, demonstrates we up-hold the Acts objectives. Require a technical standards policy.	Policy	Yes – Gambling Act 2005
31	Segregation of Funds	Compliance with gambling regulations, demonstrates we up-hold the Acts objectives. Require a segregation of funds policy.	Policy	Yes – Gambling Act 2005
32	Cash and Cash Equivalents	Compliance with gambling regulations, demonstrates we up-hold the Acts objectives. Require a cash and cash equivalents policy.	Policy	Yes – Gambling Act 2005
33	Access Premises	Compliance with gambling regulations, demonstrates we up-hold the Acts objectives. LHC must have in place a Access to premises policy that enable the Gambling Commission Enforcement Officers to visit LHC sites.	Policy	Yes – Gambling Act 2005
34	Anti-Bribery Policy	Responsibilities and guidance in relation to bribery and corruption issues. Supports requirement of Bribery Act 2010. Includes hospitality and gifts	Policy	Yes - Bribery Act 2010
35	Conflict of Interests Policy and Procedure	Sets out how we will identify and manage conflicts of interests. To include gifts and hospitality.	Policy	Yes - Charity Commission
36	Trustee Expenses Policy	Set out the Charity's policy for paying expenses to Trustees.	Policy	Yes – Charity Commission
37	Risk Management Policy	Outlines the Charity's' Risk Management Framework which aims to identify and manage the possible and probable risks that the charity may face.	Policy	Yes – Other - Charities (Accounts and Reports) Regulations 2008
38	Public Interest Disclosure Policy and Procedure	This policy sets out the way in which individuals may raise any concerns that they have about the conduct of others in the Charity or the way the Charity is run and how those concerns will be dealt with by the Charity.	Policy	Yes - Public Interest Disclosure Act
39	Data Protection Policy & Privacy Standard	How data is to be treated at the Charity. Responsibilities and GDPR requirements.	Policy	Yes – General Data Protection Regulation / Data Protection Act
40	Data Retention & Destruction Policy	Details procedures and policy for the retention and disposal of information gathered and processed	Policy	Yes – General Data Protection Regulation / Data Protection Act
41	GDPR Appropriate Policy Document	Explains how and why we collect, process and share special category and criminal convictions data in order to carry out our functions, in accordance with the principles set out in the Data Protection Act 2018; schedule 1.	Policy	Yes – General Data Protection Regulation / Data Protection Act
42	Complaints Policy and Procedure	To set out the policy (and procedures) The Charity undertakes when handling complaints.	Policy	Yes – Fundraising Regulator
43	Data Breach Policy and Procedure	Policy and procedure for identifying and managing Personal Data Breaches	Policy	Yes – General Data Protection Regulation / Data Protection Act
44	Privacy Policy (includes Cookie Policy)	Describes how the Charity captures and uses data, and also includes the cookies policy.	Policy	Yes – General Data Protection Regulation / Data Protection Act
45	Disaster Relief / Business Continuity policies	Sets out how the Charity will respond to disasters and also how it will ensure business continuity	Policy	No
46	Health and Safety Policy Statement	Charity's Health and Safety Policy that sets out how the Charity manages health and safety	Policy	Yes – Health & Safety at Work
47	Procurement Policy	Sets out guidelines for the procurement of goods and services in support of the Charity objects; ensures organisational expenditure is managed effectively and that any applicable statutory obligations and legislative requirements are complied with.	Policy	Yes - Bribery Act
48	Code of Ethics	Umbrella policy that will sit across a number of policies relating to fundraising and donations etc. map to investment policy.	Policy	No
49	Equality, Diversity & Inclusion Statement	Sets out the Charity's approach and commitment as an employer to equality, diversity and inclusion.	Statement	No
50	Comments, Compliments and Complaints Statement	Demonstrates our commitment to receiving and acting on feedback with the highest level of care and respect	Statement	Yes – Fundraising Regulator
51	Employee Handbook	This Handbook contains information, rules, policies, and procedures concerning employment at the charity.	Policy	Yes – Employment Law

Appendix B - Bradford Teaching Hospitals and Bradford Hospitals Charity Risk Log

Category	Risk	Mitigation
Financial Sustainability	Financial Instability:	Develop a financial strategy; expenditure budget, income generation plan, investment plan etc
	Not meeting target income	Create a 5 year plan to define annual fundraising, specified by activity, with target for each activity
	Increased expenditure, without growth	Recruit an experienced team of fundraisers to deliver the fundraising plan (Bid writer, community, legacy etc)
		Develop an independence transition plan, which sets budgets for transition expenditure (individual elements)
		Agree with BTHFT a reasonable cost base for premises rent, estates, cleaning & maintenance, supplies, rent, IT etc.
	Lack of sufficient cash reserves	Financial forecasts for the independence model and an estimate of additional costs have been assessed as manageable and appropriate
	Potential burden of additional taxation (inc.VAT)	KPMG to advise - although minimal impact for other independent charities (accounting mechanisms to manage this effectively)
	Reduced charity expenditure on/within BTHFT	Agree basic principles of charity purpose, vision and objects with the Trust, within the governing document (Articles of Association)
Governance & Leadership	Implications for legal requirements (impact of errors)	Engage with experienced Solicitor firm, who will advise and will write the statutory documents (Articles of Association)
	Concerns re: lack of robust Governance	Create an experienced Board with a diverse skillset to lead the strategy and governance of the organisation.
		Utilise all published processes from DHSC and Charity Commission to ensure that legal requirements are identified and included in plan
		Ensure Trustees understand and meet their strategic roles, responsibilities and obligations
		Ensure that the Charity has the appropriate Director to deliver operational leadership and performance manage aligned to strategy
	Appointment of Trustees (costs and diversity issues)	Use agency for search, within defined budget; set clear criteria to define skills set and assess diversity implications
Ineffective use of Resources	Additional regulatory demands	Appointing third party agents, with experience and reputation for quality services (HR, Finance, IT)
	Additional costs for conversion processes	Negotiating cost effective contracts for required services (appointing Management Accountant instead of current arrangements)
	Risks re: failure to meet statutory deadlines	Focus of Trustees on timelines and contracts with providers linked to performance timelines etc.
	Additional costs overall for support services	Need to balance the impact of potential additional cost with the ability to increase income levels with freedoms of independence
Human Resources	Costs and impact of TUPE for existing staff	Use HR support and legal advice re provision of equivalent protected T&Cs OR explore secondment option (small numbers of staff)
	Development of new HR policies, JDs etc	Utilise support from other independent charities - HR policies will be provided by external HR company.
	Impact on staff and volunteers (transition is unsettling)	Regular communication (general) and in 1-2-1 consultations; setting shared ambitions for growth and performance success
Reputational Risks	Impact of Charity or BTHFT receiving 'bad press'	Ensure good communication between organisations, define standards of behaviour, utilise comms/media support as required
	Relationship management between BTHFT and Charity	Define and agree mutual benefits, establish regular formal and informal meetings between organisations - shared benefit in growth

	Timeframe	Action	Notes	Who	Cost Incurred
	Stage 1 – Registration				
The outline project timelines below are based on and aligns to the national document published by The Department of Health & Social Care; ***"NHS Charities – Conversion to Independent Status"*** published in February 2020.					
1	Trust Board March 2024	Agreement from Chartable Funds Committee and from Trust Board	Potential delay due to Trust Board agenda, may be allocated to Board meeting in March 2024	Trust Board	N/A
2	March 2024	Undertake internal 'processing' to tidy up and consolidate funds in preparations for any financial transfer.	Primarily an internal process, with support from the BTHFT Finance team, to include discussions and decision regarding the novation or retendering for any investment company.	Charity Director Finance Team	N/A
3	End March 2024	Contact recruitment agency to commence the search for suitable Trustee candidates for Charity Board of Trustees	Engage agency with sector appropriate skills and experience agreed with HR/Chair and Charity Director – plan interviews for June/July 2024	Charity Director Charity Chair	Recruitment Fees
4	Early April 2024	Joint letter to the Department of Health (DHSC) and Charity Commission (CC) formally notifying both organisations of the decision to convert	Letter can be drafted by Charity Director, but should be reviewed by legal advisor	Exec Director (Trust) Charity Director Wrigley's	Legal Costs
5	Early April 2024	Consider and agree the form of charitable company, Company Limited by Guarantee (CLG) or Charitable Incorporated Organisation (CLO)	Legal advice has already been provided by Wrigley's and advice from other Hospital Charities is that all conversions to date have moved to Company Limited by Guarantee (CLG)	Trust Board Lead Exec Director Charity Director	N/A
6	Mid-April 2024	Apply for consent from the Charity Commission, to use the name decided/agreed with the Trust, for the new independent charity	This should not be a problem, as the name has been agreed in principle, if conversion takes place to remain as Bradford Hospital Charity (only Charity Number will change)	Charity Director	Registration Fees
7	Mid-April 2024	If CLG selected, then application made to register with Companies House	Charity Director to be appointed as 'Director' to make application to register a new company/legal entity.	Charity Director	Registration Fees
8	April 2024 – June 2024	Prepare draft constitution – Articles of Association if CLG, to define the purpose and objects of the new charity.	Trust Executives (and legal team) will wish to oversee, review and agree the draft constitution, to ensure any fundamentals or non-negotiables have been defined and shared.	Trust Execs (TBC) Charity Director Wrigley's	Legal Costs
9	Late April – July 2024	Prepare draft Memorandum of Understanding in conjunction with project group from the Trust (incorporating representatives from appropriate departments)	Since the MOU is effectively an internal contract, there should not be a requirement for significant legal involvement. Template MOUs from other Hospital Charities can be used and a list of items to be covered and included can be provided by both Trust and Charity.	Trust Reps (TBC) Charity Director Charity Chair	N/A

10	Late April	Commence TUPE consultation for existing staff	Utilising advice from Wrigley's and internal HR team	Charity Director/HR	N/A
11	May 2024	Apply to NHS Pensions Authority to allow staff to continue as active members	This may not be necessary if existing staff members do not wish to remain as active members in NHS pension scheme	Charity Director	N/A
12	July 2024	Provide DHSC with a draft version of Articles of Association and MOU	The regulations linked to transfer of hospital charities to independence require acknowledgement and approval from DHSC	Trust Execs – Finance Director Trust CEO	N/A
13	July 2024	Prepare and submit application to Charity Commission, to include evidence of due diligence re: Trust Fund audits, endowments and clarification of unrestricted funds	Current timescales for approval from Charity Commission (dependent on complexity) are 4-6 months	Charity Director Wrigley's	Legal Costs
	Stage 2 – Transfer Process				
14	August 2024	Establish Charity 'Shadow Board' of Trustees, aligned to governance framework (defined within Articles of Association)	Shadow Board members (Trustees) to meet and finalise any remaining governance standards, Terms of Reference, purpose of committees and membership of each. Shadow Board to commence meeting schedule and support Charity Director in discussions re: Memorandum of Understanding.	Charity Director Charity Chair Charity Trustees	N/A
15	August 2024	Set up new bank accounts and register the new legal entity with HMRC	Applications for financial accounts will require documents from BTHFT re: financial references, accounts information, audits etc	Charity Director Charity Chair	Service Fees
16	August – December 2024	Development of Charity Policies, SOPs and governance framework, committee structures and terms of reference.	The development of policies can be informed by existing independent hospital charities, with advice from external HR service provider. Committees and terms of reference to be developed with Trustees, Chair and Charity Director	Charity Director Charity Chair Shadow Board	Service Fees
17	September – November 2024	Finalise Memorandum of Understanding document and agree any outstanding issues of concern or which require resolution.	It would be assumed that almost all issues will be negotiated, resolved and agreed between the Trust and the Charity, but this may require formal (independent) resolution and/or legal oversight.	Charity Director Trust Board Wrigley's?	Legal costs?
18	October 2024	Prepare transfer agreement, detailing the specific actions by week, counting down - Day 1 for the independent Charity	Ensure all legal and logistical requirements are actioned and implemented on the required date.	Charity Director Trust Execs (TBC) Project Manager	N/A
19	October – December 2024	Novate any existing provider contracts with external providers and seek quotes for independent services (IT/HR/Auditors)	Negotiate contracts for additional external service provision (if not provide by the Trust within the MOU) – including IT service provider	Charity Director Project Manager	Service Fees

20	December 2024	Prepare Job Descriptions for additional fundraising posts and support staff, advertise, set interview schedule etc.	Using HR service provider and aligned to Charity T&Cs	Charity Director HR Provider	Service Fees
21	January 2025	Apply for Scheme and linking direction from the Charity Commission and potentially may require a S105 order	Can apply for Scheme after the new charity is registered with the Charity Commission (legal actions in relation to Endowments and any legacies)	Charity Director Wrigley's	Legal Costs
22	April 2025	Go Live – launch date	Final sign-off by Trust (?CEO) and Charity Director or Chair, with oversight and witnessing by legal advisor.	Charity Director Trust CEO Wrigley's	Legal Costs
	Stage 3 – Post Transfer Completion				
23	April/May 2025	Take action to wind up the old charity and register on register of mergers	Option to keep the former charity active to protect any legacy income. (May depend on the endowment position and the scheme/orders from the Charity Commission	Charity Director	Service Fees
24	May 2025	Update website, materials, email addresses etc with new charity number and logo/branding if required	Communication with any key stakeholders, who are not yet informed.	Project Manager	N/A

Notes:

1. The negotiation, development and completion of a Memorandum of Understanding between the Charity and the Trust, will require representation from a number of representatives of the Trust, both from the Executive team and from a range of Trust departments. In order to agree many of the actions in the table above, it will be necessary to establish a 'Charity Independence Working Group' (or similar) potentially to include:
    a. Charity Director
    b. Trust Chair
    c. Lead Trust Executive (TBC)
    d. Medical Director (or Associate/Deputy)
    e. Trust Non-Exec Director
    f. Finance Department
    g. HR Department
    h. IT Department
    i. Corporate Governance

The Independence Working Group should have Terms of Reference, timelines and Project Management support.

2. The key document for reference is ***"NHS Charities – Conversion to Independent Status";*** Department of Health & Social Care, February 2020. This document contains details of all the legal requirements, key actions, key activity plan and DHSC requirements for conversion.

Outline Costs – as built into the Independence Business Case

Charity Conversion to Independence – Estimated Project Costs	
Requirement	**Cost**
Trustee recruitment (Charity Board)	£20,000
Legal Fees	£30,000
Professional services/registration fees	£20,000
Project management/ admin support	£30,000
IT Equipment purchase costs	£15,000
Total	**£115,000**

BO.3.24.24 - FIT AND PROPER PERSON TEST

REFERENCES

Only PDFs are attached

Bo.3.24.24 - Fit and Proper Person Test.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.24

FIT AND PROPER PERSON TEST FRAMEWORK

Presented by	Faeem Lal, Interim Director of HR / Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Faeem Lal, Interim Director of HR / Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Lead Director	Faeem Lal, Interim Director of HR	
Purpose of the paper	This paper provides an update in relation to the Fit and Proper Person Framework and associated guidance which has been published recently.	
Key control	Compliance with the Fit and Proper Person Framework is a key component of being a well led organisation.	
Action required	For information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Background

As reported to the Board on 21 September 2023, NHS England published the Fit and Proper Person Framework on 2 August 2023, which is applicable to all board members (executive and non-executive, voting and non-voting). All of the existing elements of CQC Regulation 5: fit and proper persons: directors are incorporated within the Framework and there have been no changes to the regulation itself.

Board members are already subject to FPPT checks on appointment, and on an annual basis thereafter. The Framework has been introduced in response to the recommendations made by Tom Kark KC in his review of the FPPT, to strengthen the arrangements already in place. The new elements that have been introduced are as follows:

- a Leadership Competency Framework (LCF);
- the introduction of FPPT fields in the Electronic Staff Record (ESR) to record testing;
- a revised Board Member Reference template;
- a strengthening of some elements of the FPPT assessment;
- extending the scope of FPPT to include ICBs and some ALBs; and
- a clear statement of accountability of chairs in implementing the framework in their organisation, including an annual submission to the NHSE Regional Director.

Key Options, Issues and Risks

Annual FPPT checks – due to be sent to the NHSE Regional Director by June 2024

There is a requirement to fully implement the Framework by 31 March 2024, and checks for each Board member must be completed and sent to the NHSE Regional Director by June 2024. The checks must be reviewed and signed off by the Chief Executive (for executive directors), Chair (for the CEO and non executives (NB the Chair is also required to review the executive director results)), and the Senior Independent Director (for the Chair).

The checks are currently in progress, and Board members have been contacted to provide any required information and complete any outstanding training. Our submission will be made by the deadline of June 2024.

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.24

Leadership Competency Framework and Chair appraisal framework
On 28 February 2024, NHS England published the Leadership Competency Framework (LCF) for board members and a revised chair appraisal framework, incorporating the new competencies.

The LCF is a key management and leadership development publication for NHSE. The Board is asked to note that NHSE plans to introduce a large number of coordinated initiatives aimed at improving support for NHS managers, seeking to address the recommendations from several reviews into NHS leadership and culture. It intends to publish its three year 'roadmap' setting out details of this work shortly.

Leadership Competency Framework (LCF) for board members

The LCF responds to the recommendation made by Sir Tom Kark in his 2019 review of the FPPT, which included a recommendation for 'the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed'. The LCF has been built around six competency domains which inform a series of competencies.

The six domains are:
- Driving high quality and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance
- Creating a compassionate, just and positive culture
- Building a trusted relationship with partners and communities

For each domain there is a description of what good looks like. 'Core' board member competencies are set across the six domains, formulated as 'I' statements 'to indicate personal actions and behaviours that board members will demonstrate in undertaking their roles'.

NHSE have designed it to:
- Support the appointment of diverse, skilled and proficient leaders
- Support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- Help organisations to develop and appraise all board members
- Support individual board members to self-assess against the six competency domains and identify development needs

The competencies are presented as aspirational. It is recognised that those in director roles for the first time in particular are unlikely to be able to demonstrate all competencies and the LCF can be used to identify and work on areas for development.

The LCF aims to support board members in their role as part of a unitary board. Differences between NED and executive roles, and between different executive roles, are recognised but the LCF does not set out role-specific competencies.

Recruitment
The competency domains will be incorporated into all board member job descriptions and recruitment

processes from 1 April 2024. They will also be used to help evaluate applications and design assessment processes.

Appraisal
The competency domains will be used in board member appraisals and to support the development of individuals and the whole board. A new board member appraisal framework (due to be published by NHSE) will support this but will not be available until autumn 2024. The LCF sets out specific responsibilities for different board members in relation to appraisals, which notably include:

For chairs:
- Assure themselves that individual board members can demonstrate broad competence across the domains
- Assure themselves there is 'strong, in-depth evidence of achievement against the competency domains collectively across the board' and ensure appropriate development if not
- Include relevant information in board member references

For all board members:
- Self-assess against the six competency domains as preparation for annual appraisal, incorporating development activity, for review with line managers.

In addition, Chief executives and senior independent directors should carry out appraisals for executives and chairs respectively, based on the framework and other objectives, and ensure findings feed into personal development plans.

The LCF notes that board members will also have detailed objectives, however the domains identify the competency areas and give examples of leadership practice and behaviours that will support their delivery.

The chair appraisal framework is optional for organisations to use, but says chairs should be assessed against the 'broad principles' of the LCF through multi-source assessment. It will be discussed with the Governors' NRC, alongside the LCF, in agreeing the Chair and NED appraisal processes for 2024/25.

The appraisal process for executives will be reviewed to ensure it is incorporating the LCF. This will be presented to the Board NRC by June 2024.

Both the executive and Chair/NED appraisal processes will be reviewed once the new Board member appraisal framework is published later in 2024, to be used for the appraisals in 2025/26.

Development
The LCF recognises that 'even the most talented and experienced individuals are unlikely to be able to demonstrate how they meet all the competencies… all of the time'. National leadership programmes and support for board directors and aspiring directors will have the competencies built into them.

Recommendation

The Board is asked to receive and note this report.

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.24

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)
	People Academy

BO.3.24.25 - ANY OTHER BUSINESS

BO.3.24.26 - ISSUES TO REFER TO BOARD COMMITTEES OR ELSEWHERE

BO.3.24.27 - REVIEW OF MEETING

BO.3.24.28 - DATE AND TIME OF NEXT MEETING

BO.3.24.29 - BOARD WORK PLAN

REFERENCES

Only PDFs are attached

Bo.3.24.29 - Board Open Work Plan 2024-25.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			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						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			SFIs/SOD - Nov 2024 SOs - Sept 2025
Constitution - annual review	Director of Finance			x							
Self Certification of Provider Licence	Director of Finance			x							
NED Independence Test	Director of Finance			x							
Compliance with NHS Code of Governance	Director of Finance			x							
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							

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)
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				x			March - deferred from Nov 23
Fit and Proper Person Test - annual review	Chief People & Purpose Officer		x								
COG Engagement Policy	Director of Finance		x	x							
STANDING ITEMS											
Patient Story - every alternate board	Chief Nurse			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	
Integrated Dashboard	All	x	x	x		x	x	x	x	x	
Finance Report	Director of Finance	x	x	x		x	x	x	x	x	
Performance Report	Chief Operating Officer	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	
Adults & Children Safeguarding Annual Report	Chief Nurse					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	
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.3.24.30 - GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT

REFERENCES

Only PDFs are attached

Bo.3.24.30 - Guardian Of Safe Working Hours Q3 2023 24.pdf

Meeting Title	People Academy		
Date	28 February 2024	Agenda item	PA.2.24.11

GUARDIAN OF SAFE WORKING HOURS DOCTORS AND DENTISTS IN TRAINING QUARTER 3 2023-24

Presented by	Dr Ray Smith, Chief Medical Officer	
Author	Dr Joanna Glascodine, Guardian of Safe Working Hours	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	Provide assurance that doctors and dentists in training are working safe hours	
Key control	High Level Control for Objective 1 & 3	
Action required	For information	
Previously discussed at/informed by		
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

The 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the Board to provide assurance that doctors and dentists in training are working safe hours. Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1 October – 31 December 2023.

Analysis

Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. The Guardian monitors hours-related reports, while the Director of Education monitors training-related reports.

In Quarter 3 there were 31 exception reports. 28 of these were related to hours/working patterns, 1 was education related and 2 exception reports were relating to the service support available to the doctor. In addition, 2 reports were flagged as an immediate safety concern.

In total, 17.75 additional hours were reported.

Recommendation

Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainees in post are happy with their current pattern. This will be discussed every time a new trainee rotates and approved at Junior Doctors' Forum (JDF).

The highest number of additional hours claimed this quarter was from Foundation doctors in General Surgery.

2 of the 31 reports were flagged as an immediate safety concern. These were from Foundation doctors on General Surgery.

Meeting Title	People Academy		
Date	28 February 2024	Agenda item	PA.2.24.11

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: Choose an item.

Meeting Title	People Academy		
Date	28 February 2024	Agenda item	PA.2.24.11

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 and Patient Safety	Finance and Performance	Other (please state)
☒	☒	☒	☐

Meeting Title	People Academy		
Date	28 February 2024	Agenda item	PA.2.24.11

GUARDIAN OF SAFE WORKING HOURS DOCTORS AND DENTISTS IN TRAINING QUARTER 3 2023-24

1 PURPOSE/ AIM

To provide a quarterly update report to give assurance that doctors and dentists in training are working safe hours.

2 BACKGROUND/CONTEXT

The 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the Board to provide assurance that doctors and dentists in training are working safe hours.

3 PROPOSAL

Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1 October – 31 December 2023. No fines were levied within this period.

4 RISK ASSESSMENT

Risks have been identified but actions have been taken and continue to be taken to mitigate against the risk.

5 RECOMMENDATIONS

Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainee in post is happy with their current pattern. This will be discussed every time a new trainee rotates and approved at JDF.

There were 17.75 additional hours claimed this quarter. The highest number of hours came from General Surgical Foundation doctors mostly due to busy on-calls and reduced staffing. The next highest hours came from Registrars in Obstetrics and Gynaecology. The main issue for them is around delayed handovers especially after nightshifts.

There were 2 immediate safety concerns this quarter. Both came from foundation trainees in General Surgery. 1 felt there was a concern due to poor staffing on a weekend and another trainee was unable to take a break due to a busy shift which meant they were unable to take their own regular medication. I have spoken to this trainee separately.

6	Appendices

Introduction
The 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the Board to provide assurance that doctors and dentists in training are working safe hours. Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1 October – 31 December 2023.

Exception reports
Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. The Guardian monitors hours-related reports, while the Director of Education monitors training-related reports. In Quarter 3 there were 31 exception reports. 28 of these were related to hours/working patterns, 1 was education related and 2 exception reports were relating to the service support available to the doctor. This is similar levels of reporting compared with Quarter 2. In addition, 2 reports were flagged as an immediate safety concern. This is selected as an option on an exception report if the trainee feels that they saw something that could have led to an issue for patient safety. This is most commonly due to understaffing for that shift. 1 report came from a Foundation trainee on General Surgery following a busy on-call weekend with reduced staffing due to sickness. The other report came from another Foundation trainee on General surgery who was unable to take their break and therefore time to take their regular medication. I have spoken to this trainee separately to discuss the matter further and make sure this does not happen again.

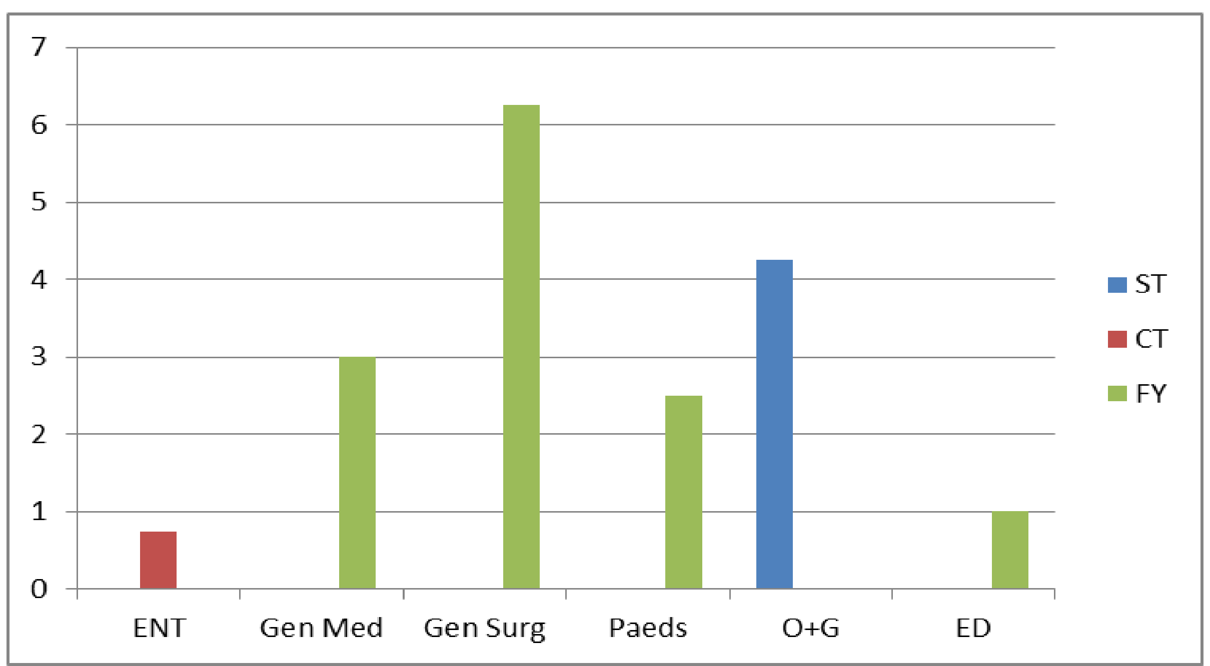
The highest number of additional hours was from Foundation doctors on General Surgery This was mostly due to staying late during on-call shifts due to poor staffing for that day. The next highest reported overtime was from Obstetrics trainees. The biggest issue for them currently is around the delayed handover after nightshifts; the registrars are currently auditing this and hope to propose different start times for midwives and doctors to rectify this. The other trainees claiming additional hours came from General Medicine, Paediatrics, ENT and the Emergency Department (ED).

The 5 specialities with the most reports are shown below in Table 1 and additional hours claimed by speciality and grade in Figure 1.

Table 1: Number of exception reports by top 5 specialties October – December 2023.

Exceptions by Speciality	Hours/work pattern	Educational	Service support	Patient safety
General Surgery	13	0	1	2
O+G	8	0	0	0
ENT	1	1	1	0
ED	3	0	0	0
General Medicine	3	0	0	0

Figure 1: Exception reports (hours) by specialty and training grade October – December 2023



Work schedule reviews
Every trainee agrees a work schedule with their educational supervisor. A work schedule review takes place when changes are needed to ensure safe working hours or to provide better training opportunities. There were no work schedule reviews this quarter.

Meeting Title	People Academy		
Date	28 February 2024	Agenda item	PA.2.24.11

Rota gaps
A rota gap results from a post not being filled or from long term sickness. Gaps may be filled by doctors who are not in training. There are currently 67 unfilled training posts out of a total of 497.

The Trust employs 14 post-foundation fellows, 7 post-core fellows and 52 locally employed doctors to help cover the rota gaps and enhance the junior medical workforce.

Locum bookings
Rota gaps may be filled by bank or agency locums via the flexible workforce team. This quarter there were 1878 requests which is a reduction of 22% on the previous quarter. 8% of the shifts remained unfilled compared with 4% in quarter 2. The two departments requesting the highest numbers of trainee doctor locums were as always; the Emergency Department and Medicine (see Figure 2).

Figure 2: Locum shifts by department October – December 2023

Fines
The Guardian levies a fine against a department if contract rules on hours or breaks are broken. Some is paid to affected doctors with the remainder being disbursed via the Junior Doctor Forum to improve the working lives of junior doctors during their time in Bradford. No fines have been levied in this quarter.

Issues arising and actions taken
The highest number of exception reports came from Foundation trainees in General Surgery. The most common reason was staying late due to busy shifts and reducing staffing. There

were 2 patient safety reports submitted this quarter, 1 was concerning a busy General surgical weekend on-call with some gap in cover due to sickness. The 2nd was from a trainee who felt they were too busy to take a break and take their regular medication. I contacted the trainee directly to discuss further and make plans for this not happening again.

The February 2020 TCS requirement for maximum weekend frequency working of 1:3 has been achieved across all rotas with the exception of palliative medicine (Marie Curie Hospice) although there is agreement from the hospice, the trust, the guardian and the current trainee on the rota that this will continue and will remain under review. There are no new updates.

Summary

- There were 31 exception reports in Quarter 3 compared with 25 in Quarter 2.
- The highest reporting group of doctors were Foundation doctors from General Surgery. This was mostly due to staying late after busy shifts. There were only 2 immediate safety concerns and they have been reviewed.
- The highest amount of overtime is from General Surgery Foundation trainees but this is low at 6.25 hours.
- There was a 22% reduction in locum requests this quarter with around 8% going unfilled. ED and Medicine remain the departments in need of most locums.
- Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainees in post are happy with their current pattern whilst we work to find a long-term solution.

BO.3.24.31 - WORKFORCE REPORT

REFERENCES

Only PDFs are attached

Bo.3.24.31 - Workforce Report (Cover).pdf

Bo.3.24.31 - Workforce Report.pdf

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.31

Workforce Report

Presented by	Faeem Lal, Interim Director of Human Resources	
Author	Samia Hussain, Associate Director of HR and other contributors	
Lead Director	Faeem Lal, Interim Director of Human Resources	
Purpose of the paper	To provide a summary of key workforce indicators as well as an overview of HR activity in support of the Trust's strategic objectives.	
Key control	To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion	
Action required	For information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	People Academy	31.01.2024

Key Options, Issues and Risks

This report contains key workforce metrics and trends as at December 2023 unless otherwise stated. The report also provides an update to the Academy on the recruitment, retention and Organisational Development activity.

Analysis

The metrics in this report focus on the substantive workforce. The previous report was presented in November 2023 based on data up to the period October 2023.

Since the last report staff in post FTE has increased from 6,250.50 in October 2023 to 6,321.86 in December 2023 representing an overall increase across all staff groups of 71.36 FTE. The year to date sickness absence rate has dropped from 5.91% reported in November to 5.78% as at the end of December 2023.
Turnover has continued to decrease to 9.73% in December 2023 from 10.01% in October 2023. Turnover has reduced slightly across all staff groups apart from Administrative & Clerical, Healthcare Scientists and Nursing & Midwifery Registered where it has increased slightly.

In view of the vacancy position Nursing and Midwifery staffing was on the Chief Nurse Risk Register (Risk ID 3732) as 5x4 (13th April 2023), however this has been reduced to 4x4 (31 October 2023). Our Nurse and midwifery Staffing Fill Rates at a ward level remain unchanged with an average fill rate of 77% for Registrants and 92% for Healthcare support workers.

The report also provides a comprehensive update from Pharmacy inlight of the OPS programme.

Updates are provided by Organisational Development on items such as the Leadership Development Pathways and the staff survey.

Recommendation

It is recommended that the People Academy discusses and notes the content of this report and determines if any issue needs escalating to the Board of Directors.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature

Meeting Title	Board of Directors		
Date	14 March 2024	Agenda item	Bo.3.24.31

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: Choose an item.
NHS Improvement 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)
☒	☒	☐	☐

Introduction

The last Workforce report was presented to the People Academy in January 2024. This report picks up key workforce themes and trends since then and is presented in the format previously used to report to Workforce Committee.

This report will continue to be presented to the People Academy on a quarterly basis as agreed in July 2021.

Trust Data as at 31st December 2023

	DIVISION						
	Unplanned Services	Planned Services	Diagnostic & Corporate Operational Services	Corporate Services	Estates & Facilities	Research	Whole Trust
Staff in Post (Headcount)	2,056	2,114	1,393	773	571	245	7,152
Staff in Post (FTE)	1,801.37	1,904.97	1,234.44	700.78	466.94	213.36	6,321.86
Establishment	2130.71	2118.95	1325.33	771.86	616.77	205.34	7168.96
Agency Usage (FTE)	21.56	30.63	38.43	0	49.45	0	140.07
Bank Usage (FTE)	264.36	156.01	87.96	8.11	104.81	0.99	622.24
Turnover	9.80%	9.80%	9.88%	11.72%	7.67%	4.60%	9.73%
Leavers within 12 months/Joiners	36/291	34/310	23/204	14/80	3/94	0/0	110/980
Monthly Sickness %**	7.31%	6.38%	6.55%	4.34%	8.04%	3.10%	6.46%
YTD Sickness %**	6.12%	5.86%	6.30%	3.91%	6.99%	2.42%	5.78%
Jnr Dr Sickness (Monthly) %	3.46%	4.28%	2.59%	2.79%	0.00%	0.00%	3.48%
Jnr Dr Sickness (YTD) %	4.56%	3.10%	2.72%	3.26%	0.00%	0.00%	3.66%

	STAFF GROUP								
	Add Prof Scientific & Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical & Dental	Nursing & Midwifery Registered	Whole Trust
Staff in Post (Headcount)	169	1,265	1,631	502	547	118	969	1,951	7,152
Staff in Post (FTE)	143.71	1,108.54	1,445.86	442.58	435.54	107.58	908.70	1,729.35	6,321.86
Establishment	145.45	1284.39	1589.31	488.18	605.87	95.09	952.67	2008.00	7168.96
Agency Usage (FTE)	8.85	0	2.64	22.02	49.96	2.88	10.11	43.61	140.07
Bank Usage (FTE)	6.67	292.68	14.28	26.19	107.35	0	46.20	128.87	622.24
Turnover	13.65%	9.44%	11.38%	8.81%	6.68%	8.53%	6.00%	10.32%	9.73%
Leavers within 12 months/Joiners	0/13	41/386	29/200	6/66	3/84	0/18	1/15	30/197	110/980
Monthly Sickness %**	4.71%	9.12%	6.58%	5.48%	9.28%	4.98%	2.59%	6.49%	6.46%
YTD Sickness %**	3.82%	8.51%	5.26%	4.11%	8.24%	4.19%	2.76%	6.14%	5.78%

*** ODP's/Theatre Nurses are split out into the relevant staff groups for the staff in post figures but not for the Establishment figures.**
**** The above Sickness figures are an indicative figure as at the end of December 23**
***** Includes usage for centralised budget code for COVID-19**

NOTE - Establishment, agency and bank usage data is supplied by Finance. The Establishment figures for Research staff are included within the overall Research Division, however where staff are line managed in Clinical Divisions the rest of the figures include them under the relevant Division. Therefore, there is a mismatch between the Establishment data and the rest of the data for Research staff only.

Staff in post at the start and end of each month

Month	1/6/22	30/6/22	1/7/22	31/7/22	1/8/22	31/8/22	1/9/22	30/9/22	1/10/22	31/10/22	1/11/22	30/11/22
Headcount	6515	6508	6503	6489	6486	6525	6514	6603	6588	6655	6657	6662
Month	**1/12/22**	**31/12/22**	**1/1/23**	**31/1/23**	**1/2/23**	**28/2/23**	**1/3/23**	**31/3/23**	**1/4/23**	**30/4/23**	**1/5/23**	**31/5/23**
Headcount	6659	6674	6663	6717	6713	6778	6765	6779	6737	6776	6768	6799
Month	**1/6/23**	**30/6/23**	**1/7/23**	**31/7/23**	**1/8/23**	**31/8/23**	**1/9/23**	**30/9/23**	**1/10/23**	**31/10/23**	1/11/23	30/11/23
Headcount	6787	6814	6801	6827	6815	6868	6853	6,960	6,996	7,078	7,070	7,143
Month	**1/12/23**	**31/12/23**										
Headcount	7,148	7,152										

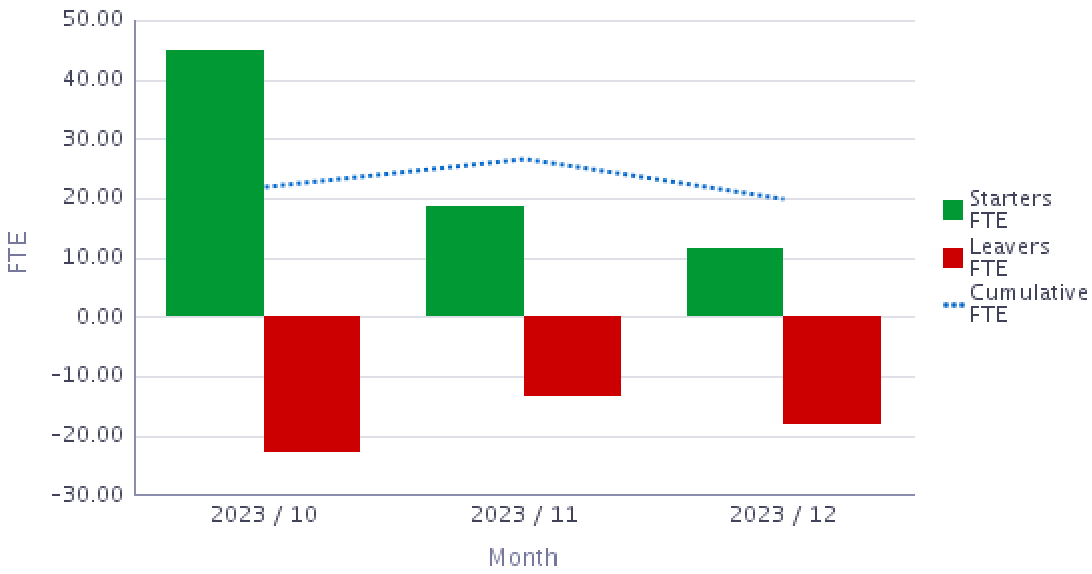
Staff in Post

Since the last report staff in post FTE has increased from 6,250.50 in October 2023 to 6,321.86 in December 2023 representing an overall increase across all staff groups of 71.36 FTE.

The largest increase in FTE over the period was in the Nursing & Midwifery Registered Staff Group (35.78 FTE) followed by the Additional Clinical Services Staff Group (7.61FTE). The increase in the Nursing & Midwifery Registered staff group is linked to Newly Qualified Nurses joining aswell as Nurses recruited as part of international recruitment. Some overseas Nurses are still awaiting their NMC Registration so are included in the Additional Clinical Service Staff Group.

The only staff group that has shown a reduction is Medical & Dental which has reduced by 5.92 FTE over the period.

The table below shows the position with respect of qualified nursing / midwifery starters and leavers which demonstrates the position over the last three months. The cumulative position for the 3 months is +20.11 FTE with 74.68 FTE registered nurses / midwives joining the Trust and 54.57 FTE leaving.



e-Job Planning and e-Rostering

In December the total number of requests sent to bank was 11157 compared with November's requests of 12423 a decrease of -1266 requests. This is split as 4726 requests for registered staff and 6431 requests for unregistered staff. Of those 11157 requests a total of 7201 were filled by bank staff which is 64.5% compared with 63.4% in November – a increase of 1.1%. 2266 are filled by registered and 4935 filled by unregistered staff. Out of the 4726 requests for registered staff, the filled shifts were 2266 (47.9%) and for the 6431 requests for unregistered staff the filled shifts were 4935 (76.7%). Compared with

November, fill rates decreased by -1.% for registered and increased by .5% for unregistered. Out of the 2266 filled registered shifts, 375 were filled by registered Theatre staff.

Agency staff filled 737 shifts in the month of December. This is split 737 registered and 0 unregistered staff. Out of the 737 filled registered shifts, 213 were filled with registered theatre staff. In December Agency fill rates decreased by -.7% for registered staff and increased by 0 for unregistered staff.

Agency shifts for HCA's have reduced to 0 as we have stopped using Agency for HCAs from September.

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 880 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 350 Medics, 350 AHPs and 180 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. Currently there are 97 Job plans signed off for Medics with 10 awaiting 1st Sign off, 40 awaiting the 2nd sign off and 180 in review. Despite the drop in job plans required (due to SAS Dr's being removed – please see below) 1st and 2nd Sign off job plans have increased.

Previous reports have included SAS Dr's but from December we have excluded these so that only consultants are recorded for Medics hence the dip in total job plans and Medics numbers.

Rostering Optimisation and Flexibility Programme

As part of the People Promise programme of work, BTHFT were selected as 1 of 3 Trusts to take part in a programme supported by NHS England. The programme utilised the roster to promote flexible working via the Team Based roster model, ensuring fairness, consistency and transparency. This programme is now being assessed and a plan for further roll out developed.

Turnover

Turnover has continued to decrease to 9.73% in December 2023 from 10.01% in October 2023. Turnover has reduced slightly across all staff groups apart from Administrative & Clerical, Healthcare Scientists and Nursing & Midwifery Registered where it has increased slightly.

Board of Directors – 31st January 2024
Agenda Item: PA.1.24.10

Nursing and Midwifery

Background

Data from the Model Hospital Portal can be used to Benchmark against peer organisations, locally and nationally. Our Nursing and Midwifery Vacancy Rate as reported via Model Hospital is 18.6% (Sept 2023) compared to a median of 10% with peers. This places us within the upper quartile of Trusts within the Northern and Yorkshire region (Figure 1 and 2). We continue to see our vacancy position reduce since the arrival of the international staff and the transition of our student workforce to registrants through September/October 2023.

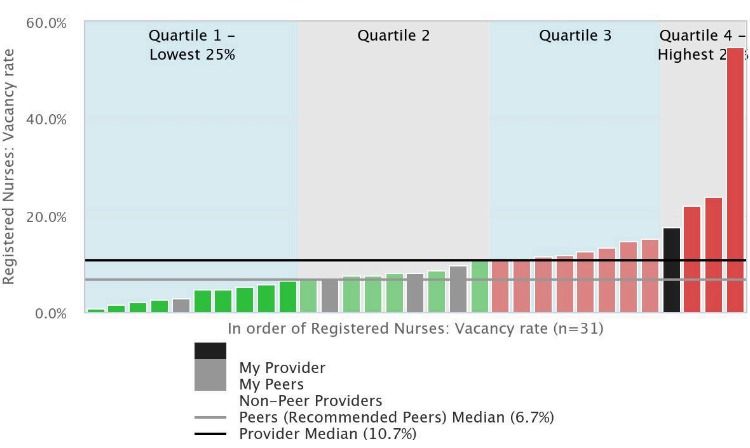


Figure 1

Registered Nurse Vacancy position

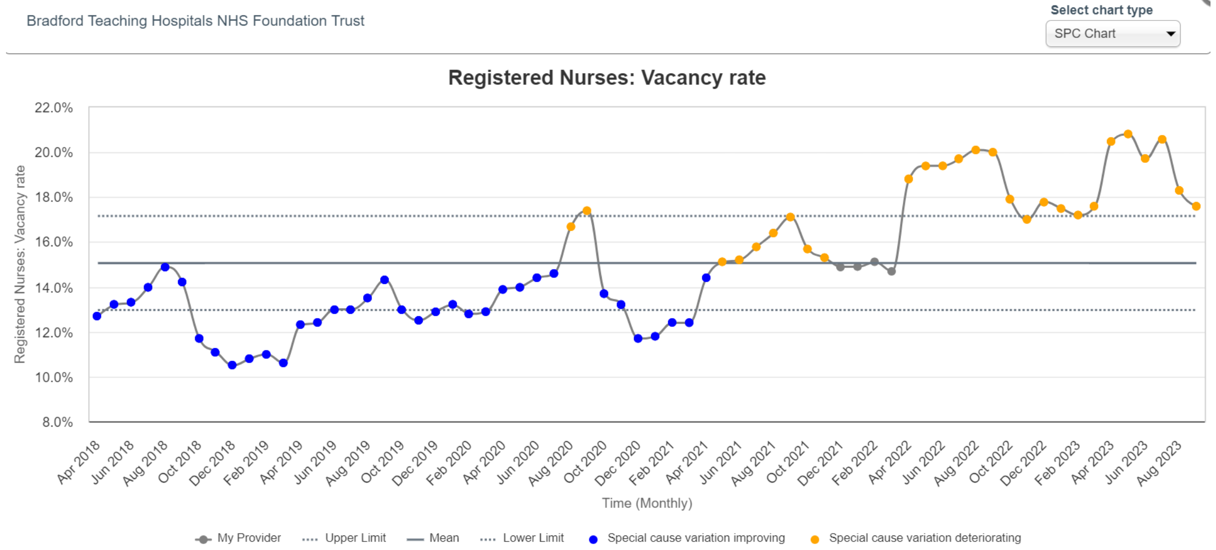


Figure 2

Although we have a higher number of vacancies than other organisations, our registered nurse turnover rate continues to reduce (Figure 3).

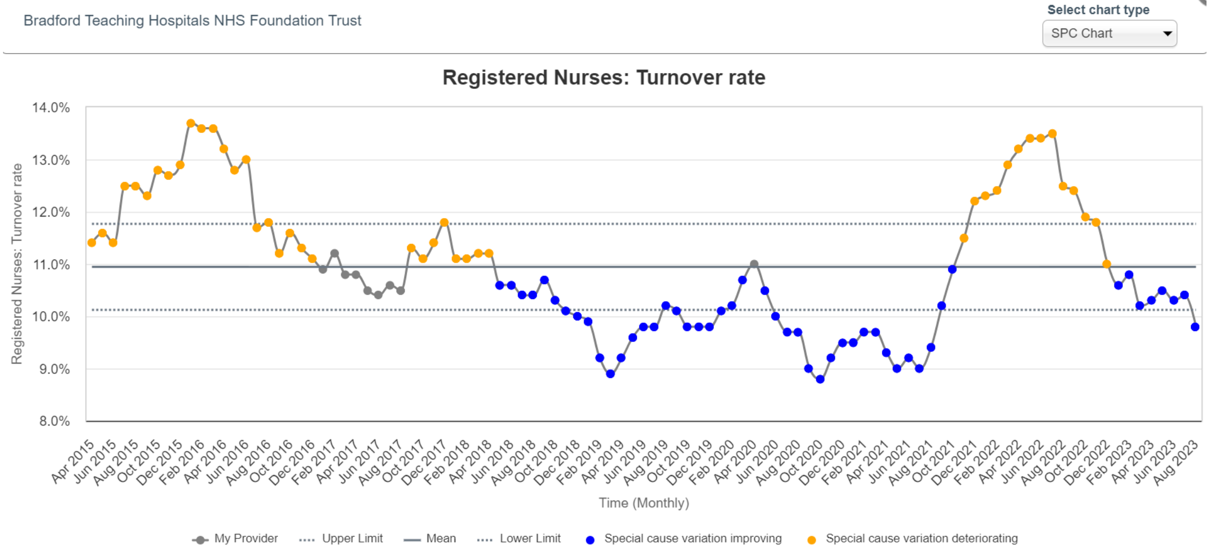


Figure 3

The leavers data over the last 12 months, (January 2023-December 2023), has shown the monthly nurse leavers rate has fallen to an average of 12 WTE (14 WTE 2022). The total number of nurse leavers (Headcount) for the last 12 months was 147 WTE (187 WTE 2022). (all bands). In 2023 the number HCA leaving the organisation was an average of 6 WTE per month (8 WTE 2022) with a total 67 WTE leaving in 2023 (90 WTE 2022).

Risks and Recruitment

In view of the vacancy position Nursing and Midwifery staffing was on the Chief Nurse Risk Register (Risk ID 3732) as 5x4 (13th April 2023), however this has been reduced to 4x4 (31 October 2023). Our Nurse and midwifery Staffing Fill Rates at a ward level remain unchanged with an average fill rate of 77% for Registrants and 92% for Healthcare support workers.

From our monthly finance data we are reporting 181 (300) vacant Band 5 nursing posts and 181 Band 2 Healthcare Assistant posts. Our aim is to reduce our vacancy position to 10% by March 2023 (Figure 4). We know this position will improve due to recent recruitment events.

Band 5 Recruitment Events

From the January and May (2023) open days we were expecting 98, Band 5 newly qualified nurses and 30 Midwives to start in September/October 2023. The latest figures show, 23 newly qualified midwives are due to start, however only 11 will start in October with the remaining starting over the next 12 weeks. In addition, 2.35 midwives with post registration experience are expected to start within BTHFT.

Of the 98 newly qualified nurses, we have 66 booked on or undergone corporate induction. We know there has been some attrition during the (17) onboarding process, and we have several students (15) awaiting confirmation of placement hours or results. We are working with the university to see how we can support those awaiting results to start in the organisation. We will also be contacting those candidates who dropped out during the onboarding process to see how we can improve engagement.

In October 2023, a further 38 nurses were appointed from the open day (26th October 2023)

Recruitment of Internationally Educated Nurses and Midwives

Since April 2023, with support from the organisation and NHS England, we made a commitment to recruit 150 internationally educated nurses by 31 January 2024. We have welcomed 117, with a further 33 due in January 2024. To date, all staff have passed their NMC OSCE, on the first or second attempt.

We have submitted evidence to NHS England for their Pastoral Care Award Accreditation Scheme and are awaiting feedback on the submission. We have no indication from NHS England regarding future IN recruitment plans, however we will be looking at what expertise and resource may be required to support direct applications from non UK residents.

Band 2 Recruitment

We currently have 188 Band 2 Healthcare Assistant vacancies within the organisation. The leavers rate for healthcare assistants is an average of 60 per year or 6 per month. In July 2023, we moved to a monthly recruitment process, to support our New to Care programme. The New to Care Programme was developed to encourage the recruitment of trainee Health Care Assistants with minimal qualifications or experience of care. All HCA's when they start in the organisation undergo a 10 day bootcamp and are supported by two newly appointed Band 4 Associate Educators who are experienced Healthcare Assistants. All HCA's are expected to complete their care certificate but will also have support to access college programmes to undertake further qualifications. This Career conversation is now planned for month 4 of their preceptorship, to allow them to consider trainee ODP and Trainee Nursing Associate roles in the future. This is part of our ongoing "Grow your own" workforce agenda.

We expect to see the number of HCA vacancies reduce as the number as the table below sets out attendance on the new starter HCA bootcamp.

2023	July	August	Sept	Oct	Nov	Dec	Jan	Total
Substantive	9	12	10	26	18	No	26	101
Bank only	6	9	20	13	14	BC	3	65
Total	15	21	30	39	32	0	29	166

Although we have vacancies, our turnover rate within the support to nursing staff group remains one of the lowest in the region (Figure 5).

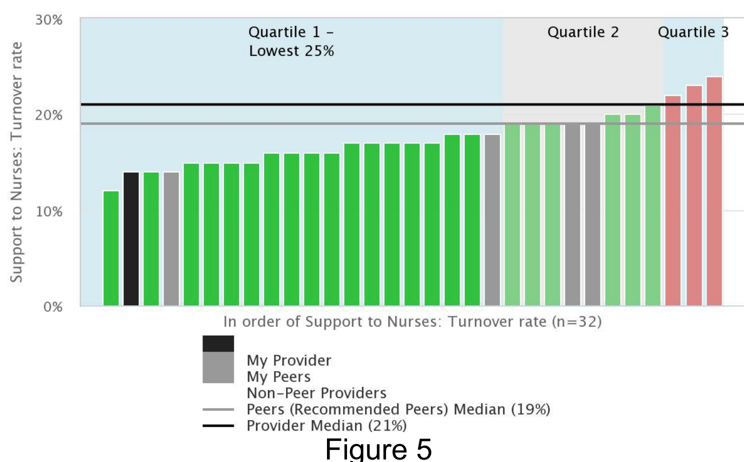


Figure 5

In addition to the work outlined above, several other initiatives are ongoing to improve our vacancy position and reduce our reliance upon bank and agency. These include;

- **Bradford St Luke's, Day Case Unit**: The unit will open in April 2024 and staff have been recruited and are undergoing training in preparation.

- **Endoscopy**. Planning is underway to review the workforce requirements for a new Endoscopy Unit at Bradford Royal Infirmary planned to open in 2025. The staffing requirements estimated to be an additional 12 registrants.

- **Changes to NMC English Language Requirements:** From February 2023, the NMC changed the English language requirements for internationally educated registrants. We are supporting several staff within the organisation to make this transition; however we are in the process of redesigning the bootcamp to support these learners. This will be in place in January 2024. We predict we will support 10 staff per year through this programme and have been asked to support our community partners with a member of their team. Once established we could offer the bootcamp to our colleagues across Place if needed.

- **Trainee Nursing Associates:** We have appointed 30 Trainee Nursing Associates to start in October and December 2023, (Course length 20 months, Bolton, Bradford).

- **Top up Nursing Associate to Degree:** We have appointed 10 Nursing Associates to Top up to become a Registered Nurse, the course starts in September 2023, (Course length 20 month Open University).

- **Engagement events Universities:** We are now engaged with our community mental health partners and University of Bradford to develop a career pathway for Dual Qualified Registrants, (Adult/Child and Mental Health) and new approaches and collaboration to supporting post registration employment. We have a monthly meeting with 2 and 3rd year student nurses via education and a recruitment event for 3rd student nurses is planned for February 2024

- Recruitment Website has been launched www.bthftjobs.co.uk and work is ongoing to update and link this to BTFHT external website.

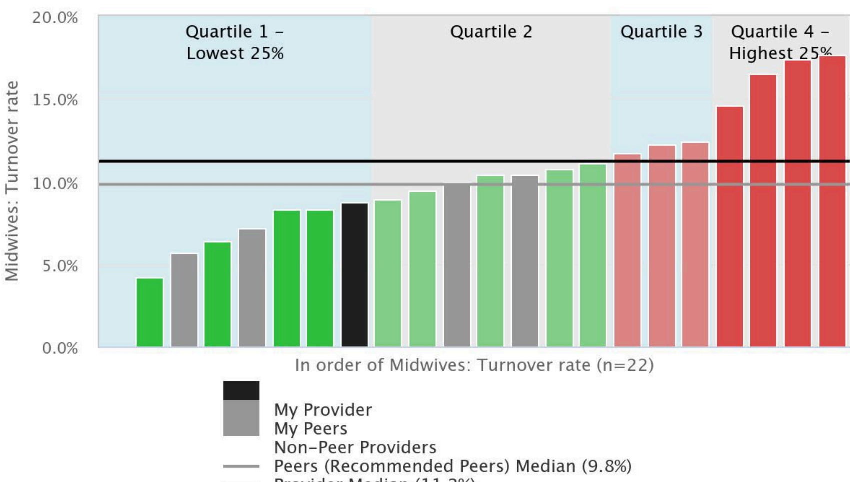
Advanced Clinical Practitioners

Within the organisation we currently have approximately 37 Advanced Practitioners with a further 17 due to qualify over the next 18 months, and 16 Trainee ACP's across a range of specialities started in September 2023. Work is ongoing to support Critical care with a business case for the introduction of ACP roles within intensive care.

Midwifery

Their current staffing position remains challenging despite having one of the lowest turnover and leavers rate in the region and nationally, with 18.5 WTE midwives leaving in 2023 compared to 22 WTE in 2022. The current vacancy rate for safe staffing is -26.28 WTE and -45.26 WTE Midwifery Continuity of Carer (MCoC) teams.

International recruitment has seen the appointment of 5 staff and this programme is currently paused to evaluate the impact and benefit of further recruitment.



Retention

The retention of staff is a key objective of the NHS People Promise and an important step in providing safe staffing. We continue to be engaged in a number of initiatives to improve recruitment including;

- Embedding the Professional Nurse Advocate role and Legacy mentor.
- Learning from exit interviews and career conversations.

- Recognition of staff via Daisy and NHS England's Chief Nurse Awards.
- Embedding Self Rostering.
- Revisiting E-roster principles in line with NHS England's best practice guidance.
- Retaining staff on Bank when they leave the organisation. Currently we only retain 5% of staff on bank when they leave BTHFT; work is therefore ongoing to understand the barriers to retaining experienced staff on our bank.
- Support to move staff from Bank to substantive contracts.

Allied Health Professionals

Physiotherapy vacancies remain low (< 2% in Therapies), however the data does not tell the whole story. In Therapies physio is over-established for B5 and under-established for B6, mainly due to apprentices being counted in the B5 establishment. There are ongoing issues with B6 recruitment locally and regionally and to mitigate this some B5 posts have been converted to B6 to retain staff.

Occupational Therapy vacancies are 12% with significant recruitment issues at B6 (regional and national problem). Currently looking at converting some B6 posts to B7 to retain experienced and skilled B6 staff.
For both Physio and OT further recruitment to apprenticeships and B5 are planned.

Speech & Language Therapy vacancies (within Therapies) are currently 23%. However, there is a new B7 starting in January and adverts currently are out for B5, B6 and B7 therapists.

Dietetics vacancies remain relatively low. This is due to 'over-recruitment' to capture new graduates as they qualify. This practice has been successful and well managed to prevent overspend.
There are challenges recruiting at B6 level, being successfully managed via B5 to B6 progression posts. Two 8a clinical lead dietitians have been appointed to strengthen leadership in specialties – these internal appointments are a great example of 'growing our own'.

Operating Department Practitioners
There are currently 19 apprentice ODP's on the programme. 3 qualified in September and are completing their induction. By 2026 the vacancies will have been filled via the apprentice programme.

Orthoptics is in a good position with no vacancies and have not struggled to recruit recently. Staff mainly leave the Trust for promotion or a job closer to home.

Radiographers
The current international recruitment initiative has finished with 6 recruits out of an initial target number of 8 having joined the Trust from Kerala and the Philippines. There are no significant vacancies for Radiographers in the modalities except for Sonography (Vacancy rate 12%) where a plan was approved some months ago to manage the waiting list – this involves recruitment as well as upskilling staff, increasing retention.

Healthcare Scientists

Audiology

Several staff on are maternity leave but have been able to recruit to 2 x Band 5 fixed term posts.
Have 2 specialist Audiologists that will retire in the next 12 months, but it's likely to be difficult to recruit given lack of experienced Band 6/7 staff nationally.
In the process of recruiting another Band 4 apprentice and have put in an expression of interest for 2 STP posts (HCS 3 Year M level training) for 2024/25.
Have secured some project funding to develop a Band 5 development programme/resources
Sickness rate presently 4.99%

Cardiac and Respiratory Scientists

Unable to recruit to experienced Band 6, band 7 and band 8a posts. Have recruited new graduates however this has had major impact on training and mentorship which in view of lack dedicated training facilitator has caused issues, with associated increase in work related stress.
Continue to make use of HEE funding support for trainees at Level 2 and Level 7.
In the absence of dedicated CPD funding or additional support from HEE, funding from income streams being utilised to support the development of staff in an effort to 'grow our own' and increase retention.
Sickness absence over the last quarter 8.38%

Medical Illustration

There are no vacant healthcare scientist positions. A previous B5 has progressed in a 'grow our own' B6 position resulting in successful retention of qualified staff member'.
Sickness position is currently difficult with 50% WTE staffing in HCS Clinical Photography role (2 staff long term sick, & short term sickness at 6.79% overall for team)

Other Clinical Professions

Optometry

This team of 10 plus a Head Optometrist (5.05 WTE) is fully recruited. Recruitment is OK at this band (staff are B7) but very few applicants have previous hospital experience. One person is starting maternity leave in February but cover for the role is not possible due to the specialist nature of the clinics and the fixed term. Sickness is 5.67% mainly due to 2 x long-term sick.

Clinical Health Psychology

Remain committed to diversifying the workforce but were not successful in a bid for NHSE money to support this. Have recruited a Consultant Clinical Psychologist to head the Paediatric Psychology team (the only Consultant Clinical Psychologist of Pakistani origin in West Yorkshire). Retention rates are good, currently there are 2 vacancies (although nationally recruitment of psychological therapists is a challenge). The workforce has increased following successful development of new posts to work into Sickle Cell and Audiology.

Pharmacy

The Outstanding Pharmacy Services (OPS) Programme is now underway with work stream leads identified, work stream charters finalised and work programmes started. The Wellbeing Workstream is in full flow and has had a number of successes.

Staff Survey

Thanks to the support of OPS and a team of designated staff survey leads (DSSL)s, 79% of Pharmacy and Medicines Optimisation colleagues completed the annual staff survey. This is an increase of 29% on last year's results representing the largest increase in responses of any service and placing the service in the top three of respondents.

Wellbeing events continued to be undertaken throughout the season with a festive gift given to all staff which also entered them into a chance to receive an even better gift provided by the senior team. In addition to this senior colleagues hosted a warm welcome for staff during the week before Christmas. The Warm Welcome involved the senior team being available in the tea room every morning to welcome colleagues with a warm drink, juice, and pastries.

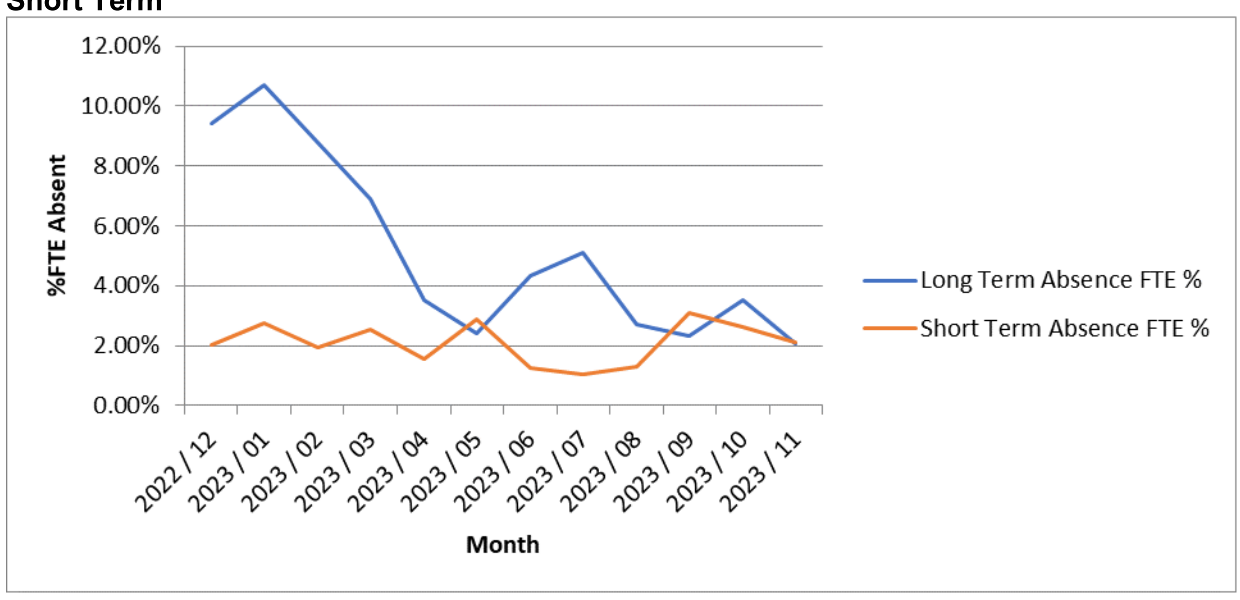
Civility Training

Civility training has been offered to all colleagues with over 40 colleagues completing the training prior to the festive period. Further training will be added in the New Year with a view to all colleagues having completed the training by the end of spring.

Sickness

The year to date absence percentage rate in November is 7.19% with an in month figure of 4.21 percent. The ansence rate is now the lowest it has been for well over 12 months.

Chart 1: Percentage of Full Time Equivalents (FTE)s Absent Per Month Long Term / Short Term



This chart shows both long and short-term sickness trends. Long-term sickness showed an increase between May and July but is now reduced to 2.08%. Short-term sickness remained stable between May and August but showed an increase in September before again declining in October and November. Short-terms sickness is now 2.13%.

At the time of the report there are four people off long term with no return date. They are all being managed appropriately under the Attendance Management Policy.

Table 1, overleaf shows the top 5 absence reasons

Table 1: Top 5 Absence Reasons by FTE Lost

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S27 Infectious diseases	27	33	793	23.1
S10 Anxiety / stress/ depression / other psychiatric Illnesses	12	15	590	17.2
S98 Other known causes – not elsewhere classified	30	39	463	13.5
S29 Nervous system disorders	5	8	332	9.7
S13 Cold, cough, flu – influenza	39	56	284	8.3

The classification of infectious diseases was the number one reason for days lost followed by anxiety / stress / depression / other psychiatric illnesses and other known causes.

Staff Appraisals

Staff appraisals continue to be lower than desired, however the team has taken the decision to offer all appraisers refresher training with a view to delivering better more meaningful appraisals. Appraisal rates will increase when this training is completed.

Mandatory Training

Mandatory training levels continue to improve with the department showing over 90% compliance at the beginning of January. However, performance is expected to dip due to the introduction of the new Oliver McGowan training because only 50% of the course is available for completion at the current time.

Pharmacy Race Equality Standard

Nationally work was commissioned to look at the equality and diversity of the pharmacy workforce. This showed some disappointing results reproduced in the charts 2 and 3 below.

Chart 2: Pharmacists By Ethnicity, Gender And Pay Band – March 2022 (England)

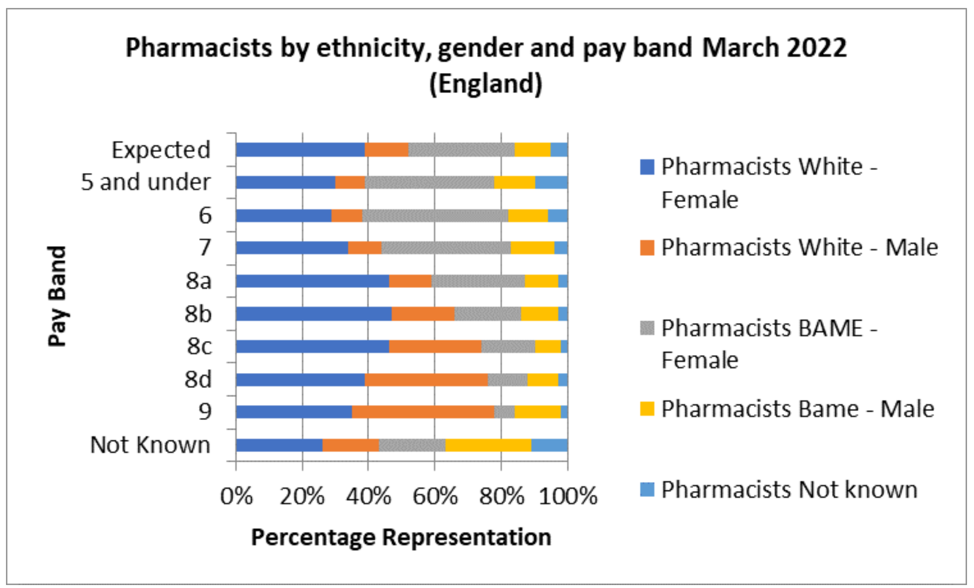
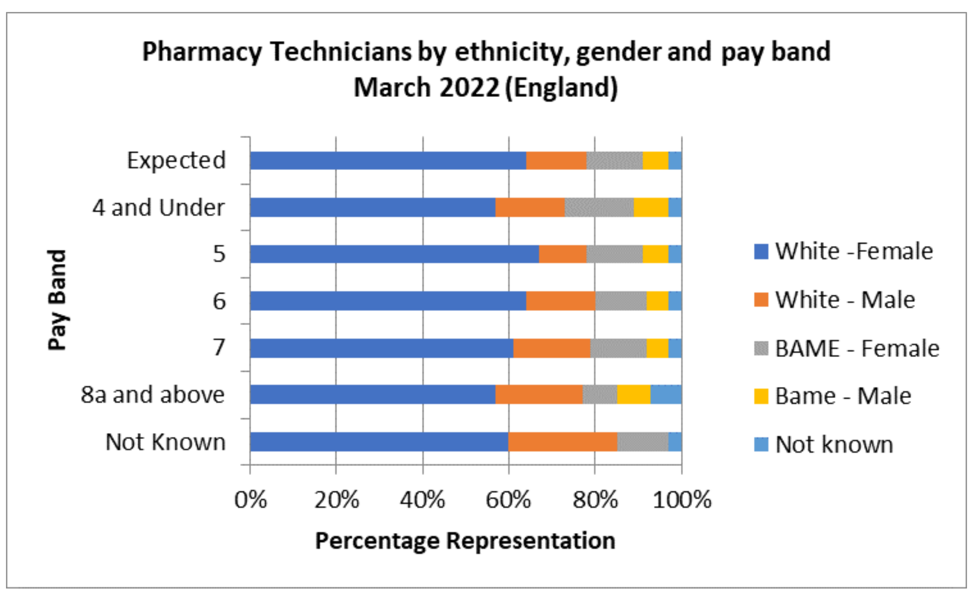


Chart 3: Pharmacy Technicians By Ethnicity, Gender And Pay Band – March 2022 (England)



Data in a similar format is not currently readily available for Pharmacy and Medicines Optimisation. The data we do have is shown in Table 2 Below

Table 2: Black, Asian, Minority Ethnic as a Percentage of Workforce

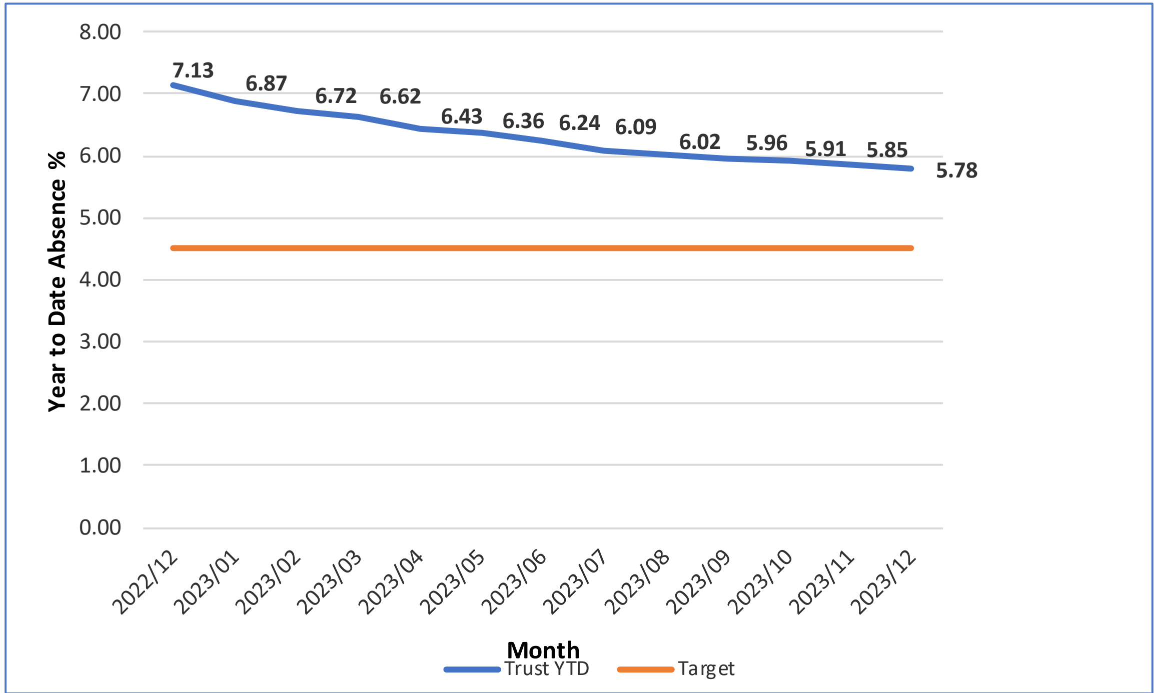
Ethnic Group	Headcount	%	FTE
A White - British	60	39.22%	50.57
C White - Any other White background	4	2.61%	3.92
F Mixed - White & Asian	2	1.31%	2.00
G Mixed - Any other mixed background	1	0.65%	0.00
H Asian or Asian British - Indian	10	6.54%	8.68
J Asian or Asian British - Pakistani	53	34.64%	41.46
K Asian or Asian British - Bangladeshi	5	3.27%	3.00
L Asian or Asian British - Any other Asian background	2	1.31%	2.00
N Black or Black British - African	4	2.61%	4.00
R Chinese	2	1.31%	2.00
S Any Other Ethnic Group	3	1.96%	2.67
SC Filipino	1	0.65%	0.80
Z Not Stated	6	3.92%	4.53
Grand Total	**153**	**100.00%**	**125.64**

The data shows that 53% of Pharmacy colleagues are from a BAME background.

PRES is currently on the national agenda for the pharmacy profession, and an action plan has been developed. The PRES does include further data around bullying, harassment and discrimination. The intention is to compare the outputs from the staff survey with this national data to understand how BTHFT compares and inform any potential actions arising from the data.

Board of Directors – 31st January 2024
Agenda Item: PA.1.24.10

Absence Timeline – Year to Date Absence % Rate – Table 1



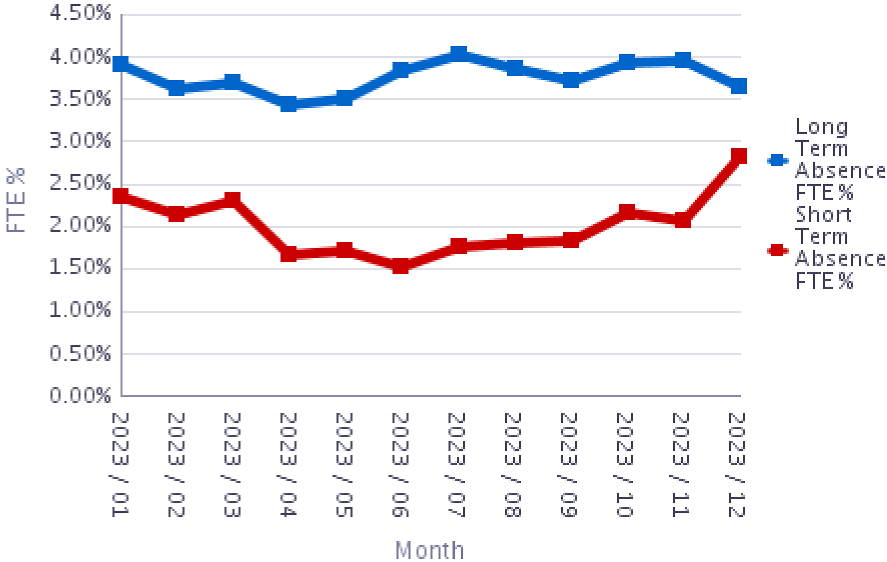
The year to date absence percentage rate in December 2023 is 5.78%. The absence rate has shown a continuous steady reduction through to December 23. At this time last year the year to date absence rate was 7.13%. The graph above also shows Year to Date sickness absence (%) up to December 2023.

Top 5 Absence Reasons by FTE Lost – Table 2

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	25.3
S98 Other known causes – not elsewhere classified	14.5
S12 Other musculoskeletal problems	7.8
S13 Cold, Cough, Flu - influenza	7.0
S25 Gastrointestinal Problems	6.3

Anxiety / stress / depression are the most common reasons for absence. This is followed by other known causes.

Absence Long Term / Short Term – Table 3



This table shows the long-term and short-term sickness trend. Long-term sickness remained stable in November but has shown a decrease in December. Short-term sickness reduced slightly in November but has risen sharply in December.

Organisational Development (OD) Update

Leadership & Development

Leadership Pathways

We have delivered 9 cohorts of face-to-face Leadership Pathways to 94 leaders since the commencement of the 2023 development year. For remainder of 2023/24 we have one 1 cohort of each pathway left to deliver, at the end of the year we will have delivered 12 cohorts.

Please see the tables below for the current year's delivery plot and the 2024/25 delivery year plan. A standout point is that the first three pathways are almost all fully booked, with considerable waitlists.

2023/24 Delivery

Pathway	Cohorts delivered	Completions	Booked on future cohorts	Total
Aspiring Leaders	3	37	12 (1 Cohort remaining)	49
Developing Leaders	3	31	14 (1 Cohort remaining)	45
Progressing Leaders	3	26	13 (1 Cohort remaining)	39
Total	9	94	39	133

2024/25 Planned Delivery

Pathway	Cohorts Planned	Places Reserved	Places Available	Potential Total
Aspiring Leaders	6 x 12 per Cohort	65	7	72
Developing Leaders	6 x 12 per Cohort	65	7	72
Progressing Leaders	4 x 12 per Cohort	48	0	48
Advancing Leaders*	2 x 12 per Cohort	0	24	24
Total	18	178	38	216

***Advancing Leaders**

EMT approved piloting two cohorts of the recently developed Advancing Leaders Pathway. This pathway is a dynamic, modular, learning and development programme, aimed at senior leaders (bands 8a and above). The programme will last 12months and in addition to taught development, it will also include Action Learning sets, a Psychometric Assessment; Lumina Leader including a 360-feedback assessment, a Quality Improvement (QI) project and reach in, reach out mentoring opportunities. Delivery will commence in April '24 with the second cohort starting 6 months later.

Development Masterclasses

Commencing April '24 we will start to introduce half day Development Masterclasses. The purpose of these sessions is to act as standalone development opportunities that cover gaps in our delivery plot that can be used at the individual level for the development of staff, but also as a tool by the OD Team or others to work with teams on the relevant subjects.
We have some working titles, but these are still very much in development but to give an idea of what we are considering:

- Courageous conversations
- The Art of Delegation & time Management
- The Art of Facilitation
- Presentation Skill

As this element of the offer develops, we will update this report accordingly.

Management Development Sessions

For future reports we will be reporting on the delivery and attendance numbers of the Management Development Sessions, although the majority aren't 'owned' by the OD Team, we do support the coordination and communication of the sessions to staff, the owners are spread across the trust so for clarity we felt it appropriate to collate the data here.

Session Title	Sessions Delivered	Completions	Sessions Remaining
Equality, Diversity & Inclusion for Managers	4	29	4
Introduction to Finance	3	17	4
Managing Health, Wellbeing & Attendance	4	48	1
Recruitment & Selection Training	8	88	4
Time2Thrive Appraisal Training (OD)	8	75	1
Wellbeing Conversation Training (OD)	5	9	2
Total	32	266	16

There may be ambiguity in final numbers due to the closing down process of sessions. This is simply a handrail to demonstrate the development being offered.

Manager as Coach

The Manager as Coach programme is currently planned to launch in April 2024. This will be offered as a standalone programme for managers following on from 'Everyday Coaching Skills' and offered to delegates of the Progressing Leaders Programme.
The programme will consist of modules that introduce managers to coaching techniques and allows real practice of these techniques using real examples brought by delegates. Delegates will be encouraged to practice these techniques in between modules to aid in their development of a coaching approach.

Psychometric Update – Lumina

Lumina Select; a recruitment psychometric tool which is designed to increase awareness for both the recruiter and the candidate so they can both get a better sense of the qualities needed for a particular role within the culture of an organisation. This tool was used to support the recent Director of Strategy and Transformation interviews. Our next step is to evaluate with all stakeholders.

Lumina Leader 360; a Leadership psychometric tool with 360 feedback which increases self-awareness, decision making capability and confidence to lead others in times of increased competition and ambiguity. This tool including debrief and follow up coaching sessions have been embedded into the new Advancing Leaders Pathway.

Lumina Spark; a personalised psychometric assessment that aids increased self-awareness. One day workshops are being piloted with two senior leadership teams. The aim is to increase self-knowledge and awareness, value diversity and appreciate other ways of being, build rapport, creating a connection and adapting styles to match other preferences and use this to empower and inspire a high performing team.

Action Learning facilitation training

We now have 10 trained Action Learning Sets (ALS) facilitators within the trust, follow-up sessions with the provider are planned for this month, we will then be meeting as an informal task and finish group to discuss how we can embed this concept further within the trust beyond embedding it as part of the Advancing Leaders Pathway.

Appraisals

Our current appraisal rate for the Trust stands at 77.6%.

The OD Team are currently undertaking an internal audit of appraisals following feedback from the external audit in 2022 to ensure consistency and compliance. A full report will be shared in February 2024.

People Promise

As the People Promise reaches its final three months, projects are moving to business as usual. A second round of Exemplar sites are due to be announced with additional sites expected within the region. The development of a manager support pack is awaiting completion, and will be finalised before the People Promise programme ends.

Wellbeing

Health and Wellbeing (HWB) Group
The HWB group are supporting several wellbeing events for staff during winter pressures which include mindfulness, knitting club, meditation, Andy's Man club and clubercise. The showing of ELF in the lecture theatre was unfortunately cancelled due to the strikes, however the group will be looking in to showing other films in 2024.

The group is exploring ways to communicate with staff through different avenues, this includes a Wellbeing Facebook page which has now been created. This will highlight offers and support for staff; we would urge teams & departments who have Facebook pages to like the page. We are exploring producing leaflets with wellbeing offers on to distribute and put on notice boards around the Trust.

We are also looking into providing a map for staff to highlight where space is available to go, to relax or support their wellbeing such as the purple room, garden by Costa, wobble rooms, water fountains, rest areas etc.

In January we will be looking at the NHS staff survey data received around wellbeing.

Financial Wellbeing

Our financial wellbeing offer continues to be reviewed and updated with all available support on Thrive.

Reward and Recognition

Team of the Month

Winners:

September: Rheumatology Nurse Specialist Team
October: Estates Team
November: Westbourne Green Inpatient Ward

There is a backlog on Team of the Month presentations as up until this month we were unable to source a winners hamper. These have now been ordered to fill the backlog and presentations can now be arranged.

Greatix

Submissions received:

October: 162
November: 106
December: 59

In December 2023 we migrated the Greatix form to an automated system using Jotform. Now when a colleague is nominated for a Greatix, a certificate and email notification is automatically sent to their work email. The free subscription we're using on Jotform does have some limitations (110 submissions per month) but we're reviewing how we can overcome these.

NHS Staff Survey 2023

The final Trust response rate for 2023 was 43% - an increase of 6% on last year. 2905 colleagues answered the Staff Survey. For the first time, we recruited Designated Staff Survey Leads (DSSLs) from some areas of the Trust - these colleagues had a significant impact on local response rates and proved to be a successful initiative.

Initial results show that BTHFT has increased on all People Promise theme scores from 2022 to 2023. All results will be published nationally in March 2024 and we will receive a Benchmark Report at this time.

This year we have a breakdown of results across all services and any team that received more than 10 responses in the Staff Survey. Staff Survey results are under national embargo until March 2024 which means they cannot be shared beyond the organisation before this date. The national embargo states that results can be used ahead of publication to '*progress internal work relating to measuring and improving staff experience'*. Staff Survey data is

being shared much earlier than in previous years to ensure that the data is more valid to enable managers and leaders to progress internal improvement work.

Work is currently underway in the OD team on the process in which we share these initial results and a *'Staff Survey Pack'* is being finalised. This will include local heatmap(s); a *'Guide for Managers'* about the staff survey and local action planning expectations; templates that managers can use to share staff survey results with their team.

Support for services/teams to interpret their staff survey results will be available from the HR Business Partners and OD Team. The OD Team are also scheduling a series of *'Staff Survey Surgeries'* where colleagues will be able to book an appointment for information/ advice/support around their local results.

The National Quarterly Pulse survey

The most recent Pulse Survey is live in January 2024. Staff are being engaged in the survey via screensavers, posters, Thrive Bulletin, Global Emails and direct communication to managers.

The previous Pulse survey was in July where we received 270 responses. The Pulse Survey was paused whilst the 2023 Staff Survey was live in November.

The July 2023 survey focused on rest breaks as part of the 'We are safe and healthy' People Promise element. For the first time, we made use of the survey's new ability to include local questions, where organisations are able to add in up to 5 additional questions. We are one of 35 organisations nationally using the local questions function.

The January survey focus will include the six core questions and nine employee engagement questions, to support delivery of the NQPS. In addition, two flexible questions will focus on the 'We work flexibly' element of the people promise, which were asked in January 2023.

Our local questions are focused around we are recognised and rewarded' and includes 5 questions:

1. Are you satisfied with the amount of recognition you receive at work?
2. Where did you last receive recognition at work? (Examples could include during team meetings, 1:1s or through awards such as Greatix)
3. Do you provide recognition to others, either formally (through awards) or informally through feedback?
4. How does receiving recognition make you feel?
5. Do you have any suggestions on how we could improve recognition at BTHFT?

Reach in Reach out

Future recommendations following a mid-point evaluation of the current pilot were presented to Executive Management Team in November. The next phase which includes all nine recommendations, is due to roll out in Spring 2024 with a further planned evaluation in Quarter 3 2024/2025.

Culture

Thriving Together (NHS Culture and Leadership Programme)

Five diagnostic subgroups are undertaking discovery work which will help us to understand our current culture, any issues, and the culture we wish to create for our organisation going forward. The sixth subgroup; Board Interviews, will commence once vacant Board posts have been recruited to. Fortnightly drop-in meetings (culture corners) are available for all change team members to attend and create a sense of support, belonging and psychological safety. A Steering Group, chaired by Mel Pickup (CEO) met for the first time in November and will continue to meet bi-monthly to monitor progress.

Next Steps include holding a full change team development day (Feb 24) and additional local SME development masterclasses.

Workplace Civility development session (all staff)

'Civility in the Workplace' training for all staff has now been launched with monthly sessions taking place. There is a dedicated OD practitioner and EDI manager supporting this. Whilst the ambition is to reach all staff over the next 12-18 months, it has been agreed that this will need to be a phased approach, taking into account the biggest areas of need and the context in which we are operating in. There has been a pilot taking place with Outstanding Pharmacy Services where the training has received full attendance and fantastic feedback.

The training is a two hour session in which videos created (Found on Thrive) are used to aid discussion around Civility and introduces delegates to the options they have to address incivility in the workplace. Delegates are also given further information about the Civility Toolkit, Our People Charter, Staff Advocates, Internal Mediation, civility posters and wellbeing information etc.

In some cases, there may be further / different support needed. The OD team have developed a number of additional products which can be utilised dependent on need / staff group which include shorter sessions that can be self-facilitated by teams/ services and short 'huddle' presentations.

Equality, Diversity and Inclusion

- **EDI Strategy**

As part of the EDI strategy implementation, the EDI team are continuing to engage with CSU/Departmental management meetings to provide an overview of the strategy, along with the role and remit of managers in its' implementation and delivery. This is gaining momentum and increasing awareness across the Trust including the development of local EDI plans within departments.

- **Staff Equality Networks**

Our staff equality networks have been instrumental in arranging a range of events which have taken place on the main concourse these, include celebrating and acknowledging, South Asian Heritage Month, Black History Month and National Inclusion Week. This is

having a positive impact and helping in raising the profile of our staff networks and increasing overall engagement and involvement of our wider staff across the Trust.

Our staff equality networks and the EDI team were awarded the **Nursing Times Award** in the category of **'Best Employer for Equality, Diversity & Inclusion'**. The award ceremony took place in London on 22nd November 2023. The wider team and members of our networks are very pleased with obtaining this award.

- **Equality Delivery System 2022**

A range of colleagues from across the Trust are currently working on preparing the Trust's evidence for the three different domains within the framework. EDS22 is a framework that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act 2010.

At the heart of EDS 2022 are 3 Domains, in which there are eleven outcomes, against which NHS organisations measure their successes and challenges with protected characteristics and vulnerable community groups using evidence and insight. The 3 Domains are:

- Commissioned or Provider Services
- Workforce health and well-being
- Inclusive Leadership

Two events have been arranged to take place where evidence and data will be presented for all 3 domains. The staff event for domain 2 & 3 will take place on 29th January and the community engagement event will take place on 1st February where a range of our evidence and data will be scored and graded in line with EDS22 requirements.

- **Staff Advocates**

The refreshed half day training for newly appointed staff advocates took place on 18th December. The training went well and positive feedback has been received on the content of the delivery. A full re-launch of the service is planned to coincide with the ratification of the Respect, Civility & Resolution policy and will involve the development of a leaflet, poster campaign and other comms and engagement.

Recommendation

The People Academy is asked to note the contents of this report.

Glossary - Appendix 1

Indicator	Description	Source
Staff in post WTE	The number of whole time equivalent staff in post at that point in time.	HR Department via ESR (Electronic staff record).
Mandatory Training	The proportion of staff who have undertaken the statutory and mandatory training for the rolling year. The threshold is now 100%.	HR Department – via ESR
Appraisals	The proportion of staff who have undertaken an annual appraisal. The threshold is equal to or greater than 75% of staff.	HR Department – via ESR
Sickness	The proportion of staff that are absent due to sickness. The threshold is less than or equal to 4.50%.	HR Department – via ESR
Friends and Family Test	% of patients who complete a friends and family questionnaire following an inpatient admission.	Picker Services
Staff Group	Staff are coded to one of a national set of Staff Groups as follows: **Add Prof Scientific and Technic** – Pharmacists, Psychologists, Counsellors, Chaplains **Additional Clinical Services** – All clinical staff who don't need to be Professionally registered i.e. Bands 1-4 **Administrative and Clerical** – All Admin staff inc Managers who aren't Clinical **Allied Health Professionals** – OT, Physio, Dieticians, Radiographers **Estates and Ancillary** – Estates Officers, Porters, Cleaners, Catering **Healthcare Scientists** – Audiologists, Clinical Scientists, Physiologists **Medical and Dental** – All Medical & Dental Staff **Nursing and Midwifery Registered** – All Registered Nurses and Midwives.	HR Department – via ESR
Workforce Planning	NQB (2013) *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability.* https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf	NHS England

BO.3.24.32 - FREEDOM TO SPEAK UP QUARTERLY REPORT

REFERENCES

Only PDFs are attached

Bo.3.24.32 - Freedom to Speak Up Q3 report 2023-24 (cover).pdf

Bo.3.24.32 - Freedom to Speak Up.Appendix 5.Board development action plan FTSU Sep 2023.pdf

Meeting Title	Board of Directors		
Date	14.03.24	Agenda item	Bo.3.24.32

FREEDOM TO SPEAK UP (FTSU) QUARTER 3 REPORT 2023-24

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Sue Franklin, Associate Chief Nurse, Freedom To Speak Up Guardian	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide assurance in relation to the conduct and outcome management of the FTSU arrangements in the Trust	
Key control	A key control for the strategic objectives to provide outstanding care for patients and to being in the 20% of NHS employers.	
Action required	For information	
Previously discussed at/ informed by	None	
Previously approved at:		Date
	People Academy PA.2.24.10	28.02.24
	Quality and Patient Safety Academy QA.2.24.19	28.02.24

Key Options, Issues and Risks

This paper provides the 2023-24 Quarter (Q) 3 update for the People Academy and the Quality and Patient Safety Academy on FTSU at Bradford Teaching Hospitals (BTHFT).

Analysis

This paper describes the number of concerns that have been raised during Q3 2023-24 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern (Appendix 1).

It shows a trend line of the number of concerns raised here at BTHFT (Appendix 2).

This paper also provides an update on feedback received from staff in Q3 (Appendix 3).

It includes a summary from the National Guardian's office (NGO)on the national data for Q2 (Appendix 4).

It includes the action plan from the Board Development session held in June 2023 (Appendix 5).

It provides an update from Speak Up month (Oct 2023).

Recommendation

For the Board/Academy to note the contents of the report and the FTSU concerns that have been raised at BTHFT during Q3 2023-24.

For the Board/Academy to note the feedback from staff who have spoken up in Q3.

Meeting Title	Board of Directors		
Date	14.03.24	Agenda item	Bo.3.24.32

For the Board/Academy to note the NGO's Q2 data summary.

For the Board Academy to note the board development action plan from June 2023.

For the Board/Academy to note the work of the FTSU Guardian and Associate Guardians at BTHFT.

For the Board to note the Non-Executive Director's support to the FTSU team and also their involvement with the NGO.

For the Board/Academy to encourage all grades of staff to complete the eLearning FTSU training.

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	☐	☐

Meeting Title	Board of Directors		
Date	14.03.24	Agenda item	Bo.3.24.32

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	14.03.24	**Agenda item**	**Bo.3.24.32**

1	**PURPOSE/ AIM**

1.1 This paper provides assurance to the Board/Academy in relation to the conduct and outcome management of the FTSU arrangements in the Trust by:

- Providing an update, using the National Guardian's Office (NGO) template, on FTSU and the progress in Q3 2023-24 (Appendix 1).
- Representing the number of concerns raised per Quarter and year as a line graph of data plotted over time (Appendix 2).
- Providing feedback received in Q3 from staff who have raised concerns (Appendix 3).
- Sharing the national Q2 data headlines from the NGO (Appendix 4).
- Providing the FTSU action plan that was developed following the Board development session held in June 2023 (Appendix 5).

2	**BACKGROUND/CONTEXT**

2.1 Freedom to Speak Up is vital in healthcare. When workers feel psychologically safe, they will speak up to avoid harm, bring great ideas and be able to express their concerns. The National Guardian's office (NGO) believes a good speaking up culture makes for a safer workplace, for workers, patients and service users. Here at BTHFT we are working to make speaking up business as usual across the Trust. The FTSU team are helping to promote and support workers to speak up and to effect culture change to make speaking up business as usual.

2.2 Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust.

2.3 The FTSU Guardian has a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patients' safety and/or the way that the concern has been handled. The Guardian's role is to listen to and empower staff to speak up and support the organisation to a healthy speaking up culture. Besides raising awareness and working to remove barriers to speaking up the guidance from the NGO is that we must input data quarterly; keep up to date with FTSU knowledge by attending the Guardian network meetings and keeping on top of annual refresher courses.

2.4 The FTSU Guardian is Sue Franklin, Associate Chief Nurse for Quality Improvement. The deputy FTSU Guardian is Dr LeeAnne Elliott, Deputy Chief Medical Officer - Quality.

2.5 Karen Dawber, Chief Nurse, is the Executive Lead for FTSU and the Non-Executive Director lead is Karen Walker.

2.6 There are 11 FTSU Ambassadors who have completed the training provided by the NGO. These are:

- Sarah Freeman – Director of Nursing.
- Amandeep Singh – Partnership Lead.
- Rupert Allen – Principal Dietitian.

- Anthony Doggett – Business Support Lead.
- Simon Kirk – General Manager.
- Faye Alexander – Education Manager (on Mat leave).
- June Thomas – Midwife.
- Nazia Amir – Personal Assistant.
- Helen Fearnley – Lead Tissue Viability Advanced Practitioner.
- Rebecca Carter – Education Lead.
- Emma Fleary – Specialist midwife for pastoral care and preceptorship.
-

We have recently lost the two student midwives as part of the FTSU team due to personal issues within the university and their training. There are plans to hold a Maternity event by Emma Fleary, the specialist midwife for pastoral care and preceptorship, to recruit more student midwives to the FTSU team.

2.7 BTHFT's FTSU policy was reviewed and updated in Jan 2024. This went through the Academy on the previous FTSU Board report (Q2) and is now in the Trust format on the intranet.

2.8 The FTSU group meets every four to six weeks. This meeting is to update the FTSU group on any new updates from the National Guardian's Office (NGO) and also to discuss and monitor any ongoing FTSU concerns and issues. The NGO directs how we listen to concerns and document those concerns. Any new data is also discussed.

2.9 The FTSU group have a Human Resources (HR) link who they liaise with as/when necessary to discuss any concerns that need HR support or guidance.

2.10 Following any case review published by the NGO, the FTSU group discuss the review and check each recommendation to ascertain which ones are relevant to BTHFT. These recommendations are actioned to ensure we meet the expected standards.

2.11 The FTSU Guardian attends the FTSU regional network; North East, Yorkshire and Humber monthly meeting, where there is attendance from the NGO. She also has close working links with the Equality, Diversity and inclusion team and the Organisational development team and is on the Civility programme Board here at BTHFT. She is a mentor for new FTSU Guardians led by the national team. She has regular buddy meetings with the FTSU Guardian at Calderdale NHS Trust.

2.12 The NGO requests regular updates and currently requests quarterly reports (in a standard template) on the concerns raised from each NHS Trust. We have complied with this submission.

2.13 The NGO, in collaboration with Health Education England, have three modules for FTSU on the eLearning platform:

- **Speak Up** – is for all workers and covers what speaking up is and why it matters.
- **Listen Up** – for managers, focuses on listening and understanding the barriers to speaking up.
- **Follow up** – is for senior leaders throughout health care, including Executive and non-executive directors, lay members and governor – its aim is to provide an opportunity for them to pause and reflect on the influence they and their fellow leaders have in shaping the speak up culture in our organisation.

The National Guardian, Dr Jayne Chidgey-Clark has asked that all senior leaders commit to undertake this training and make a Speak Up Pledge to show how they will Speak Up, Listen Up and Follow Up and role model these behaviours in our organisation.

2.14 The Equality monitoring form is ongoing and is sent out to any member of staff who raises a concern through FTSU. This data is shared in the Annual report.

2.15 The NGO recently asked for Guardians to get in touch with them if we could share positive examples of the relationship with the FTSU Non-Executive director and how they have supported the Guardian in her role. Karen Walker and Sue Franklin recently met with the national team who are going to be developing a short informative film for Freedom to Speak Up non-executive directors outlining the supportive role they can provide to a Freedom to Speak Up Guardian, and useful 'starting out' tips for them in their role.

3 PROPOSAL

3.1 The FTSU team at BTHFT are working hard to truly make speaking up business as usual but the National Guardian states that the system as a whole needs to firmly commit to living up to the values of supporting and listening to workers. FTSU is an additional route for workers to speak up to, but they cannot improve the speaking up culture on their own.

3.2 The NGO have a Speak up month in October every year. In October 2023 the topic was 'overcoming the barriers preventing people from speaking up'. The FTSU team took part in this event throughout October within the Trust. They have been visits to staff meetings, induction sessions for new staff and the team were in the main concourse throughout October. The stands in the concourse linked in well with other important events like Black history month, staff networks and Thrive.

4 BENCHMARKING IMPLICATIONS

4.1 Alongside the data headlines for each quarter, the NGO publish on their webpages the data submitted by all the Trusts in England. This enables each organisation to benchmark against similar types and sizes of organisations. This data is varied, but on average at BTHFT (classified as a medium sized Trust in the NGO data set) the data is consistent with other medium sized Trusts. There are however some examples of 'medium sized Trusts' reporting a lot more concerns than BTHFT.

4.2 In addition the annual NHS staff survey on safety culture about raising concerns provides an opportunity to monitor how BTHFT is performing in relation to other organisations classified as the best, average and worst performing. The latest NHS staff survey results are due to be published soon.

4.3 The FTSU team are working hard to ensure staff feel safe to speak up but need the support of leaders throughout the organisation to make speaking up just what we do here at BTFHT, The National Guardian states that FTSU Guardians do not work in isolation. All leaders are responsible for setting the tone when it comes to fostering a healthy speak up, listen up, follow up culture.

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5	RISK ASSESSMENT

5.1 The FTSU Guardian has 12 hours protected time within their substantive role to perform their FTSU duties. The deputy and FTSU Ambassadors currently have no protected time within their substantive roles.

5.2 The FTSU team, following the board development plan for FTSU, are going to be reviewing how we can develop the FTSU team further and appoint more Guardians/Ambassadors across the Trust.

5.2 It was highlighted in a previous internal audit report that if there was to be a sudden influx of concerns we would need to address the resource requirements; this could be a potential weakness in the system. As the number of FTSU concerns are rising every year we are going to be reviewing the staffing requirement for this.

6	RECOMMENDATIONS

6.1 To note the number of FTSU concerns that have been raised during Q3 2023-24 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern.

6.2 To support the work of the FTSU group to continue with raising awareness of FTSU for staff and education for Guardians.

6.3 To continue with quarterly reports to the Board/Academy to update on progress with FTSU at BTHFT.

6.4 To support the staff across the organisation to complete FTSU training on the eLearning platform, including the Executive and Non-Executive team.

6.5 To continue supporting the FTSU team to deliver the two elements of their role. One part is the reactive – listening to workers, thanking them and supporting them so that their voices can be heard and actions taken. The other part is the proactive element – supporting the organisation to learn from the opportunities which speaking up brings.

7	Appendices

Appendix 1 – BTHFT Q3 data.

Appendix 2 – Run charts of number of concerns.

Appendix 3 – Feedback received in Q3.

Appendix 4 – NGO Q2 data headlines.

Appendix 5 – Board development action plan.

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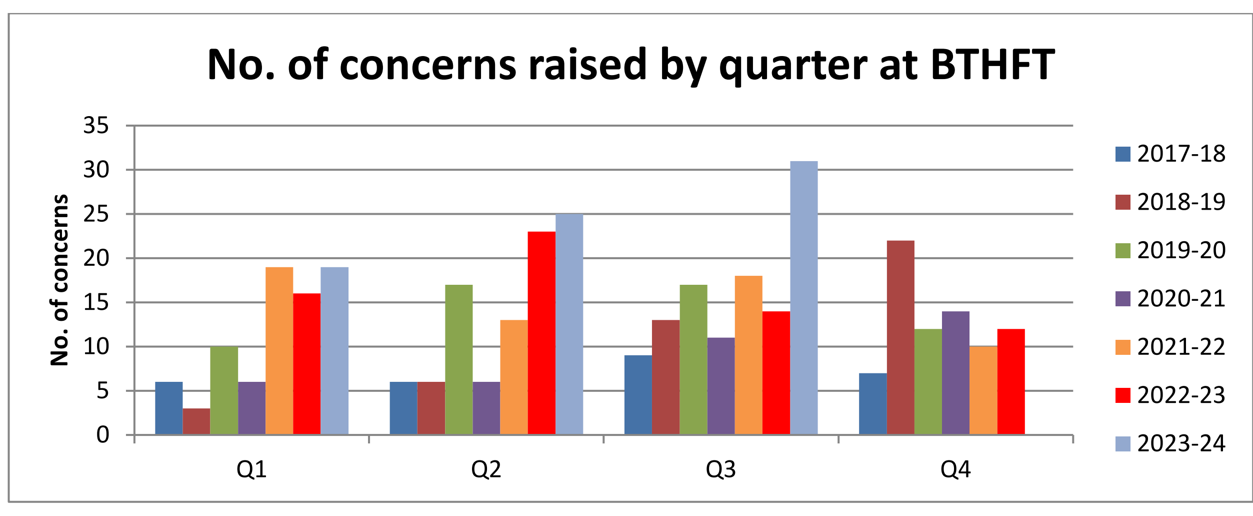
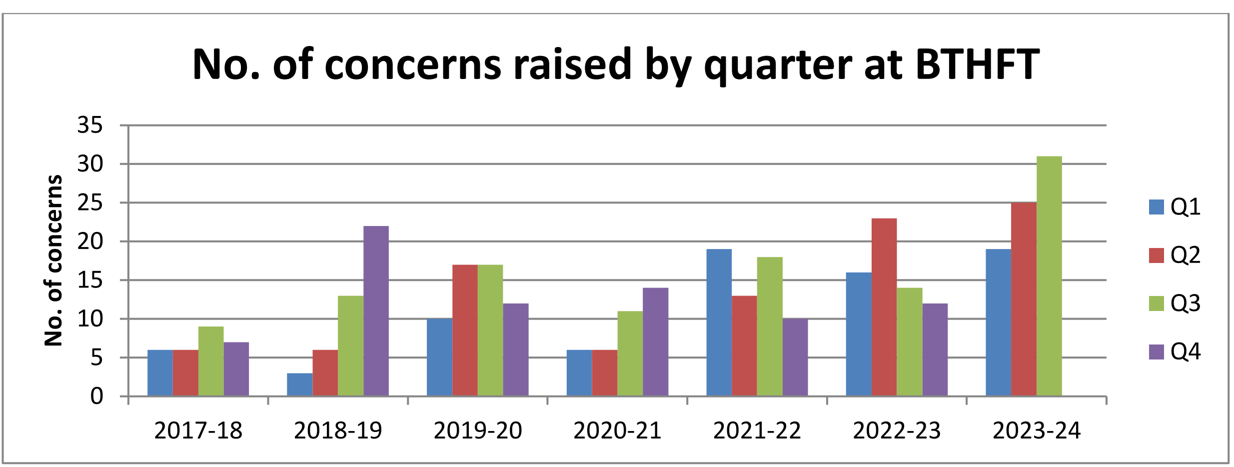
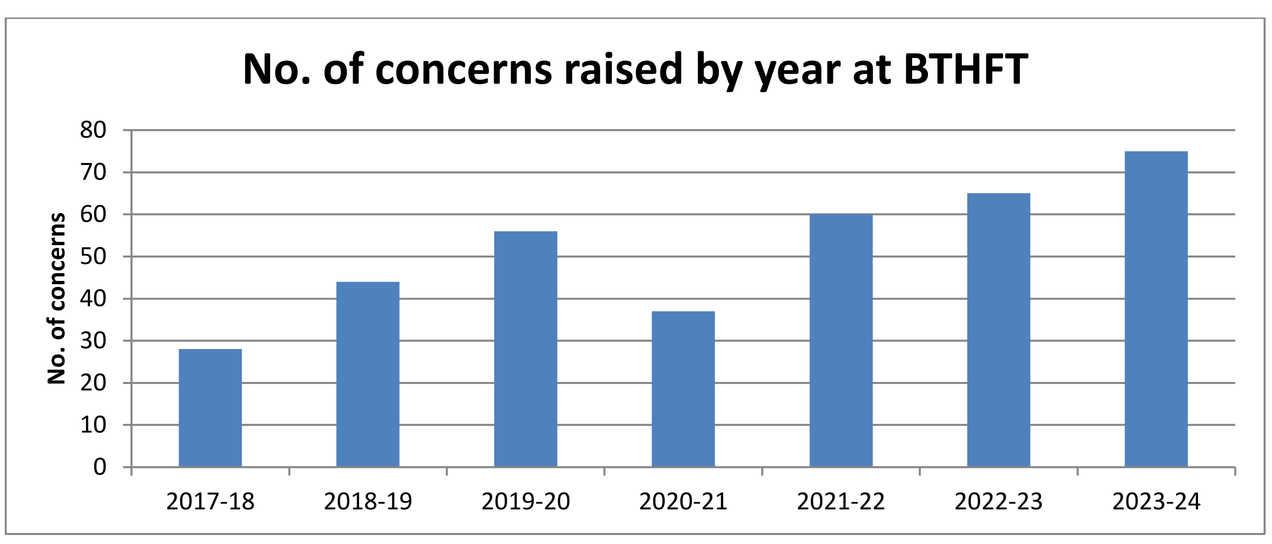
7	Appendices

Appendix 1 – FTSU Concerns raised at BTHFT by Quarter and by Year.







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7.1 These graphs show the number of concerns raised since the start of FTSU at BTHFT by quarter and by full year. It is displayed alongside the previous year's data to facilitate comparison.

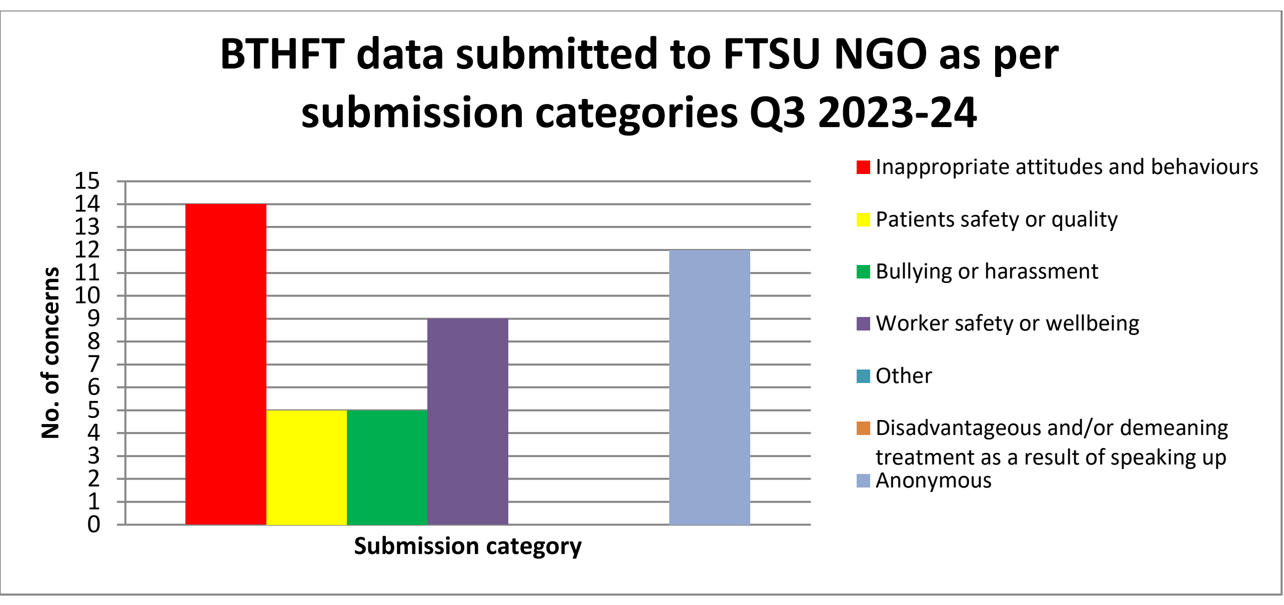
7.2 In Q3 there were 31 concerns raised to the FTSU team, this is the highest number of concerns raised in any quarter since FTSU started at BTHFT. In Q3 there was the October speak up month and also the Lucy Letby investigation and findings was published too.

7.3 There were 12 concerns this quarter raised anonymously via the FTSU App. An anonymous concern can be difficult in that you cannot support the staff member or give any feedback on progress, but they are all always followed through as much as possible. The NGO advocate that staff should be able to raise concerns anonymously if necessary.

Concerns raised by category (Using the NGO's submission categories)

The graph below shows the concern categories for Q3 2023-24*

*** A FTSU concern may have more than one category.**



7.4 In Q3, of the 31 concerns raised,

- **5 had an element of patient safety/quality -** (Any case that may indicate a risk or adverse impact on patient safety or the quality of care)
- **5 had an element of bullying and/or harassment -** (This can be a current or past matter and may identify risks or be about actual events)
- **14 had an element of inappropriate attitudes and/or behaviours -** (Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute Bullying or harassment)
- **9 had an element of worker safety or wellbeing –** (Any case that may indicate a risk of adverse impact on worker safety or wellbeing)
- No one this quarter has reported any disadvantageous and/or demeaning treatment as a result of speaking up (Detriment)

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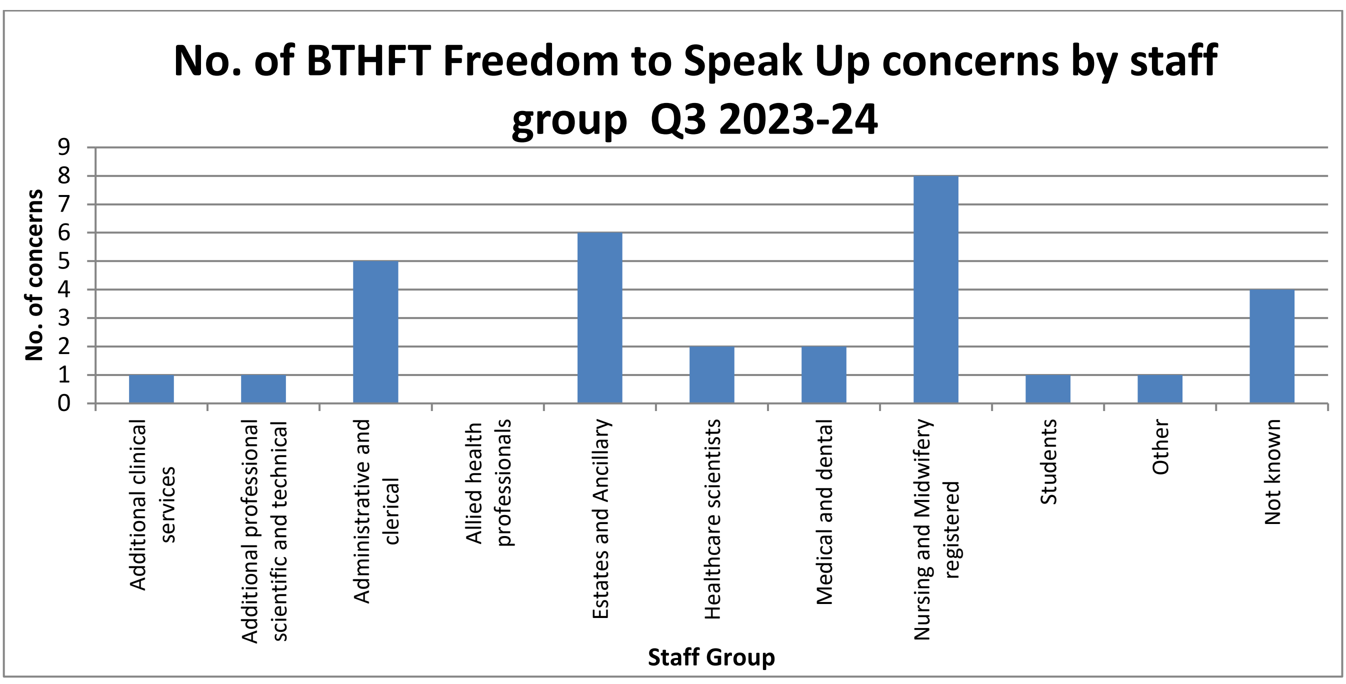
- 12 people reported their FTSU concerns anonymously to us. A poll across the North East and Yorkshire region has shown that 43% of FTSU Guardians do not have an official route for staff to report anonymous concerns through. At BTHFT we have a FTSU App that staff can report concerns through to us anonymously if they wish to do so.

Number of Concerns by staff group for Q3 (Using the NGO's grouping)

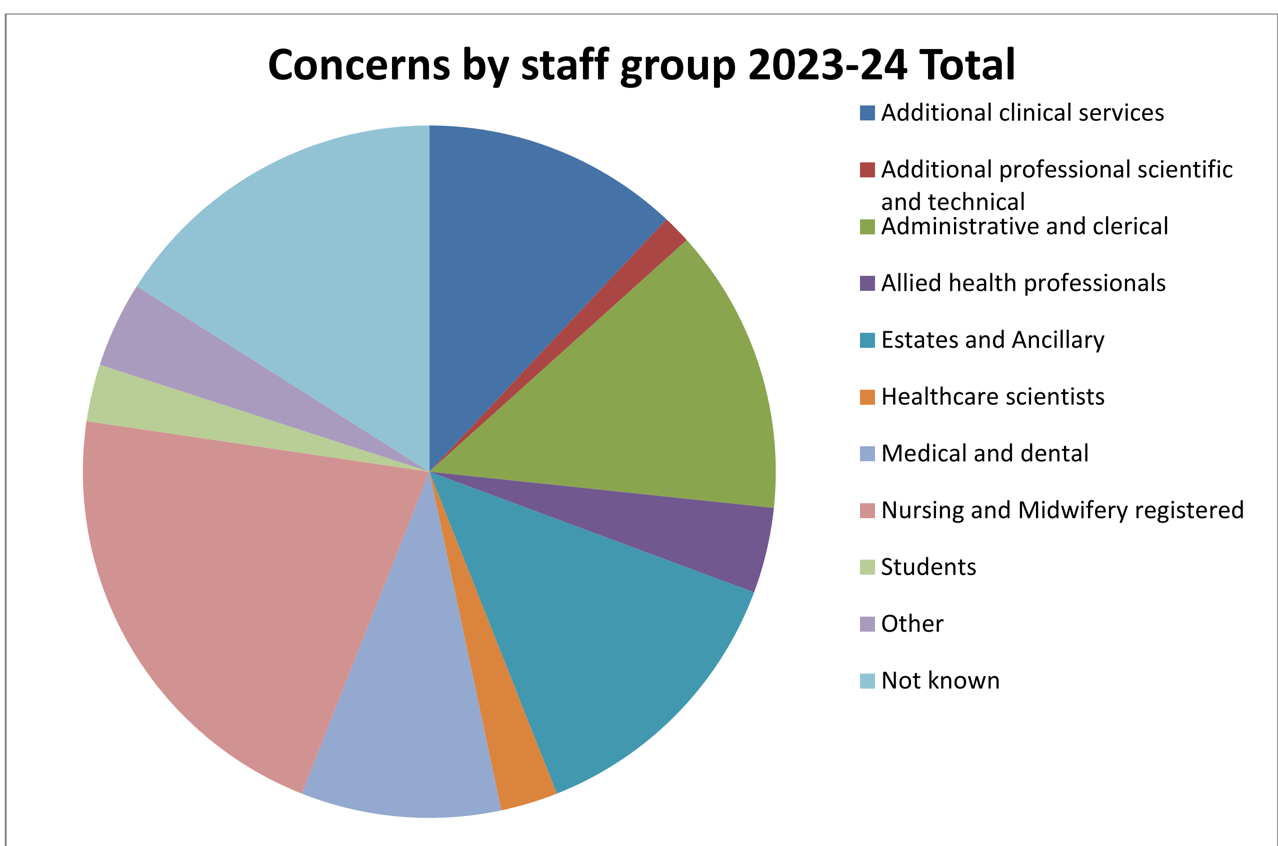


7.5 The above table shows the staff groups who have raised concerns in Q3.

- 8 concerns were raised by either a registered nurse or midwife
- 2 concerns were raised by medical staff
- 0 concerns were raised by AHPs
- 1 concern was raised by additional clinical service staff
- 5 were raised from Admin and clerical staff
- 6 concerns were raised by staff working in Estates and facilities
- 1 concern was raised by a student
- 1 concern was raised by additional and professional scientific and technical staff
- 2 concerns were raised by healthcare scientists
- 5 of the concerns raised it was not possible to determine which staff group they were from as they didn't stipulate or were anonymous

The pie chart below show the FTSU concerns by staff group for 2023-24 up to Q3

7.6 This data is utilised to identify areas where promotion/education around FTSU may be required.



7.7 Workers from a range of professional groups spoke up to the FTSU team. Nurses and midwives accounted for the bigger portion (28%) of cases raised. This is mirrored in the national data too for all FTSU Guardians where 29% of workers who spoke up were registered nurses or midwives.

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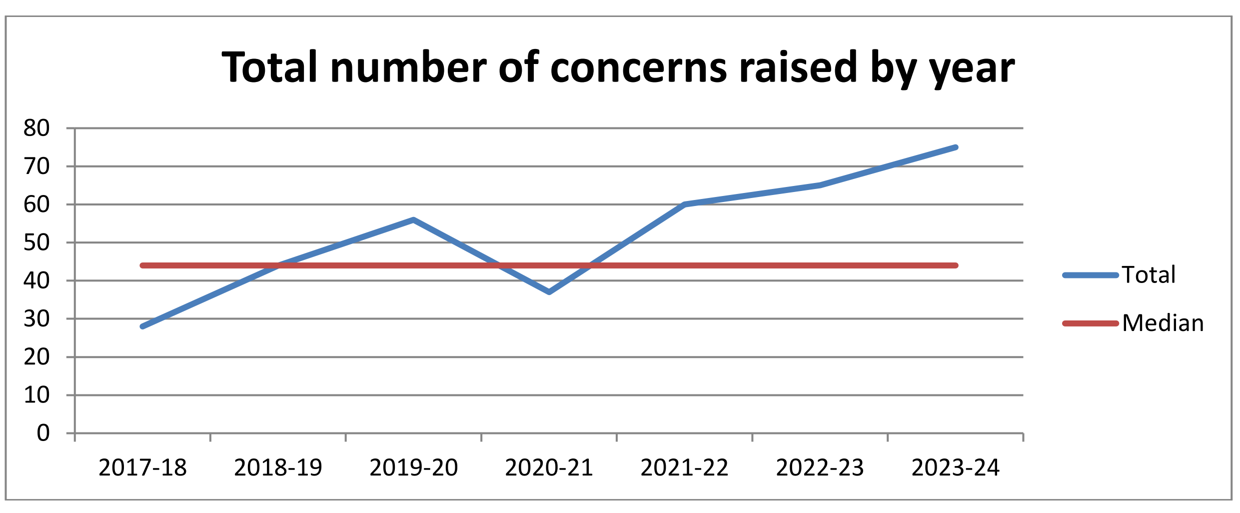
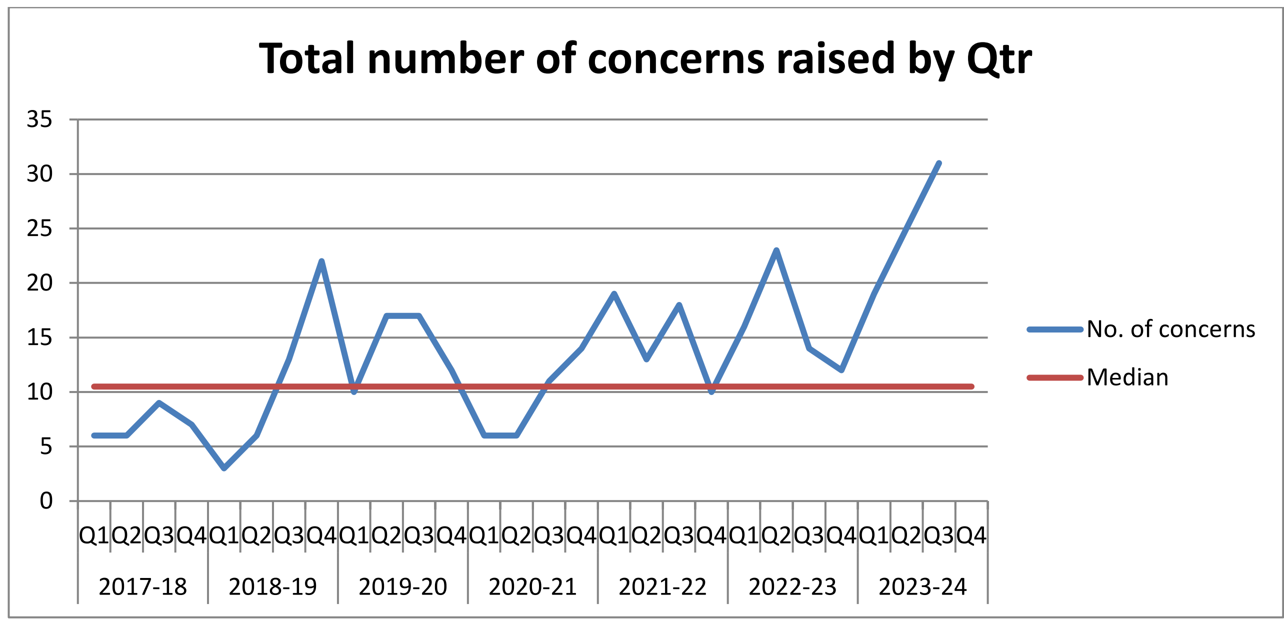
Appendix 2 – Run charts of the Total number of FTSU concerns raised by quarter and year





These two charts show the number of FTSU concerns raised over time at BTHFT. In Q3 there were 31 concerns raised to the FTSU team, this is the highest number of concerns raised in any quarter since FTSU started here at BTHFT.

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Appendix 3 – Feedback from staff for Q3 (The numbers represent the person who raised the concern to maintain confidentiality)

Person who raised the concern	Given your experience would you speak up again?	Feedback from the person raising the concern
1	Yes	The FTSU Guardian made me feel listened to and respected.
2	Yes	Being listened to was so reassuring for me and I will certainly use FTSU again if needed.

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Appendix 4 – National FTSU data for Q2 2023/24

A summary of the national speaking Up data from the NGO for Q2 2023/24

- 7,173 speak up cases were raised with guardians in Q2 2023/24; an 8% increase in the number of cases reported compared to the previous quarter (6,673 cases) and a 16% increase compared to the same quarter last year.
- Just under two-fifths of cases (36%) included an element of inappropriate behaviours and attitudes (other than bullying and harassment) and almost one third of cases (32%) included an element of worker safety or wellbeing.
- Almost one-fifth of cases (20%) included an element of patient safety, an increase from 17% in the previous quarter.
- 19% of cases included an element of bullying and harassment, a decrease from 21% in the previous quarter.
- 1 in every 25 cases (4%) reported to Guardians are from workers indicating that they have suffered detriment after speaking up.

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Appendix 5 – BTHFT Action plan developed from the Board development session in June 2023

- Document attached separately.

FTSU Action Plan – Following on from Board Self-Assessment in June 2023			Date initiated	15/06/2023
			Date of update	
Accountability		**Responsibility**		
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**	
Karen Dawber - Chief Nurse	Workforce Academy Executive team meeting	Sue Franklin – FTSU Guardian & Associate Chief Nurse	FTSU Operational Meeting	

Aim	Objective Ref	Objective	Expected Outcome	Assurance Mechanism	Review date
For the Board to be assured that they are proactively overseeing the role of FTSU at BTHFT and a commitment that speaking up must come from the Board in order to develop a speaking up culture across the organisation.	1	All staff feel safe and can confidently share their voice and speak up and are supported to do this.	Improved scoring in the staff satisfaction survey in regard to the questions relating to FTSU	Trust Board & Workforce Academy	
	2	Regular update to the Board that include outcomes and examples so that lessons are learned and care improves as a result	Examples of learning included in regular Board updates	Trust Board & Workforce Academy	

Communications plan				
What?	**Who?**	**By whom?**	**How?**	**How frequently?**
Action plan support	Deputy FTSU Guardian	**LeeAnne Elliott**	Via FTSU Operational Group	6 weekly
Action Plan Oversight	Chief Nurse	**Karen Dawber**	Worforce Academy	
Action Plan Management	FTSU Guardian - Associate Chief Nurse Quality Improvement	**Sue Franklin**	Via FTSU Operational Group	6 weekly

Change team members			
Name	**Job title**	**Contact details**	**Initial**
Sue Franklin	FTSU Guardian, Associate Chief Nurse		SF
LeeAnne Elliott	Consultant radiologist		LE
Karen Dawber	Chief Nurse		KD
Karen Walker	Non-Exec Director		KW
Cat Shutt	Head of Organisational development		CS

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

Objective	1	Principle 1 – Valuing speaking up - For a speaking up culture to develop across the organisation, a commitment to speaking up must come from the top						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1.1	The Executive lead should be accountable for the; • fair and inclusive recruitment of the FTSU team • capacity of the Guardian and ring fenced time – checks and balances to show that this is sufficient and effective for all aspects of the guardian job description	KD	3/10/23		**O**		.	
1.2	The NE director responsible for FTSU should be able to;	KW	3/10/23		**O**			

Objective	1	Principle 1 – Valuing speaking up - For a speaking up culture to develop across the organisation, a commitment to speaking up must come from the top						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
	• Ensure that there is sufficient Board support for speaking up and wider cultural transformation • Challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking up culture							

Objective	2	Role-model speaking up and set a healthy Freedom to speak up culture						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
2.1	The person responsible for Organisation development can evidence that they have a crucial role in promoting a speaking up culture and behaviours – especially in ensuring that this permeates throughout the organisation, e.g. building widespread cultural change	CS	03/10/23		O			
2.2	The Exec lead can evidence that the leaders in this organisation role model behaviour that leads to a healthy speaking-up culture.	KD	03/10/23		**O**			
2.3	The Exec lead for FTSU is assured that all staff are completing the FTSU eLearning modules, Speak up, listen up and follow up	KD	03/10/23		**O**			

Objective	3	Make sure workers know how to speak up and feel safe and encouraged to do so						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
3.1	That staff know how to access the FTSU policy on the intranet and are aware of how they can raise concerns	KD	3/10/23		**O**			
3.2	The FTSU team need to regularly communicate and promote FTSU throughout the Trust	SF/LE	03/10/23		**O**			
3.3	Plan the communication strategy for FTSU alongside the Comms team to ensure that we are reaching the whole workforce	SF/LE	03/10/23		**O**			

Objective	4	When someone speaks up, thank them, listen and follow up						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
4.1	Ensure that there is support for managers and leaders to handle speaking-up concerns by training on listening and providing emotional and psychological support.	KD/CS	03/10/23		**O**			
4.2	Create support material for managers to help them create healthy, business as usual, speaking up cultures.	SF/CS / LE	03/10/23		**O**			

Objective	5	Use speaking up as an opportunity to learn and improve						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
5.1	The FTSU Guardian and Exec lead must identify patterns, trends and potential areas of concern. By using other data and information to show ‘hotspots’ and to identify what aspects of patient safety and quality, worker wellbeing and culture need attention.	KD/SF	03/10/23		O			

Objective	6	Support guardians to fulfil their role in a way that meets workers' needs and NGO's requirements						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
6.1	The Exec lead must ensure that the FTSU Guardian and team have enough time in their role to fulfil all aspects of the role that meets the NGO standards.	KD	03/10/23		**O**			
6.2	The Exec led will work with other senior leaders to ensure speak up cases are progressed in a timely manner	KD	03/10/23		**O**			

Objective	7	Identify and tackle barriers to speaking up						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
7.1	The Guardian and FTSU team must have strong connections with the staff networks to be able to make a difference to staff speaking up.	SF	03/10/23		**O**			
7.2	The NE lead for FTSU should have sight of any grievances that involve allegations of detriment through speaking up	KW	03/10/23		**O**			

Objective	8	Continually improve our speaking up culture						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
8.1	The FTSU improvement strategy should set out clearly how speaking up fits in with the organisation's overall strategy and how it supports the delivery of related strategies.	KD/SF	O3/10/23		**O**			
8.2	We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up.	KD	03/10/23		**O**			

BO.3.24.33 - VIOLENCE PREVENTION & REDUCTION STANDARD

REFERENCES

Only PDFs are attached

Bo.3.24.33 - Violence Prevention Reduction Standard Update March 2024.pdf

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Violence Prevention Reduction Standard

Presented by	Sajid Azeb, Chief Operating Officer and Deputy Chief Executive	
Author	William Hall – Violence Prevention & Reduction Lead / Local Security Management Specialist Karon Snape – Head of Facilities	
Lead Director	Sajid Azeb, Chief Operating Officer and Deputy Chief Executive	
Purpose of the paper	The report provides an update on the ongoing work in relation to Violence Prevention and Reduction (VPR) within BTHFT during the preceding six months.	
Key control	Progress on this work will be monitored through six monthly updates to the Health and Safety Committee and the People Academy and reported annually through the 2023/24 Annual Security Board report.	
Action required	For information	
Previously discussed at/informed by		
Previously approved at:		**Date**
	Peoples Academy	31 January 2024

Key Options, Issues and Risks

As outlined in the Violence Prevention and Reduction Standard introduced in 2021, the Trust is required to review its status against the standard and provide Board assurance that the standards have been met twice a year.

This report highlights the work undertaken in the preceding six months, specifically the review of the existing VPR workstream structure and a proposed change to enable progress to achieve improved compliance to the standard.

Since the last update attendance at the VPR meetings has been low compounded by the recent industrial action limiting attendance, therefore the team have reviewed the agenda, terms of reference and membership to improve engagement and review workstreams and reporting structure to further improve engagement and progress.

Analysis

The VPR Standards have been reviewed in line with the requirement and the updated results are highlighted in the table below:

Section	Indicators	Compliant Jan 2023	Non compliant 2023	Compliant Jan 2024	Non compliant 2024	Section rating
Plan	14	5	9	6	8	Partially compliant
Do	11	7	4	8	3	Partially compliant
Check	12	5	7	7	5	Partially compliant
Act	6	1	5	2	4	Partially compliant
Total	43	18	25	23	20	
					Overall rating:	Partially compliant

The full detail of each of the VPR indicators are available in Appendix 1

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Recommendation
In conclusion, over the preceding six month period some progress has been made in improving compliance, furthermore the VPR group is encouraging work stream updates from sub-group meetings that are already taking place across the organisation such as clinical and HR related meetings, therefore the Trust Board are recommended to: • Note the improved compliance position this period. • Note and support the revised structure, focus groups and workstreams to improve engagement and progress compliance to the VPR Standard.

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	☐	☒

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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: Safe	
Care Quality Commission Fundamental Standard: Safety	
NHS England Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities	
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

As outlined in the Violence Prevention and Reduction Standard introduced in 2021, the Trust is required to review its status against the standard and provide Board assurance that they have been met twice a year.

This report highlights the work undertaken in the preceding six months, specifically the review of the existing VPR structure and required focus groups and workstreams to progress work across the Trust.

2 BACKGROUND/CONTEXT

Since the last update the key points of the standard have been reviewed and the table below highlights matters of concern affecting achievement of the standard.

Item	Assurance	Comments
Violence prevention and reduction standard reviewed within last six months		These are subject to continued reviewed
Violence prevention and reduction standard action plan in place and current		Action plan is in place
Violence prevention and reduction steering group meeting quarterly		The meetings have not progressed due to not meeting quoracy. The review has now established a structure of focus groups and workstreams which will be discussed and agreed at the next meeting scheduled for February 2024.
Data analysis of all DATIX related to violence and aggression		New VPR dashboard data report produced
Violence prevention and reduction lead in post		VPR Lead in post

Attendance at the Steering Group meetings has been low and therefore the team have reviewed the agenda, terms of reference and membership to improve engagement and review workstreams and reporting structure to further improve engagement and progress.

3 PROPOSAL

Three distinct key areas requiring focus to achieve Violence Prevention and Reduction across the Trust have been identified and proposed to progress VPR, categorised as follows:

1. **Clinically related challenging behaviour (CRCB)**
   Where the patient did not know what they were doing or did not know what they were doing was wrong due to medical illness, mental ill health, severe learning disability, substance abuse withdrawal or treatment administered. This category is currently managed by the clinical teams with limited support from security. This area has been a significant factor in previous years reporting on physical assaults on staff.

2. **Visitors/Public non-patient related behaviour**
   This relates to non-patient violence and aggression from/to visitors and the public where there are no clinically related factors and managed by the security and police teams.

3. **Staff on staff behaviours (Civility, H&B etc)**
   This relates to staff-on-staff incidents which are managed through HR processes within the Trust currently.

It is proposed that these 3 areas require significant focus and senior leadership to support engagement and compliance to the VPR. It is therefore recommended that:

1. Clinically related Challenging Behaviour would be led by the Chief Nurse supported by the Chief Nurse team. These types of incidents are generally because of underlying clinical conditions, the preventative measures, or risk reduction measures are often clinically/treatment related. This focus group will review the 'patients who pose a risk pathway', MH, LD, Alcohol, substance abuse, decision making, management planning, enhanced care pathways/models and assessments, security ward-based observations, physical intervention etc.

2. Visitors/Public – non patient related behaviour would be led by the Deputy Director, Estates and Facilities supported by the Security Management Team.
   This group will review the data relating to 'intentional' rather than clinically related behaviours to review the current strategies in place and assess how effective they are in managing this group of attenders. Often those involved in these types of incidents are not requiring clinical care.

3. Staff on staff would be led by the Director of HR and supported by the HR Business Managers.
   They would be responsible for reviewing available data relating to incidents and to review the effectiveness of current policy, procedures with representation from the focus and workstream groups. These types of incidents are more likely to be reported through HR processes than security reporting routes. This group will be responsible for supporting the development of the Violence Prevention and reduction Strategy and related policies.

In addition, there are key workstreams identified to support the focus groups.

a) Education and Training - led by the Education Manager
   (review delivery of CRT, breakaway, restraint, undertake training needs analysis, including MH training requirements). The Trust needs to ensure that the training delivered is targeted to the needs of the Trust and is risk based.
b) Metrics and data validation - led by Head of Non-Clinical Risk
   (Pulse survey, staff survey, risk incidents, complaints, SI, number of physical assaults, verbal, threats, ASBO's behaviour agreements, warning letters, treatment withdrawal, prosecutions, etc) this is to ensure we improve reporting mechanisms to enable best effective use of data to target resource and reduce incidents. The organisational risks associated with Violence and Aggression will be assessed and shared with appropriate stakeholders

The VPR Lead will work across all focus and workstreams to enable the update of the overall workplan and submission of the twice-yearly updates.

The new structure and workstreams will be discussed and agreed at the next meeting scheduled for April 2024 and will enable improved engagement and progress.

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4 BENCHMARKING IMPLICATIONS

Whilst all organisations are required to achieve compliance to the Violence Prevention and Reduction Standard, there is currently no benchmarking with other organisations.

As part of the VPR Lead network other Acute organisations have adopted the structure proposed within this report.

5 RISK ASSESSMENT

Existing violence reduction policies and procedures currently support ongoing reduction of violence and aggression and high reporting areas of violence and aggression are risk assessed and measures put in place with support from the Security Management Team.

6 RECOMMENDATIONS

In conclusion, over the preceding six-month period some progress has been made in improving compliance, however, without focussed work streams, progress will be limited going forward. It is therefore recommended:

- To support the revised structure, focus groups and workstreams to improve engagement and progress compliance to the VPR Standard.
- Note the improved compliance position this period.

7 Appendices

Appendix 1

Plan

Compliant	Evidenced (how)	Indicators	
The board (non-exec and exec members) endorses the violence prevention and reduction policy	• The organisation has developed a violence prevention and reduction strategy which has been endorsed by the board and is underpinned by the relevant legislation and government guidance.	No	Evidence: • The Strategy will be written as part of the review of the VPR Standard.
	• The organisation has developed a violence prevention and reduction policy which has been endorsed by the board and is underpinned by workforce and workplace risk assessments.	Yes	Evidence: • Existing Trust policy on the prevention and management of violence and aggression has a review date of October 2022. The Policy was compliant with the legal and statutory standards required at the time. This policy will now be reviewed

			against the new standard. • Ward / Department Risk Assessments held by **CSU's**
	• The organisation has engaged with key stakeholders, including trade unions, health and safety representatives and other appropriate stakeholders.	Yes	Evidence: • The VPR task and delivery group has staff side reps and Trust CSU reps and clinical stakeholders represented • Evidence meeting minutes
	• The organisational risks associated with violence have been assessed and shared with appropriate stakeholders in the sustainability and transformation partnership (STP) or integrated care system (ICS).	No	Evidence: • Organisational risks linked to violence will be reviewed and shared as outlined within strategy & policy.
	• The senior management (the chief executive and the board) is accountable for the violence prevention and reduction strategy and policy, and this is clearly set out in both documents.	Yes	Evidence: • Existing Policy details the CEO responsibilities. • The strategy will include once finalised • Trust Policy
	• Senior management is informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and **made available to all stakeholders**.	No	Evidence: • All Trust policies are subject to EqIA and V&A trends are monitored and reported on. However, a specific EqIA relating to VPR is required.
Clearly defined objectives and performance criteria	• The violence prevention and reduction objectives and expected performance criteria outcomes have been incorporated into the policy.	No	Evidence: • These will be incorporated within the revised VPR Policy.
	• There are practical and efficient methods for measuring status against the objectives identified and agreed by the senior management team in consultation with key stakeholders.	Partially	Evidence: On-going work • VPR dashboard which enables analysis of data to allow a thematic review

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	• The organisation is compliant with relevant health and safety legislation and any other applicable statutory legislation, and this has been validated, i.e. via the organisation's auditors.	Yes	Evidence: • Policies / Procedures in place – Security / Lone Worker / Violence and Aggression / Restraint. • Risk assessment process in place • Risk registers to escalate • Policies and Procedures reviewed periodically by Trust Policy and Procedure Review Group
	• Inequality and disparity in experience for any staff groups with protected characteristics have been addressed, and this is clearly referenced in the equality impact assessment.	No	Evidence: • Policy and Procedures are subject to an equality impact assessment
Violence prevention and reduction plans recorded, implemented and maintained	• Plans have been developed and documented for achieving violence prevention and reduction objectives, and the outcomes are clearly set out in the policy.	No	Evidence: On-going work
	• The plans are updated and maintained to consider improvements; lessons learnt and updated risk assessments, annually as a minimum schedule.	No	Evidence: • Plans to be developed as part of VPR standard review.
	• Risk assessments are available to managers, their staff, trade union representatives and other relevant stakeholders.	Yes	Evidence: • Existing available, updated as part of VPR review will also be shared appropriately.
	• The plans are reviewed in consultation with subject matter experts pertaining to the Equality Act 2010.	Yes	Evidence: • Representation from EQI will form part of the Task & Delivery Group. • Work plans, processes and other related work is shared with subject matter experts • Policies / Procedures in place and subject to

			equality impact assessments

Summary of Plan:
Of the 14 indicators within the Plan section 6 are compliant and 8 are non-compliant.
Compliance rating for the Plan section is AMBER partial compliance.

Do

Compliant	Indicators Evidenced (how)		
Board members approve resources	• The senior management assesses and provides the resources required to deliver the violence prevention and reduction objectives.	Yes	Evidence: • Appointed VPR Lead to support the delivery of the VPR objectives. • Additional HCA's provided ad-hoc to carry out 1-1 enhanced care • Additional security staff provided ad-hoc to carry out 1-1 security observations
	• A designated board-level (director) manages the violence prevention and reduction workstream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).	Yes	Evidence: • Director of Estates & Facilities designated board-level director. • A process is in place to assure appropriate levels of resource, determined by risk assessment, IRIS trend analysis, recommendations and business case as appropriate. • Chief Nurse leads on clinical matters related to V&A / challenging behaviours • Director of HR / OD leads on staff on staff • Director of E&F all other matters – those with capacity, ASB etc.
	• The senior management team regularly provides accessible communications on the violence	No	Evidence: • Will be implemented through the VPR work

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Regular workforce engagement	prevention and reduction objectives and priorities.		plan developed by the Task & Delivery Group.
	• Communications cover all staff groups and functions within the organisation.	No	Evidence: • As above.
	• The recognised trade unions are consulted and involved in the development of violence prevention and reduction objectives.	Yes	Evidence: • Trade Union representation will be included in the VPR Task & Delivery group membership.
	• A diversity lens is applied to objectives development, to provide due diligence for Public Sector Equality Duty, and this is validated by the subject matter expert pertaining to the Equality Act 2010.	Yes	Evidence: • The Head of Equality, Diversity & Inclusion (or a member of the team) will be included in the VPR Task & Delivery Group membership.
Clear roles, responsibilities and training	• The organisational roles and responsibilities across all levels are clearly set out in a violence prevention and reduction policy.	Yes	Evidence: • This is clear within the existing V&A Policy and will be revised as part of the VPR revision of the policy reflecting the new standard.
	• A training needs analysis (violence) informed by the risk assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.	Yes	Evidence: • A representative from the Education & Training Department will be included in the VPR Task & Delivery Group membership. Previous analysis informed the delivery of Conflict Resolution Training
Regular risk assessment	• Violence prevention and reduction workforce and workplace risk assessments are managed and reviewed as part of an ongoing process and documented in the appropriate organisational risk registers.	Yes	Evidence: • The top 5 V&A reporting areas are risk assessed annually by a MDT consisting of Clinical staff, LSMS, Risk and Estates representatives and placed on Directorate Risk registers as appropriate.
	• Violence risks are co-ordinated across the organisation, and are accessible and shared with	Yes	Evidence: • As above the top 5 reporting areas risk

	senior management and all appropriate stakeholders.		assessments are included within the annual security board report and shared via the Security Steering Group Membership for dissemination. Review risks wider than top 5 reporting areas.
	• Identified violence risks and their mitigations/controls are communicated to all staff in regular bulletins.	No	Evidence: • Ad-hoc global emails as and when required. Consider more specific bulletins for communication.
Summary of Do: Of the 11 indicators within the Do section 8 are compliant and 3 are non-compliant. Compliance rating for the Do section is AMBER partial compliance.			

Check

Indicators			
Compliant	Evidenced (how)		
Process to assess violence prevention and reduction performance	• The efficiency and effectiveness of the violence prevention and reduction plans and processes are assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.	No	Evidence: • To be agreed as part of the VPR standard review and implementation programme.
	• The senior management is directly accountable for ensuring that the system is working effectively and providing assurance that the violence prevention and reduction objectives are being achieved.	No	Evidence: • As above.
	• Staff members are actively encouraged to report all incidents, including near misses.	Yes	Evidence: • Incident Reporting Policy • Staff are regularly encouraged to report incidents and near misses.
Data is traceable	• Violence data is managed in accordance with the General Data Protection Regulations (GDPR)	Yes	Evidence: • Trust Policy and Procedure followed.

retrievable and accessible	• Violence data is frequently analysed using primary metrics to support the violence prevention and reduction assessments and inform the audit process.	Yes	Evidence: • The top 5 V&A reporting areas are risk assessed annually. • IRIS incident trends are monitored through the Security Steering Group and included within the annual security Board report. • Recorded incidents checked daily and followed up • IRIS / Security Logs are monitored for themes and trends
	• Violence data is analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability and sexual orientation.	No	Evidence: • HR & EDI membership of Task & Finish Group.
	• The protection and storage of data about violence follows the organisation's information governance policies.	Yes	Evidence: • Trust Policy and procedure followed. • IG regulations complied with
	• Data collected about violence assures that the processes are effective and identifies where lessons can be learnt and that the policy objectives are being achieved.	Yes	Evidence: • To be reviewed as part of VPR Standard implementation. • Recorded incidents checked weekly and followed up • IRIS / Security Logs monitored for themes and trends • Additional Needs Team enhanced care documentation • Ward initiative (Security & Safeguarding weekly visit to hotspot areas) • Unacceptable behaviour warning letters Concerns from those investigating passed to stakeholders within CSU's
	A process exists for auditing violence prevention and reduction performance and ensuring that associated	No	Evidence: • To be implemented as part of VPR Standard review.

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Established audit and assurance process for violence prevention and reduction	systems are effectively managed and assessed regularly.		
	The audit outcomes inform a regular senior management review held at least twice a year.	No	Evidence: • To be implemented as part of VPR Standard review.
Process for corrective and preventative actions for violence prevention and reduction	All incidents are logged, reviewed, assessed and any corrective actions are recorded within acceptable timeframes, and where this may be prolonged by investigations and or staff support, this is recorded and communicated to senior management, relevant staff and stakeholders.	Yes	Evidence: • Incidents are recorded on IRIS, this is reliant on staff completing the IRIS report • Security complete Security Log report on IRIS – and or request the persons involved to complete a IRIS after every incident • Dependant on the seriousness of the incident other reports may be completed SUI / Police investigation or it may just be through IRIS • Time scales are set by IRIS – local governance groups will track compliance in CSU's • Trust Risk Registers reviewed (Quality assurance Committee)? • Corporate Risk register reviewed
	The violence prevention and reduction risk registers are updated accordingly.	Yes	Evidence: • Each CSU has a risk register and there is a corporate risk register • CSU's present risk registers and risks at the Risk Management Committee quarterly • As risks are identified risk registers would be updated • Risk registers held with IRIS system

Summary of Check:
Of the 12 indicators within the Check section 7 are compliant and 5 are non-compliant.
Compliance rating for the Check section is AMBER partial compliance.

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Act

Compliant	Evidenced (how)	Indicators	
Board reviews the violence prevention and reduction performance	• A senior management review is undertaken twice a year and **as required or requested** to evaluate and assess the violence prevention and reduction programme, **the findings of which are shared with the board.**	No	Evidence: • This will be incorporated within the VPR work plan and included in a twice yearly Board Report.
	• Inputs to the process include: 1. local risk management system (data about violent incidents) 2. Risk registers 3. Audit and governance reports that include violence performance 4. Lessons learned (STP and ICS level) 5. Review of the violence prevention and reduction processes 6. Risk assessments (workplace and workforce) 7. Triangulated with WRES and WDES 8. Staff experiences (causation themes, impact on health and wellbeing, consequences, etc) 9. Serious Incidents 10. NHS Staff Survey, local or pulse surveys 11. Local HR intelligence (staff recruitment and leavers rates, absenteeism or retention rates) 12. Key stakeholders. 13. Trade union concerns raised through the health and safety committee 14. Meetings with chief constable or designated representative, police and crime commissioners, etc.	No	Evidence: • 1. IRIS used to record incidents • 2. Entry on Trust risk registers and CSU's have local risk registers • 3. Annual board report • 4. SUI's shared as required • 5. To be agreed/developed • 6. Top 5 reporting areas for V&A • 7. To be agreed/developed (HR and EDI) • 8. To be agreed/developed • 9. SUI carried out as required and supported by action plans • 10. To be agreed/developed (Exit interview champions) • 11. To be agreed/developed • 12. To be agreed/developed • 13. VPR group feeds up to the H&S committee, staff side represented there • 14. Meetings take place and regular communications with

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			West Yorkshire Police. Not at Chief constable or PCC level, but issues could be escalated as required
Violence prevention and reduction policy updated with lessons learned	Following the senior management review (twice a year) the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.	No	Evidence: • The VPR Lead will be responsible for all updates following senior management review.
Informed decisions at senior management level	Senior management has enough information **from the violence prevention and reduction performance inputs** to make informed decisions about the violence prevention and reduction policy, and this information is based on credible intelligence and risk assessments.	Yes	Evidence: • IRIS information, Security reports and Staff Survey provide information that details trends and data. • Reports are available from Security and IRIS and can be analysed
	Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS planning arrangements.	No	Evidence: • To be agreed/developed.
	Staff receive timely responses to incident investigations, and where this may be prolonged by process requirement, this is recorded and communicated to staff, senior management and relevant stakeholders.	Yes	Evidence: • Security reports of incidents and IRIS reviewed daily and incidents followed up on. Staff receive automatic feedback once a IRIS has been finalised. • Trust employs (part funds) 3 PCSO's from West Yorkshire Police to assist in the follow up with staff as part of their role.

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Summary of Act:
Of the 6 indicators within the Act section 2 is compliant and 4 are non-compliant.
Compliance rating for the Act section is AMBER partial compliance.

Overall compliance rating for BTHFT against the VPR standard is AMBER partially compliant.

BO.3.24.34 - BRADFORD HOSPITALS CHARITY ANNUAL REPORT AND ACCOUNTS 2022/23

REFERENCES

Only PDFs are attached

- Bo.3.24.34 - Bradford Hospitals Charity Annual Report and Accounts 2022-23 (cover paper).pdf
- Bo.3.24.34 - Appendix 1 Post Audit Management Report.pdf
- Bo.3.24.34 - Appendix 2 BHC Annual Report and Accounts 22-23 - track change.pdf
- Bo.3.24.34 - Appendix 3 BHC Annual Report and Accounts 22-23 - Final.pdf
- Bo.3.24.34 - Appendix 4 BHC Letter of Representation.pdf

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ISA260 – Charitable Funds

Presented by	Michael Quinlan, Deputy Director of Finance	
Author	Laura Parsons, Associate Director of Corporate Governance	
Lead Director	Matthew Horner, Director of Finance	
Purpose of the paper	To confirm the approval of Bradford Hospitals Charity's annual report and accounts 2022/23	
Key control	N/A	
Action required	For information	
Previously discussed at/ informed by	Audit Committee – 21 November 2023 Charitable Funds Committee – 7 November 2023	
Previously approved at:	**Meeting**	**Date**
	Charitable Funds Committee	19/01/24 (via e-mail)
	Audit Committee	23/01/24 (via e-mail)
	Board	26/01/24 (via e-mail)

Key Options, Issues and Risks

The draft unaudited 2022-23 annual accounts and report for Bradford Hospitals Charity were previously presented at the Charitable Fund Committee and Audit Committee meetings in November 2023. The accounts were then audited in December 2023 / January 2024.

As the deadline for submission of the annual report and accounts was 31 January 2024, approval was sought from the Charitable Funds Committee, Audit Committee and Board via e-mail. Approval was confirmed and the documents were submitted to the Charity Commission on 31 January.

The papers previously circulated to the Committee via e-mail are attached at Annex 1 for information.

Recommendation

The Board is asked to receive this report for information and note the approval of Bradford Hospitals Charity's annual report and accounts for 2022/23.

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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	Audit Committee
☐	☐	☐	☒

Bradford Hospitals' Charity

Post-Audit Management Report
Year Ended 31 March 2023

MOORE Kingston Smith

Post-Audit Management Report – Bradford Hospitals' Charity

We have completed the audit of Bradford Hospitals' Charity for the year ended 31 March 2023 and we expect to issue an unqualified audit opinion.

This report covers the findings from our audit, the scope of which was communicated to you prior to commencing the work. It includes some recommendations for improving the accounting and internal control systems as well as highlighting some future developments that may be of interest to the board.

We hope that the recommendations are practical and are able to be implemented. We would be grateful if you could discuss the points as a board and will welcome a written response. Please extend our thanks to the finance team for all their help with the audit.

If you have any concerns or questions arising from this report, please contact Adam Fullerton.

Yours faithfully,

Moore Kingston Smith LLP

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Moore Kingston Smith LLP

18 January 2024

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This report has been prepared for the sole use of the Trustee of Bradford Hospitals Charity and must not be shown to any third parties without our prior consent. No responsibility is accepted by Moore Kingston Smith LLP towards any third party acting or refraining from action as a result of this report.

1. Audit approach – Risks

As outlined in our pre-audit letter sent on the 18 December 2023 our audit approach is based on an assessment of the audit risk relevant to the individual financial statement areas. Areas of risk are categorised according to their susceptibility to material misstatement, whether through complexity of transactions or accounting treatment. For each area we calculated a level of testing and review sufficient to give comfort that the financial statements are free from material misstatement.

The following table lists any risks identified at the planning stage and during the course of the audit, our approach to mitigate the risk and our conclusions from completing this work.

Risk	Audit Approach	Conclusion
Income Recognition There is a risk that income may be materially misstated, or not recognized in the correct financial period. There is a particular risk in relation to period-end legacy accounting when considering if legacy accruals meet the SORP recognition requirements of entitlement, probable receipt and reasonable measurement.	We will: • substantively test, document and assess income for all material income streams of the charity. • examine income records and documentation and assess the recognition of income against the SORP criteria and verify that it has been recognized in the correct period and is not materially misstated. • select a sample of accrued and (if relevant) deferred income and trace to supporting documentation; • review the income recognition policies in the financial statements and ensure these are being adhered to; • document the systems and controls relating to income and observe for potential weaknesses in controls. We will perform walkthroughs to corroborate whether the controls in place are adhered to; • perform legacy cut-off testing on a sample basis and review post period end legacy receipts along with legacy correspondence files for the period; • test transactions around the financial year-end to determine whether cut-off has been treated correctly.	From the sample testing performed on income we have gained reasonable assurance that income is not materially misstated and has been included within the correct period. Based upon the audit work undertaken, there were no errors identified in the treatment of cut off of income during the year. We have gained reasonable assurance that income streams are not understated and have been recognised within the correct period. Given the informal documentation (mainly email correspondence) regarding the £500,000 Sovereign Healthcare income, a specific point has been included in the management letter of representation to confirm that the charity was entitled to this income as at 31 March 2023.

1. Audit approach – Risks (continued)

Risk	Audit Approach	Conclusion
Management override There is an inherent risk of management override which could lead to fraudulent transactions in the financial statements. International Standard on Auditing (UK) 240 requires auditors to consider management override of controls as a significant audit risk. Our work covers three broad areas, being: • Controls around journal entries and the financial reporting processes; • Significant accounting estimates and judgements; and • Significant transactions outside the normal course of business	We will: • document and evaluate the systems and control processes in place; • review a sample of miscellaneous bank payments to ensure that payments are valid expenses of the charity and that the controls in place over payments are being adhered to; • review a sample of journal entries to ensure these represent valid accounting adjustments; • critically review any areas of estimation or judgement for evidence of management bias; • carry out a review and an evaluation of controls over BACS payments, supplier set up/amendments and approval, and processing of payments	Our sample testing did not identify any instances of management override of controls. All samples selected indicated that expenditure was for valid purposes in line with the objectives of the charity. There was no evidence of management bias noted when testing areas requiring judgements or estimates. Our review of the controls over BACS payments, supplier set up/amendment and approval, and processing of payments concluded that the control environment was robust with appropriate levels of authorisation and delegation in place.
Opening Balances Given that the 2023 year end is the first year of our audit engagement, there is a risk that opening balances may be materially misstated	We will: • agree opening balances per the accounting system to the signed 2022 financial statements; • obtain additional information for key areas of the financial statements to support the opening position, not limited to but including, aged debtors, aged creditors, bank balances and fixed asset investments	We have agreed the material opening balances to supporting documentation. We are also satisfied that the opening balances per the accounting system agreed to the 2022 signed financial statements.

1. Audit approach – Risks (continued)

Risk	Audit Approach	Conclusion
Grant creditors and financial commitments There is a risk that grant commitments are not correctly recognised and therefore materially misstated in the financial statements. Grants expenditure is a material balance and there is a risk that full commitments have not been accounted for	We will: • test a sample of grant commitments to ensure they have been recognised in the correct financial period • review the agreements in place with grantees and review award dates to award letters and whether an acknowledgement of receipt has been retained, where appropriate; • review board minutes for any grant commitments not recognised; • test a sample of payments after the period end to ensure cut-off is treated appropriately • review any grants that have had terms and conditions re-issued during the period, to determine the grants are being accounted for in line with updated conditions, and • check if follow up reports are received and reviewed in line with grant awards.	From the sample-based testing performed we have gained reasonable assurance that grant expenditure and year end creditors are not materially misstated.
Classification of funds The charity has a number of endowment, restricted and designated funds. There is a risk that classification of funds between restricted, designated and unrestricted activities are materially incorrect. There is a risk due to the number of restricted and designated funds that transactions are not allocated against the correct funds, leading to misstatement.	We will: • substantively test both unrestricted, designated and restricted income back to supporting documentation, to ensure that any restricted income has been treated in line with the expression of the donor; • substantively test designated and restricted expenditure to ensure it meets with the requirements of the restriction placed by the donor/designation by trustees; • review any transfers between funds to determine the reason for the movement	We have reviewed the management workings that support the various fund allocations and are satisfied that these have been split out appropriately. From the testing performed we have gained reasonable assurance that income and expenditure have been accounted for within the correct fund.

1. Audit approach – Risks (continued)

Risk	Audit Approach	Conclusion
Investments Investments are a significantly material balance and involve potentially complex accounting for the movements and period end valuations apportioned between funds	We will: • obtain independent 3rd party confirmation of the investment balances from the investment managers, check that the required disclosures are included in the financial statements and that they are valued in accordance with FRS 102. • request a systems and internal controls report directly from your investment managers to provide further assurance over the figures they provide to us. Where this is not available, we will complete additional substantive sample testing of investment transactions • review the controls and procedures over any instructions given by the Trustees to effect changes to the investment portfolio and sample check that transactions have been made in accordance with the instructions	Investment portfolio values have been verified to third-party confirmations from Rathbones and The Charles & Elsie Skyes Charitable Trust. We have also obtained Rathbones' December 2022 controls report which was unqualified. Consequently, we are satisfied that the year end investment portfolio values, as well as movements in the year, are not materially misstated.

2. Significant findings from the audit

We are required under International Standards on Auditing to request you to correct all misstatements identified during our audit, with the exception of those that are clearly trivial.

Corrected material misstatements and reclassifications

No material misstatements were identified during the course of our audit work.

Uncorrected immaterial misstatements and reclassifications

See page 11 for the uncorrected immaterial material misstatements that were not trivial were identified during the course of our audit work.

Observations concerning the operation of the accounting and control systems

We detail in the next section other matters concerning the operation of the accounting and control systems that we consider should be brought to your attention. The observations have been ranked in order of potential risk to the business.

We look forward to receiving your responses on the points raised.

Due to the nature of an audit, we may not have identified all weaknesses within the accounting and internal control systems which may exist, and the contents of this section of our letter and any items disclosed in this report should not therefore be taken as a comprehensive list of such weaknesses.

Management Representation Letter

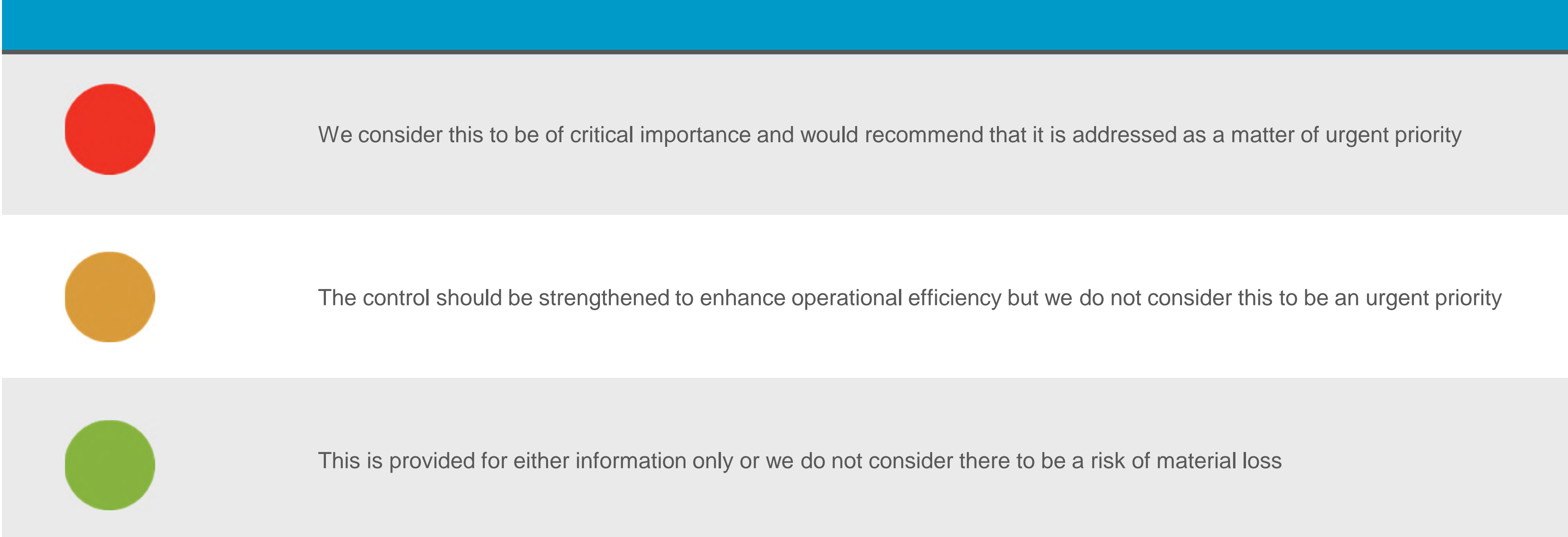
A draft of our proposed management representation letter has been sent to you under separate cover. All of the matters included in this letter on which we seek the Trustee's formal confirmation are in respect of routine matters, except for the following:-

- Point 13 regarding the accrued Sovereign Healthcare income of £500,000
- Point 14 regarding £500,000 Da Vinci robot grant to the Trust.
- Point 15 regarding the HSBC bank balances

3. Operation of the accounting and internal control system

We are required to report to you in writing, significant deficiencies in the internal control environment that we have identified during the course of our audit. These matters are limited to those which we have concluded are of sufficient importance to be reported to you. Our audit cannot necessarily be expected to disclose all matters that may be of interest to you and, as a result, the matters reported may not be the only ones which exist. As part of our work, we considered internal controls relevant to the preparation of the financial statements such that we were able to design appropriate audit procedures. This work was not for the purpose of expressing an opinion on the effectiveness of internal control.

We have categorised the internal deficiencies noted via a colour-scale rating system. The key to which follows:



3. Operation of the accounting and internal control system

	Current year observation	Recommendation	Management Response
	Sovereign Healthcare income and Da Vinci robot grant We noted that there is no formal agreement with Sovereign Healthcare for their £500k contribution towards the Da Vinci robot. Similarly, there is no formal grant agreement with the Trust confirming the charity's contribution towards the Da Vinci robot and key terms such as the amount and what they must use the funds for. The lack of formal agreements potentially leaves the charity more exposed in the event of any dispute.	For such material amounts, we recommend that formal agreements are set up with both funders and the trust outfling key terms and conditions for the transactions to protect the charity's interests.	The Charity will ensure formal agreements are set with funders and the Trust outlining key terms and conditions.
	Agreement with Charles and Elsie Sykes Charitable Trust The agreement with the Charles & Elsie Sykes Trust regarding their management of the Elsie Sykes endowment fund investments is not signed. Furthermore, whilst it mentions that income will be allocated to Bradford Hospitals' Charity on a pro-rata basis, it is silent on whether investment manager fees and gains/(losses) will also be shared with the charity on a similar basis.	The lack of a signed agreement with defined terms and conditions to cover the full arrangement as well as the responsibilities of both parties increases the risk of a disagreement in future. We recommend that a new, more detailed agreement is implemented to mitigate this risk.	The Charity will review if it wishes to continue the existing agreement with Charles and Elsie Skyes Trust or consolidate all investments with Rathbones. Should the investment remain with Charles and Elsie Sykes Trust an updated agreement will be sought.

4. Uncorrected immaterial misstatements and reclassifications

Unadjusting journals

			SOFA		Balance Sheet		
No.	**DR/CR**	**Details**	**DR**	**CR**	**DR**	**CR**	**Effect of SOFA**
1	DR	Audit fees	12,722				(12,722)
	CR	Audit fee provision				12,722	
		Adjustment for under provision of audit fee accrual					

4. Sector update

Webinar Recordings – issues in the non-profit sector

We produce an ongoing blog-style discussion series – “Charity Chats” – which are short 10-minute features on topical matters. The recordings can be accessed through these links:

Charity chats: too many charities – what does the future hold?

Charity chats: ethical investments – is this a momentous new judgement?

Charity chats: how well are charities served in parliament?

Charity Chats: Founder syndrome and trustee motivations

Charity Chats: Should trustees be paid?

Charity Chats: Financial Reporting – are charity accounts useful?

Charity Chats: reflections on 2022 and thoughts for 2023

Charity Chats: cybercrime, fraud and social media

Charity Chats: multi-funder challenges and unleashing the power of civil society

Charity Chats: Is the Charity Commission changing its approach – and will it be helpful to the sector?

Charity Chats: Trust, kindness and “the weaponisation of the Charity Commission”

4. Sector update (continued)

THE CHARITY SORP

Following the delay to the triannual review of FRS 102 and FRS 105, the next iteration of the Charities Statement of Recommended Practice (SORP) is expected to be implemented from 1 January 2026, so for most charities this will be applicable for the first time in the year ended 31 December 2026 or 31 March 2027. Feels like a long way away, but when a new SORP is applied for the first time it is "retrospectively applied" so this will require restatements for the comparative period and an opening balance sheet as at the start of the prior year (so 1 January 2025 or 1 April 2025). Suddenly, not so far away.

Back in January 2022, the SORP Committee (the body responsible for developing the next iteration) issued an overview document that introduced four drafting aims as "themes" for the next SORP, as follows:

- Considering key readers and explaining social purpose
- Compliance with FRC requirements and changes since the last SORP
- Promoting consistency across the Sector
- Relevant to charities and their socioeconomic context

and then provided more detailed context on eight drafting principles to underpin the next SORP:-

Principle 1 - the majority of preparers using the SORP are volunteers, advisors or practitioners assisting smaller charities and so in writing the SORP we will keep the needs of smaller charities in mind and seek to provide clarity to enable practitioners to understand the requirements of, and good practice recommendations made by, the SORP. As far as practicable and to the extent that accounting standards permit the SORP will be written with language and terminology that is clear and not overly technical to a practitioner who is otherwise familiar with basic accounting concepts and terms.

Principle 2 - to provide guidance to assist practitioners to prepare accounts that give a 'true and fair' view in accordance with current GAAP including addressing any charity specific matters not addressed by GAAP.

Principle 3 - when making changes to the reporting and accounting requirements to have regard to the potential impact of those changes on the public's continuing support for the legitimate charitable endeavour and to the practical challenges of addressing public perception of charities' reporting and accounting practices.
Principle 4 – to ensure that the narrative reporting requirements address the interests of the main users of the report and accounts.

Principle 5 - to innovate by introducing or changing reporting requirements where this is necessary to either assist practitioners or meet the needs of the main users of the report and accounts and to reduce the need for additional bespoke requirements by any charity law jurisdiction adopting the SORP.

Principle 6 - to disseminate good practice reporting where the SORP Committee recommends that this is in the best interests of the sector as a means of helping the wider charity sector and practitioners to meet the needs of the main users of the report and accounts.

Principle 7- to reflect the requirements of charity law and company law as they apply to reporting and accounting by charities in those jurisdictions adopting the SORP.

4. Sector update (continued)

THE CHARITY SORP

Principle 8 - to take account in our decision-making on any changes to the reporting and accounting requirements and recommendations of the SORP of both the potential value of the information to the user and the demands placed on the preparer of making those changes or recommendations.

As we move into the period of time where a new draft SORP will be issued for consultation it appears areas such as “a further tiering of charitable organisations by size for reporting” (where smaller Charities could see reduced disclosure, whilst larger entities could experience more PLC type reporting requirements), “future proofing the SORP for ESG, sustainability and digital innovations” and considering “comparability” (will the discussions around a “one page key facts statement for all charities” remain) will all need to come to the forefront and be concluded upon.

FRS 102 and FRED 82

The financial reporting exposure draft (“FRED”) 82 from the FRC completed its consultation period, closing on 30 April 2023, in relation to its proposed changes to the UK accounting framework including FRS 102.

Underlying the Charities SORP is the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102). The SORP provides guidance for charities on how to apply FRS 102 in order to ensure that charity accounts are ‘true and fair’. FRS 102 also takes precedence over the Charity SORP.

In relation to Charities,it appears the proposed changes will have three key considerations for the future of the annual Financial Statements:-

•Incoming resources - FRED 82 proposes the introduction of a five-step model for revenue recognition in FRS 102. The model will be based on the requirements of IFRS 15 'Revenue from Contracts with Customers', but with simplifications aimed at ensuring the requirements remain cost-effective to apply. Many charities have diverse sources of funding, including income from charitable activities, donations and legacies, where funds are given freely. However, some transactions such as contracts and sales in the financial statements could be impacted by the FRED 82 updates. It is hoped that any update here will be accompanied with sector specific guidance for Charities, alongside the SORP.

•Leases - Leasing requirements in FRS 102 are set to change significantly. An IFRS 16 'leases'-based model has been proposed, requiring lessees to recognise all leases on the balance sheet, subject to limited exemptions. This change could be very onerous, with an on-balance sheet “right to use asset” which will then be amortised over the length of the operating lease being the likely outcome here for all Charities to consider.

•Other feedback - The FRED 82 consultation also notes that there may be changes to the length, complexity and detailed nature of the notes to the financial statements (further exemptions may be provided from drafting comparative notes in certain areas for example). This would be welcome news for many Charities (including conversations we have had with many clients regarding the ever increasing length of the financial statements) and particularly those with complex fund structures including unrestricted, designated, restricted and endowment funds.

4. Sector update (continued)

Fundraising and Governance Updates

Gift acceptance issues for fundraising charities

Charities are obliged to accept donations unless they have a very strong reason not to. This was an issue with The President's Club affair, where it was difficult for some of the charities involved to return donations, even when public opinion believed they should do so.

This can be an issue with ESG considerations in fundraising. A number of trusts and foundations have chosen to declare a climate emergency, which will have implications for the types of organisations they will accept donations from and additionally provide donations and grants to. This list of exclusions moves beyond previous exemptions of tobacco and the arms industry. If an oil or gas giant, for example, wished to make a sizeable donation with naming rights, how would the charity deal with the issue?

Addressing Environment Social and Governance challenges

"ESG" are three letters with growing significance for the corporate sector and this is starting to be seen across the nonprofit sector too. Consumers and employees are increasingly expecting that companies consider purpose as well as profit. These same individuals may be donors of charities and will start to apply the same views to their giving. The Social Value Act already imposes ESG principles into how statutory commissioners contract with providers, so many charities who may also look to provide services under these agreements will already be thinking about ESG matters. Charities also need to start to consider their greenhouse gas emissions in more detail beyond SECR, including Scope 3 emissions that are created through third parties as a result of charitable activities, such as donors driving to a fundraising event, rather than using public transport or cycling.

Next Steps for the Charity Governance Code ("CGC")

The Charity Governance Code is a practical tool to help charities and their trustees develop high standards of governance and a number of charities use this Code as a framework for a full external governance review of their organisation.

The Charity Governance Code steering group has had a new Chair since the middle of 2022. Radojka Miljevic has recently shared her first blog, where she reflected on the future of the Code, and talked about the importance of frameworks and the value of hearing from a wide range of voices.

Radojka also looks at the future of the Code, which will be reviewed in 2023. She shares her thoughts on key governance challenges, including:

- digital and cyber concerns;
- our wider environment;
- our engagement with nature and the climate; and
- social changes from power dynamics to wellbeing.

It would be an excellent governance development if more charities in the sector embraced the CGC and referenced it in their work (along with any changes as a result of the reviews completed) and in their trustees' annual report.

4. Sector update (continued)

CC8 – Internal Controls

The Charity Commission has recently updated its guidance on internal controls, known as CC8. This is a longstanding piece of guidance which had not been updated since it was first published in 2012. It provides invaluable guidance to trustees and senior management teams around the operation of a charity's internal controls. Whilst the existing guidance covered many relevant areas, the regulator has acknowledged that there are a number of new issues and threats which were not relevant when the previous guidance was published. The guidance also includes a refreshed checklist which can be used to benchmark systems and processes.

What has changed?

The guidance includes a new section on donations of cryptoassets, such as bitcoin and NFTs. It sets out a number of risks associated with cryptocurrencies, and emphasises the importance of charities understanding those risks before accepting donations of cryptoassets. If such donations are accepted, there are a range of recommendations including having a policy in place on the acceptance of cryptoassets, the need to ensure that any platform used is compliant with UK regulations, the requirement to keep accurate records of donations and the importance of following HMRC guidance around the taxation of cryptoassets.

A further new area addressed is around the risk of cybercrime, an area which become significantly more prominent in recent years. The guidance focuses on the need to ensure there are suitable policies in place, for example in relation to storage and processing of electronic data. As in a number of areas, it cross-refers to more detailed guidance on this topic issued by the Charity Commission.

The guidance has also been updated for other areas which have become relevant since 2012, such as the use of mobile payment systems (for example Google Pay or Apple Pay). In addition to the new areas, the guidance also includes a refresh on advice for more traditional risks – for example, those around fundraising and holding public collections, making payments to related parties and operating internationally. A number of these have been recent areas of focus for the Charity Commission.

What should you do?

We recommend that relevant individuals utilise CC8 to assess how your charity's policies, systems and processes compare to the guidance. The guidance is most relevant for senior members of the finance team and the charity's treasurer, but an awareness of the guidance will be helpful for a range of individuals involved in charity finance. The guidance can also form helpful reading as part of an induction pack.

We suggest using the internal controls checklist to benchmark processes at least annually. Completing the checklist periodically can be a helpful way of focusing on systems and processes; but note the checklist does not assess the underlying quality of the controls in place. However, it is a helpful way to review the core controls in place and an excellent starting point to benchmark what is in place.

4. Sector Updates (continued)

Cyber Crime

The charity and non-profit sector is recognised as one of the top 5 in terms of cyber attack risk and level of impact. So much so, that the National Cyber Security Centre (NCSC) convened a special threat report in January 2023, specifically focused on the UK charity sector. The report can be found here - Small Charity Guide - NCSC.GOV.UK

Within the report, Helen Stephenson (Chief Executive, Charity Commission for England and Wales) says, “All charities ultimately rely on public trust and continued public generosity.” The impact of any cyber attack on a charity can therefore be devastating, not just for the organisation and those who rely on its services, but also in undermining public confidence and support.

There are 169,029 registered charities in England and Wales with an annual sector revenue value of £99.7 billion. All of these charities collect huge volumes of data from donors through to beneficiaries, and a significant number of these share data with external organisations such as marketing companies or donor management providers. It is therefore quite easy to see the motives for direct attacks on charities and cyber criminals aim to access charities’ networks and/or information through the supply chain.

The Department for Science, Technology and Innovation reported some alarming statistics in 2023:

- 24% of charities had been victims of cyber breaches or attacks in the last 12 months
- Higher income charities were significantly more likely to record breaches or attacks: 56% for those with annual revenue of £500K, or more, and 76% for those with revenues of £5m, or more.
- 785,000 known cyber attacks on charities in the last 12 months

Furthermore, the 2022 NCSC Security Breaches Survey found that, in terms of prioritization of cyber security as a core area of focus, charities are 5-6 years behind private businesses. On that basis, it is essential for the sector to increase its commitment and awareness of cyber threats, and to ensure that, going forwards, adequate risk measures, training and technical controls are implemented.

Charities must factor in the responsibilities of trustees, in respect of their heightened data privacy and security responsibilities. Currently, per the NCSC Survey, only 33% of charities have trustees taking responsibility for cyber security.

The Board is ultimately responsible for making sure a charity is taking appropriate measures to protect itself from a cyber attack (***not*** the IT team) and taking steps to stay secure online is deemed to be a core component of good governance. Trustees don’t need to be technical experts but they do need to know enough about the importance of cyber security, to facilitate educated discussions and collaboration with key staff, volunteers and stakeholders.

In summary, the risks to all charities from cyber-crime are increasing in terms of impact, significance, cost and repercussions. The nature of the sector model and its reliance on financial donations (often processed by a third-party), means that all organisations need to be aware of (and guard against) the cyber threat.

Further information on the role of trustees can be found here: DATA PRIVACY: Understanding the responsibilities of the Trustee - MOORE ClearComm

.

4. Sector Updates

Fraud in the Charity Sector

According to the latest BDO Charity Fraud Report, the level of financial fraud at charities is up 36% with almost half of all frauds being committed by staff members, volunteers or trustees.

Detecting fraud is considered very challenging but with the introduction of the Economic Crime and Corporate Transparency Act it is becoming all the more important that the Charites have robust systems procedures and controls in place to demonstrate they have done their level best to mitigate against this risk.

According to the BDO report, Charities that experienced losses of £10,000 or more, in 2023, doubled according to 43% of charities. Respondents who lost between £100,000 and £1m accounted for 12% of these, with 2% reporting over £1m lost due to fraud.

The most common fraud, according to the report, was the misappropriation of cash or assets with 42% of charities suffering from theft in 2023, followed by expense and subsistence fraud at 35%.

Alongside our own Moore Kingston Smith specialists in this area, the sector has developed a suite of tools, guides and blogs which are worth a visit. The Charity Commission, with the Fraud Advisory Panel, also run a campaign called Charity Fraud Awareness Week. All are designed to ensure you are aware of the vulnerabilities that exist and provide help.

This area is notoriously fast moving, with new areas of attempted fraud arising daily, but some of the prevalent current frauds and potential controls to protect your charity from these, include:

“Supplier mandate fraud”

Contact is made from a “supplier” employee who is noting (either by phone or official headed notepaper) a change of bank details. The bank details are fraudulent.

Control to mitigate the risk – review and approval of all standing data supplier changes and calls to confirm BEFORE updates processed.

“Batch supplier duplication”

An example of an internal fraud – the details of a supplier are duplicated onto the system and the duplicate given the fraudulent parties bank details. “Real invoices” are paid twice, hidden in the batch run, once real and once fraudulent.

Controls to mitigate the risk – Approval of new suppliers and monthly management accounts reviews. The additional payment debit will need to be either to a balance sheet code or will be seen through an inflated expense code on the SOFA.

“Fraudulent staff/temp staff costs”

The fraudulent party continues to pay staff after they have left (using updated fraudulent bank details), enrols ghost employees for payment or processes fake invoices through “busy” nominal codes such as temp staff costs.

4. Sector Updates

Controls to mitigate the risk - This fraud is almost always discovered through a review of management accounts vs budgets. Preventive controls would include approval of staff detail changes and "lock down" on leavers details in a timely fashion.

"Email takeover"

An internet-based fraud that is expanding rapidly (and becoming more sophisticated). The finance team receive an email "from" the FD/CEO usually late afternoon, indicating they have forgotten to pay a key supplier and it should be paid immediately.

The email is fraudulent and so are the bank details given.

Controls to mitigate the risk – Communication by phone or face to face to confirm details. Do not allow payments to supplier details that do not match those saved on the standing data.

Further information can be found at the following:

The Fraud Advisory Panel (a registered charity and independent voice of the anti-fraud community) - https://www.fraudadvisorypanel.org/

10 questions every Trustee should ask about Fraud and suggested policies - https://www.gov.uk/guidance/protect-your-charity-from-fraud

The National Cyber Security Centre - https://www.ncsc.gov.uk/news/advice-thwart-devastating-cyber-attacks-small-charities

Action Fraud for reporting - https://www.actionfraud.police.uk/

BDO Prevent Charity Fraud report: Home Page - Prevent Charity Fraud

4. Regulatory Updates

Minimum standard for Audit Committees Published

The FRC has published a minimum standard for Audit Committees and the External Audit. The need for a standard was highlighted through the Government's Restoring Trust in Audit and Corporate Governance. When the FRC becomes ARGA (Audit, Reporting and Governance Authority), they will be given the statutory powers to mandate minimum standards for audit committees. Whilst the standard will apply to FTSE 350 companies we would recommend that Audit Committees should refer to the guidelines, consider if they should adopt any or a modified form of any of the requirements, as examples of good governance. The standard will be voluntary until ARGA has been established. The standard can be found Audit Committee Minimum Standard (frc.org.uk)

FRC launches a consultation on revisions to the UK Corporate Governance Code

The FRC has launched a consultation covering its review of the UK Corporate Governance code. Here are five priority areas of focus:

- Aligning the code with the changes to the legal and regulatory requirements, including strengthening reporting on directors' remuneration on malus and clawback arrangements.
- Revising the parts of the Code which cover the framework for prudent and effective controls to provide a stronger basis for reporting and evidencing their effectiveness.
- Including responsibilities for sustainability and ESG reporting and appropriate assurance.
- Reflecting the Minimum Standard for Audit Committees.
- Improving comply or explain functioning where reporting is currently weaker.

The consultation closes on 13 September. The paper can be downloaded from Consultations | Financial Reporting Council (frc.org.uk)

5. Other matters

Engagement & Independence

Our engagement objective was the audit of Bradford Hospitals' Charity.

We have implemented policies and procedures to meet the requirements of the Financial Reporting Council's (FRC) Ethical Standards. To this end we considered our independence and objectivity in respect of the audit for the period under review before commencing planning our audit and communicated with you on these matters in our audit scoping report dated 18 December 2023.

No other matters have come to our attention during the audit which we are required to communicate to you and the safeguards adopted were as described in our audit scoping report.

Qualitative aspects of accounting practices, accounting policies and financial reporting

Based on our audit work performed, we believe that the Trustee's Report and financial statements for the period under review comply with United Kingdom Accounting Standards and the Charities Act 2011.

During the course of our audit of the financial statements for the period under review, we did not identify any inappropriate accounting policies or practices.

Matters specifically required by other Auditing Standards to be communicated to those charged with governance

Other than as already explained in our Engagement Letter, and this Post-Audit Management Report, there are no other specific matters to communicate as a result of our audit of the financial statements under review.

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Annual Report and Accounts 2022 – 2023

Bradford Hospitals Charity
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Bradford Hospitals Charity is the official NHS charity for Bradford Teaching Hospitals NHS Foundation Trust

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The Trustee Report below aims to provide sufficient information to understand the Charity, its purpose, and how it has performed during the year.

1. Chairman and Board Members Foreword

On behalf of the Trustee of Bradford Hospitals Charity ("the Charity"), we are pleased to present the Charity's Annual Report and Accounts for the year ended 31 March 2023.

This document provides an overview for stakeholders and interested parties of what the Charity has achieved during 2022/23. This Annual Report, including the Trustee Report and Accounts has been prepared in accordance with accounting policies set out in the notes of the accounts and complies with the Charity's governing document (the Trust Deed) the Charities Act 2011 and the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" ("FRS 102").

The Charity is committed to enhancing the care and treatment of patients and improving the health of local people. The Charity works with Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") to improve health and healthcare across the Bradford City Region. We are proud that the general public trust us to invest in projects that are over and above the responsibility of the NHS and exchequer.

During 2022/23, the Charity funded projects that improved patient services, and helped staff practically and emotionally, so they could continue their life-saving work. A new initiative the Charity undertook this year was the Ramadan Allies project, created by the Spiritual, Pastoral and Religious Care (SPaRC) team to support our Muslim colleagues through their periods of fasting and spiritual growth. The Charity supported managers in the hospital in understanding the needs of their staff by supplying information and pointing out when their staff needed to take time out to pray. We worked hard with our SPaRC team to deliver this fantastic initiative.

The Charity also successfully invested in many well-being initiatives to support young children, working on the 'fear' of coming to hospital. The Charity purchased Virtual Reality kits as a distraction tool when having blood taken, and feedback from nurses and staff tells us this initiative is working well in calming children down.
An initiative the Charity continues to fund, and support is 'Baggins the Bear'. Purchasing small teddy bears to give to children before they come into hospital has also helped to lessen the fear of entering the hospital for an operation. This project has seen operations increase from 7 to 10 per day because the child and family are less daunted by the experience. The family feedback has been some of the best the hospital has seen, and cancellations have almost disappeared.

I want to thank the fantastic individuals and corporate supporters who enabled all this work to be delivered by financially supporting the Charity's work. You have made an enormous difference to our staff in feeling supported at a significant time of year.

2. Review of activities

2.1. Review of the year

During the year, funds were used to enhance service provision for the benefit of both patients and staff. The Charity received a large number of very generous donations from many parts of the community and as a result of this generosity; the Charity purchased a number of items of equipment for the wards and departments to support staff and patients, including:

- Double scalp cooling machine for patients undergoing chemotherapy at the Meadows unit at Eccleshill Hospital

- Menopause balance application licences, that provide medically approved content for support with the menopause
- 12 benches for outdoor spaces for staff to relax and unwind
- Virtual reality goggles to provide a soothing distraction and prepare younger patients for their upcoming treatment
- Art and craft materials to distract young people whilst in hospital by engaging them in fun activities

2.2. Our Strategic Objectives

The Charity has as its sole objective to use its funds:

For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust

The Corporate Trustee considers that this objective does not unreasonably restrict access to charitable benefits within the scope of the Declaration of Trust. The Corporate Trustee of the Charity seeks to achieve this objective, considering general guidance, by two main routes:

1. The Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality.

2. Staff throughout the organisation identify small but valuable differences where the fund monies can deliver benefits to patients and staff, such as attendance at extra training courses or conferences.

2.3. Activities for public benefit

Thanks to the continued generosity of our supporters, the Charity has continued to develop and during 2022/23 the Charity spent £1,046,105 (£548,600 in 2022) in the following ways:

	2023 £000	**2022 £000**
Medical equipment	503~~2~~	34
Staff education and welfare	94	221
Patient welfare	210~~1~~	134
Other activities	61	37
Raising funds	178	122
Total	**1,046**	**548**

2.4. Fundraising

The Charity is registered with the Fundraising Regulator and abides by their codes of conduct and their fundraising promise, which ensures that our fundraising is legal, open, honest, and respectful. The Charity has a fundraising team that is compliant with the recognised standards of fundraising as well as those required under charity law and wider law. Controls are in place to ensure any fundraising is within the Fundraising Code of Practice. It is inevitable that fundraisers will come into contact with people who may be in a vulnerable circumstance or need additional support to make an informed decision. If a fundraiser reasonably believes that

an individual is unable to decide, then they will not accept a donation from that person. The fundraising team use a checklist to help identify signs that an individual may be in a vulnerable circumstance.

The fundraising team have a policy where they get to know their donors by sending out relevant and often personalised communications. They also give individuals clear information and opportunities to change how, when and if they want to hear from the Charity and follow the General Data Protection Regulation (GDPR) principles. The Charity raises funds to enhance the care and treatment of local patients and those who care for them. The Charity has not used any professional fundraisers and has not received any complaints. Fundraising record-keeping and monitoring are coordinated through the Harlequin Customer Relationship Management (CRM) system.

This financial year saw the appointment of a Charity Director - a substantive role put in place to lead the Charity to success. The aim is to grow the Charity's income, profile, and fundraising team. The Charity has had a successful year and to maintain this needs to build continuous support from donors.

An immediate aim is to increase our profile within the Bradford Community. Next year, the Charity will showcase a new events calendar that will be key to increasing donor support, internally and externally. As the Charity advances, we aim to work more closely with our NHS teams to raise money and further support projects from a broad range of services.

In November 2022, the Charity launched the '100 Club', a membership aimed at Business and Community groups, to bring in £1,000 per member per year. Retention and stewardship of these members are both crucial factors in securing success. The Charity expects to grow more income from these relationships as many will take up 'Charity of the Year' as part of their fundraising activities, and we hope to organise events to provide all members with a networking opportunity.

This year legacy donations increased significantly compared to previous years; this type of income is an unpredictable area of fundraising. The long-term aim is to develop legacy fundraising by employing a legacy fundraiser.

The large donation from Sovereign Healthcare towards the Da Vinci Robot was a welcome donation towards a significant, transformational project for the Urology department. We hope to enhance services by providing more equipment and support service innovation.

This year, we were awarded a Development Grant from NHS Charities Together to support infrastructure work; we have decided to invest this money into a new, better-functioning website, refresh our current branding to include new brand guidelines and a new fundraising database, with more time-saving functionalities. This investment will ensure we can move forward with current plans making it easy for donors to support our work.

We hope to continue expanding the diverse income streams and increasing income in all the key areas, such as Community, Corporate Giving and Trusts and Foundations. It is also essential to focus on 'in aid of giving' and regular giving. This is an exciting time for the Charity with our focus being on:

- Delivering for our beneficiaries
- Fundraising opportunities
- Creating new opportunities through our existing and new networks.

As the Trust develops its volunteer service, the Charity will work with the volunteer's team to create opportunities for a wide range of individuals. Volunteers are the backbone of any charity, and a great area of support for the Charity. The Charity will create a robust volunteer process, with clear guidelines and make internal adjustments to onboard the volunteers promptly and safely.

The Fundraising team will continue to raise awareness of the Charity through its digital channels; social media will be our focus next year and something we look forward to developing as we grow. Understanding the Charity's work is critical to building a strong following in these current times. We have had many articles and local PR stories in the local press. There is an expectation of a high online presence with many public followers, and we have made some improvements in some critical areas. We now have 'Facebook Giving', a valuable and accessible platform for supporters to donate and we have introduced QR codes, making it easy for people to access our website's donate page.

3. Financial Review

3.1. Summary

The net assets of the Charity as at 31 March 2023 were £2,137,552 (compared to £2,217,902 in 2022).

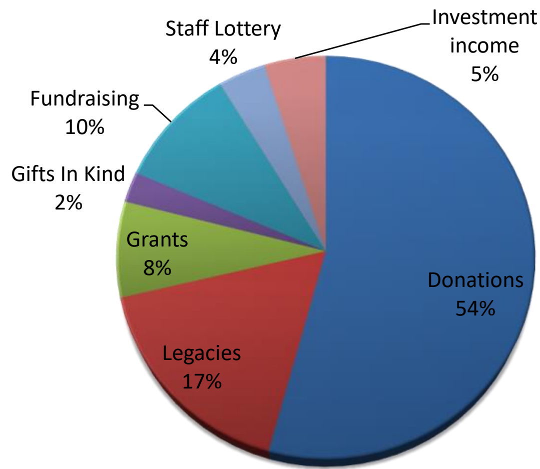
During the year, income (excluding unrealised and realised investment losses) was £1,057,247, an increase of £755,002 on the previous year, £302,245. Total expenditure for the year was £1,046,105, which represents an increase of £497,505 on the previous year, £548,600. This resulted in excess income over expenditure of £11,142 which, together with realised and unrealised gains and losses from the investment portfolio totalling £91,492, has led to an overall decrease in net assets of £80,350. The Charity will only fund items when it has cash available. It also has funds in reserves to cover operating costs.

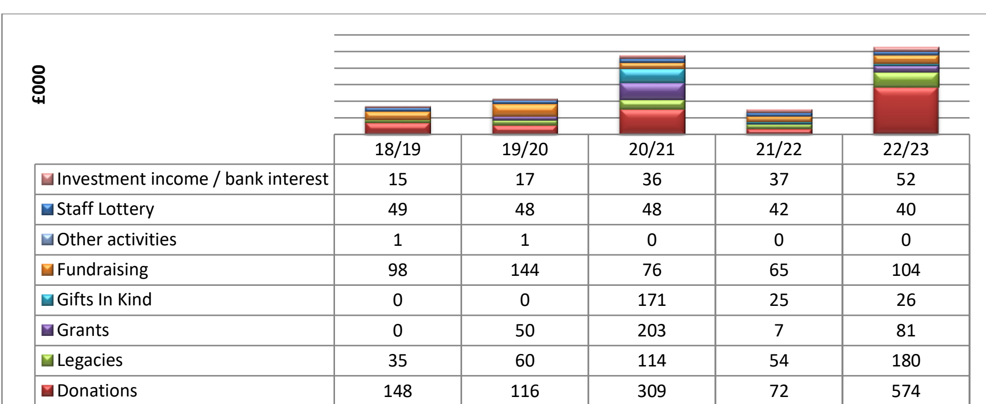
The Charity continues to rely on donations, fundraising, legacies, and investment income as the main sources of income. Fundraising income has gradually started to increase to near pre-pandemic levels. The Charity continues to invest in its growth to secure long term sustainable income.

The Charity uses Rathbones Investment Management to manage its investments and also holds an investment with The Charles and Elsie Sykes Trust. For this financial year, there has been a realised and unrealised loss on investments of £91,492 (£74,064 unrealised gain in 2022).

The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts.

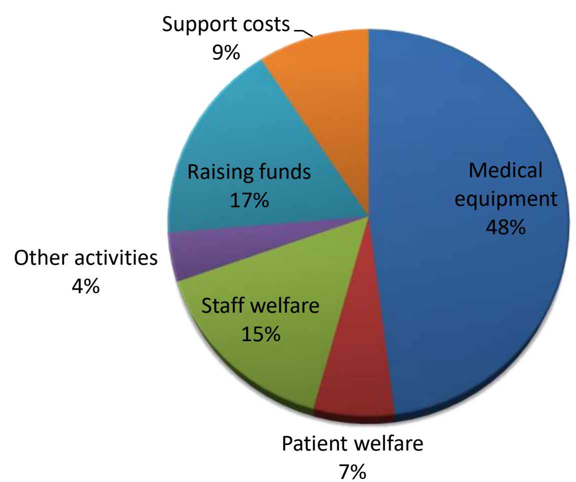
3.2. Sources of Income for the Charity 2022/23 (£000)

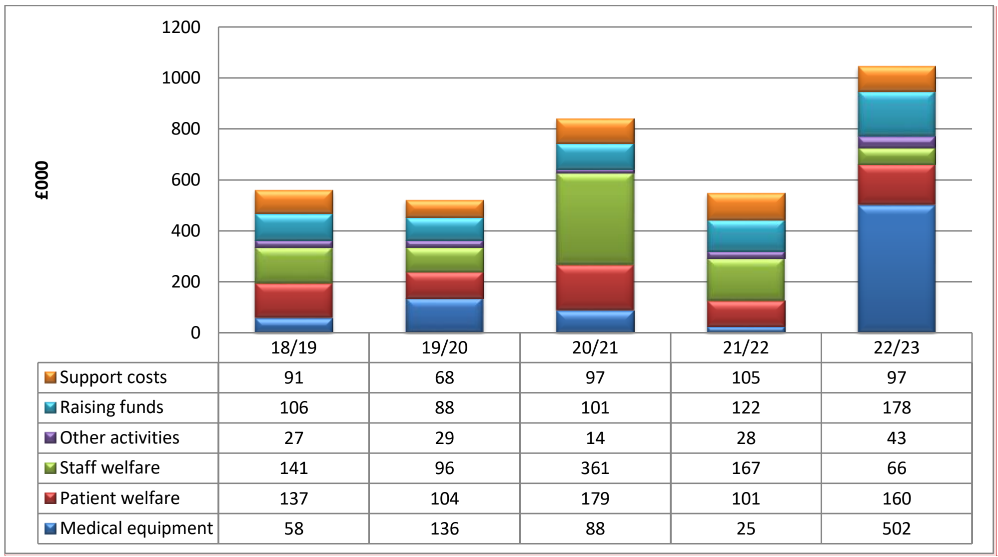




	18/19	19/20	20/21	21/22	22/23
Investment income / bank interest	15	17	36	37	52
Staff Lottery	49	48	48	42	40
Other activities	1	1	0	0	0
Fundraising	98	144	76	65	104
Gifts In Kind	0	0	171	25	26
Grants	0	50	203	7	81
Legacies	35	60	114	54	180
Donations	148	116	309	72	574

3.3. How funds were spent 2022/23 (£000)





	18/19	19/20	20/21	21/22	22/23
Support costs	91	68	97	105	97
Raising funds	106	88	101	122	178
Other activities	27	29	14	28	43
Staff welfare	141	96	361	167	66
Patient welfare	137	104	179	101	160
Medical equipment	58	136	88	25	502

Commented [PT1]: Q - Auditors - Note 3 should be 503 for medical equipment.

A. this table is showing direct charitable activities and the support costs separately, so whilst ME is £503k in total, £502k is the charitable activity and £1k is the support cost which is in the £97k

4. Structure, governance, and management

4.1. Corporate Trustee

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to NHS Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee ("the Committee"), which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity.

Members of the Trust Board of Directors are not individual Trustees under Charity Law but act as agents of the Corporate Trustee. The Board of Directors approves which members become the agents of the Corporate Trustee and are introduced to the Charity through Board standing orders / Executive Leads.

The following members of the Board of Directors served on behalf of the Corporate Trustee during the year:

Maxwell Mclean (Chairperson)
Altaf Sadique (Non-Executive Director and Deputy Chair)
Mel Pickup (Chief Executive)
John Holden (Director of Strategy & Integration / Deputy Chief Executive)
Karen Dawber (Chief Nurse)
Matthew Horner (Director of Finance)
Julie Lawreniuk (Non-Executive Director)
Mohammed Hussain (Non-Executive Director)
Karen Walker (Non-Executive Director)

The Charity General (unrestricted) Fund was established using the model Declaration of Trust, and all funds held on trust as at the date of registration (April 1997) were either part of this unrestricted fund or registered as separate designated funds within the Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund, and by designating funds the Corporate Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers, and staff.

4.2. Charity Operational Committee

The Charity Operational Committee meets every two months and is a Committee of the Charity. Its purpose is to give additional assurance to the Committee that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the Charity's own governing document. It does not remove from the Committee the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary.

Membership:

Chair:
Director of Strategy & Integration / Deputy Chief Executive
Members:
Associate Director of Corporate Governance / Board Secretary (Deputy Chair)
Charity Director
Deputy Finance Director
Assistant Director of Finance
Head of Charity Operations
Head of Fundraising
Charity PR and Communications Officer
AHP Representative
Nurse Representative
Doctor Representative
Manager Representative
HR Representative
Estates and Facilities Representative
Representative of each of the Four Funds (Sunshine, Childrens, Cancer and Dementia & Elderly)

4.3. Structure of funds

The primary issue to be considered in any expenditure decision is whether the expenditure is within the scope of the objects of the Charity. Charitable purposes within the NHS translate to prevention or relief of sickness, disease or human suffering of patients served by the NHS. This does not preclude expenditure on staff as long as the benefit to staff translates demonstrably to relief of sickness of NHS patients.

The Charity has a decision making and approval process whereby an expenditure form needs to be completed. The expenditure form is structured in sections covering the key principles that fund holders need to consider and includes the requirement for the appropriate authorised signatories.

The Charity has started an exercise to rationalise the existing trust funds into four main funds - Sunshine, Childrens, Cancer and Dementia & Elderly. A fifth fund ('Other') has also been set up for funds that are related to governance and admin. Over the next two years, the intention is to merge the existing trust funds into one of the four new funds.

The General Fund

This comprises of gifts received by the Charity where no particular preference as to their expenditure has been expressed by donors.

Designated (earmarked) Funds

Under the new structure, this will be the Childrens, Cancer, and Dementia & Elderly. These usually contain donations where the donor expressed a preference to benefit a particular department or activity of the Trust at the time of making the donation. This preference can also include benefit to staff welfare, thereby enhancing both patient care and public benefit.

Whilst the donor's preference is not binding on the Corporate Trustee, the designated funds reflect these preferences. The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area. Fund holders' recommendations are generally accepted, and these funds can be spent at any time.

The funds available for spending are allocated to specialties within the Trust's clinical management structure.

Restricted Funds

This comprises of gifts received by the Charity where a specific instruction as to their expenditure has been expressed by donors. These funds must only be used in accordance with specific restrictions imposed by the donor. At present, the Charity has one restricted fund, which was primarily established for the grants received from NHS Charities Together.

Endowment Funds

The Charity has "Capital in Perpetuity" (CIP) funds, which consist of five expendable endowment funds and one permanent endowment fund (which cannot be spent). These funds provide investment income.

4.4. Public benefit

The Corporate Trustee conducts its activities with regard to the Charity Commission guidance on Public Benefit in section 4 of the Charities Act 2011.

The key principles of public benefit are:

- there must be identifiable benefit(s); and
- benefit must be to the public or to a section of the public.

The Corporate Trustee seeks to meet these principles in a number of ways. It has established a system of expenditure approval that ensures proper consideration is given to what the benefits of its activities are and who will benefit. The Corporate Trustee considers that, because its activities are patient focussed and contribute to the health of NHS patients, it clearly provides public benefit. In providing public benefit the Corporate Trustee is careful to ensure that its activities do not unreasonably restrict access to charitable benefit within the scope of Declaration of Trust or cause any detriment or harm. Charitable funds may be used to partially fund staff welfare and professional education / training, where this is in addition to the provision ordinarily afforded by the NHS. As professional education / training can also be a personal benefit, care has been taken to establish that this is incidental to the patient benefit. These requests demonstrate a direct link between professional education / training and the benefit for Bradford patients. To minimise risk and restrict harm, medical equipment purchases are made through the Trust's procurement processes, which help to ensure compliance with legislation, including Health and Safety and Equality and Diversity.

Staff appointments are subject to the Trust's policies and procedures to reflect good practice in recruitment and retention. The members of the Board of Directors receive a comprehensive induction upon their appointment to the Trust; this includes relevant information regarding the Charity and the Committee. Specific training regarding the duties of trustees has been paused during the pandemic but is being planned to take place again during 2022/23.

4.5. Governance

The Charity is constituted by trustees incorporated as a body and is governed by a Declaration of Trust of 25 March 1997. This is the formal document which sets out information on what the Charity is set up to do (objects), how the Charity will do this (powers) and administrative provisions.

Acting for the Corporate Trustee, the Committee is responsible for the overall management of the Charity and is required to:

- control, manage and monitor the use of the Charity's resources;

- provide support, guidance, and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income, ensure that "best practice" is followed in the conduct of all its affairs fulfilling all its legal responsibilities;
- ensure that the approved investment policy approved by the Board of Directors as Corporate Trustee is adhered to, and that performance is continually reviewed, and ethical considerations are applied; and
- keep the Board of Directors fully informed on the activity, performance, and risks of the Charity.

These are all included in the Committee's terms of reference. The accounting records and the day-to-day administration of the Charity are dealt with by the finance department of the Trust. These costs are re-charged to the Charity. The Charity has policies on expenditure, investments and reserves as well as guidelines for fund holders.

4.6. Day to day management of the Charity

The Director of Strategy & Integration / Deputy Chief Executive, John Holden, has day to day responsibility for the management of the Charity.

Matthew Horner, Director of Finance, is the Executive Director with overall responsibility for financial management and accounting for the Charity during the year. Matthew Horner can personally approve, on behalf of the Corporate Trustee, all expenditure over £500, with an upper limit of £10,000, using his delegated authority. For expenditure from £10,000 to £50,000, approval must be obtained from the Chief Executive of the Trust. For any expenditure over £50,000, approval needs to be obtained from the Chairperson of the Trust. For any expenditure over £100,000, approval needs to be obtained from the Corporate Trustee.

Michael Quinlan, Deputy Director of Finance, acted as the principal officer overseeing the day-to-day financial management and accounting for the Charity during the year.

Principal office

Bradford Hospitals' Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Principal professional advisers:

Auditors	Investment Advisors	Bankers
~~To be confirmed~~	Rathbone Investment Management	HSBC
Moore Kingston Smith LLP	Port of Liverpool Building	47 Market Street
6th Floor	Pier Head	Bradford
9 Appold Street	Liverpool	BD1 1LW
London EC2A 2AP	L3 1NW	

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4.7. Board of Directors

The Charity has a Corporate Trustee, the Trust. The members of the Trust Board of Directors who served during the financial year and up to the date of signing of the financial statements were as follows:

Executive directors:

Name	Role	Appointed	To
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer / Deputy Chief Executive	12/10/2020	Present
Ms Pat Campbell*[1]	Director of Human Resources	01/12/2008	31/03/2023
Professor Karen Dawber	Chief Nurse	29/08/2016	Present
Mr John Holden	Director of Strategy and Integration / Deputy Chief Executive	22/08/2016	Present
Mr Mark Holloway*	Director of Estates and Facilities	06/07/2020	Present
Mr Matthew Horner	Director of Finance	01/08/2012	Present
Dr Paul Rice*	Chief Digital and Information Officer	01/01/2021	Present
Dr Ray Smith	Chief Medical Officer	01/01/2021	Present
*Non-voting Executive Director [1]Ms Pat Campbell retired on 31 March 2023			

Non - executive directors:

Name	Role	Term start	Term end
Dr Maxwell Mclean	Chairman	01/05/2019	30/04/2025
Professor Janet Hirst	Non-Executive Director	13/09/2021	Resigned 31/01/2023
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	31/08/2025
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2025
Ms Sughra Nazir	Non-Executive Director	20/01/2022	19/01/2025
Mr Jon Prashar	Non-Executive Director	01/02/2018	31/01/2024
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2023
Mr Barrie Senior	Non-Executive Director	01/12/2017	30/11/2023
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2023

Reference and administrative details

The Charity, registered charity number 1061753, was entered on the Central Register of Charities on 09 April 1997. The name of the charity changed from 'Bradford Teaching Hospitals NHS Foundation Trust Charitable Fund' in August 2014 to 'Bradford Hospitals Charity', with no change being made to the objectives of the Charity.

The Charity consists of 158 funds as at 31 March 2023 (2022: 160), and the notes to the accounts distinguish the types of funds held and disclose separately all material funds (funds with balances over £50,000). The funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Trustee.

4.8. Investments policy and performance

The Charity uses Rathbone Investment Management to invest the funds of the Charity. The assets of the Charity must be invested in accordance with the declaration of Trust and are governed by the Trustee Act 2000. The investment policy addresses the needs of the Charity and its beneficiaries in the short, medium, and long term by aiming to balance both capital growth and income generation. The Charity has an investment policy which is reviewed annually.

The overall objectives are to generate sufficient income and capital growth to enable the Charity to carry out its purposes consistently year on year with due and proper consideration for future needs and the maintenance of and, if possible, enhancement of the value of the invested funds while they are retained. The Charity recognises that every investment carries risk. Equally, not investing at all carries the risk of lost asset value in real terms, and the consequent reputational risk of poor stewardship.

The Charity has considered the seven types of risk identified by the Charity Commission in its guidance Charities and investment matters: a guide for trustees (CC14), namely:

- Capital risk – loss of capital and volatility
- Liquidity risk
- Market risk (e.g., inflation; interest rate; exchange rate; regulatory risks)
- Valuation risk
- Counterparty risk
- Tax risk
- Environmental, social and governance

The Charity has decided that to mitigate risk it will have a diversified portfolio of investments, both in asset class and individual investment, and will be invested such that the overall risk profile of the funds is 'medium' with the specific investment strategy to be agreed with our investment manager.

The Charity permits investments in the following assets:

- Listed UK equities
- International equities quoted on a recognised stock exchange
- Government gilts
- Corporate bonds
- Interest bearing cash deposits in UK banks or building societies
- Cash

The Charity has appointed professional investment managers to oversee its investments. In addition to managing the Charity'sies portfolio of investments, they provide the Charity with advice on specialist areas including market risk. The Charity does not pay tax on investment income as it is applied to a charitable purpose. The investment managers also ensure the Charity's portfolio reflects environmental, social and governance concerns such as ceasing investments with Russian companies since the start of the war in Ukraine.

Ethical considerations are included which in general terms seek to obtain the best financial return from the Charity's investments consistently and with commercial prudence. The Charity will not invest directly in companies which are primarily involved in the production of alcohol, tobacco, armaments, or gambling. Our investment manager is encouraged to monitor the collective investments held, in so far as is practicable, such that any indirect exposure in these areas is minimised.

In the year to 31st March 2023, the investment portfolio of the Charity, managed by Rathbones, produced a total return (the combination of capital growth and income) of -4.0%, giving back some of the gains achieved in the prior year. This compares to the benchmark (MSCI PIMFA Income Index) total return of -3.9%.

This year has been tumultuous, caused by a rapid increase in inflation, the subsequent rise in interest rates and the conflict in Ukraine creating significant geopolitical tensions. Against this backdrop, Gilts were down 16.3%, UK equities rose 2.9% while global equities were down 1.0%.

The driving factors for markets remain centred on the outlook for inflation, interest rates and the impact this will have on the real global economy as well as the continuing Russia/Ukraine conflict. Our investment manager will continue to actively manage the portfolio in response to the changing economic and political landscape.

The Charity has a capital in perpetuity fund (Elsie Sykes CIP fund) that is held for investment, with income generated to be used for charitable purposes, as specified in the endowment terms. This is currently invested with the Charles and Elsie Sykes Trust and was valued at £229,874 as at 31 March 2023.

4.9. Reserves policy

The Charity has a reserves policy requiring reserves to be maintained at a level equivalent to the cost of maintaining the Charity team for one year. The Charity has total funds of £2,137,552 of which, £36,299 is restricted and not available to fund general purposes and £293,000 which is held in the permanent endowment funds and are excluded from reserves. The Charity holds £1,809,090 of designated funds as its reserves. This is equivalent to approximately 4 years of expenditure. As at 31 March 2023, there are no material designated funds or commitments, with expenditure of approximately £200,000 forecast in the forthcoming year. In addition to the unrestricted and designated funds held in reserves, the Trustee has the power, if it so wishes, to spend any of the expendable endowment. However, the expendable endowment is used to generate income, supplementing the income from donations and legacies. The Trustee will therefore only spend the expendable endowment on an exceptional basis.

It is not anticipated that the Charity will deploy funding towards any projects before donations have been received which mitigates the risk of any planned commitments, or designations, that cannot be met by future income alone. In other words, commitment is made by the Charity after funding has been identified / receipted.

4.10. Risk management

The Corporate Trustee has considered any major risks to which the Charity is exposed. The Corporate Trustee aims to mitigate the risk that income will fall by engaging with the fFundraising department. The fFundraising department works with the Charity and engages with the local community to raise funds through a programme of events and encouraging donations. The Charity seeks to generate income from multiple sources to help mitigate shortfalls in any one area. This includes a programme of fundraising activity, fundraising appeals, legacies and, applying for grants.

The Corporate Trustee has agreed to invest in a fundraising strategy, with a long-term ambition to engage with the public and to further enhance the environment of the Trust.

The investment portfolio is well diversified to help protect the Charity against any fall in value of a particular market. The Investment Manager holds a discretionary mandate which enables them to make investment and divestment decisions on the Charity's behalf. The Charity works closely with the Investment Manager to ensure that the investment policy is reviewed regularly.

The investment strategy is to protect the long-term value of the portfolio in absolute terms and in terms of purchasing power once the impact of inflation is considered. To achieve this, the Investment Managers have inevitably invested a substantial amount of the portfolio in equities, both in the UK and overseas.

Any investment gains and losses, although reflected in the Charity's accounts are not, realised as such unless and until the investments concerned are actually sold.

4.11. Partnership working and networks

The Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee of the Charity. Effective partnership with the Trust ensures that the funds are used to best effect. When deciding upon the most beneficial way to use the Charity funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Trust.

5. Future plans

The Charity's priorities are those set out in the Trust's mission statement: 'to provide the highest quality healthcare at all times'. The vision for the Trust that describes its ambition and where it wants to be as an organisation in five years' time is 'to be an outstanding provider of healthcare, research and education, and a great place to work'. Meeting this mission and vision will maximise the impact of the Charity and its benefits to the beneficiaries of the Charity who are primarily the NHS patients of Bradford, through three core values:

- We care;
- We value people; and
- We are one team.

In order to enhance and improve the current levels of care for NHS patients throughout the Trust, the Charity has planned expenditure in a number of areas. The Charity will also continue to enhance the refurbishment of wards and clinical areas from basic specification to higher quality.

The Fundraising department will also look to expand its fundraising activities towards achieving its goal of raising additional funds over the next five years. The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises.

6. Financial Statements for the year ended 31 March 2023

The accounts of the funds held on trust by the Trustee appointed as stated below:

6.1. Foreword

The Corporate Trustee present their report and the audited financial statements of the Charity for the year ended 31 March 2023. The Trustee has adopted the provisions of the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" (FRS 102) in preparing the annual report and financial statements of the Charity.

The financial statements have been prepared in accordance with the accounting policies set out in the notes to the accounts and comply with the Charity governing document, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable to the UK and Republic of Ireland published on 16 July 2014, updated with the second edition released in October 2019.

6.2. Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

The Trustee is responsible for preparing the Trustee Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust Deed. It is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By order of the Trustee

Signed:

--	--
Chairperson of the Corporate Trustee	Date
--	--
Chief Executive of the Corporate Trustee	Date

6.3. Independent Auditor's Report to the Trustees of Bradford Hospitals Charity

Opinion

We have audited the financial statements of Bradford Hospitals Charity for the year ended 31 March 2023, which comprise the Statement of Financial Activities, the Balance Sheet, the Cash Flow Statement, and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including FRS 102 'The Financial Reporting Standard Applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2023, and of its incoming resources and application of resources, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the audit of the financial statements section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The trustee is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on

the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other matter

The comparative figures in the financial statements of Bradford Hospitals Charity were not audited, as the charity did not require a statutory audit under the Charities Act 2011 in the prior year.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

- the information given in the Trustee's Annual Report is inconsistent in any material respect with the financial statements; or
- the charity has not kept adequate accounting records; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we required for our audit.

Responsibilities of trustee

As explained more fully in the trustee's responsibilities statement set out on page 16, the trustee is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustee either intends to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's Responsibilities for the audit of the financial statements

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK) we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the charity's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustee.

- Conclude on the appropriateness of the trustee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the charity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the charity to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

The objectives of our audit in respect of fraud, are; to identify and assess the risks of material misstatement of the financial statements due to fraud; to obtain sufficient appropriate audit evidence regarding the assessed risks of material misstatement due to fraud, through designing and implementing appropriate responses to those assessed risks; and to respond appropriately to instances of fraud or suspected fraud identified during the audit. However, the primary responsibility for the prevention and detection of fraud rests with both management and those charged with governance of the charity.

Our approach was as follows:

- We obtained an understanding of the legal and regulatory requirements applicable to the charity and considered that the most significant are the Charities Act 2011, the Charity SORP, and UK financial reporting standards as issued by the Financial Reporting Council.

- We obtained an understanding of how the charity complies with these requirements by discussions with management and those charged with governance.

- We assessed the risk of material misstatement of the financial statements, including the risk of material misstatement due to fraud and how it might occur, by holding discussions with management and those charged with governance.

- We inquired of management and those charged with governance as to any known instances of non-compliance or suspected non-compliance with laws and regulations.

- Based on this understanding, we designed specific appropriate audit procedures to identify instances of non-compliance with laws and regulations. This included making enquiries of management and those charged with governance and obtaining additional corroborative evidence as required.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

Use of our report

This report is made solely to the charity's trustee, as a body, in accordance with Chapter 3 of Part 8 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to any party other than the charity and charity's trustee as a body, for our audit work, for this report, or for the opinion we have formed.

Moore Kingston Smith LLP
Statutory auditor

6th Floor
9 Appold Street
London
EC2A 2AP

Date:

Moore Kingston Smith LLP is eligible to act as auditor in terms of Section 1212 of the Companies Act 2006.

6.4. Statement of financial activities for the year ended 31 March 2023

	Notes	Unrestricted funds 2023 £000	Restricted funds 2023 £000	Endowment funds 2023 £000	Total funds 2023 £000	Total funds 2022 £000
Income from:						
Donations and legacies	**4**	361	500	0	861	158
Other trading activities	**5**	144	0	0	144	107
Investment income	**7**	52	0	0	52	37
Total incoming resources		**557**	**500**	**0**	**1,057**	**302**
Expenditure on:						
Raising funds	**8**	(177)	(1)	0	(178)	(122)
Charitable activities	**9**					
Medical equipment		(2)	(501)	0	(503)	(34)
Staff education & welfare		(94)	0	0	(94)	(221)
Patient welfare		(170)	(40)	0	(210)	(134)
Other expenditure		(61)	0	0	(61)	(37)
Total charitable activities		**(327)**	**(541)**	**0**	**(868)**	**(427)**
Total expenditure		**(504)**	**(542)**	**0**	**(1,046)**	**(548)**
Net gains / (losses) on investments	**156**	(82)	0	(9)	(91)	74
Net expenditure		**(29)**	**(42)**	**(9)**	**(80)**	**(172)**
Net movement in funds		**(29)**	**(42)**	**(9)**	**(80)**	**(172)**
Reconciliation of funds						
Total funds brought forward	**212**	1,838	78	302	2,218	2,390
Total funds carried forward		**1,809**	**36**	**293**	**2,138**	**2,218**

Commented [PT2]: Q - No IM fees

A - No fees are applied to the Endowment Funds

The statement of financial activities includes all gains and losses recognised during the year.

The notes on pages 241 to 396 form part of these accounts and the comparative Statement of financial activities on page 285.

6.5. Balance Sheet as at 31 March 2023

	Note	Unrestricted funds 2023 £000	Restricted funds 2023 £000	Endowment funds 2023 £000	Total funds 2023 £000	Total funds 2022 £000
Fixed assets						
Investments	156	1,188	0	230	1,418	1,520
Total fixed assets		**1,188**	**0**	**230**	**1,418**	**1,520**
Current assets						
Debtors	167	152	500	0	652	66
Cash and cash equivalents	178	500	36	63	599	694
Total current assets		**652**	**536**	**63**	**1,251**	**760**
Liabilities						
Creditors due within one year	189	(31)	(500)	0	(531)	(62)
Net current assets		**621**	**36**	**63**	**720**	**698**
Total assets less current liabilities		**1,809**	**36**	**293**	**2,138**	**2,218**
Total net assets		**1,809**	**36**	**293**	**2,138**	**2,218**
The funds of the Charity:	212					
Unrestricted funds		20	0	0	20	152
Restricted funds		0	36	0	36	78
Designated funds		1,789	0	0	1,789	1,686
Endowment funds		0	0	293	293	302
Total Charity funds		**1,809**	**36**	**293**	**2,138**	**2,218**

These accounts together with notes on pages 241 to 396 were approved and authorised for issue by the Corporate Trustee on:

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Director of Finance Date

6.6. Statement of Cash Flows for the year ending 31 March 2023

	Note	Total funds 2023 £000	Total funds 2022 £000
Cash flows from operating activities:			
Net cash used in operating activities	~~20~~19	**(193)**	**(201)**
Cash flows from investing activities:			
Dividends and interest from investments	**7**	52	37
Proceeds from sales of investments	15~~6~~	135	135
Purchase of investments	15~~6~~	(89)	(186)
Net cash provided by / (used in) investing activities		**98**	**(14)**
Change in cash and cash equivalents in the reporting period		(95)	(215)
Cash and cash equivalents at the beginning of the reporting period	1~~8~~7	694	909
Cash and cash equivalents at the end of the reporting period	1~~8~~7	**599**	**694**

The Charity had no cash equivalents and no net debt as at 31 March 2023 (2022: None)

Notes to the accounts

1.0 Accounting policies

a. Basis of preparation of the financial statements

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) issued in October 2019 and the Charities Act 2011 and UK Generally Accepted Practice. The Charity constitutes a public benefit entity as defined by FRS102.

The significant accounting policies are set out below.

b. Accounting convention

The financial statements are prepared under the historic cost convention, except for investments which are held on a revaluation basis, and are rounded to the nearest thousand. . The Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future as it does not intend to liquidate the Charity or to cease its operations. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts. A robust reserve policy, strengthened by the fact the Charity has no material long term commitments, and having internal governance to ensure the Charity is only spending funds that are available, allows the Corporate Trustee to consider the Charity to be a going concern.

c. Income

Income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of income can be measured with sufficient reliability.

Where there are terms or conditions attached to income, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

d. Accounting for legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted;
- The executors have established that there are sufficient assets in the estate to pay the legacy; and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

e. Investment income

Dividends are included in the Statement of Financial Activities when they are declared and at an amount which includes the tax credit recoverable from HM Revenue and Customs.

f. Recognition of liabilities

Liabilities are recognised on an accrual's basis in accordance with generally accepted accounting practice.

g. Expenditure

Expenditure is accounted for on an accruals basis and has been classified under appropriate headings.

Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the appropriate heading for the expenditure on which it was incurred.

h. Commitments

Expenditure is recognised as a commitment liability where a recipient has a reasonable expectation that they will receive the assets or services in lieu of a grant.

i. Fundraising costs

Fundraising costs are those costs attributable to generating income for the Charity and are distinct from costs incurred in undertaking charitable activities.

j. Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal audit and external independent examination (audit) costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 12.

k. Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

l. Realised and unrealised gains and losses

Realised gains and losses are included in the accounts at the date on which a contractual obligation is entered into.

Unrealised gains and losses are computed by reference to the market value of the investments at the balance sheet date as compared to the brought forward cost or valuation, and gains and losses arising on similar categories of investments are netted off.

m. Investments held by the Charity

Investments are stated at mid-market value at the balance sheet date. Investments in non-puttable ordinary shares (where shares are publicly traded, or their fair value is reliably measurable) are measured at fair value through the Statement of Financial Activities. Where fair value cannot be measured reliably, investments are measured at cost less impairment. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

n. Taxation

As a registered charity, the Charity is exempt from income and corporation tax to the extent that its income and gains are applicable to charitable purposes only.

o. Fund's structure policy

The Charity maintains a General (unrestricted) Fund, which comprises monies which are expendable at the discretion of the Corporate Trustee in the furtherance of the objects of the Charity. These monies may be held in order to finance both working capital and capital investment.

Designated Funds are that part of the Charity's unrestricted funds in respect of which a preference has been expressed by donors that they be used for particular purposes. The Corporate Trustee has the power to re-designate such funds within unrestricted funds.

Endowment Funds are funds which are to be used in accordance with specific restrictions imposed by the donor in the sense that the restriction requires the gift to be invested to produce income. Where the Corporate Trustee has the power to spend the capital, these are expendable endowments. The Charity has five expendable endowments and one permanent endowment, which are disclosed in note 22.

Restricted Funds are funds to be used in a specific way or for a specific purpose. They are considered as a contract between the donor and the Charity.

There is no formal policy of transfer between funds other than that described above.

p. Debtors

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. Trade and other debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

q. Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due. Amounts which are owed in more than a year are shown as long-term creditors.

r. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.
This includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

s. Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, which are described in note 1, the Corporate Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Corporate Trustee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure.

t. Gifts in kind

~~Gifts in kind, such as food and care packages are not accounted for when they are accepted and immediately distributed.~~ Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed. Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed. Gifts in kind, such as food and care packages are not accounted.

Commented [PT3]: Q - when are they?!

A - Sentence provided by previous Auditors to make it clear to the user how GIK are accounted for

Commented [JS4R3]: Updated

Commented [PT5]: Q - when are they?!

A - Sentence provided by previous Auditors to make it clear to the user how GIK are accounted for

Commented [JS6R5]: Updated

2.0 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the three types of funds that the Charity manages.

2.1 Unrestricted funds – Statement of Financial Activities for the year ended 31 March 2023

	Notes	2023 £000	2022 £000
Income from:			
Donations and legacies	**4**	361	139
Other trading activities	**5**	144	100
Investments	**7**	52	37
Total incoming resources		**557**	**276**
Expenditure on:			
Raising funds	**8**	(177)	(116)
Charitable activities	**9**		
Medical equipment		(2)	(34)
Staff education & welfare		(94)	(203)
Patient welfare		(170)	(122)
Other activities		(61)	(37)
Total charitable activities		**(327)**	**(396)**
Total expenditure		**(504)**	**(512)**
Net gains / (losses) on investments	**16**	(82)	61
Net expenditure		**(29)**	**(175)**
Net movement in funds		**(29)**	**(175)**
Reconciliation of funds			
Total funds brought forward	**22**	1,838	2,013
Total funds carried forward		**1,809**	**1,838**

Unrestricted funds – Balance Sheet as at 31 March 2023

	Notes	As at 31 March 2023 £000	As at 31 March 2022 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	1,188	1,281
Total fixed assets		**1,188**	**1,281**
Current assets			
Debtors	**17**	152	66
Cash and cash equivalents	**18**	500	553
Total current assets		**652**	**619**
Liabilities: -			
Creditors due within one year	**19**	(31)	(62)
Net current assets		**621**	**557**
Total assets less current liabilities		**1,809**	**1,838**
Total net assets	**22**	**1,809**	**1,838**
Total assets for unrestricted funds		**1,809**	**1,838**

2.2 Restricted funds – Statement of Financial Activities for the year ended 31 March 2023

	Notes	2023 £000	2022 £000
Income from:			
Donations and legacies	**4**	500	19
Other trading activities	**5**	0	7
Income from investments	**7**	0	0
Total incoming resources		**500**	**26**
Expenditure on:			
Raising funds	**8**	(1)	(6)
Charitable activities	**9**		
Medical equipment		(501)	0
Staff education & welfare		0	(18)
Patient welfare		(40)	(12)
Other activities		0	0
Total charitable activities		(541)	(30)
Total expenditure		**(542)**	**(36)**
Net gains/(losses) on investments	**16**	**0**	**0**
Net expenditure		**(42)**	**(10)**
Net movement in funds		**(42)**	**(10)**
Reconciliation of funds			
Total funds brought forward	**22**	78	88
Total funds carried forward		**36**	**78**

Restricted funds – Balance Sheet as at 31 March 2023

	Notes	As at 31 March 2023 £000	As at 31 March 2022 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	0	0
Total fixed assets		**0**	**0**
Current assets			
Debtors	**17**	500	0
Cash and cash equivalents	**18**	36	78
Total current assets		**536**	**78**
Liabilities: -			
Creditors due within one year	**19**	(500)	0
Net current assets		**36**	**78**
Total assets less current liabilities		**36**	**78**
Total net assets	**22**	**36**	**78**
Total assets for restricted funds		**36**	**78**

2.3 Expendable Endowment funds – Statement of Financial Activities for the year ended 31 March 2023

The Charity has five expendable endowment funds (capital in perpetuity funds (CIP)), with a combined balance of £62,290 (2022: £62,290) and one permanent endowment fund, with a balance of £229,874 (2022: £239,316), that have been brought forward from previous years. During 2022-23, any income received has been recognised within the investment income.

The permanent endowment fund has been invested with the Charles and Elsie Sykes Trust.

3.0 Related party transactions

The Trust (which succeeded Bradford Teaching Hospitals NHS Trust on 1 April 2004) is the Corporate Trustee of the Charity and is governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Committee, which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity from the Trust. None of the trustees or members of the Trust or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind.

Related party expenditure transactions relate to items such as salary recharges and internal audit fees with the Trust.

Payables

	2023 £000	2022 £000
The following amounts were owed by the Charity to the Trust as at 31 March	515	13
	515	**13**

Expenditure

	2023 £000	2022 £000
Value of transactions during the year with the Trust	733	284
	733	**284**

4.0 Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Donations	74	500	574	72
Grants	81	0	81	7
Legacies	180	0	180	54
Gifts in Kind	26	0	26	25
Total	**361**	**500**	**861**	**158**

Donations are from corporates, the community, patients and relatives of patients and staff. Donations of gifts in kind have been valued at their market value. All these donations have been distributed during the year.

Commented [PT7]: Q - Have they?

A - Yes, all GIK are distributed in year by the fundraising team

Commented [JS8R7]: Check with Adam - can we delete comment if not needed

5.0 Analysis of income from other trading activities

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Staff lottery	40	0	40	42
Fundraising	104	0	104	65
Total	**144**	**0**	**144**	**107**

The staff lottery is operating within the guidelines set out by the Gambling Commission.

6.0 Role of volunteers

The Charity does not have any general volunteers, but it does have approximately 100 fund holders. The fund holders are Trust staff members who manage how the Charity's designated funds should be spent, as part of their day-to-day duties. These funds are designated (or earmarked) to be spent for a particular purpose or in a particular ward or department. Each fund holder has delegated powers to approve spend for the designated funds that they manage, subject to the scheme of delegation as approved by the Corporate Trustee.

7.0 Gross investment income

The Charity earned interest and investment income of £52,004 (2022: £36,841).

8.0 Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Fundraising costs	33	0	33	18
Support costs	144	1	145	104
Total	**177**	**1**	**178**	**122**

9.0 Analysis of charitable expenditure

The Charity did not make any grant funding to third parties. All the charitable expenditure incurred was directly with third parties or reimbursed expenditure.

Unrestricted funds	**Direct charitable activities £000**	**Support costs £000**	**Total 2023 £000**	**Direct charitable activities £000**	**Support costs £000**	**Total 2022 £000**
Medical equipment	2	0	2	25	9	34
Staff education & welfare	66	28	94	152	51	203
Patient welfare	120	50	170	91	31	122
Other activities	43	18	61	28	9	37
	231	**96**	**327**	**296**	**100**	**396**

Commented [PT9]: Q - £1k diff to note 12

A - the £1k is under restricted funds, under support costs. The total support costs then come back to £97k for charitable activities.

Restricted funds	**Direct charitable activities £000**	**Support costs £000**	**Total 2023 £000**	**Direct charitable activities £000**	**Support costs £000**	**Total 2022 £000**
Medical equipment	500	1	501	0	0	0
Staff education & welfare	0	0	0	15	3	18
Patient welfare	40	0	40	10	2	12
Other activities	0	0	0	0	0	0
	540	**1**	**541**	**25**	**5**	**30**

10.0 Analysis of grants

The Charity did not make any grants to individuals or other institutions.

11.0 Movements in funding commitments and liabilities

	Current liabilities £000	Non-current liabilities £000	Total 2023 £000	Total 2022 £000
Opening balance as at 01 April	62	0	62	105
Additional commitments made during the year	1,046	0	1,046	549
Amounts paid during the year	(577)	0	(577)	(592)
Closing balance as at 31 March	**531**	**0**	**531**	**62**

The Charity has expenditure that has been approved but not yet delivered or services not yet provided. Most expenditure is paid out in the same financial year. As the Charity has control over the expenditure, there is little uncertainty around these payments.

12.0 Allocation of support costs and overheads

	Raising funds £000	Charitable activities £000	2023 Total £000	Raising funds £000	Charitable activities £000	2022 Total £000	Basis
Internal audit	0	0	0	0	0	0	Salaries
External audit	4	3	7	6	8	14	Salaries
Other	7	6	13	6	8	14	Salaries
Governance	11	9	20	12	16	28	
Salaries	130	86	216	88	88	175	Hours
Computer expenses	4	2	6	4	2	6	Salaries
Total	**145**	**97**	**242**	**104**	**105**	**209**	

Commented [PT10]: Q - £1k diff V note 9

A - total support costs are £97k, please see note 9 above

Salaries: this is proportionate to staff salaries where costs are related to the employed staff

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2023 Total £000
Raising funds	144	1	0	145
Charitable activities	96	1	0	97
	240	**2**	**0**	**242**

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2022 Total £000
Raising funds	98	6	0	104
Charitable activities	100	5	0	105
	198	**11**	**0**	**209**

13.0 Trustees' remuneration, benefits, and expenses

The Corporate Trustee receives no remuneration for the work it undertakes as trustee and claims no expenses from the Charity.

14.0 Analysis of staff costs and remuneration of key management personnel

The key management personnel of the Charity comprise the Charity Director and Deputy Director of Finance. The total cost of employing the charity's key management personnel during the year, including employer's social security and pension contributions was £46,731 (2021/22: £6,426). Key management personnel is a term used by FRS 102 for those persons having authority and responsibility for planning, directing and controlling the activities of the charity, directly or indirectly, including any director (whether executive or otherwise) of the charity. This definition includes trustees and those members of staff who are the senior management personnel to whom the trustees have delegated significant authority or responsibility in the day-to-day running of the charity.

The Charity does not employ members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity as a single cost. No employees had emoluments in excess of £60,000 (2022: £nil).

	2023 £000	2022 £000
Salaries and wages	170	142
National insurance costs	19	13
Employer's pension contribution	26	20
Total	**215**	**175**

The Charity does not employ members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity as a single cost. No employees had emoluments in excess of £60,000 (2022: £nil).

15.0 Auditor's remuneration

The auditor's remuneration of £12,722XXXX inclusive of VAT (2022: £8,006) related solely to the audit with no other additional work being undertaken. In 2022, the Charity had an independent examination of its accounts. The independent examination fee in 2022 was £8,006.

165.0 Fixed asset investments

Investments held with Rathbones Investment Management:

	2023 £000	2022 £000
Market value at 01 April	1,281	1,231
Add: additions at cost	89	187
Less: disposals at carrying value and in year gain / (loss) on disposals	(125)	(125)
Add: net gain / (loss) on revaluation	(82)	61
Add: net gain / (loss) on disposals	10	11
Less: Movements in broker held bank accounts	15	(84)
Market value at 31 March of unrestricted investments	**1,188**	**1,281**

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Commented [PT11]: Q - why is there a line for disposal of gains / losses if already factored into disposals line?

A- Two figures provided by Rathbones, can add to one line if required

Fixed asset investment by type

	2023 £000	2022 £000
Fixed Interest	164	174
UK Equities	266	296
Overseas Equities	406	407
Alternatives	281	348
Total listed investments	**1,117**	**1,225**
Cash	71	56
Market value at 31 March of unrestricted investments	**1,188**	**1,281**

The historic cost of investments held with Rathbones Investment Management is £1,150,000 (2022: £1,150,000).

Commented [PT12]: Q - No change? There have been additions and disposals

A - Only the initial amount of £1.150m was invested. Dividends are paid to the Charity each month

Investments held with the Charles and Elsie Sykes Trust:

	2023 £000	2022 £000
Market value at 01 April	239	226
Add: additions at cost	0	0
Add net gain (loss) on revaluation	(9)	13
Market value at 31 March of the permanent endowment fund	**230**	**239**

Fixed asset investment by type

	2023 £000	2022 £000
Equities	164	175
Bonds	50	32
Real Estate	5	6
Alternatives	5	5
Total listed investments	**224**	**218**
Cash	6	21
Market value at 31 March of the permanent endowment fund	**230**	**239**
Total value of investments held at 31 March	**1,418**	**1,520**

The historic cost of investments held with Charles and Elsie Sykes Trust is £228,365 (2022: £228,365).

Included in the above figures, are investment management charges of £10,868 (2022: £11,563).

1~~7~~6.0 Analysis of current debtors

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Prepayments and accrued income	152	500	652	66
NHS Debtor	0	0	0	0
Total	**152**	**500**	**652**	**66**

1~~8~~7.0 Analysis of cash and cash equivalents

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2023 £000	Total 2022 £000
Cash in hand	500	36	63	599	694
Total	**500**	**36**	**63**	**599**	**694**

No cash or cash equivalents were held in non-cash investments or outside of the UK. The Charity had no cash equivalents as at 31 March 2023 (2022: None).

1~~9~~8.0 Analysis of liabilities

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Creditors due within 1 year				
NHS Creditor	15	500	515	16
~~Accruals~~	~~0~~	~~0~~	~~0~~	~~0~~
Other creditors	16	0	16	46
~~Commitments~~	~~0~~	~~0~~	~~0~~	~~0~~
Total	**31**	**500**	**531**	**62**

The Charity has no creditors falling due after more than 1 year and has no contingent liabilities. An amount of £514,909~~512,082~~ is owed to the Trust.

~~20~~19.0 Reconciliation of net expenditure to net cash flow from operating activities

	2023 £000	2022 £000
Net (expenditure) / income (as per the statement of financial activities)	(81)	(172)
Adjustments for:		
Interest from Investments	(52)	(37)
Loss / (profit) on the sale of fixed assets investments	(35)	62
(Gains) / losses on investments	91	(74)
Decrease / (increase) in debtors	(585)	63
(Decrease) / increase in creditors	469	(43)
Net cash used in operating activities	**(193)**	**(201)**

Commented [PT13]: Q - there are none? Investments?

A - Figures as per note 16

20~~1~~.0 Transfers between funds

There has been no transfer of funds between restricted and unrestricted funds.

21~~2~~.0 Analysis of charitable funds

a) Analysis of unrestricted and material designated fund movements

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
General Fund	151	0	(132)	0	19
Bradford Cardiac	234	6	(41)	0	199
Rays A Smile	6	1	(6)	0	1
Born In Bradford	44	2	(35)	0	11
Ward 15 Legacy	61	0	(12)	0	49
Sunshine Fund	79	244	(62)	0	261
ICU Fund	66	10	(13)	0	63
The HJ Gajdecki Fund	70	0	0	0	70
NNU Appeal	78	37	(22)	0	93
Other designated funds	1,049	257	(181)	(82)	1,043
Total	**1,838**	**557**	**(504)**	**(82)**	**1,809**

	2022 Balance b/f £000	2022 Income £000	2022 Expenditure £000	2022 Gains and losses £000	2022 Fund c/f £000
General Fund	324	1	(174)	0	151
Bradford Cardiac	103	166	(35)	0	234
Rays A Smile	5	3	(2)	0	6
Born In Bradford	50	0	(6)	0	44
Ward 15 Legacy	69	0	(8)	0	61
Sunshine Fund	94	10	(25)	0	79
ICU Fund	68	6	(8)	0	66

The HJ Gajdecki Fund	70	0	0	0	70
NNU Appeal	72	28	(22)	0	78
Other designated funds	1,158	62	(232)	61	1,049
Total	**2,013**	**276**	**(512)**	**61**	**1,838**

An exercise to reduce the number of trust funds to four main funds will be taking place over the next two years.

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b) Analysis of restricted fund movements

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Covid Fund	78	0	(42)	0	36
Sunshine Fund	0	500	(500)	0	0
Total	**78**	**500**	**(542)**	**0**	**36**

	2022 Balance b/f £000	2022 Income £000	2022 Expenditure £000	2022 Gains and losses £000	2022 Fund c/f £000
Covid Fund	88	26	(36)	0	78
Total	88	26	(36)	0	78

c) Analysis of endowment fund movements

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	239	0	0	(9)	230
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**302**	**0**	**0**	**(9)**	**293**

In 2019/20, the permanent endowment fund was invested with the Charles and Elsie Sykes Trust. The funds are held by the Charles and Elsie Sykes Trustees on trust for the Charity. £9,442 relates to an unrealised loss based on share values as at 31 March 2023.

	2022 Balance b/f £000	2022 Income £000	2022 Expenditure £000	2022 Gains and losses £000	2022 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	226	0	0	13	239
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**289**	**0**	**0**	**13**	**302**

223.0 The Charity as a subsidiary

The Trust, its patient's and its staff are the main beneficiaries of the Charity. The Trust is a related party by virtue of being the Corporate Trustee of the Charity. For accounting purposes, this means that the Charity is deemed to be a subsidiary of the Trust as it is 'controlled' by another entity through the trusteeship arrangements.

All Trusts are required to have a constitution, containing detailed information about how that Trust will operate. The purpose of the Trust is set out in its Constitution as follows:

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

The Trust may provide goods and services for any purposes related to:

- the provision of services provided to individuals for or in connection with the prevention, diagnosis, or treatment of illness, and
- the promotion and protection of public health.

The Trust accounts are available to the public online at the following web address:

https://www.bradfordhospitals.nhs.uk

They are also available by request from the Trust Secretary, using the details below:

Trust Secretary
Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ

Annual Report and Accounts 2022 – 2023

Bradford Hospitals Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Bradford Hospitals Charity is the official NHS charity for Bradford Teaching Hospitals NHS Foundation Trust

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The Trustee Report below aims to provide sufficient information to understand the Charity, its purpose, and how it has performed during the year.

1. Chairman and Board Members Foreword

On behalf of the Trustee of Bradford Hospitals Charity ("the Charity"), we are pleased to present the Charity's Annual Report and Accounts for the year ended 31 March 2023.

This document provides an overview for stakeholders and interested parties of what the Charity has achieved during 2022/23. This Annual Report, including the Trustee Report and Accounts has been prepared in accordance with accounting policies set out in the notes of the accounts and complies with the Charity's governing document (the Trust Deed) the Charities Act 2011 and the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" ("FRS 102").

The Charity is committed to enhancing the care and treatment of patients and improving the health of local people. The Charity works with Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") to improve health and healthcare across the Bradford City Region. We are proud that the general public trust us to invest in projects that are over and above the responsibility of the NHS and exchequer.

During 2022/23, the Charity funded projects that improved patient services, and helped staff practically and emotionally, so they could continue their life-saving work. A new initiative the Charity undertook this year was the Ramadan Allies project, created by the Spiritual, Pastoral and Religious Care (SPaRC) team to support our Muslim colleagues through their periods of fasting and spiritual growth. The Charity supported managers in the hospital in understanding the needs of their staff by supplying information and pointing out when their staff needed to take time out to pray. We worked hard with our SPaRC team to deliver this fantastic initiative.

The Charity also successfully invested in many well-being initiatives to support young children, working on the 'fear' of coming to hospital. The Charity purchased Virtual Reality kits as a distraction tool when having blood taken, and feedback from nurses and staff tells us this initiative is working well in calming children down.
An initiative the Charity continues to fund, and support is 'Baggins the Bear'. Purchasing small teddy bears to give to children before they come into hospital has also helped to lessen the fear of entering the hospital for an operation. This project has seen operations increase from 7 to 10 per day because the child and family are less daunted by the experience. The family feedback has been some of the best the hospital has seen, and cancellations have almost disappeared.

I want to thank the fantastic individuals and corporate supporters who enabled all this work to be delivered by financially supporting the Charity's work. You have made an enormous difference to our staff in feeling supported at a significant time of year.

2. Review of activities

2.1. Review of the year

During the year, funds were used to enhance service provision for the benefit of both patients and staff. The Charity received a large number of very generous donations from many parts of the community and as a result of this generosity; the Charity purchased a number of items of equipment for the wards and departments to support staff and patients, including:

- Double scalp cooling machine for patients undergoing chemotherapy at the Meadows unit at Eccleshill Hospital

- Menopause balance application licences, that provide medically approved content for support with the menopause
- 12 benches for outdoor spaces for staff to relax and unwind
- Virtual reality goggles to provide a soothing distraction and prepare younger patients for their upcoming treatment
- Art and craft materials to distract young people whilst in hospital by engaging them in fun activities

2.2. Our Strategic Objectives

The Charity has as its sole objective to use its funds:

For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust

The Corporate Trustee considers that this objective does not unreasonably restrict access to charitable benefits within the scope of the Declaration of Trust. The Corporate Trustee of the Charity seeks to achieve this objective, considering general guidance, by two main routes:

1. The Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality.

2. Staff throughout the organisation identify small but valuable differences where the fund monies can deliver benefits to patients and staff, such as attendance at extra training courses or conferences.

2.3. Activities for public benefit

Thanks to the continued generosity of our supporters, the Charity has continued to develop and during 2022/23 the Charity spent £1,046,105 (£548,600 in 2022) in the following ways:

	2023 £000	2022 £000
Medical equipment	503	34
Staff education and welfare	94	221
Patient welfare	210	134
Other activities	61	37
Raising funds	178	122
Total	**1,046**	**548**

2.4. Fundraising

The Charity is registered with the Fundraising Regulator and abides by their codes of conduct and their fundraising promise, which ensures that our fundraising is legal, open, honest, and respectful. The Charity has a fundraising team that is compliant with the recognised standards of fundraising as well as those required under charity law and wider law. Controls are in place to ensure any fundraising is within the Fundraising Code of Practice. It is inevitable that fundraisers will come into contact with people who may be in a vulnerable circumstance or need additional support to make an informed decision. If a fundraiser reasonably believes that

an individual is unable to decide, then they will not accept a donation from that person. The fundraising team use a checklist to help identify signs that an individual may be in a vulnerable circumstance.

The fundraising team have a policy where they get to know their donors by sending out relevant and often personalised communications. They also give individuals clear information and opportunities to change how, when and if they want to hear from the Charity and follow the General Data Protection Regulation (GDPR) principles. The Charity raises funds to enhance the care and treatment of local patients and those who care for them. The Charity has not used any professional fundraisers and has not received any complaints. Fundraising record-keeping and monitoring are coordinated through the Harlequin Customer Relationship Management (CRM) system.

This financial year saw the appointment of a Charity Director - a substantive role put in place to lead the Charity to success. The aim is to grow the Charity's income, profile, and fundraising team. The Charity has had a successful year and to maintain this needs to build continuous support from donors.

An immediate aim is to increase our profile within the Bradford Community. Next year, the Charity will showcase a new events calendar that will be key to increasing donor support, internally and externally. As the Charity advances, we aim to work more closely with our NHS teams to raise money and further support projects from a broad range of services.

In November 2022, the Charity launched the '100 Club', a membership aimed at Business and Community groups, to bring in £1,000 per member per year. Retention and stewardship of these members are both crucial factors in securing success. The Charity expects to grow more income from these relationships as many will take up 'Charity of the Year' as part of their fundraising activities, and we hope to organise events to provide all members with a networking opportunity.

This year legacy donations increased significantly compared to previous years; this type of income is an unpredictable area of fundraising. The long-term aim is to develop legacy fundraising by employing a legacy fundraiser.

The large donation from Sovereign Healthcare towards the Da Vinci Robot was a welcome donation towards a significant, transformational project for the Urology department. We hope to enhance services by providing more equipment and support service innovation.

This year, we were awarded a Development Grant from NHS Charities Together to support infrastructure work; we have decided to invest this money into a new, better-functioning website, refresh our current branding to include new brand guidelines and a new fundraising database, with more time-saving functionalities. This investment will ensure we can move forward with current plans making it easy for donors to support our work.

We hope to continue expanding the diverse income streams and increasing income in all the key areas, such as Community, Corporate Giving and Trusts and Foundations. It is also essential to focus on 'in aid of giving' and regular giving. This is an exciting time for the Charity with our focus being on:

- Delivering for our beneficiaries
- Fundraising opportunities
- Creating new opportunities through our existing and new networks.

As the Trust develops its volunteer service, the Charity will work with the volunteer's team to create opportunities for a wide range of individuals. Volunteers are the backbone of any charity, and a great area of support for the Charity. The Charity will create a robust volunteer process, with clear guidelines and make internal adjustments to onboard the volunteers promptly and safely.

The Fundraising team will continue to raise awareness of the Charity through its digital channels; social media will be our focus next year and something we look forward to developing as we grow. Understanding the Charity's work is critical to building a strong following in these current times. We have had many articles and local PR stories in the local press. There is an expectation of a high online presence with many public followers, and we have made some improvements in some critical areas. We now have 'Facebook Giving', a valuable and accessible platform for supporters to donate and we have introduced QR codes, making it easy for people to access our website's donate page.

3. Financial Review

3.1. Summary

The net assets of the Charity as at 31 March 2023 were £2,137,552 (compared to £2,217,902 in 2022).

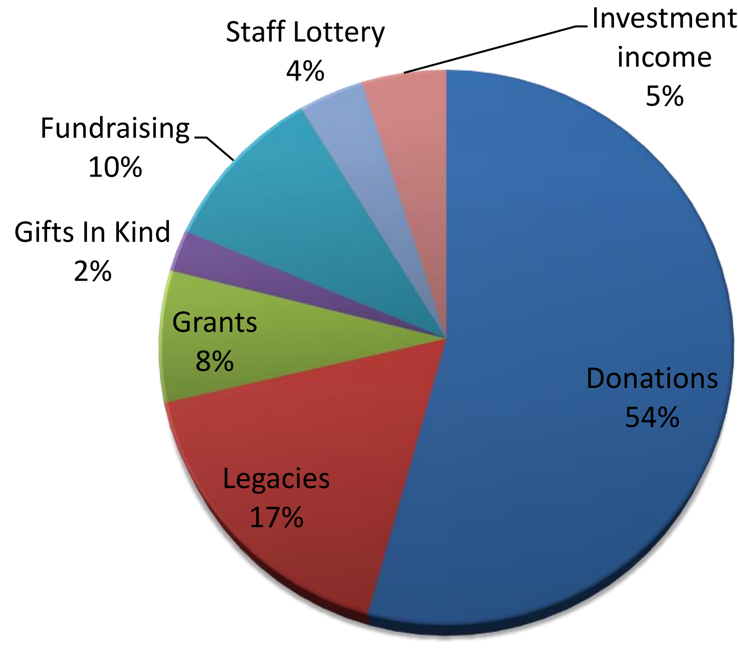
During the year, income (excluding unrealised and realised investment losses) was £1,057,247, an increase of £755,002 on the previous year, £302,245. Total expenditure for the year was £1,046,105, which represents an increase of £497,505 on the previous year, £548,600. This resulted in excess income over expenditure of £11,142 which, together with realised and unrealised gains and losses from the investment portfolio totalling £91,492, has led to an overall decrease in net assets of £80,350. The Charity will only fund items when it has cash available. It also has funds in reserves to cover operating costs.

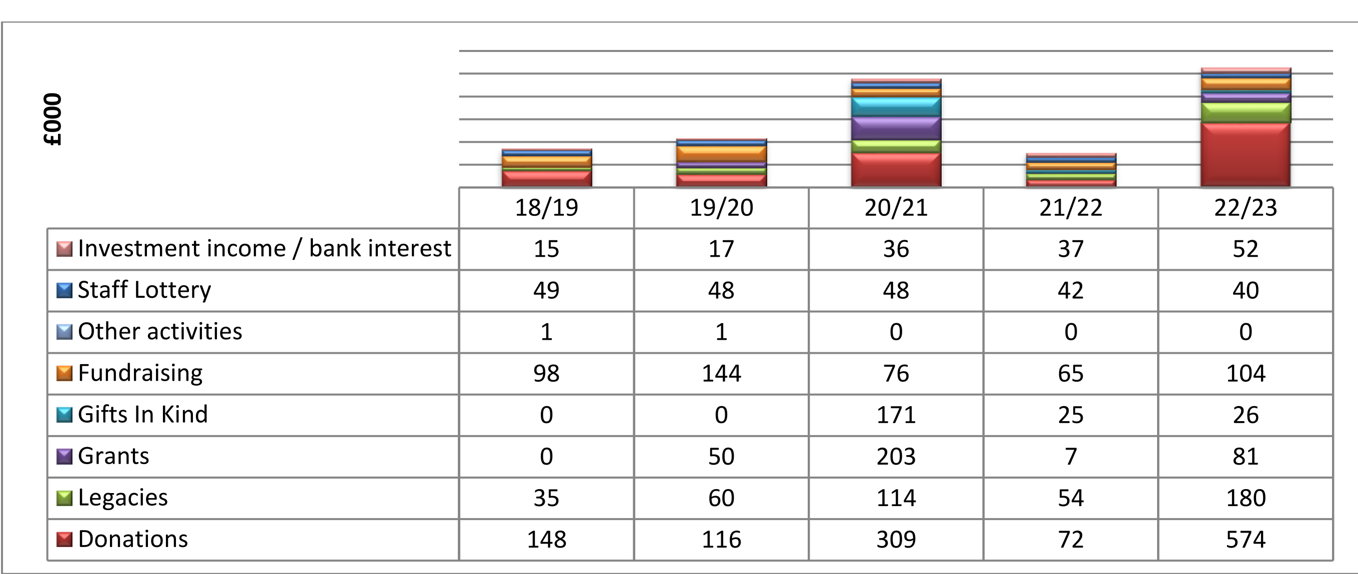
The Charity continues to rely on donations, fundraising, legacies, and investment income as the main sources of income. Fundraising income has gradually started to increase to near pre-pandemic levels. The Charity continues to invest in its growth to secure long term sustainable income.

The Charity uses Rathbones Investment Management to manage its investments and also holds an investment with The Charles and Elsie Sykes Trust. For this financial year, there has been a realised and unrealised loss on investments of £91,492 (£74,064 unrealised gain in 2022).

The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts.

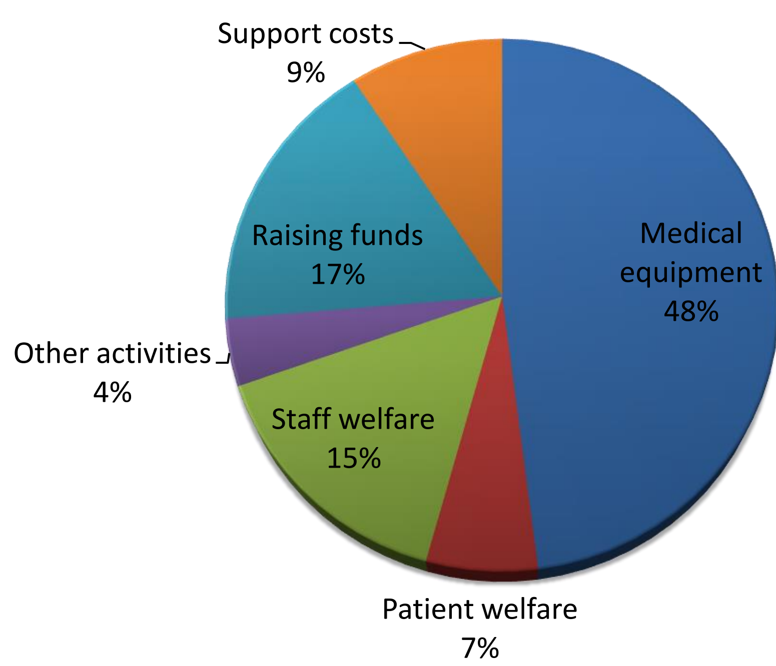
3.2. Sources of Income for the Charity 2022/23 (£000)

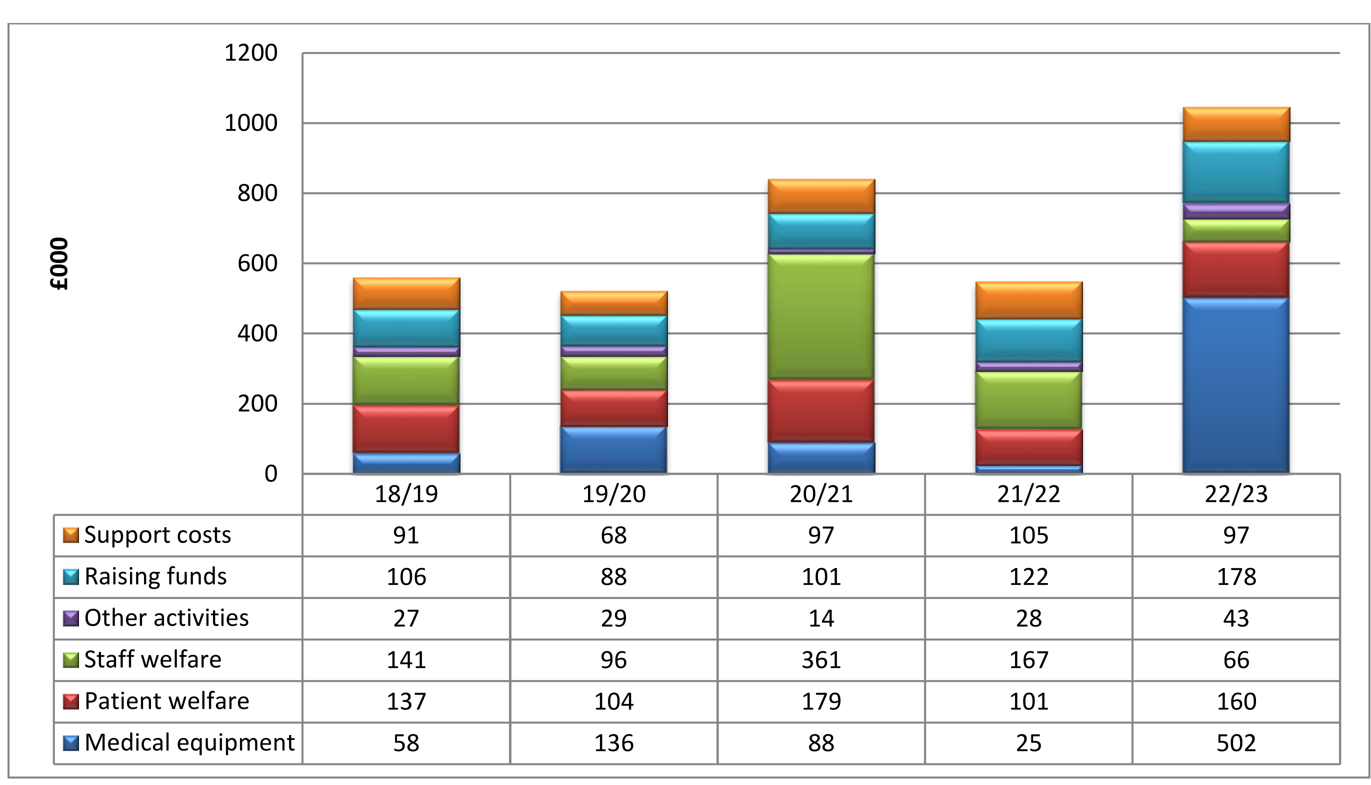




	18/19	19/20	20/21	21/22	22/23
Investment income / bank interest	15	17	36	37	52
Staff Lottery	49	48	48	42	40
Other activities	1	1	0	0	0
Fundraising	98	144	76	65	104
Gifts In Kind	0	0	171	25	26
Grants	0	50	203	7	81
Legacies	35	60	114	54	180
Donations	148	116	309	72	574

3.3. How funds were spent 2022/23 (£000)





	18/19	19/20	20/21	21/22	22/23
Support costs	91	68	97	105	97
Raising funds	106	88	101	122	178
Other activities	27	29	14	28	43
Staff welfare	141	96	361	167	66
Patient welfare	137	104	179	101	160
Medical equipment	58	136	88	25	502

4. Structure, governance, and management

4.1. Corporate Trustee

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to NHS Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee ("the Committee"), which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity.

Members of the Trust Board of Directors are not individual Trustees under Charity Law but act as agents of the Corporate Trustee. The Board of Directors approves which members become the agents of the Corporate Trustee and are introduced to the Charity through Board standing orders / Executive Leads.

The following members of the Board of Directors served on behalf of the Corporate Trustee during the year:

Maxwell Mclean (Chairperson)
Altaf Sadique (Non-Executive Director and Deputy Chair)
Mel Pickup (Chief Executive)
John Holden (Director of Strategy & Integration / Deputy Chief Executive)
Karen Dawber (Chief Nurse)
Matthew Horner (Director of Finance)
Julie Lawreniuk (Non-Executive Director)
Mohammed Hussain (Non-Executive Director)
Karen Walker (Non-Executive Director)

The Charity General (unrestricted) Fund was established using the model Declaration of Trust, and all funds held on trust as at the date of registration (April 1997) were either part of this unrestricted fund or registered as separate designated funds within the Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund, and by designating funds the Corporate Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers, and staff.

4.2. Charity Operational Committee

The Charity Operational Committee meets every two months and is a Committee of the Charity. Its purpose is to give additional assurance to the Committee that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the Charity's own governing document. It does not remove from the Committee the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary.

Membership:

Chair:
Director of Strategy & Integration / Deputy Chief Executive
Members:
Associate Director of Corporate Governance / Board Secretary (Deputy Chair)
Charity Director
Deputy Finance Director
Assistant Director of Finance
Head of Charity Operations
Head of Fundraising
Charity PR and Communications Officer
AHP Representative
Nurse Representative
Doctor Representative
Manager Representative
HR Representative
Estates and Facilities Representative
Representative of each of the Four Funds (Sunshine, Childrens, Cancer and Dementia & Elderly)

4.3. Structure of funds

The primary issue to be considered in any expenditure decision is whether the expenditure is within the scope of the objects of the Charity. Charitable purposes within the NHS translate to prevention or relief of sickness, disease or human suffering of patients served by the NHS. This does not preclude expenditure on staff as long as the benefit to staff translates demonstrably to relief of sickness of NHS patients.

The Charity has a decision making and approval process whereby an expenditure form needs to be completed. The expenditure form is structured in sections covering the key principles that fund holders need to consider and includes the requirement for the appropriate authorised signatories.

The Charity has started an exercise to rationalise the existing trust funds into four main funds - Sunshine, Childrens, Cancer and Dementia & Elderly. A fifth fund ('Other') has also been set up for funds that are related to governance and admin. Over the next two years, the intention is to merge the existing trust funds into one of the four new funds.

The General Fund

This comprises of gifts received by the Charity where no particular preference as to their expenditure has been expressed by donors.

Designated (earmarked) Funds

Under the new structure, this will be the Childrens, Cancer, and Dementia & Elderly. These usually contain donations where the donor expressed a preference to benefit a particular department or activity of the Trust at the time of making the donation. This preference can also include benefit to staff welfare, thereby enhancing both patient care and public benefit.

Whilst the donor's preference is not binding on the Corporate Trustee, the designated funds reflect these preferences. The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area. Fund holders' recommendations are generally accepted, and these funds can be spent at any time.

The funds available for spending are allocated to specialties within the Trust's clinical management structure.

Restricted Funds

This comprises of gifts received by the Charity where a specific instruction as to their expenditure has been expressed by donors. These funds must only be used in accordance with specific restrictions imposed by the donor. At present, the Charity has one restricted fund, which was primarily established for the grants received from NHS Charities Together.

Endowment Funds

The Charity has "Capital in Perpetuity" (CIP) funds, which consist of five expendable endowment funds and one permanent endowment fund (which cannot be spent). These funds provide investment income.

4.4. Public benefit

The Corporate Trustee conducts its activities with regard to the Charity Commission guidance on Public Benefit in section 4 of the Charities Act 2011.

The key principles of public benefit are:

- there must be identifiable benefit(s); and
- benefit must be to the public or to a section of the public.

The Corporate Trustee seeks to meet these principles in a number of ways. It has established a system of expenditure approval that ensures proper consideration is given to what the benefits of its activities are and who will benefit. The Corporate Trustee considers that, because its activities are patient focussed and contribute to the health of NHS patients, it clearly provides public benefit. In providing public benefit the Corporate Trustee is careful to ensure that its activities do not unreasonably restrict access to charitable benefit within the scope of Declaration of Trust or cause any detriment or harm. Charitable funds may be used to partially fund staff welfare and professional education / training, where this is in addition to the provision ordinarily afforded by the NHS. As professional education / training can also be a personal benefit, care has been taken to establish that this is incidental to the patient benefit. These requests demonstrate a direct link between professional education / training and the benefit for Bradford patients. To minimise risk and restrict harm, medical equipment purchases are made through the Trust's procurement processes, which help to ensure compliance with legislation, including Health and Safety and Equality and Diversity.

Staff appointments are subject to the Trust's policies and procedures to reflect good practice in recruitment and retention. The members of the Board of Directors receive a comprehensive induction upon their appointment to the Trust; this includes relevant information regarding the Charity and the Committee. Specific training regarding the duties of trustees has been paused during the pandemic but is being planned to take place again during 2022/23.

4.5. Governance

The Charity is constituted by trustees incorporated as a body and is governed by a Declaration of Trust of 25 March 1997. This is the formal document which sets out information on what the Charity is set up to do (objects), how the Charity will do this (powers) and administrative provisions.

Acting for the Corporate Trustee, the Committee is responsible for the overall management of the Charity and is required to:

- control, manage and monitor the use of the Charity's resources;

- provide support, guidance, and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income, ensure that "best practice" is followed in the conduct of all its affairs fulfilling all its legal responsibilities;
- ensure that the approved investment policy approved by the Board of Directors as Corporate Trustee is adhered to, and that performance is continually reviewed, and ethical considerations are applied; and
- keep the Board of Directors fully informed on the activity, performance, and risks of the Charity.

These are all included in the Committee's terms of reference. The accounting records and the day-to-day administration of the Charity are dealt with by the finance department of the Trust. These costs are re-charged to the Charity. The Charity has policies on expenditure, investments and reserves as well as guidelines for fund holders.

4.6. Day to day management of the Charity

The Director of Strategy & Integration / Deputy Chief Executive, John Holden, has day to day responsibility for the management of the Charity.

Matthew Horner, Director of Finance, is the Executive Director with overall responsibility for financial management and accounting for the Charity during the year. Matthew Horner can personally approve, on behalf of the Corporate Trustee, all expenditure over £500, with an upper limit of £10,000, using his delegated authority. For expenditure from £10,000 to £50,000, approval must be obtained from the Chief Executive of the Trust. For any expenditure over £50,000, approval needs to be obtained from the Chairperson of the Trust. For any expenditure over £100,000, approval needs to be obtained from the Corporate Trustee.

Michael Quinlan, Deputy Director of Finance, acted as the principal officer overseeing the day-to-day financial management and accounting for the Charity during the year.

Principal office

Bradford Hospitals' Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Principal professional advisers:

Auditors

Moore Kingston Smith LLP
6th Floor
9 Appold Street
London EC2A 2AP

Investment Advisors
Rathbone Investment Management
Port of Liverpool Building
Pier Head
Liverpool
L3 1NW

Bankers
HSBC
47 Market Street
Bradford
BD1 1LW

4.7. Board of Directors

The Charity has a Corporate Trustee, the Trust. The members of the Trust Board of Directors who served during the financial year and up to the date of signing of the financial statements were as follows:

Executive directors:

Name	Role	Appointed	To
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer / Deputy Chief Executive	12/10/2020	Present
Ms Pat Campbell*[1]	Director of Human Resources	01/12/2008	31/03/2023
Professor Karen Dawber	Chief Nurse	29/08/2016	Present
Mr John Holden	Director of Strategy and Integration / Deputy Chief Executive	22/08/2016	Present
Mr Mark Holloway*	Director of Estates and Facilities	06/07/2020	Present
Mr Matthew Horner	Director of Finance	01/08/2012	Present
Dr Paul Rice*	Chief Digital and Information Officer	01/01/2021	Present
Dr Ray Smith	Chief Medical Officer	01/01/2021	Present
*Non-voting Executive Director [1]Ms Pat Campbell retired on 31 March 2023			

Non - executive directors:

Name	Role	Term start	Term end
Dr Maxwell Mclean	Chairman	01/05/2019	30/04/2025
Professor Janet Hirst	Non-Executive Director	13/09/2021	Resigned 31/01/2023
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	31/08/2025
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2025
Ms Sughra Nazir	Non-Executive Director	20/01/2022	19/01/2025
Mr Jon Prashar	Non-Executive Director	01/02/2018	31/01/2024
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2023
Mr Barrie Senior	Non-Executive Director	01/12/2017	30/11/2023
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2023

Reference and administrative details

The Charity, registered charity number 1061753, was entered on the Central Register of Charities on 09 April 1997. The name of the charity changed from 'Bradford Teaching Hospitals NHS Foundation Trust Charitable Fund' in August 2014 to 'Bradford Hospitals Charity', with no change being made to the objectives of the Charity.

The Charity consists of 158 funds as at 31 March 2023 (2022: 160), and the notes to the accounts distinguish the types of funds held and disclose separately all material funds (funds with balances over £50,000). The funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Trustee.

4.8. Investments policy and performance

The Charity uses Rathbone Investment Management to invest the funds of the Charity. The assets of the Charity must be invested in accordance with the declaration of Trust and are governed by the Trustee Act 2000. The investment policy addresses the needs of the Charity and its beneficiaries in the short, medium, and long term by aiming to balance both capital growth and income generation. The Charity has an investment policy which is reviewed annually.

The overall objectives are to generate sufficient income and capital growth to enable the Charity to carry out its purposes consistently year on year with due and proper consideration for future needs and the maintenance of and, if possible, enhancement of the value of the invested funds while they are retained. The Charity recognises that every investment carries risk. Equally, not investing at all carries the risk of lost asset value in real terms, and the consequent reputational risk of poor stewardship.

The Charity has considered the seven types of risk identified by the Charity Commission in its guidance Charities and investment matters: a guide for trustees (CC14), namely:

- Capital risk – loss of capital and volatility
- Liquidity risk
- Market risk (e.g., inflation; interest rate; exchange rate; regulatory risks)
- Valuation risk
- Counterparty risk
- Tax risk
- Environmental, social and governance

The Charity has decided that to mitigate risk it will have a diversified portfolio of investments, both in asset class and individual investment, and will be invested such that the overall risk profile of the funds is 'medium' with the specific investment strategy to be agreed with our investment manager.

The Charity permits investments in the following assets:

- Listed UK equities
- International equities quoted on a recognised stock exchange
- Government gilts
- Corporate bonds
- Interest bearing cash deposits in UK banks or building societies
- Cash

The Charity has appointed professional investment managers to oversee its investments. In addition to managing the Charity's portfolio of investments, they provide the Charity with advice on specialist areas including market risk. The Charity does not pay tax on investment income as it is applied to a charitable purpose. The investment managers also ensure the Charity's portfolio reflects environmental, social and governance concerns such as ceasing investments with Russian companies since the start of the war in Ukraine.

Ethical considerations are included which in general terms seek to obtain the best financial return from the Charity's investments consistently and with commercial prudence. The Charity will not invest directly in companies which are primarily involved in the production of alcohol, tobacco, armaments, or gambling. Our investment manager is encouraged to monitor the collective investments held, in so far as is practicable, such that any indirect exposure in these areas is minimised.

In the year to 31st March 2023, the investment portfolio of the Charity, managed by Rathbones, produced a total return (the combination of capital growth and income) of -4.0%, giving back some of the gains achieved in the prior year. This compares to the benchmark (MSCI PIMFA Income Index) total return of -3.9%.

This year has been tumultuous, caused by a rapid increase in inflation, the subsequent rise in interest rates and the conflict in Ukraine creating significant geopolitical tensions. Against this backdrop, Gilts were down 16.3%, UK equities rose 2.9% while global equities were down 1.0%.

The driving factors for markets remain centred on the outlook for inflation, interest rates and the impact this will have on the real global economy as well as the continuing Russia/Ukraine conflict. Our investment manager will continue to actively manage the portfolio in response to the changing economic and political landscape.

The Charity has a capital in perpetuity fund (Elsie Sykes CIP fund) that is held for investment, with income generated to be used for charitable purposes, as specified in the endowment terms. This is currently invested with the Charles and Elsie Sykes Trust and was valued at £229,874 as at 31 March 2023.

4.9. Reserves policy

The Charity has a reserves policy requiring reserves to be maintained at a level equivalent to the cost of maintaining the Charity team for one year. The Charity has total funds of £2,137,552 of which, £36,299 is restricted and not available to fund general purposes and £293,000 which is held in the permanent endowment funds and are excluded from reserves. The Charity holds £1,809,090 of designated funds as its reserves. This is equivalent to approximately 4 years of expenditure. As at 31 March 2023, there are no material designated funds or commitments, with expenditure of approximately £200,000 forecast in the forthcoming year. In addition to the unrestricted and designated funds held in reserves, the Trustee has the power, if it so wishes, to spend any of the expendable endowment. However, the expendable endowment is used to generate income, supplementing the income from donations and legacies. The Trustee will therefore only spend the expendable endowment on an exceptional basis.

It is not anticipated that the Charity will deploy funding towards any projects before donations have been received which mitigates the risk of any planned commitments, or designations, that cannot be met by future income alone. In other words, commitment is made by the Charity after funding has been identified / receipted.

4.10. Risk management

The Corporate Trustee has considered any major risks to which the Charity is exposed. The Corporate Trustee aims to mitigate the risk that income will fall by engaging with the Fundraising department. The fundraising department works with the Charity and engages with the local community to raise funds through a programme of events and encouraging donations. The Charity seeks to generate income from multiple sources to help mitigate shortfalls in any one area. This includes a programme of fundraising activity, fundraising appeals, legacies and, applying for grants.

The Corporate Trustee has agreed to invest in a fundraising strategy, with a long-term ambition to engage with the public and to further enhance the environment of the Trust.

The investment portfolio is well diversified to help protect the Charity against any fall in value of a particular market. The Investment Manager holds a discretionary mandate which enables them to make investment and divestment decisions on the Charity's behalf. The Charity works closely with the Investment Manager to ensure that the investment policy is reviewed regularly.

The investment strategy is to protect the long-term value of the portfolio in absolute terms and in terms of purchasing power once the impact of inflation is considered. To achieve this, the Investment Managers have inevitably invested a substantial amount of the portfolio in equities, both in the UK and overseas.

Any investment gains and losses, although reflected in the Charity's accounts are not, realised as such unless and until the investments concerned are actually sold.

4.11. Partnership working and networks

The Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee of the Charity. Effective partnership with the Trust ensures that the funds are used to best effect. When deciding upon the most beneficial way to use the Charity funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Trust.

5. Future plans

The Charity's priorities are those set out in the Trust's mission statement: 'to provide the highest quality healthcare at all times'. The vision for the Trust that describes its ambition and where it wants to be as an organisation in five years' time is 'to be an outstanding provider of healthcare, research and education, and a great place to work'. Meeting this mission and vision will maximise the impact of the Charity and its benefits to the beneficiaries of the Charity who are primarily the NHS patients of Bradford, through three core values:

- We care;
- We value people; and
- We are one team.

In order to enhance and improve the current levels of care for NHS patients throughout the Trust, the Charity has planned expenditure in a number of areas. The Charity will also continue to enhance the refurbishment of wards and clinical areas from basic specification to higher quality.

The Fundraising department will also look to expand its fundraising activities towards achieving its goal of raising additional funds over the next five years. The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises.

6. Financial Statements for the year ended 31 March 2023

The accounts of the funds held on trust by the Trustee appointed as stated below:

6.1. Foreword

The Corporate Trustee present their report and the audited financial statements of the Charity for the year ended 31 March 2023. The Trustee has adopted the provisions of the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" (FRS 102) in preparing the annual report and financial statements of the Charity.

The financial statements have been prepared in accordance with the accounting policies set out in the notes to the accounts and comply with the Charity governing document, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable to the UK and Republic of Ireland published on 16 July 2014, updated with the second edition released in October 2019.

6.2. Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

The Trustee is responsible for preparing the Trustee Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust Deed. It is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By order of the Trustee

Signed:

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Chairperson of the Corporate Trustee	Date
--	---
Chief Executive of the Corporate Trustee	Date

6.3. Independent Auditor's Report to the Trustees of Bradford Hospitals Charity

Opinion

We have audited the financial statements of Bradford Hospitals Charity for the year ended 31 March 2023, which comprise the Statement of Financial Activities, the Balance Sheet, the Cash Flow Statement, and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including FRS 102 'The Financial Reporting Standard Applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2023, and of its incoming resources and application of resources, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the audit of the financial statements section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The trustee is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on

the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other matter

The comparative figures in the financial statements of Bradford Hospitals Charity were not audited, as the charity did not require a statutory audit under the Charities Act 2011 in the prior year.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

- the information given in the Trustee's Annual Report is inconsistent in any material respect with the financial statements; or
- the charity has not kept adequate accounting records; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we required for our audit.

Responsibilities of trustee

As explained more fully in the trustee's responsibilities statement set out on page 16, the trustee is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustee either intends to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's Responsibilities for the audit of the financial statements

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK) we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the charity's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustee.

- Conclude on the appropriateness of the trustee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the charity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the charity to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

The objectives of our audit in respect of fraud, are; to identify and assess the risks of material misstatement of the financial statements due to fraud; to obtain sufficient appropriate audit evidence regarding the assessed risks of material misstatement due to fraud, through designing and implementing appropriate responses to those assessed risks; and to respond appropriately to instances of fraud or suspected fraud identified during the audit. However, the primary responsibility for the prevention and detection of fraud rests with both management and those charged with governance of the charity.

Our approach was as follows:

- We obtained an understanding of the legal and regulatory requirements applicable to the charity and considered that the most significant are the Charities Act 2011, the Charity SORP, and UK financial reporting standards as issued by the Financial Reporting Council.

- We obtained an understanding of how the charity complies with these requirements by discussions with management and those charged with governance.

- We assessed the risk of material misstatement of the financial statements, including the risk of material misstatement due to fraud and how it might occur, by holding discussions with management and those charged with governance.

- We inquired of management and those charged with governance as to any known instances of non-compliance or suspected non-compliance with laws and regulations.

- Based on this understanding, we designed specific appropriate audit procedures to identify instances of non-compliance with laws and regulations. This included making enquiries of management and those charged with governance and obtaining additional corroborative evidence as required.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

Use of our report

This report is made solely to the charity's trustee, as a body, in accordance with Chapter 3 of Part 8 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to any party other than the charity and charity's trustee as a body, for our audit work, for this report, or for the opinion we have formed.

Moore Kingston Smith LLP
Statutory auditor

6th Floor
9 Appold Street
London
EC2A 2AP

Date:

Moore Kingston Smith LLP is eligible to act as auditor in terms of Section 1212 of the Companies Act 2006.

6.4. Statement of financial activities for the year ended 31 March 2023

	Notes	Unrestricted funds 2023 £000	Restricted funds 2023 £000	Endowment funds 2023 £000	Total funds 2023 £000	Total funds 2022 £000
Income from:						
Donations and legacies	**4**	361	500	0	861	158
Other trading activities	**5**	144	0	0	144	107
Investment income	**7**	52	0	0	52	37
Total incoming resources		**557**	**500**	**0**	**1,057**	**302**
Expenditure on:						
Raising funds	**8**	(177)	(1)	0	(178)	(122)
Charitable activities	**9**					
Medical equipment		(2)	(501)	0	(503)	(34)
Staff education & welfare		(94)	0	0	(94)	(221)
Patient welfare		(170)	(40)	0	(210)	(134)
Other expenditure		(61)	0	0	(61)	(37)
Total charitable activities		**(327)**	**(541)**	**0**	**(868)**	**(427)**
Total expenditure		**(504)**	**(542)**	**0**	**(1,046)**	**(548)**
Net gains / (losses) on investments	**15**	(82)	0	(9)	(91)	74
Net expenditure		**(29)**	**(42)**	**(9)**	**(80)**	**(172)**
Net movement in funds		**(29)**	**(42)**	**(9)**	**(80)**	**(172)**
Reconciliation of funds						
Total funds brought forward	**21**	1,838	78	302	2,218	2,390
Total funds carried forward		**1,809**	**36**	**293**	**2,138**	**2,218**

The statement of financial activities includes all gains and losses recognised during the year.

The notes on pages 24 to 39 form part of these accounts and the comparative Statement of financial activities on page 28.

6.5. Balance Sheet as at 31 March 2023

	Note	Unrestricted funds 2023 £000	Restricted funds 2023 £000	Endowment funds 2023 £000	Total funds 2023 £000	Total funds 2022 £000
Fixed assets						
Investments	**15**	1,188	0	230	1,418	1,520
Total fixed assets		**1,188**	**0**	**230**	**1,418**	**1,520**
Current assets						
Debtors	**16**	152	500	0	652	66
Cash and cash equivalents	**17**	500	36	63	599	694
Total current assets		**652**	**536**	**63**	**1,251**	**760**
Liabilities						
Creditors due within one year	**18**	(31)	(500)	0	(531)	(62)
Net current assets		**621**	**36**	**63**	**720**	**698**
Total assets less current liabilities		**1,809**	**36**	**293**	**2,138**	**2,218**
Total net assets		**1,809**	**36**	**293**	**2,138**	**2,218**
The funds of the Charity:	**21**					
Unrestricted funds		20	0	0	20	152
Restricted funds		0	36	0	36	78
Designated funds		1,789	0	0	1,789	1,686
Endowment funds		0	0	293	293	302
Total Charity funds		**1,809**	**36**	**293**	**2,138**	**2,218**

These accounts together with notes on pages 24 to 39 were approved and authorised for issue by the Corporate Trustee on:

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Director of Finance Date

6.6. Statement of Cash Flows for the year ending 31 March 2023

	Note	Total funds 2023 £000	Total funds 2022 £000
Cash flows from operating activities:			
Net cash used in operating activities	**19**	**(193)**	**(201)**
Cash flows from investing activities:			
Dividends and interest from investments	**7**	52	37
Proceeds from sales of investments	**15**	135	135
Purchase of investments	**15**	(89)	(186)
Net cash provided by / (used in) investing activities		**98**	**(14)**
Change in cash and cash equivalents in the reporting period		(95)	(215)
Cash and cash equivalents at the beginning of the reporting period	**17**	694	909
Cash and cash equivalents at the end of the reporting period	**17**	**599**	**694**

The Charity had no cash equivalents and no net debt as at 31 March 2023 (2022: None)

Notes to the accounts

1.0 Accounting policies

a. Basis of preparation of the financial statements

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) issued in October 2019 and the Charities Act 2011 and UK Generally Accepted Practice. The Charity constitutes a public benefit entity as defined by FRS102.

The significant accounting policies are set out below.

b. Accounting convention

The financial statements are prepared under the historic cost convention, except for investments which are held on a revaluation basis, and are rounded to the nearest thousand. The Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future as it does not intend to liquidate the Charity or to cease its operations. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts. A robust reserve policy, strengthened by the fact the Charity has no material long term commitments, and having internal governance to ensure the Charity is only spending funds that are available, allows the Corporate Trustee to consider the Charity to be a going concern.

c. Income

Income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of income can be measured with sufficient reliability.

Where there are terms or conditions attached to income, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

d. Accounting for legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted;
- The executors have established that there are sufficient assets in the estate to pay the legacy; and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

e. Investment income

Dividends are included in the Statement of Financial Activities when they are declared and at an amount which includes the tax credit recoverable from HM Revenue and Customs.

f. Recognition of liabilities

Liabilities are recognised on an accruals basis in accordance with generally accepted accounting practice.

g. Expenditure

Expenditure is accounted for on an accruals basis and has been classified under appropriate headings.

Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the appropriate heading for the expenditure on which it was incurred.

h. Commitments

Expenditure is recognised as a commitment liability where a recipient has a reasonable expectation that they will receive the assets or services in lieu of a grant.

i. Fundraising costs

Fundraising costs are those costs attributable to generating income for the Charity and are distinct from costs incurred in undertaking charitable activities.

j. Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal audit and external independent examination (audit) costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 12.

k. Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

l. Realised and unrealised gains and losses

Realised gains and losses are included in the accounts at the date on which a contractual obligation is entered into.

Unrealised gains and losses are computed by reference to the market value of the investments at the balance sheet date as compared to the brought forward cost or valuation, and gains and losses arising on similar categories of investments are netted off.

m. Investments held by the Charity

Investments are stated at mid-market value at the balance sheet date. Investments in non-puttable ordinary shares (where shares are publicly traded, or their fair value is reliably measurable) are measured at fair value through the Statement of Financial Activities. Where fair value cannot be measured reliably, investments are measured at cost less impairment. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

n. Taxation

As a registered charity, the Charity is exempt from income and corporation tax to the extent that its income and gains are applicable to charitable purposes only.

o. Fund's structure policy

The Charity maintains a General (unrestricted) Fund, which comprises monies which are expendable at the discretion of the Corporate Trustee in the furtherance of the objects of the Charity. These monies may be held in order to finance both working capital and capital investment.

Designated Funds are that part of the Charity's unrestricted funds in respect of which a preference has been expressed by donors that they be used for particular purposes. The Corporate Trustee has the power to re-designate such funds within unrestricted funds.

Endowment Funds are funds which are to be used in accordance with specific restrictions imposed by the donor in the sense that the restriction requires the gift to be invested to produce income. Where the Corporate Trustee has the power to spend the capital, these are expendable endowments. The Charity has five expendable endowments and one permanent endowment, which are disclosed in note 22.

Restricted Funds are funds to be used in a specific way or for a specific purpose. They are considered as a contract between the donor and the Charity.

There is no formal policy of transfer between funds other than that described above.

p. Debtors

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. Trade and other debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

q. Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due. Amounts which are owed in more than a year are shown as long-term creditors.

r. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.
This includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

s. Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, which are described in note 1, the Corporate Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Corporate Trustee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure.

t. Gifts in kind

Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed. Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed. Gifts in kind, such as food and care packages are not accounted.

2.0 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the three types of funds that the Charity manages.

2.1 Unrestricted funds – Statement of Financial Activities for the year ended 31 March 2023

	Notes	2023 £000	2022 £000
Income from:			
Donations and legacies	**4**	361	139
Other trading activities	**5**	144	100
Investments	**7**	52	37
Total incoming resources		**557**	**276**
Expenditure on:			
Raising funds	**8**	(177)	(116)
Charitable activities	**9**		
Medical equipment		(2)	(34)
Staff education & welfare		(94)	(203)
Patient welfare		(170)	(122)
Other activities		(61)	(37)
Total charitable activities		**(327)**	**(396)**
Total expenditure		**(504)**	**(512)**
Net gains / (losses) on investments	**16**	(82)	61
Net expenditure		**(29)**	**(175)**
Net movement in funds		**(29)**	**(175)**
Reconciliation of funds			
Total funds brought forward	**22**	1,838	2,013
Total funds carried forward		**1,809**	**1,838**

Unrestricted funds – Balance Sheet as at 31 March 2023

	Notes	As at 31 March 2023 £000	As at 31 March 2022 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	1,188	1,281
Total fixed assets		**1,188**	**1,281**
Current assets			
Debtors	**17**	152	66
Cash and cash equivalents	**18**	500	553
Total current assets		**652**	**619**
Liabilities: -			
Creditors due within one year	**19**	(31)	(62)
Net current assets		**621**	**557**
Total assets less current liabilities		**1,809**	**1,838**
Total net assets	**22**	**1,809**	**1,838**
Total assets for unrestricted funds		**1,809**	**1,838**

2.2 Restricted funds – Statement of Financial Activities for the year ended 31 March 2023

	Notes	2023 £000	2022 £000
Income from:			
Donations and legacies	**4**	500	19
Other trading activities	**5**	0	7
Income from investments	**7**	0	0
Total incoming resources		**500**	**26**
Expenditure on:			
Raising funds	**8**	(1)	(6)
Charitable activities	**9**		
Medical equipment		(501)	0
Staff education & welfare		0	(18)
Patient welfare		(40)	(12)
Other activities		0	0
Total charitable activities		(541)	(30)
Total expenditure		**(542)**	**(36)**
Net gains/(losses) on investments	**16**	**0**	**0**
Net expenditure		**(42)**	**(10)**
Net movement in funds		**(42)**	**(10)**
Reconciliation of funds			
Total funds brought forward	**22**	78	88
Total funds carried forward		**36**	**78**

Restricted funds – Balance Sheet as at 31 March 2023

	Notes	As at 31 March 2023 £000	As at 31 March 2022 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	0	0
Total fixed assets		**0**	**0**
Current assets			
Debtors	**17**	500	0
Cash and cash equivalents	**18**	36	78
Total current assets		**536**	**78**
Liabilities: -			
Creditors due within one year	**19**	(500)	0
Net current assets		**36**	**78**
Total assets less current liabilities		**36**	**78**
Total net assets	**22**	**36**	**78**
Total assets for restricted funds		**36**	**78**

2.3 Expendable Endowment funds – Statement of Financial Activities for the year ended 31 March 2023

The Charity has five expendable endowment funds (capital in perpetuity funds (CIP)), with a combined balance of £62,290 (2022: £62,290) and one permanent endowment fund, with a balance of £229,874 (2022: £239,316), that have been brought forward from previous years. During 2022-23, any income received has been recognised within the investment income.

The permanent endowment fund has been invested with the Charles and Elsie Sykes Trust.

3.0 Related party transactions

The Trust (which succeeded Bradford Teaching Hospitals NHS Trust on 1 April 2004) is the Corporate Trustee of the Charity and is governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Committee, which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity from the Trust. None of the trustees or members of the Trust or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind.

Related party expenditure transactions relate to items such as salary recharges and internal audit fees with the Trust.

Payables

	2023 £000	2022 £000
The following amounts were owed by the Charity to the Trust as at 31 March	515	13
	515	**13**

Expenditure

	2023 £000	2022 £000
Value of transactions during the year with the Trust	733	284
	733	**284**

4.0 Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Donations	74	500	574	72
Grants	81	0	81	7
Legacies	180	0	180	54
Gifts in Kind	26	0	26	25
Total	**361**	**500**	**861**	**158**

Donations are from corporates, the community, patients and relatives of patients and staff. Donations of gifts in kind have been valued at their market value. All these donations have been distributed during the year.

5.0 Analysis of income from other trading activities

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Staff lottery	40	0	40	42
Fundraising	104	0	104	65
Total	**144**	**0**	**144**	**107**

The staff lottery is operating within the guidelines set out by the Gambling Commission.

6.0 Role of volunteers

The Charity does not have any general volunteers, but it does have approximately 100 fund holders. The fund holders are Trust staff members who manage how the Charity's designated funds should be spent, as part of their day-to-day duties. These funds are designated (or earmarked) to be spent for a particular purpose or in a particular ward or department. Each fund holder has delegated powers to approve spend for the designated funds that they manage, subject to the scheme of delegation as approved by the Corporate Trustee.

7.0 Gross investment income

The Charity earned interest and investment income of £52,004 (2022: £36,841).

8.0 Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Fundraising costs	33	0	33	18
Support costs	144	1	145	104
Total	**177**	**1**	**178**	**122**

9.0 Analysis of charitable expenditure

The Charity did not make any grant funding to third parties. All the charitable expenditure incurred was directly with third parties or reimbursed expenditure.

Unrestricted funds	**Direct charitable activities £000**	**Support costs £000**	**Total 2023 £000**	**Direct charitable activities £000**	**Support costs £000**	**Total 2022 £000**
Medical equipment	2	0	2	25	9	34
Staff education & welfare	66	28	94	152	51	203
Patient welfare	120	50	170	91	31	122
Other activities	43	18	61	28	9	37
	231	**96**	**327**	**296**	**100**	**396**

Restricted funds	**Direct charitable activities £000**	**Support costs £000**	**Total 2023 £000**	**Direct charitable activities £000**	**Support costs £000**	**Total 2022 £000**
Medical equipment	500	1	501	0	0	0
Staff education & welfare	0	0	0	15	3	18
Patient welfare	40	0	40	10	2	12
Other activities	0	0	0	0	0	0
	540	**1**	**541**	**25**	**5**	**30**

10.0 Analysis of grants

The Charity did not make any grants to individuals or other institutions.

11.0 Movements in funding commitments and liabilities

	Current liabilities £000	Non-current liabilities £000	Total 2023 £000	Total 2022 £000
Opening balance as at 01 April	62	0	62	105
Additional commitments made during the year	1,046	0	1,046	549
Amounts paid during the year	(577)	0	(577)	(592)
Closing balance as at 31 March	**531**	**0**	**531**	**62**

The Charity has expenditure that has been approved but not yet delivered or services not yet provided. Most expenditure is paid out in the same financial year. As the Charity has control over the expenditure, there is little uncertainty around these payments.

12.0 Allocation of support costs and overheads

	Raising funds £000	Charitable activities £000	2023 Total £000	Raising funds £000	Charitable activities £000	2022 Total £000	Basis
Internal audit	0	0	0	0	0	0	Salaries
External audit	4	3	7	6	8	14	Salaries
Other	7	6	13	6	8	14	Salaries
Governance	11	9	20	12	16	28	
Salaries	130	86	216	88	88	175	Hours
Computer expenses	4	2	6	4	2	6	Salaries
Total	**145**	**97**	**242**	**104**	**105**	**209**	

Salaries: this is proportionate to staff salaries where costs are related to the employed staff

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2023 Total £000
Raising funds	144	1	0	145
Charitable activities	96	1	0	97
	240	**2**	**0**	**242**

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2022 Total £000
Raising funds	98	6	0	104
Charitable activities	100	5	0	105
	198	**11**	**0**	**209**

13.0 Trustees' remuneration, benefits, and expenses

The Corporate Trustee receives no remuneration for the work it undertakes as trustee and claims no expenses from the Charity.

14.0 Analysis of staff costs and remuneration of key management personnel

The key management personnel of the Charity comprise the Charity Director and Deputy Director of Finance. The total cost of employing the charity's key management personnel during the year, including employer's social security and pension contributions was £46,731 (2021/22: £6,426).

The Charity does not employ members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity as a single cost. No employees had emoluments in excess of £60,000 (2022: £nil).

	2023 £000	2022 £000
Salaries and wages	170	142
National insurance costs	19	13
Employer's pension contribution	26	20
Total	**215**	**175**

15.0 Fixed asset investments

Investments held with Rathbones Investment Management:

	2023 £000	2022 £000
Market value at 01 April	1,281	1,231
Add: additions at cost	89	187
Less: disposals at carrying value and in year gain / (loss) on disposals	(125)	(125)
Add: net gain / (loss) on revaluation	(82)	61
Add: net gain / (loss) on disposals	10	11
Less: Movements in broker held bank accounts	15	(84)
Market value at 31 March of unrestricted investments	**1,188**	**1,281**

Fixed asset investment by type

	2023 £000	2022 £000
Fixed Interest	164	174
UK Equities	266	296
Overseas Equities	406	407
Alternatives	281	348
Total listed investments	**1,117**	**1,225**
Cash	71	56
Market value at 31 March of unrestricted investments	**1,188**	**1,281**

The historic cost of investments held with Rathbones Investment Management is £1,150,000 (2022: £1,150,000).

Investments held with the Charles and Elsie Sykes Trust:

	2023 £000	2022 £000
Market value at 01 April	239	226
Add: additions at cost	0	0
Add net gain (loss) on revaluation	(9)	13
Market value at 31 March of the permanent endowment fund	**230**	**239**

Fixed asset investment by type

	2023 £000	2022 £000
Equities	164	175
Bonds	50	32
Real Estate	5	6
Alternatives	5	5
Total listed investments	**224**	**218**
Cash	6	21
Market value at 31 March of the permanent endowment fund	**230**	**239**
Total value of investments held at 31 March	**1,418**	**1,520**

The historic cost of investments held with Charles and Elsie Sykes Trust is £228,365 (2022: £228,365).

Included in the above figures, are investment management charges of £10,868 (2022: £11,563).

16.0 Analysis of current debtors

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Prepayments and accrued income	152	500	652	66
NHS Debtor	0	0	0	0
Total	**152**	**500**	**652**	**66**

17.0 Analysis of cash and cash equivalents

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2023 £000	Total 2022 £000
Cash in hand	500	36	63	599	694
Total	**500**	**36**	**63**	**599**	**694**

No cash or cash equivalents were held in non-cash investments or outside of the UK. The Charity had no cash equivalents as at 31 March 2023 (2022: None).

18.0 Analysis of liabilities

	Unrestricted funds £000	Restricted funds £000	Total 2023 £000	Total 2022 £000
Creditors due within 1 year				
NHS Creditor	15	500	515	16
Other creditors	16	0	16	46
Total	**31**	**500**	**531**	**62**

The Charity has no creditors falling due after more than 1 year and has no contingent liabilities. An amount of £514,909 is owed to the Trust.

19.0 Reconciliation of net expenditure to net cash flow from operating activities

	2023 £000	2022 £000
Net (expenditure) / income (as per the statement of financial activities)	(81)	(172)
Adjustments for:		
Interest from Investments	(52)	(37)
Loss / (profit) on the sale of fixed assets investments	(35)	62
(Gains) / losses on investments	91	(74)
Decrease / (increase) in debtors	(585)	63
(Decrease) / increase in creditors	469	(43)
Net cash used in operating activities	**(193)**	**(201)**

20.0 Transfers between funds

There has been no transfer of funds between restricted and unrestricted funds.

21.0 Analysis of charitable funds

a) Analysis of unrestricted and material designated fund movements

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
General Fund	151	0	(132)	0	19
Bradford Cardiac	234	6	(41)	0	199
Rays A Smile	6	1	(6)	0	1
Born In Bradford	44	2	(35)	0	11
Ward 15 Legacy	61	0	(12)	0	49
Sunshine Fund	79	244	(62)	0	261
ICU Fund	66	10	(13)	0	63
The HJ Gajdecki Fund	70	0	0	0	70
NNU Appeal	78	37	(22)	0	93
Other designated funds	1,049	257	(181)	(82)	1,043
Total	**1,838**	**557**	**(504)**	**(82)**	**1,809**

	2022 Balance b/f £000	2022 Income £000	2022 Expenditure £000	2022 Gains and losses £000	2022 Fund c/f £000
General Fund	324	1	(174)	0	151
Bradford Cardiac	103	166	(35)	0	234
Rays A Smile	5	3	(2)	0	6
Born In Bradford	50	0	(6)	0	44
Ward 15 Legacy	69	0	(8)	0	61
Sunshine Fund	94	10	(25)	0	79
ICU Fund	68	6	(8)	0	66
The HJ Gajdecki Fund	70	0	0	0	70
NNU Appeal	72	28	(22)	0	78
Other designated funds	1,158	62	(232)	61	1,049
Total	**2,013**	**276**	**(512)**	**61**	**1,838**

An exercise to reduce the number of trust funds to four main funds will be taking place over the next two years.

b) Analysis of restricted fund movements

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Covid Fund	78	0	(42)	0	36
Sunshine Fund	0	500	(500)	0	0
Total	**78**	**500**	**(542)**	**0**	**36**

	2022 Balance b/f £000	2022 Income £000	2022 Expenditure £000	2022 Gains and losses £000	2022 Fund c/f £000
Covid Fund	88	**26**	(36)	0	**78**
Total	**88**	**26**	**(36)**	**0**	**78**

c) Analysis of endowment fund movements

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	239	0	0	(9)	230
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**302**	**0**	**0**	**(9)**	**293**

In 2019/20, the permanent endowment fund was invested with the Charles and Elsie Sykes Trust. The funds are held by the Charles and Elsie Sykes Trustees on trust for the Charity. £9,442 relates to an unrealised loss based on share values as at 31 March 2023.

	2022 Balance b/f £000	2022 Income £000	2022 Expenditure £000	2022 Gains and losses £000	2022 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	226	0	0	13	239
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**289**	**0**	**0**	**13**	**302**

22.0 The Charity as a subsidiary

The Trust, its patient's and its staff are the main beneficiaries of the Charity. The Trust is a related party by virtue of being the Corporate Trustee of the Charity. For accounting purposes, this means that the Charity is deemed to be a subsidiary of the Trust as it is 'controlled' by another entity through the trusteeship arrangements.

All Trusts are required to have a constitution, containing detailed information about how that Trust will operate. The purpose of the Trust is set out in its Constitution as follows:

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

The Trust may provide goods and services for any purposes related to:

- the provision of services provided to individuals for or in connection with the prevention, diagnosis, or treatment of illness, and
- the promotion and protection of public health.

The Trust accounts are available to the public online at the following web address:

https://www.bradfordhospitals.nhs.uk

They are also available by request from the Trust Secretary, using the details below:

Trust Secretary
Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ

LETTER OF REPRESENTATION

Bradford Hospitals' Charity
Registered Charity No: 1061753
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Moore Kingston Smith LLP
Chartered Accountants
9 Appold Street
London
EC2A 2AP

Dear Sirs,

We confirm to the best of our knowledge and belief the following representations given to you in connection with your audit of the charity's financial statements for the year ended 31 March 2023. We confirm that they are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you.

General

1) We acknowledge our responsibility for keeping adequate accounting records which disclose with reasonable accuracy at any time the financial position of the charity and enable us to ensure that the financial statements comply with the the Charities Act 2011.

2) We acknowledge our responsibility for preparing financial statements in accordance with the the Charities Act 2011 and United Kingdom Accounting Standards (UK Generally Accepted Accounting Practice/UK GAAP) and are satisfied that the financial statements give a true and fair view of the charity's financial position, and the results of its operations and charitable activities and its cash flows.

3) We acknowledge and agree it is our responsibility to design and implement internal control systems to prevent and detect fraud and error in safeguarding the assets of the charity.

4) We confirm that the accounting policies selected are suitable to the charity's circumstances and that they have been applied consistently; that any judgements and estimates made are reasonable and prudent; and that it is appropriate to prepare the financial statements on a going concern basis.

5) We confirm that the methods, significant assumptions and the data used by us in making estimates and their related disclosures, including those measured at fair value, are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of our adopted financial reporting framework.

Information Provided

6) We have provided you with:

a) access to all information, including minutes of all management and board meetings, of which we are aware is relevant to the preparation of the financial statements such as records, documentation and other matters;
b) additional information that you have requested from us for the purpose of the audit; and
c) unrestricted access to persons within the charity from whom you determined it necessary to obtain audit evidence.

7) All transactions have been recorded in the accounting records and are reflected in the financial statements.

8) We have disclosed to you the identity of all of the charity's related parties, related party relationships and transactions of which we are aware. Related party relationships and transactions have been appropriately accounted for and disclosed within the requirements of accounting standards.

Assets and Liabilities

9) All known assets and liabilities as at the balance sheet date have been included in the financial statements.

10) We confirm the charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets except those disclosed within the financial statements.

11) We confirm that the financial statements disclose appropriately all liabilities, actual and contingent and have disclosed all guarantees given to third parties.

12) The value and classification of assets and liabilities in the financial statements is not materially affected by management's plans and intentions.

13) We confirm that the charity was entitled to the £500,000 contribution towards the Da Vinci robot from Sovereign Healthcare as at 31 March 2023.

14) We confirm that the grant of the £500,000 for the Da Vinci robot was notified to the Trust before 31 March 2023 and has therefore been correctly included within creditors in the 2023 financial year.

15) We confirm that the following year-end cash and bank balances observed via the HSBC bank statements, plus/minus reconciling items, are correct in lieu of the receipt of 3rd party confirmation of the balances held with HSBC:
    - Sort: 40-13-15, account no.: 32406233- £158,991
    - Sort: 40-13-15, account no.: 53669297- £439,641

Transactions Involving Trustee/Directors and Connected Persons

16) We confirm that there are no transactions with, or on behalf of, the trustee/directors of the trustee or their associates, or contracts in which the trustee/directors of the trustee or their associates have an interest which are required to be disclosed in the financial statements under the provisions of the Charities Act 2011 other than those detailed in the notes to the financial statements.

Fraud

17) We have disclosed to you the results of our assessment of the risk that the financial statements

may be materially misstated as a result of fraud.

18) We have disclosed to you all information in relation to fraud or suspected fraud that affects the entity and involves management, employees who have significant roles in internal control and others, where the fraud could have a material effect on the financial statements.

19) We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Contingent Liabilities

20) Provision has been made where a material loss is expected to result from any litigation or claim against the charity. Other contingent liabilities at the balance sheet date, none of which are expected to result in a material loss to the charity or in commitments which it cannot meet, have been disclosed in the financial statements. We confirm we have disclosed all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Going Concern & Future Cash Requirements

21) In our opinion the charity will have adequate cash resources available to finance its operations and meet its obligations during the course of the twelve months following the date of approval of the financial statements. Accordingly, the financial statements have been drawn up on a going concern basis. We confirm that the disclosures in the accounting policies are an accurate reflection of the reasons for our consideration that the financial statements should be drawn up on a going concern basis. We confirm that we have disclosed to you details of our plans for future actions relating to our going concern assessment including the feasibility of these plans.

Post Balance Sheet Events

22) All events subsequent to the date of the financial statements and for which the financial statements require adjustment or disclosure have been adjusted or disclosed.

Data Protection Act

23) We confirm that the charity complied with the statutory requirements of the Data Protection Act during the year.

Laws and regulations

24) We confirm that we have disclosed to you all known instances we are aware of which involve actual, possible or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements. We confirm that we have disclosed to you all those events which we are aware of which involve actual or possible non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

Unadjusted Errors

25) We acknowledge the unadjusted errors on the attached schedule, in Appendix A, identified from your audit work, which you have requested that we correct, but consider that adjustments are not necessary, as they are immaterial.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware. Each director has taken all the steps that he ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully
For and on behalf of Management

....
Date

For and on behalf of the Trustee

....
Director   Date

APPENDIX A
BRADFORD HOSPITALS' CHARITY
SCHEDULE OF UNADJUSTED MISSTATEMENTS
FOR THE YEAR-ENDED 31 MARCH 2023

Unadjusting journals

			SOFA		Balance Sheet		
No.	**DR/CR**	**Details**	**DR**	**CR**	**DR**	**CR**	**Effect of SOFA**
1	DR	Audit fees	12,722				(12,722)
	CR	Audit fee provision				12,722	
		Adjustment for under provision of audit fee accrual					

BO.3.24.35 - CONFIRMED ACADEMY MINUTES

REFERENCES

Only PDFs are attached

- Bo.3.24.35 - Confirmed Finance & Performance Academy minutes - 29.11.23.pdf
- Bo.3.24.35 - Confirmed Minutes FP Academy 31 January 2024.pdf
- Bo.3.24.35 - confirmed People academy minutes - 29.11.23.pdf
- Bo.3.24.35 - Confirmed People Academy minutes - 31.1.24.pdf
- Bo.3.24.35 - Confirmed QPS Academy Minutes -29.11.23.pdf
- Bo.3.24.35 - Confirmed QPS Academy minutes - 13.12.23.pdf
- Bo.3.24.35 - Confirmed QPS Academy Minutes - 31.January 2024.pdf

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	29 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) - John Bolton, Deputy Chief Medical Officer (JB) - Louise Bryant, Non-Executive Director (LB) - Chris Danson, Director of Transformation (CD) - Sarah Freeman, Deputy Chief Nurse (SF) - Adele Hartley-Spencer, Director of Nursing - Operations (AHS) - Ellie MacIver, Deputy Director of Operations for Cancer and Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations – Unplanned Care (SM) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - James Taylor, Deputy Chief Operating Officer (JT) – intermittent attendance - Rachel Waddington, Deputy Director of Operations Planned Care (RW) - Karen Walker Non-Executive Director (KW) from 9am.		
In Attendance:	- Laura Parsons, Board Secretary/Associate Director of Corporate Governance (LP) - Barrie Senior, Non-Executive Director (BS)		

No.		**Action**
FA.11(2).23.1	**Apologies for Absence**	
	The following apologies were noted: - Matthew Horner, Director of Finance (MH) - Joanne Hilton, Director of Nursing/Deputy Chief Nurse (JH) - Mohammed Hussain, Non-Executive Director (MHu) - Michael Quinlan, Deputy Director of Finance (MQ) - Neil Scott, Head of Business Intelligence (NS) - Terri Saunderson, Director of Operations (TS)	
FA.11(2).23.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.11(2).23.3	**Unconfirmed Minutes of the Meeting held 1 November 2023**	
	The minutes of the meeting held on the 1 November 2023 were approved as an accurate record.	
FA.11(2).23.4	**Matters Arising**	
	The Academy reviewed the actions. Updates are noted within the action log and the following actions were closed: - **FA230038: 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. Workplan updated and item on agenda for next meeting on 29 November. Action complete. - **FA230039: Board Assurance Framework:** LP to share the results of the academy effectiveness survey with all attendees. Results shared by Sheridan Osbourne on 01/11/23. Action complete.	

No.		Action
	Assurance	
FA.11(2).23.5	**Finance & Performance Academy Dashboard**	
	JL reminded colleagues that the dashboard provides a single view of the F&P Academy indicators aligned to the Trust's Strategic Objectives. Throughout the meeting members of the Academy have the opportunity to review and challenge the elements of the dashboard presented relevant to the Academy Terms of Reference. SA and CSm confirmed that the details within the dashboard would be discussed under the relevant agenda items later in the meeting.	
FA.11(2).23.6	**Finance & Performance Academy Work Plan**	
	LP confirmed that no changes had been made to the workplan since the last meeting.	
FA.11(2).23.6a	**Draft 2024/25 Workplan**	
	LP advised that the draft workplan for 2024/25 is presented for approval and welcomed comments from members. The workplan will be reviewed throughout the year at each F&P Academy meeting and also as part of the effectiveness review. The Academy approved the workplan for 2024/25.	
FA.11(2).23.7	**High Level Risks Relevant to the Academy**	
	JL reminded colleagues of the Academies responsibility to review and assess the risks presented to ensure that the Academy is assured that all relevant key risks have been identified and reported and are being managed appropriately. JL noted that no new risks had been added to the register and no existing risks had changed in score since the last meeting. One risk had been closed and this was in relation to the increase in the cost of gas and electricity as the impact of increased prices will be built into next year's budgets. LB referred to the risk in relation to Haematology and asked what the plan is in terms of mitigation and the reason for the target date being extended to September 2024. SA explained that Ray Smith, Chief Medical Officer is taking the lead on this with his team as well as the Ops team. There are two key areas of work which are being undertaken. The first is an internal review to see what can be done to strengthen the provision across Bradford Place with Airedale Trust and the second is a WYAAT piece of work which is important to undertake as the pressures and challenges exist across the WYAAT patch and therefore it was important to address this together hence the extended target date. The Academy was assured by the update.	

No.		Action
	Learning & Improvement	
FA.11(2).23.8	**Finance Improvement Plan**	
	CSm gave a verbal update on the finance improvement plan noting the following key points: - Waste Reduction Group: an oversight group has been established to agree a framework for impact assessing all aspects of the CSUs' waste reduction plans and for ensuring opportunities are shared across departments where possible. The group is chaired by JB and has clinical and nursing representation. The group will assess whether quality impact assessments (QIA) are required for specific schemes and will ensure the QIAs are carried out where needed. The group will assess whether any schemes have adverse impacts in other areas or if they hinder other strategic priorities. The group will share ideas that are scalable across other departments and CSUs as well as checking that plans from one CSU do not inadvertently make a negative impact operationally on other CSUs. The group will also sense check plans to give a view on whether forecast delivery is realistic. - Rostering: the Chief Nurse team is undertaking a piece of work to review ward spend as currently 20 wards are underspending but 20 are overspending to the value of £1.2m. The reasons for this may be justifiable but a review is needed to confirm this and to determine if anything can be done to reduce the spend. - Insourcing/outsourcing: this remains a big opportunity for waste reduction and the leads from each group are providing a trajectory in relation to how long is required to continue to outsource. Progress has been made in a couple of areas where outsourcing is no longer required which is positive news. - A comprehensive piece of work is due to be undertaken in the coming weeks to review all sources of benchmarking to help determine if the Trust is an outlier in any areas where there may be opportunities to reduce costs. JL asked if a simple governance chart can be provided as part of the update at the next meeting in relation to the waste reduction group and how this fits into the formal governance structures. In terms of outsourcing JL recognised that the Trust is currently behind plan in terms of the numbers and asked if the benefit is still achievable next year and whether this is expected to be a recurrent benefit. CSm advised that the benefit is still partly achievable, but a balance will need to be taken in relation to costs verses elective recovery and an updated target will be finalised in due course as part of the planning round. The Academy noted the update.	Deputy Director of Finance FA230041
FA.11(2).23.9	**Operational Improvement Plan – Delivering Operational Excellence Plan 2023-2025 (Draft)**	
	SA provided an overview of the Operational Improvement Plan which has had input from colleagues across the Trust. The aim of the work is to deliver an operational excellence plan for 2023-25 with three key	

No.		Action
	programmes of focus: Urgent & Emergency Care, Cancer & Diagnostics and Planned/RTT Pathways. The overarching ambition of the plan is to deliver top quartile performance by March 2024 and top decile performance by March 2025 for all constitutional standards. SA referred to input from colleagues across the Trust to help form the plan and this has included a recent “Delivering Operational Excellence” event which took place in September. This event allowed us the opportunity to look back at the 2023/24 performance improvement plan, including what had worked well and what could have been done better with a forward look at identifying the actions required to meet the ambition set. CSt talked through the presentation and highlighted the key points for the attention of the Academy and in particular the successes achieved as demonstrated through the various KPIs whilst meeting national priorities and aiming to deliver the best quality care. CSt drew attention to the output plans across the three programmes and provided examples of the transformation that has taken place and the proactive improvement that has been made which has now developed into business as usual. In terms of next steps CSt explained that the objectives will be broken down by What, Why and How and shared with the CSU teams for inclusion in their own plans. The Academy reporting will be aligned to these plans with KPIs included in monthly reports along with improvement narratives. Weekly and monthly reports will also be aligned and where appropriate targets will be set. Future CSU to Exec meetings and CSU to Academy events will shape discussions with the objectives in mind. A similar approach will also be taken for Quality, Finance and Workforce domains which are also being considered. The Academy was assured by the update.	
	Finance	**Action**
FA.11(2).23.10	**Monthly Finance Report**	
	CSm provided an overview of the report and made the following key points: - There continues to be a risk to delivering the 2023/24 financial plan and this is mainly due to slow progress in delivering the Waste Reduction Plan. As at Month 7 the Trust is £2.15m in deficit due to IA costs (although subsequent to Month 7 reporting additional funding to support this deficit had been received from the ICS) and is forecasting a full year break-even position which is in line with the plan. The formal breakeven forecast is due to confirmation that NHS England (NHSE) has allocated sufficient funds to the West Yorkshire ICS to offset the costs of industrial action at the Trust in 2023/24. This confirmation was received after the Month 7 position was finalised and is therefore not reflected in the year to date position in the report but it is factored into the forecasting sections. - During November NHSE requested a rapid response review of all ICB and provider forecasts in light of the additional £0.8bn funding allocated to ICSs. To inform this forecast, the Trust carried out a comprehensive review of CSU forecasts and all potential non-recurrent technical	

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	mitigations. This forecast was also impacted by a worse than anticipated underlying Income & Expenditure position in Month 7. The forecast submitted to the ICB for inclusion in the West Yorkshire ICS rapid response review was a deficit of £1.1m which is the most optimistic position and includes the deployment of all available technical measures. At present, the Trust 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 October in-month underlying position was a deficit of £2.6m, which is £1.4m worse than previously forecast. This in-month position is distorted by £0.6m of assumed prior month pay award funding from NHSE being unrealised in month and a further £0.3m of unplanned for costs from Months 5 & 6 relating to outsourcing in excess of anticipated levels. The true underlying deficit in Month 7 for forecasting purposes was therefore £1.7m. The reported year to date position of £2.15m deficit could only be achieved by deploying £8.8m of non-recurrent flexibilities. The true average underlying run rate in the last three months is a monthly deficit of £1.7m 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 Quarters 3 and 4. The cumulative underlying deficit at Month 7, excluding the costs of industrial action cover, is £8.8m. - In terms of the forecast, there is likely to be enough flexibility to get until Month 11 but at Month 12 the Trust is likely to be in a position where the underlying run rate deficit is expected to be £1.1m at year end unless it can be mitigated. The underlying deficit for the year is projected to be just under £23m which is approximately £2m per month. In order to bridge the £1.1m gap, meetings have taken place with the CSUs that are in escalation, and they are currently in the process of submitting recovery plans to MH to demonstrate how they will contribute to bridging the gap. CSm talked through the various surplus and deficit run rate examples for months 8 to 12 as detailed at slide 4 and how the Trust will reach the £1.1m deficit in the remainder of the year. - CSm provided a detailed update in relation to the waste reduction delivery and advised that the target for the year is £29m. The CSUs have forecasted to deliver just under £24m of this target which is £5m short of the annual target. However, CSm has made a realistic assessment of what is likely to be delivered and based on this assessment CSm believes that £22.9m will be delivered which is £6.1m below plan. This assessment and function of sense checking the forecasts from the CSUs will be carried out by the newly formed Waste Oversight Group that was referred to earlier. - In terms of agency expenditure, the national target is to spend no more than 3.7% of pay costs on agency. The Trust is still well below the target currently at 2.7%. From a regulatory perspective this is a good position to be in but it was important to continue to do what we can to drive down agency costs as they are expensive. Work is ongoing to reduce this further and this will contribute to the Trust's waste reduction plans. JL referred to the waste reduction plan and the huge challenge but can see	

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	that a lot of work was being done to address this. JL was aware that this was also the case at system level and therefore recognised that the Trust is not alone in terms of the gap and was actually in a better position than others. JL asked whether there has been any indication on the position for next year from a national perspective. CSm confirmed he had not heard anything nationally yet but formal plans for next year have not yet been submitted but anticipated that as soon as the first draft plans are submitted the pressure will increase as the ICS combined deficit for West Yorkshire will be very substantial. JL referred to the agency expenditure and was pleased to note that the Trust was already below the national target. JL asked if there are any opportunities that can be explored to reduce these costs further without compromising quality and patient safety. CSm explained that the cost and saving depends on the type of agency cover as the premiums vary. CSm provided an example of one area where specialist Renal nursing agency cover is at a high premium and has been in place a long time. In order to reduce this cost, business cases have been approved in recent months to increase the establishment of nursing and the CSU is confident that these posts will be recruited to. The Academy was assured by the update.	
FA.11(2).23.11	**Contract Update**	
	CSm provided an overview of the report and made the following key points: - The Trust is continuing to negotiate with Commissioners to agree the 2023/24 NHS Contract. This is also the case for other Trusts across WYAAT. Whilst there are a number of issues outstanding, these have been assessed as low risk and there is no expectation that they would result in contracts not being agreed or for them to be escalated. - In terms of the CQUIN payment of £5.3m included within the contract the important point to note is that this payment is not variable therefore financial penalties will not be applied if quality objectives are not delivered. However, commissioners will be monitoring these and will expect to see plans of how these objectives will be achieved if there is any shortfall. - The year to date position at the end of Month 7 on contract income is an over-recovery of £1.2m which is predominantly due to the overtrade on NHS Spec Com cost and volume high-cost drugs. - In terms of the Elective Recovery Funding the baseline performance target for West Yorkshire has been increased to reflect the impact of industrial action, with the target increasing from 400 to 1,200 for +52 week waits. The Trust is ahead of the target with the latest forecast at 600 (inclusive of 85 +65 week waits). Based on the agreed framework, delivery of the forecast will result in the Trust receiving additional income of £1.2m. - In terms of Patient Initiated Digital Mutual Aid System (PIDMAS) referrals accepted by the Trust an agreed process is in place to capture these and if appropriate make income recovery for treatment provided. BS referred to the signing of the contracts with commissioners and asked if	

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	risks have been identified in terms of hidden costs or potential hidden income. CSm confirmed that this has been reviewed and no risks have been identified. The Academy was assured by the update.	
FA.11(2).23.12	**Treasury Management Update**	
	CSm gave an overview of the presentation which provides an update on the Trusts cash and treasury performance. The presentation details the latest position in relation to cash, liquidity, treasury performance and the Cash Management Group. CSm reported that the Trusts cash position is forecast to continue to deteriorate over the next few years and 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. CSm drew attention to the following key points: - The closing cash forecast is £45.7m which is £3.5m below the plan of £49.2m. This figure is in the context of using £15m-£16m of non-cash releasing technical flexibilities. Cash is forecast to decrease by £5.4m from October to March. - The worst-case scenario forecast, which assumes the waste reduction programme fails to deliver cash releasing benefits in 2024/25, is the minimum cash threshold being breached in September 2024. CSm reiterated the importance of achieving the waste reduction savings in order to avoid this position. - In terms of investments, CSm referred to slide 5 which highlights the success the Trust has had in investing cash which is a substantial amount due to the balance built up over the years by delivering the financial plan and receiving bonuses under the old regime. This has been a very fortunate position as interest rates have been high. JB asked if cash savings are expected to be deployed as they have been in the past when Trusts were asked to use them or lose them. CSm did not think there is a national strategy asking Trusts to spend cash in a certain way. Ideally the Trust would like to keep the cash for investment in transformation rather than to offset it against a waste reduction shortfall. CSm assured colleagues that the Trust is using the cash in line with expectations. The Academy was assured by the update.	
FA.11(2).23.13	**Service Development – Post Implementation Reviews**	
	CSm provided an overview of the report and explained that the paper outlines the results of a post implementation review (PIR) of approved business cases on a six-monthly basis. CSm advised that completion of the completed PIR templates has been hindered by operational pressures and the impact of industrial action. Of the 13 PIRs undertaken 9 were returned with all benefits realised, 3 with benefits partially realised and there were no cases where none of the benefits have been realised. One PIR has been deferred to allow more time for the case to be fully implemented and the benefits to be measured. There is no instance in the current cycle	

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	where a PIR was requested but not received without a response or meaningful dialogue with the department or specialty in question. BS was surprised to note that the PIRs do not include any details in relation to monetary benefits. Although BS recognised the importance of including the non-financial and productivity benefits he felt it was important to include the detail of the project plans at the outset of activity including benefits and value for money particularly where they are waste reduction opportunities. CSm explained that although it is not captured in the report all business cases are supported by detailed financial modelling to ensure a revenue, capital and workforce plan is included behind every business case. The PIR templates do request headline financial figures such as costs and projected income but that does not appear to have been included within this report as it is a summary in the current format. KW asked if the timeline of delivery could also be included so it was clear what period of time the reviews covered and when benefits were gained. CSm confirmed he would request that explicit costs that were projected are included in future reports as well as timelines. The Academy was assured by the update.	Deputy Director of Finance FA230042
	Performance	
FA.11(2).23.14	**Operational Highlight Report**	
	SA asked the Academy to note the Red ratings in the context of the expected performance due to winter pressures. This is expected at this time of the year before performance starts to improve following the winter. CSt presented the report and highlighted the following key points: - Demand continues to be a pressure and Type 1 & 3 Emergency Department (ED) attendances remain high. Type 2 attendances have increased in recent weeks and this is reflected during October 2023. Fast track and urgent referrals from primary care are also putting pressure on cancer pathways but it was important to note that the work in relation to health inequalities and case finding for stage 1-2 diagnosis has likely impacted this but work is being undertaken with primary care to address the imbalance. It should, however, be viewed as a positive as it means that there are opportunities for earlier stage cancer diagnosis, which is the right thing for patients. - Inpatient Pathway Activity: CSt described the performance implications as a result of the industrial action and the requirements for the next six months. Inpatient activity is an area that requires continued focus, particularly in relation to theatres but this is not something new and remains reasonably stable up to the end of October. Improvements in inpatient activity were not seen during the first half of the year due to industrial action but the remainder of the year will focus on embedding some of the agreed improvements. This will happen alongside reducing the use of the independent sector and supplementing this with internal capacity. Focus within the weekly Access cycle has shifted towards a forward-looking view of theatre utilisation which supports improvements in surgeon allocation with services continuing to work on booking out to	

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	6 weeks and filling lists appropriately. Observations in theatres by the Outstanding Theatre Service programme and a visit from GIRFT have identified opportunities to improve efficiencies and processes which are being rolled out. Start times and case duration continue to be monitored to inform list composition. - Outpatient Pathway Activity: outpatient provision has been good with high levels of delivery. One of the key items of focus is to reduce the number of follow ups particularly those that do not require a procedure. A lot of work is being done with regards to improving the build of clinics in order to facilitate virtual reviews and alternative models of delivery. - 18 Week Referral to Treatment: performance remains in the best quartile nationally but continues to deteriorate as the 18 week wait cohort increases and validation below 18 weeks reduces the denominator. Patients waiting 40+ weeks has reduced by 4% in the last 12 months. CSt was pleased to report on the robust validation work being undertaken. - 52 Week Referral to Treatment: as a percentage of overall waits those over 52 weeks continue to remain stable and the Trust benchmarks favourably. There were 0 patients reported over 78 weeks at the end of October with 0 patients projected to breach by the end of November. - Diagnostics: DM01 performance for October improved to 65.78% and it is forecast to improve very slightly again in November. Endoscopy continues to improve month on month and although there are challenges in some of the other areas, improvement work is being rolled out to help improve the position. - Cancer: demand remained high during September and capacity was reduced due to industrial action. There has been a 50% increase in skin cancer referrals during the summer and although skin cancer referrals do increase in the summer, this spike was unprecedented. Histology delays have been a significant problem for certain tumour groups and intensive work with the service continues. Skin and Gynae were impacted most by these delays but demand is reducing and turnaround of requests is improving. From November improvements in booking processes along with services returning to full clinical capacity are supporting a continued improvement in 2 Week Wait performance. - UEC – Ambulance Handover: following the changes in handover reporting the Trust has continued to maintain its position in the upper quartile in the region. This position has been achieved through a continued collaborative approach between YAS's Hospital Ambulance Liaison Officer (HALO) and the Senior Leadership Team within ED. Observations carried out in October 2023 by the ED team demonstrated that YAS colleagues were not routinely recording patient handovers on the screens within the ED following the changes implemented in October which has resulted in extended handover times being recorded by YAS. Further work across WYAAT and YAS is required to understand if any improvements can be made to mitigate issues identified. YAS have confirmed that the Trust will be allocated one HALO (a senior paramedic) from December 2023 to work weekdays between 10am and 8pm. - ECS Performance: work is continuing with the clinical teams to review decision making to reduce avoidable admissions. The introduction of the Ambulatory Emergency Care Unit model is expected to relieve overcrowding and improve department metrics as well as conversion	

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	rates and length of stay metrics. - Length of Stay: CSt advised that the Trust is monitoring several discharge KPIs using the medically fit for discharge date (MFFD) 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. There is good compliance with recording and the data is positive in terms of discharge practices. BS was pleased to note the plans to increase the stroke bed capacity and asked if this was still on track to be in place before the end of the year. SA explained that these beds will be on Ward 9 which will run as a specialist stroke rehab unit and the aim is to have the unit running by 11 December pending final details of nurse staffing which is also currently on track. BS was concerned in relation to the staffing shortage within the substantive stroke establishment which has been the position for quiet some time now and asked how this is being addressed. SF confirmed that the Trust does not have a 24 hour stroke responder model as the data has not supported a requirement for middle of the night cover but there is cover from 8am until midnight which is the model that has been in place for a number of years. SF added that recruitment is underway for Physicians Associate posts who are due to start soon following a period of training there are also a number of senior nurses, instructors and responder roles in place although there has been significant pressures due to long term sickness which are currently being managed. SM referred to the stroke data for Mid Yorkshire Hospital where they have consistently scored an A or B for SSNAP data and advised that a similar model is being established at the Trust. In terms of stroke responder vacancies, SM agreed this has been a struggle but once recruitment and training has been completed the stroke responders will be able to undertake additional duties such as supporting TIA clinics which should demonstrate an improvement in stroke performance. KW was pleased to note how solutions are sought that are tracked through an improvement programme with results being shared through the Academy for a number of indicators. In terms of the length of stay and MFFD data KW asked how this impacts the rest of the hospital and what can be done to reduce the impact. SM referred to improvements that can be made and although some of the delays are out of our control i.e. lack of availability of social care beds, there are some improvements that can be made internally such as transport booking and TTOs. SM was pleased to report that the Trust has one of the best averages of four days across WYAAT compared to eleven days for other Trusts. SA provided some background in relation to the impact of delayed discharges associated with some of the provision of packages of care or intermediate care beds which is starting to show an increase in longer length of stay. This is being closely monitored and there is a positive working relationship with the local authority to address and manage this. KW reflected on the huge opportunity that the SLH Day Case Unit brings and asked how things can be done differently in terms of designing processes and services that drive waste out and optimising performance overall particularly because there will be new teams with new ways of working. AHS provided examples of how this is being done including best	

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	practice from others by attending events and meeting other hospitals running similar surgical hubs. SA advised that he is the Executive Lead for this programme and there are three specific workstreams that are focussed on this – estates, workforce and clinical pathways which will review opportunities to streamline pathways and bring improvements. The workstreams report into the programme board which is chaired by SA. SA wished to draw attention to the support of mutual aid across the system and provided examples of how the Trust has supported this over the last month in terms of urgent and emergency care as well as divert support for ambulance patients because of the pressure other Trusts are under. SA also provided examples of providing mutual aid support in terms of RTT and cancer pathways to support other Trusts in the region. This demonstrates that relative to where the rest of the system is the Trust's performance remains strong in comparison with West Yorkshire peers therefore being able to offer and provide this mutual aid support. The Academy was assured by the report.	
FA.11(2).23.15	**Performance Report**	
	The performance report was noted.	
FA.11(2).23.16	**Any Other Business**	
	JL referred the Academy to the Internal Audit reports that are attached for information – both have a high level of assurance. JL requested that going forward any reports with low assurance should be added to the agenda for discussion for future meetings. LP to update the workplan to reflect this. No other business was raised. JL thanked the attendees for their time.	Associate Director of Corporate Governance/ Board Secretary FA230043
FA.11(2).23.17	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.11(2).23.18	**Matters to Escalate to Board**	
	JL advised that the following matters would be escalated to Board via the formal Finance & Performance Academy Chair report: - The financial outlook - Risks in relation to the cash position	
FA.11(2).23.19	**Date and Time of the Next Meeting**	
	31 January 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 29 November 2023

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	Covered at item FA.1.24.11 Operational Improvement Plan – Cancer and Diagnostic Performance. Action closed.
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	Covered at item FA.1.24.18. Action closed.
FA230041	29/11/23	**FA.11(2).23.8**	**Finance Improvement Plan:** A simple governance chart to be provided as part of the update at the next meeting in relation to the waste reduction group and how this fits into the formal governance structures.	Deputy Director of Finance	31/01/24	Covered at FA.1.24.4a under Matters Arising. Slides 10-12 of the presentation that was presented to the Board Development Session in April 2023 provides details of the governance arrangements in relation to the Waste Reduction Group. Action closed.
FA230043	29/11/23	**FA.11(2).23.16**	**Any other business:** Internal Audit reports - any reports with low assurance to be added to the agenda for discussion for future meetings. LP to update the workplan to reflect this.	Associate Director of Corporate Governance/Board Secretary	31/01/24	Work plan updated. Action closed.

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	27/03/24	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. Update 11/01/24: Review of Academies to be part of wider board development work. Update to be provided in March 2024.
FA230042	29/11/23	**FA.11(2).23.13**	**Service Development – Post Implementation Reviews:** costs and timelines projected to be included in future reports.	Deputy Director of Finance	22/05/24	To be included in the next report which is due at the May meeting.
FA230044						

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	31 January 2024	**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) - John Bolton, Deputy Chief Medical Officer (JB) - Louise Bryant, Non-Executive Director (LB) - Chris Danson, Director of Transformation (CD) - Sarah Freeman, Deputy Chief Nurse (SF) - Ellie MacIver, Deputy Director of Operations for Cancer and Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations – Unplanned Care (SM) - Terri Saunderson, Director of Operations (TS) - Neil Scott, Head of Business Intelligence (NS) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - Rachel Waddington, Deputy Director of Operations Planned Care (RW) - Karen Walker Non-Executive Director (KW)		
In Attendance:	- Laura Parsons, Board Secretary/Associate Director of Corporate Governance (LP) - Katie Shepherd, Corporate Governance Manager (KS) - Steve Amos, Emergency Planning Manager (SAm) for item FA.1.24.8 - Leah Pollard, Service Improvement Lead (LPo) for item FA.1.24.11		

No.		**Action**
FA.1.24.1	**Apologies for Absence**	
	The following apologies were noted: - Matthew Horner, Director of Finance - Mohammed Hussain, Non-Executive Director - Michael Quinlan, Deputy Director of Finance - James Taylor, Deputy Chief Operating Officer	
FA.1.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.1.24.3	**Unconfirmed Minutes of the Meeting held 29 November 2023**	
	The minutes of the meeting held on the 29 November 2023 were approved as an accurate record.	
FA.1.24.4	**Matters Arising**	
	The Academy reviewed the actions. Updates are noted within the action log and the following actions were closed: - FA230035**: Operational Improvement Plan – Cancer and Diagnostic Performance:** National and local directives to be listed separately in the next update. Covered at item FA.1.24.11 Operational Improvement Plan – Cancer and Diagnostic Performance. Action closed. - FA230040**: Operational Improvement Plan – RTT:** SA & MH to bring	

No.		Action
	back an update to a future F&P Academy to share the work ongoing in relation to closing the productivity gap. Covered at item FA.1.24.18. Action closed. - FA230041**: Finance Improvement Plan:** A simple governance chart to be provided as part of the update at the next meeting in relation to the waste reduction group and how this fits into the formal governance structure**.** Slides 10-12 of the presentation to the Board Development Session in April 2023 provides details of the governance arrangements in relation to the Waste Reduction Group. CSM advised that a revised governance structure is currently being finalised and will be provided at a future meeting. It was agreed to add this as a new action and close the current action. Action closed. - FA230043**: Any other business: Internal Audit reports -** any reports with low assurance to be added to the agenda for discussion for future meetings. LP to update the workplan to reflect this. Work plan updated. Action closed. - **Action from Audit Committee (A23060).** JL referred to the paper and advised that the paper closes an action which first arose in F&P Academy during 2021/2022 and was assigned to the Audit Committee. The action is now closed.	Deputy Director of Finance FA24001
	Assurance	
FA.1.24.5	**Finance & Performance Academy Dashboard**	
	JL reminded colleagues that the dashboard provides a single view of the F&P Academy indicators aligned to the Trust's Strategic Objectives. Throughout the meeting members of the Academy have the opportunity to review and challenge the elements of the dashboard presented relevant to the Academy Terms of Reference. SA and CSm confirmed that the details within the dashboard would be discussed under the relevant agenda items later in the meeting.	
FA.1.24.6	**Finance & Performance Academy Work Plan**	
	LP referred to the WYAAT and ICS Programme Updates which are listed as quarterly updates on the workplan. MH had advised LP that the updates for this item are presented to Closed Board Meeting and asked whether this is sufficient and if the item could be removed from the F&P Academy workplan. The Academy agreed that the items can remain on the Closed Board Meeting workplan and can be removed from the F&P Academy Workplan. LP to action this. LP confirmed that no changes had been made to the workplan since the last meeting.	Board Secretary/ Associate Director of Corporate Governance FA24002
FA.1.24.7	**High Level Risks Relevant to the Academy**	
	JL reminded colleagues of the Academy responsibility to review and assess the risks presented to ensure that the Academy is assured that all	

No.		Action
	relevant key risks have been identified and reported and are being managed appropriately. JL noted that one new risk has been added to the register in relation to paediatrics (Risk ID 3474), no existing risks had changed in score and no risks have been closed since the last meeting. There are three risks which have now passed their review date. SA referred to the new risk that has been added and advised that ETM noted there were a number of risks relating to paediatrics and therefore the risk was not accepted onto the High-Level Risk Register pending a more in-depth discussion with the CSU by Karen Dawber, Chief Nurse. The Academy was assured by the update.	
FA.1.24.8	**EPRR Governance Proposal**	
	Steve Amos, Emergency Planning Manager (SAm) presented the item and reminded the Academy of the NHS England requirement that all NHS organisations are required to assess their ability to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations on an annual basis. Following the core standards submission to NHSE in November 2023, the Trusts compliance was rated as non-compliant with the core standards. This was mainly due to a revised process for the 2023-24 EPRR Assurance Process. SAm explained that all other WYAAT Trusts were also in this position. The comments received back from NHSE included a number of queries in relation to the governance route for EPRR within the Trust which included how EPRR policies were approved, overarching governance of EPRR work, progress of business continuity plans and procedures, general EPRR updates including the workplan and EPRR risk assessments. SAm explained that there is an explicit requirement for EPRR to report to an Academy/Board and proposed that the F&P Academy provides the governance required going forward. It was proposed that a paper is provided quarterly which will include progress on the core standards action plan three times a year and sign off by the Academy once a year. This will help strengthen the governance associated with EPRR going forward. The Academy approved the proposal, and it was agreed that the workplan would be updated to explicitly show when updates are due and when the approval is required.	Board Secretary/ Associate Director of Corporate Governance FA24003
	Learning & Improvement	
FA.1.24.9	**Act as One Programme Update**	
	JL advised that the item has been deferred to the next update which is due in March and will provide a deep dive into a specific topic.	
FA.1.24.10	**Finance Improvement Plan**	

No.		Action
	This item was covered as part of the Finance section of the agenda later in the meeting.	
FA.1.24.11	**Operational Improvement Plan – Cancer & Diagnostic Performance**	
	SA introduced the item and explained that the update incorporates the latest changes in relation to cancer and diagnostic standards as well as areas for improvement derived from the Delivering Operational Excellence workshop held at the end of last year. SA invited EM to provide an overview of the presentation. EM made the following key points: - In terms of the key performance indicators the Trust is above trajectory for three out of the four indicators. The indicator for Cancer 62 Day First Treatment is below trajectory but this in line with what other Trusts are experiencing both locally and nationally. The focus from the Cancer Alliance has been on reducing the backlog for those patients waiting over 62 days to 42 days by the end of March and the Trust is currently on target to achieve this. - There was an action from a previous Academy meeting to list national and local directives separately and these are included at slides four and five within the presentation. EM talked through the local and national cancer priorities for 2023/24 as detailed within the presentation. One of the priorities is for the Trust to employ three Band 4 FIT navigators to support the delivery of the FIT pathway developed by the Cancer Alliance to support the GI pathways. Recruitment to these positions has been a challenge but a third recruitment campaign is underway. - The standards measuring waiting times for cancer diagnosis and treatment have been modernised and simplified from 1 October 2023 (reduced from ten standards to three). - In terms of priorities for 2024/25 the NHSE Planning Guidance has been delayed until the end of January, however the Cancer Alliance has shared a provisional early indication as detailed within slide seven. - NHSE has recently published guidance on diagnostic imaging reporting turnaround times which states that reporting should be reduced from six weeks down to four weeks for routine reporting, down to one week from two weeks for urgent patients and down to three days from a week for fast-track patients. This is good from a patient perspective, but the requirements will have a cost pressure. - EM referred to the purchase of a complete Cancer IT solution which was approved at a recent Planning Committee. The system is expected to be in place by the end of March 2024 and will include a digital remote monitoring system and implementation and monitoring of best practice timed pathways to support operational improvement against the faster diagnosis standard and cancer waiting times. EM welcomed Leah Pollard, Service Improvement Lead (LPo) to introduce the HISTO Programme. LPo explained that Histopathology is the study of organs, tissues, cells and genetics to help provide a diagnosis and is a highly specialised department which has seen an increase in demand that does not meet current capacity. The Trust's laboratory is part of a Joint	

No.		Action
	Venture that covers both BTHFT and Airedale NHS FT. The staff within the department are Consultant Histopathologists from our Trust. The current risk is turnaround time which is below the best practice recommended by the Royal College of Pathologists. The recommended best practice is for 80% of cases to be reported within seven days and 90% of cases to be reported within ten days. The Trust is at 40% and 50% respectively which is significantly below the recommended KPI. The HISTO Programme is a structured improvement programme which LPo is leading on by working closely with the team. Some of the intended benefits include improved patient outcomes, improved cancer performance, reduced expenditure on outsourcing and locum staff and an improved staff experience. The next steps are to agree the workstreams which are likely to be under the headings of People, Place and Process. Progress will be reported through an agreed governance structure which will eventually report to the Academy via the quarterly Cancer and Diagnostic Performance update. Updates will also be provided through Let's Talk, Mel's podcast and other internal Trust communications. KW was pleased to note the overall achievements and performance on cancer and diagnostics. KW complemented LPo on her energy and passion for the programme and was pleased to see staff and patient feedback. KW asked if any learning and good practice can be taken from other Trusts who are doing well within this area. EM responded that Harrogate NHS FT and Calderdale and Huddersfield NHS FT have good turnaround times, are in the top few within the country and, have been approached to gain insight and learning. However, it was important to note that we do not have the correct resource in place for the current demand and this is being reviewed. KW asked how invested are the locum and outsourced resources as this can also impact on performance. EM said that outsourcing was an inefficient way of reporting, and this is something that will be addressed as part of the improvement work. KW asked if learning from other internal outstanding improvement programmes such as theatres, pharmacy and maternity in relation to people and processes has been taken and EM confirmed it has. SA added that it was important to recognise that offering internal colleagues' opportunities to lead on improvement programmes such as this one allows the Trust to develop its internal capacity, capability and resource to help staff to progress within the Trust whilst maintaining the excellent skills of colleagues in house rather than losing them to other Trusts. JB acknowledged that Histopathology also deals with non-cancer and benign samples and whilst he recognised the importance of improving the cancer metrics it was also important to ensure that non-cancer and benign metrics are not impacted adversely. EM acknowledged this and agreed to include the RTT data within the metrics. The Academy was assured by the update.	
	Performance	

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FA.1.24.12	**Operational Highlight Report**	
	SA introduced the item and invited CSt to present the report. CSt highlighted the following key points: - Demand Patterns: Demand remains busy across all metrics but CSt asked the Academy to note that non-elective and same day admissions remain below the baseline with the same day reductions, and this is attributable due to the introduction of the AECU model implemented in November which is a national reporting change for Type 5 attendances. - Inpatient Pathway Activity: Two positive points to note are that day case theatre utilisation is improving and Medinet use is reducing. Theatre productivity has not moved to the point that was hoped for due to the impact of industrial action which has diverted the focus of management time but the day case unit which is due to open in the coming months will provide opportunities in terms of throughput. - Outpatient Pathway Activity: Approximately 9000 activities across all activity types were lost due to the impact of industrial action – this is for the total capacity lost and not the number of patients cancelled. This has resulted in approximately 2000 extra patients on the waiting list. However, the waiting list has reduced despite this, although it would have reduced further without the impact of the industrial action. Consequently, the insource activity for outpatients has largely netted off against the industrial action. - 18 Week Referral to Treatment: The waiting list continues to reduce, and this is a result of the combined validation efforts both from an administrative and clinical team perspective. In terms of the long wait position the Trust continues to benchmark well against peers particularly within the WYAAT footprint. - 52 Week Referral to Treatment: This is currently forecasting between 450 and 500 patients with more patients between 40 and 52 weeks being seen. Daily management of long waits, aligned to prioritisation processes remains in place along with looking at clinic templates and clinic capacity to try and alleviate some of the pressures of services. The capacity and demand analysis will help resolve the waits into the new financial year to ensure a similar type of 52-week profile is sustained as for the current year. - Waiting List Data Quality: Since February the Prevent-Correct-Clear model has been adopted by the Access Team to shift emphasis from correcting errors to preventing them in the first place. This has been very successful and has resulted in the Trust being at 99% or above confidence on RTT and has increased from the previous figure of 93%. - UEC – Ambulance Handover: The Trust continues to benchmark the same as previously against peers and the same challenges remain with pressures on a day-to-day basis. Attendances have increased which have resulted in operational pressures due to patients not flowing from the emergency department into the bed base and this is one of the major challenges being faced which has impacted ambulance handovers. - UEC – ED Measures: The impact of the AECU model has impacted positively on several measures. This has improved performance significantly in comparison to peers. - 21-day Length of Stay: Discharging patients who are fit for discharge is	

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	one of the biggest challenges currently being faced. This is a multi-agency challenge and particularly challenging for the IMC pathway capacity. The Trust is working closely with the local authority to address this but due to the financial challenge faced by the local authority a different model to support discharge is in the early stages of development. Internally work is ongoing to strengthen processes to support efficient discharge and flow as best as possible. - Sentinel Stroke National Audit Programme (SSNAP): Ward 9 was opened in December which has had a positive impact, and the stroke responder position has now been recruited to although not all the positions have yet been filled. Both positive changes will likely show an improving position in the data in the coming months although it is important to note that the speed of improvement and recovery is highly dependent on the other pressures currently being faced around the hospital. JL referred to the IMC challenge and asked if this has been added to the risk register, particularly as this risk is likely to increase given the local authorities financial position and the impact this has on performance. SM confirmed this is currently incorporated into the risk in relation to overcrowding in the emergency department. However, it may be that a separate risk is required depending on what actions are required. SM agreed to provide a full update at the next meeting of the Academy as part of the urgent and emergency care focus. SA shared details of a meeting that took place the previous day with the national team in relation to urgent and emergency care. SA, SM along with a few other colleagues were invited to present and share the work that the Trust has undertaken on urgent emergency care and the team has also been invited to London at the end of February to share the good work and learning with other Trusts. SA put into context the Trust's figures which currently places the Trust second regionally out of 45 Trusts and fourth nationally out of 128 trusts. SA expressed how proud he is of the team and the work they do in the department as well as across the whole Trust which has taken the Trust to this position. However, it was also important to note that despite being in this position the Trust is still not achieving the 95% constitutional standard, but this does demonstrate how pressured the system is nationally. Work will continue to improve patient experience regardless of this high ranking as poor patient experience still exists for patients who wait longer than 12 hours for a bed. Overall SA acknowledged the amazing performance and for being recognised for this nationally which was very positive for the Trust. JL applauded SA and his team and colleagues for this recognition and thanked colleagues for their ongoing efforts. The Academy was assured by the report.	Deputy Director of Operations/ Unplanned Care FA24004
FA.1.24.13	**Performance Report**	
	The performance report was noted.	
	Finance	

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FA.1.24.14	**Monthly Finance Report**	
	JL highlighted that MH had provided a detailed finance update for Month 8 and the expected position for Month 9 at the recent Board meeting. CSm confirmed that the position reported by MH has not changed since the report to Board. The underlying deficit for Month 9 was as expected at £2.2m with a forecast to formally break even at the end of March 2024. There is potentially a gap of approximately £1m which is being addressed as best as possible hopefully through contributions from recurrent waste reduction. There has been positive news in relation to a reduction in insourcing for theatres recently which can also contribute to the gap as well as some other non-recurring measures to help bridge the £1m gap in totality to get to a breakeven position at the end of this financial year. The Academy was assured by the report.	
FA.1.24.15	**Bradford Place and ICS System Financial Update**	
	CSm wished to highlight one point from the report in relation to the £5.9m overall forecast deficit for the ICS which is related to the December and January industrial action. There is a £9.8m stretch target which is a hidden gap in the overall forecast and shared across all the ICS partners. Discussions will continue at ICS level to determine if there is any slack in other balance sheets to help address this. Therefore, it was important to note that if the Trust breaks even then we would contribute to bridging the £9.8m gap which would be the Trust's targeted contribution. The Academy noted the report.	
FA.1.24.16	**Capital Update**	
	CSm provided an overview of the report and reminded the Academy that the allocated capital programme for the current year was £59m. As at Month 9 only £20m has been spent. CSm reported that the project leads have confidence that the majority of the £59m will be spent by the end of the year. This will be a significant increase in spending during Q4 and particularly during Months 11 and 12 therefore it was important to note the risk as it is a very ambitious target. CSm added that some large projects are now gathering pace such as the SLH Day Case which will increase spend over the coming weeks therefore it is possible but still a risk to note. The Academy was assured by the update noting the risk highlighted.	
FA.1.24.17	**Budget Setting Process and Timetable (Draft plan for information)**	
	CSm provided an overview of the report headed "Addressing the Financial Deficit in 2024/25". The paper was discussed at the Executive Team Meeting (ETM) on 15 January 2024 and is presented to the Academy to provide an update on the financial outlook and plan for 2024/25. The Executive Team supported the recommendation for a dedicated ETM session to agree the approach to addressing the financial challenges identified at a meeting which took place on Monday 29 January 2024. The paper highlights the significant financial risk facing the Trust in 2024/25 with the projected deficit in the range £36m-£50m.	

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	A few things are driving this position including the current Quarter 3 run rate which is an annualised deficit of £26m due to investments and recruitment which are both positive from a staffing and operational perspective but do have an impact financially. In addition to this tariff efficiency, cost inflation, utilities inflation and demand growth are all contributors to the projected deficit for 2024/25. JL reflected on the figures and noted this was approximately 10% of current spend that needs to be reduced which was a very large amount and one that has not been seen before. CSm agreed and said the scale of the ask is extremely challenging and a decision needs to be taken by the Trust about which plan to submit at the end of March – a breakeven plan or a deficit plan. The latter may not be acceptable to the ICS or NHS England but if an unrealistic breakeven plan is submitted which is likely to go off plan at Quarter one this will also be unacceptable to the regulators. There is no easy answer to this but the consensus from the Executive Team was that the challenge was not achievable in one year and that would need to be recognised in any plan that was submitted. JL said Board appetite should also be taken in relation to this decision. The Board will be guided by the Executive Team, but it was important to have a Board level discussion. CSm agreed this would be important to do. CSm talked through the paper highlighting potential risks and mitigations not recognised in unmitigated deficit forecast scenarios for 2024/25, the deficit plan, waste reduction and the CSU escalation meetings. Considering everything that is being done to reduce costs i.e., theatre, productivity, rostering and medicines management a revised approach needs to be taken to add more focus to meet the challenge. CSm talked through the slides presented to ETM on 15 January and made the following key points that discussed at the meeting: - Planning guidance is yet to be issued by NHSE – now expected late February or March. - The mid case forecast deficit is £46m and the worst-case forecast is a £50m deficit. - The likely deficit by June 2024 if the run rate does not improve will be £9m-£11m. - There are no material waste reduction plans to mitigate this at present. - The NHSE protocol is likely to be invoked on submission of a deficit plan or on reporting off plan at Q1. If this protocol is invoked, then the Trust is required to provide a credible Financial Recovery Plan. - It is not considered feasible that a financial recovery plan could deliver a breakeven position in 2024/25. - A detailed discussion was held at the ETM meeting about whether it would be more credible to submit a plan that was a deficit for two years before getting to break even in the third year. However, it was worth noting that Mel Pickup attended a WYAAT Committee in Common Meeting the previous day at which there was significant doubt cast on whether a three-year recovery plan will be acceptable. - CSm talked through the indicative three-year income and expenditure plan and the phasing of the illustrative recovery plan.	

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	- Running a deficit in Years 1 and 2 would reduce the Trust's cash balance by £35m. Previous forecast based on breaking even in 2024/25 was £23m cash at March 2025. This latest scenario suggests the Trust would fall below minimum working capital floor mid-year and run out of cash by year end. The reality is that if we continue to spend on the capital programme as is currently planned then this ultimately has the potential to impact on the cash needed for Payroll and cash support would be needed. - ETM were presented with figures to illustrate the art of the possible and what might be the prime targets for waste reduction and cost improvement. If the waste reduction plan focuses on the proposal to addressing the premium costs, then all plans would require robust Quality Impact Assessments to ensure patient safety is not adversely impacted. - There was consensus at the ETM meeting that the current approach of delegating responsibility to deliver the waste reduction plan to the CSUs, albeit with dedicated support, has proven to be ineffective. This approach is inadequate to address a challenge on the scale currently faced. ETM considered a number of alternative approaches including the suggested preferred option of implementing a matrix structure which has delegated defined workstream targets to named lead Executive Directors totalling £23m. This suggests that Executives are accountable for delivery of their workstreams and engage with CSUs to support and performance manage CSU delivery within their workstreams. CSUs are also accountable for their own £23m targets with a requirement to engage with Executive workstreams to realise cost savings within their own budgets. ETM discussed this option in detail and concluded that each Executive is allocated a CSU for which they are the waste reduction lead, and they would work directly with the CSU and make reference to workstreams, but the waste reduction relationship and structure would be between the named Executive and the CSU rather than a named Executive and a workstream. KW talked about the importance of buy in from staff to help deliver what is required and different approaches that can be used to encourage staff motivation with the support of other teams such as Organisational Development. Ideas such as offering an incentive to deliver savings may be appealing to staff and will encourage healthy competition. CSm concluded that the outcome of the discussion at ETM was to ensure a strong comms process is put in place as well as agreement of the terminology to be used. From a governance structure perspective, it was agreed that Mel Pickup as Chief Executive will chair an "Executive WRP Delivery Meeting" noting that the name is yet to be agreed. Executive Directors will report into this and be held accountable by the Chair for their delivery of their responsible areas. The CSUs would be held accountable by their nominated Executive Director as well as by the normal governance processes. The entirety of this yet needs to be worked through and confirmed. In summary the Academy was asked to note that a decision may be required on whether the Trust has no option but tosubmit a deficit plan. The Academy was also asked to note that the Executive Team recognised that	

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	some difficult choices will need to be made in relation to the level of performance that is affordable, what the red line is in terms of the required level of performance to ensure patient safety and quality of care is not adversely affected along with the understanding that the £49m challenge cannot be addressed without sacrificing some of the performance ambitions. A compromise and balance will need to be made from an operational and financial perspective. LB reflected on the update provided and the financial difficulty faced by the Trust. LB referred to the matrix structure and asked if consideration will be given to targeting specific areas to ensure the least impact on performance, quality and safety rather than a blanket approach across all areas. CSm confirmed that nursing and midwifery staffing establishments are not changed without going through the process of the already established Safer Staffing Review which happens twice a year and is approved by Karen Dawber, Chief Nurse. This group of staffing will not be affected but in terms of rostering and agency spend to cover gaps will need to be reviewed and reduced. CSm referred to the proposed process which will provide exact focus on each CSU individually with bigger value opportunities. JL emphasised the importance of ensuring that all waste reduction opportunities have been fully explored to help meet the challenge before beginning the process of stopping certain elements. The following comments were taken from the chat feature which JL asked to be captured within the minutes: *CD asked if impact assessments against the "confirmed" and "opportunity" savings have been undertaken.* *KW suggested "Magical Thinking/the Magic Circle – an online ideas community where people list their ideas and other vote on them.* *EM suggested an online platform called Wayfinder where staff ideas can be captured – this worked well at another organisation.* JL thanked CSm for the detailed update and noted that some very important conversations will need to take place with the full Board in due course. The Academy noted the update.	
FA.1.24.18	**Financial Plan/NHSE Operational Plan Submission**	
	The item was discussed at agenda item FA.1.24.18.	
FA.1.24.19	**WYAAT/ICS Programme Quarterly Updates**	
	As referred to at agenda item FA.1.24.6 this item will remain on the Closed Board Meeting workplan and can be removed from the F&P Academy Workplan.	

No.		Action
FA.1.24.20	**Any Other Business**	
	There were no further items of business to discuss.	
FA.1.24.21	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.1.24.22	**Matters to Escalate to Board**	
	JL advised that the following matters would be escalated to Board via the formal Finance & Performance Academy Chair report: - The scale of the financial risk and the choices that need to be made in terms of the deficit plans.	
FA.1.24.23	**Date and Time of the Next Meeting**	
	28 February 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 31 January 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FA24001	31/01/24	**FA.1.24.4**	**Matters arising:** Revised governance chart for the Waste Reduction Group is currently being finalised and will be provided at a future meeting.	Deputy Director of Finance	28/02/24	Verbal update to be provided.
FA24002	31/01/24	**FA.1.24.6**	**F&P Workplan:** WYAAT and ICS Programme Updates are listed as quarterly updates on the workplan and are also presented to Closed Board Meeting. The Academy agreed that the items can remain on the Closed Board Meeting workplan and can be removed from the F&P Academy Workplan.	Board Secretary/ Associate Director of Corporate Governance	28/02/24	Workplan updated. Action closed.
FA24003	31/01/24	**FA.1.24.8**	**EPRR Governance Proposal:** Quarterly update to include progress on core standards action plan three times a year and sign off by the Academy once a year. Workplan to be updated to explicitly show when updates are due and when approval is required.	Board Secretary/ Associate Director of Corporate Governance	28/02/24	Added to work plan. Dates TBC depending on core standards submission deadline. Action closed.
FA24004	31/01/24	**FA.1.24.12**	**Operational Highlight Report:** JL referred to the IMC challenge and asked if this has been added to the risk register, particularly as this risk is likely to increase given the local authorities	Deputy Director of Operations/Unplanned Care	28/02/24	Covered within the report provided at agenda item FA.2.24.10. Action closed.

			financial position and the impact this has on performance. SM agreed to provide a full update at the next meeting of the Academy as part of the urgent and emergency care focus.			
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	27/03/24	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. Update 11/01/24: Review of Academies to be part of wider board development work. Update to be provided in March 2024.
FA230042	29/11/23	**FA.11(2).23.13**	**Service Development – Post Implementation Reviews:** costs and timelines projected to be included in future reports.	Deputy Director of Finance	22/05/24	To be included in the next report which is due at the May meeting.
FA24004						

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 29 November 2023	**Time:**	11:30-13:30
Venue:	MS Teams meeting	**Chair:**	Karen Walker, Non-Executive Director
Present:	- Karen Walker, Non-Executive Director (KW) - Faeem Lal, Interim Director of HR (FL) - Ray Smith, Chief Medical Officer (RS) - 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 (SF) - Adele Hartley-Spencer, Director of Nursing (AHS) - Amandeep Singh, Partnership Lead (ASi) - Georgi Dyson, Assistant Director of HR (GD) - Sonia Sarah, Co-Chair of the Enable Staff Equality Network (SS) - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) - Amanda Grice, Workplace and Wellbeing Centre Manager (AG) - Abbie Wild, Chair of Staff LGBT Network (AW)		
In Attendance:	- Sean Willis, Associate Chief Nurse (SW) - Ruth Haigh, Equality, Diversity and Inclusion Manager (RH) - John Bolton, Deputy Chief Medical Officer and Medical Director (JB) - Kate Lavery, OPS Programme Manager in attendance for agenda item PA.11.23.5 only (KL) - Sophie Detraux, Pharmacy Lead for Outstanding Pharmacy Services, in attendance for agenda item PA.11.23.5 only (SD) - Ali Al-Enbaree, Lead Pharmacist - Surgical Services, in attendance for agenda item PA.11.23.5 only (AAE) - Nada Sabir, Consultant in Obstetrics and Gynaecology, in attendance for agenda item PA.11.23.14 only (NS) - Sam Wallis, Clinical Neonatology, in attendance for agenda item PA.11.23.14 only (SW) - Katie Shepherd, Corporate Governance Manager (KS)		
Observers	- Liam Bilson, HR Graduate Trainee (LB) - Daniel Lane, Organisational and Development Officer (DL)		

Agenda Ref	Agenda Item	Actions
PA.11.23.1	**Apologies for Absence**	
	Jon Prashar, Non-Executive Director Altaf Sadique, Non-Executive Director Sughra Nazir, Non-Executive Director Catherine Shutt, Head of Organisational Development Absent:	

	- Karen Dawber, Chief Nurse - James Taylor, Deputy Chief Operating Officer - Joanne Hilton, Deputy Chief Nurse - Amy Ilsley, Clinical Lead for Medical Workforce - Susan Parker, Co-chair of the Enable Staff Equality Network - David Smith, Director of Pharmacy - Adam Griffin, Deputy Chief Information Officer - Carly Wilson, People Promise Manager - Laura Gornall, Education Manager, Professional Education	
PA.11.23.2	**Declarations of Interest**	
	No interests were declared.	
PA.11.23.3	**Draft minutes of the meeting held on 25 October 2023**	
	The minutes of the meeting held on 25 October 2023 were approved as an accurate record.	
PA.11.23.4	**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.11.23.5	**Staff Story – Outstanding Pharmacy Services**	
	KL shared the presentation distributed with the papers providing an update on Outstanding Pharmacy Services (OPS). AAE provided some information regarding wellbeing and cultures within the department, including improvements that have been made regarding training, recognition, wellbeing, and inclusivity. SD shared with the Academy the details of upcoming work to explore further improvements in OPS and noted that latest staff survey completion rates were at 79%. KW commented that to give more accountability to the team the OPS programme may want to consider a “we said, we did” approach to showcase improvements, rather than the “you said, we did” style mentioned in the presentation. KW noted that 55% of people were not engaged with the programme directly, and queried how those staff were being reached. SD explained that utilising staff to help engage their colleagues and maintaining clear communication was important in developing engagement. ASi queried whether there had been any progress made regarding personal development planning. KL confirmed that a bespoke appraisal training package is being developed by HR; SD added that some work is also being developed with the Education department to ensure appraisals are of a high quality. In response to a query regarding Safety Huddles, AAE confirmed that each Team Huddle does include a safety briefing, and that	

	staff are able to raise any items in that space. KH advised OPS colleagues that a half a day EDI briefing session is available for team leaders and line managers. RS queried whether there had been any challenges in collaborative working between Senior Leadership and OPS. KL explained that this has been a challenge for the programme but noted progress over recent months as a result of small interventions.	
	Assurance	
PA.11.23.6	**People Academy Dashboard**	
	FL drew attention to the Dashboard shared with the papers, noting that the Education Dashboard had also been circulated. FL shared the following highlights from the People Academy Dashboard: • Staff advocacy contacts have dipped in the last six months, though there has been a 20% increase in those resolved informally. • Six bullying and harassment cases have been completed, with a further six ongoing. • Two referrals to the mediation service over the last six months. • There has been a decrease in staff turnover. • There are 331 members of staff on an apprenticeship programme. • There has been a slight increase in Ethnic Minority senior leadership over the last six months. Though it was acknowledged that representation in higher banded roles was a challenge. • It was noted that there is proportionate representation of the female workforce in lower bands, overrepresentation at middle management, and underrepresentation of females at senior management level. • The sickness absence rate is as expected. There was an in-depth discussion regarding the data on Ethnic Minority Senior Leaders, but also leadership representation amongst other protected characteristics. It was recognised that within the People Academy Dashboard, Consultants do not make up part of the data with regards to Senior Leadership. KH noted that there is some work to be done to look into how data is represented, in order to give assurances about the diversity of the workforce. KW suggested that this information could be brought to the Academy once consolidated. The Academy were assured by the People Academy Dashboard.	
PA.11.23.7	**Workforce Report**	
	FL introduced the Workforce Report, highlighting the newly rolled out Culture Leadership Programme and Staff Survey response. FL noted that the response rate has increased this year from 37% to 43%. Further to this, FL shared that services with 10 or more	

	members of staff will receive a bespoke report based on the response received by the team. The Academy were assured by the Workforce Report.	
PA.11.23.8	**High level operational risks**	
	LP highlighted the following risks from the report, for the attention of the People Academy: • 3810 - Service risk to Haematology The risk target date has been extended. • 3732 - Nursing & Midwifery Staffing Levels The risk score has been reduced from 20 to 16. • 3881 – Medicines reconciliation rates The risk score has been reduced from 16 to 12, subject to an improvement in the medicines reconciliation rate which will be looked into before the reduced score is confirmed. FL highlighted risk ID 3808 regarding impact on patient care and safety, and impact on staff morale, as a result of industrial action. It was suggested that because of an offer put forward to consultants the risk may be more manageable going forward. KW queried whether there are any further nurse strikes expected in response to the Consultant settlement, pointing out that news reports suggest nurses are let down by the decision. FL acknowledged the apparent frustrations shared from nurses across the country and commented on the difficulty of accommodating further strike action in winter months. The Academy were assured that all relevant key risks have been identified, reported to the academy, and were being managed appropriately.	
PA.11.23.9 **PA.11.23.9a**	**People Academy workplan** • **Draft 2024/25 workplan**	
	The Academy approved the People Academy draft workplan for 2024/25 that has been shared with the papers.	
PA.11.23.10	**NHS Long Term Workforce Plan**	
	FL presented the slides shared with the papers giving detail of the NHS Long Term Workforce Plan, sharing the background of the purpose of the plan, and explaining the aims of 'Train, Retain, Reform' in detail. RS commented that this was a great opportunity but expressed concerns regarding the infrastructure of the training and education programmes. The Academy were assured by the NHS Long Term Workforce Plan update.	

PA.11.23.11	**Guardian of safe working hours/quarterly report**	
	This item was taken as read.	
PA.11.23.12	**Nursing and Midwifery Staffing Data Publication Report**	
	This item was taken as read.	
PA.11.23.14a PA.11.23.14b	**Maternity Incentive Scheme Year 5** • **Obstetric medical workforce and audit update** • **Safety Action 4 – Progress with Neonatal workforce planning**	
	NS and SW joined the Academy to provide a presentation on the Maternity Incentive Scheme Year 5. NS gave a presentation addressing Consultant attendance for clinical situations as per the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document. NS shared data within the presentation that represented consultant attendance. Additionally, good practice points and areas for improvement were identified and shared, as detailed on the slides. Regarding documentation issues highlighted during the presentation, FL queried whether this was down to a system issue or a cultural change. NS explained that this was an impact from both factors. Following a query, NS explained that there are additional audits required to answer the question posed with Safety Action 4, which are being addressed. SW shared a presentation regarding progress with neonatal workforce planning, summarising the paper shared with the agenda. This included areas of non-compliance and a summary of 2022 – 2023 action plans. SW highlighted that the plans in place for the coming year are outlined in appendices two and three, noting some significant gaps across the unit. SW requested that the Academy approved the plans outlined in the paper in order to submit for Board approval. There was a conversation regarding the doctor recruitment process, and the difficulties experienced by the neonatal team with recruitment. SW gave some insight into a network-based recruitment drive which BTHFT is keen to be a part of. There were some questions posed regarding progress and staff retention. SW explained how progress has been made but highlighted that numbers of trainees continue to decline. SW explained that Jamie Steele, Matron for Neonatal Services has done a lot of work to maintain retention but noted challenges with uptake from Qualified in Speciality (QIS) nurses and Advanced Nursing Practitioners (ANP). There was a discussion regarding reasons in which BTHFT may lose neonatal staff. SW explained that the majority of trust nurses do not live locally and often leave due to the pressures of travel. SW added that the intensity of the role and work-life balance are	

	also factors which have an impact on retention. It was recognised that learning from past issues and supporting neonatal nurses to thrive was important in ensuring BTHFT is a desirable place to work. SW highlighted that the detailed risk assessment can be found on Apprendix 6 with the papers. The Academy were assured by the updates presented and gave approval for the action plans discussed to be submitted to the Board of Directors.	
PA.11.23.15	**Equality Delivery System Annual data – EDS2022**	
	KH presented an overview of the NHS Equality Delivery System (EDS2022) KH explained that this is a framework which enables NHS organisations to focus on their responsibilities regarding the Equality Act 2010 and the public sector equality duty. A review was undertaken of this framework in 2022, bringing to light some of the learning taken from Covid-19. KH provided some further detailed information regarding EDS22 explaining that at the heart of the EDS2022 are 3 Domains, in which there are eleven outcomes, against which NHS organisations measure their successes and challenges with protected characteristics and vulnerable community groups using evidence and insight. The 3 Domains are: • Domain 1: Commissioned or Provided Services. • Domain 2: Workforce health and wellbeing • Domain 3: Inclusive Leadership KH gave an overview of the nine protected characteristics which have been identified under the Equality Act 2010. KH added that it was also important to have the views of other inclusion health groups represented, giving examples of these type of groups on the slides. KH informed the academy of the plans that are in place to ensure the framework is implemented by the end of February in line with our contractual responsibilities. This will involve targeted engagement with our diverse staff across the Trust including our patients and communities. KH informed colleagues that he will bring the results back for Domain 2 and 3 to PA for approval and publication once the engagement events have taken place and then to publish in line with contractual requirements.	
PA.11.23.16	**Healthcare worker flu vaccination Best Practice Assurance**	
	This item was taken as read.	
PA.11.23.17	**Industrial Action**	
	This item was discussed at agenda item PA.11.23.8.	
Learning and Improvement		
PA.11.23.18	**Looking after our People**	
	This item was taken as read.	

PA.11.23.19	**NHS Staff survey results and action plan**	
	This item was taken as read.	
PA.11.23.20	**Any other business**	
	KH shared with colleagues that BTHFT recently received the Best Employer for Equality, Diversity and Inclusion, Nursing Times Award. KH took the opportunity to thank all members of the academy for the support, commitment, and hard work in making this happen. FL shared that the BTHFT SPaRC team won the HSA award for Staff Wellbeing for the Ramadan Allies project, the academy congratulated all members of the SPaRC team for their recognition.	
PA.11.23.21	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.11.23.22	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.11.23.23	**Date and time of next meeting**	
	31 January 2024 – 11.00 - 13.00	
PA.11.23.24	**Internal Audit Reports relevant to the Academy – BH/17/2024 Control of Substances Hazardous to Health (COSHH) report**	
	The Academy was asked to refer to the circulated paper for updates.	

ACTIONS FROM PEOPLE ACADEMY – 29th November 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	

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 31 January 2024	**Time:**	11:00-13:00
Venue:	MS Teams meeting	**Chair:**	Karen Walker, Non-Executive Director
Present:	- Karen Walker, Non-Executive Director (KW) - Faeem Lal, Interim Director of HR (FL) - Ray Smith, Chief Medical Officer (RS) - Karen Dawber, Chief Nurse (KD) - 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 (SF) - Amandeep Singh, Partnership Lead (AS) - Georgi Dyson, Assistant Director of HR (GD) - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) - Abbie Wild, Chair of Staff LGBT Network (AW) - David Robinson, Consultant in emergency Medicine/Director of Education (DR) - Laura Gornall, Education Manager, Professional Education (LG)		
In Attendance:	- Sean Willis, Associate Chief Nurse (SW) - Katie Shepherd, Corporate Governance Manager (KS) - Jade Stephenson, Matron, Theatres, Critical Care and Day case (JS) for agenda item PA.1.24.5 only. - Liz Melsom, OTS Service Improvement Lead (LM) for agenda item PA.1.24.5 only. - Carol Close, OTS Lead, Theatres (CC) for agenda item PA.1.24.5 only. - Caroline Nicholson, Head of non-clinical risk (CN) - William Hall, Violence Prevention Reduction Lead\ Local Security Management Specialist (WH) for agenda item PA.1.24.14 only. - Thomas Brown, Head of Service Security (TB) for agenda item PA.1.24.14 only.		
Observers	- Amanda Nicholson, HR Business Partner (AN) - Sindy Jones, ANHH Consulting (SJ)		

Agenda Ref	Agenda Item	Actions
PA.1.24.1	**Apologies for Absence**	
	Jon Prashar, Non-Executive Director Altaf Sadique, Non-Executive Director Sughra Nazir, Non-Executive Director Catherine Shutt, Head of Organisational Development Absent: - James Taylor, Deputy Chief Operating Officer - Joanne Hilton, Deputy Chief Nurse - Amy Ilsley, Clinical Lead for Medical Workforce - Susan Parker, Co-chair of the Enable Staff Equality Network	

	- David Smith, Director of Pharmacy - Adam Griffin, Deputy Chief Information Officer - Sonia Sarah, Co-chair of the Enable Staff Equality Network	
PA.1.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.1.24.3	**Draft minutes of the meeting held on 29 November 2023**	
	The minutes of the meeting held on 29 November 2023 were approved as an accurate record. With regard to the action log: The actions marked as closed were confirmed as such by the Academy. The following actions were discussed. • PA23008 Gender Pay Gap: *LP to arrange an exceptional People Academy session on EDI and Gender Pay Gap.* KH advised that data analysis would be completed by end March. Therefore session would be scheduled for May 2024 Action to remain open. • PA23027 Nursing and Midwifery staffing establishment review: *RL to discuss the concerns relating to staff facilities with JH outside of the meeting.* Noted that feedback to DDoNs and wards will be built into future staffing reviews. Action closed.	
PA.1.24.4	**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.1.24.5	**Staff Story – Outstanding Theatre Services**	
	LM shared the presentation distributed with the papers providing an update on Outstanding Theatre Services (OTS). Following two years of intense work to transform Theatre Services through the Outstanding Theatres programme, this was the last day of the initiative - the work has now been handed over to the Theatres team to continue to transform the service. JS provided an overview of the sustainability plan and approach. The work originally was formed by the team leaders within Theatres to sustain this programme. The staff within Theatres, have now renamed the programme to 'Theatres – moving to outstanding.' JS referred to the mission statement which described the reason for the change. The pathways have been aligned to the CQC standards and OTS have workstreams within each of the pathways. The safe pathway covers how civility saves lives and the well-led pathway includes targeted staff progression, mentoring and preceptorship. Significant effort has been made into the integration of the Band 5's, as well as the development of the leadership development matrix.	

	The presentation referred to the well-led pathway, where improvements were made within the team and positive feedback received. The team would like to launch the updated service in March 2024 with a celebration event taking place in the summer, as well as regular celebratory event throughout the year. KD queried whether the Band 7 staff will be given dedicated time to focus on the work of OTS: how will metrics be measured, and will there be some targeted recruitment for freedom to speak up guardians? In response to KDs questions, JS confirmed that the team leaders working pattern has changed to include protected management time. The 'freedom to speak up' work will be included in the band 7 staff members job description and success will be measured in the monthly forums/catch- ups. Surveys and the CSUs will maintain the measurement of the programme. JS mentioned that Marianne Downey has done a large piece of work for the Band 7's in the theatre establishments. Management time has been deducted, this will be included in the next establishment review. KD asked if the review undertaken in theatres for the leadership protected time can be shared at the next meeting. JS agreed to share this at the next meeting. KW asked, 'how will we know we have achieved outstanding' and how will outcomes be measured? Again, KD asked if an update can be provided at a future meeting? **Action**: JS to share a copy of the review undertaken in theatres for the leadership protected time. AS queried how much thought has been given to career progression for the band 4 staff, to progress to higher bands? JS responded by saying that all the work that has been completed has been focused on career progression - the band 4 roles are trainee roles which will progress to band 5 or above. There are 3 ATP roles which are difficult to progress to a higher band, as these roles have been phased out, but the team are working within the WYAAT group to look at how these individuals can be supported to progress. The Academy congratulated the team on the amazing progress over the last 2 years to change the culture, create meaningful change and take ownership. The academy noted the update.	Matron in Theatres (PA24001)
	Learning and Improvement	
PA.1.24.6	**Workforce Growth and Transformation**	
	SW provided an update on Quarter Q4 of the Workforce Growth	

	and Transformation Subgroup. The following key points were highlighted: • Appointment has been made to the Head of Volunteering position. The recruitment process for appointing new volunteers has been revised, as well as the mandatory training requirements. The volunteering services have launched their website to aid with recruitment and all enquires relating to volunteering. • As the focus for this year is staff retention, the OD team will be working with informatics and facilities to promote scope for growth and career conversations. • The training allowance was reviewed, to determine whether this is in line with the trust's ambitions. Further work will be conducted to promote and develop in-house courses. The academy noted the update.	
PA.1.24.7	**Workforce Civility update**	
	FL referred to the circulated paper and informed the Academy how the Trust is embedding Civility into the Workplace. At a previous Programme Board meeting, the focus was on triangulating data and consistency of approach, recognising that in an organisation of our size, there will inevitably be disagreements and relationship issues. At the previous meeting, the key discussion was focused on ensuring that line managers in the organisation, have the skills that require to identify and resolve issues relating to civility at an early stage, before reaching a formal process. The programme board will dedicate the next meeting to staff feedback, through the Staff Survey, national education and training survey, as well as understanding the feedback from our newly international recruited staff. Having an overview of staff feedback, allows opportunities to consider any themes that may require particular attention and programmes of work. The People Pulse survey, was also given importance, quarterly pulse surveys have been nationally rolled out. Engagement with the Pulse survey has been poor and the workplace civility programme board will be reviewing how uptake can be increased, by encouraging better engagement. The freedom to 'speak up' concerns will also need be reviewed, to understand where the focus should be and where improvements can be made. KW asked with regards to the triangulation of data, for FTSU, staff survey etc, if the data can be presented at a future meeting, which FL agreed to present at the next civility update. **Action:** FL to present the triangulation of data, for FTSU, staff survey etc.	(PA24002) Interim Director of HR

	KW also asked if the retention data for international nurses can be shared at a future meeting to understand how this has impacted on the people's experience, as well as the STIP and tenure rates. FL agreed to share this data at a meeting towards the end of the year. **Action**: FL agreed to share retention data for international nurses, to understand how this has impacted on the people's experience, as well as the STIP and tenure rates. KH advised that the civility, respect and resolution policy which previously was the Harassment and bulling policy, will be presented at a future meeting for approval. The academy noted the update.	(PA24003) Interim Director of HR
	Assurance	
PA.1.24.8	**Nursing and Midwifery staffing data publication report**	
	SW provided an overview of the paper which was circulated and informed colleagues. • Vacancy rates are continuing to reduce and fill rates have improved monthly. • The trust is still on target with vacancies, to reduce vacancies from 20% in March 2023, to 10% in March 2024. • Turnover data continues to fall – in line with other organisations. • HCA vacancy target is 3.7%. We are not expected to achieve this until April 2024 as our bootcamp capacity has been reduced to 30 due to the location of clinical services into Ward 10. • Staffing concerns are being rated via Red flags, Datix and IRIS. These are in line with previous month. Processes are in place to mitigate staffing challenges on a daily basis. • 150 international nurses have been recruited in the current financial year. The academy was assured by the Nursing and Midwifery staffing data publication report.	
PA.1.24.9	**People Academy Dashboard**	
	FL drew attention to the Dashboard shared with the papers. FL shared the main highlight from the People Academy dashboard, informing members that Staff Turnover for December had decreased to 9.73% from 10.01% in October 2023. Since June 2022 there has been monthly reduction in staff turnover, which is positive for the Trust. The academy was assured by the People Academy dashboard.	
PA.1.24.10	**Workforce Report**	
	FL provided an overview of the workforce report and informed colleagues of the following:	

	• Year to date sickness absence rate has dropped from 5.91% reported in November, to 5.78% at the end of December 2023. • Risk number ID3732 – in view of the vacancy position for Nursing and Midwifery staffing, this has reduced from 20 to 16. • The report also includes a comprehensive update from the Pharmacy team in light of the OPS Programme, where there has been increased responses to the staff survey. The Academy were assured by the Workforce Report. KW agreed to share the risk highlight with the Board of Directors in her report to the Chair. **Action**: KW agreed to share the risk highlight, Risk number ID3732 – in view of the vacancy position for Nursing and Midwifery staffing (reduction from 16 from 20) with the Board of Directors, in her report to the Chair.	(PA24004) Chair
PA.1.24.11	**Revised Disciplinary Policy**	
	FL presented the revised policy and informed members that Staff side colleagues were consulted and involved in the review and have now agreed the amendments proposed at the Trusts Joint National Consultative Committee (JNCC). It has been agreed to change the approach and management of disciplinary cases. The Trust has embedded some of the practices from Merseycare, to instil some of those practices into our work. The disciplinary policy did not reflect some of the work we were doing. The revised policy now matches some of our practice changes. The new policy centres around the 'just and learning culture' approach and encourages managers to resolve matters informally, rather than going down the route of disciplinary sanctions. The policy also looks at whether our processes/procedures and practices need to change to consider other options. The policy also states that investigation managers will need to be trained and will undergo in-house training, supported by the HR team. The aim of the policy is to have an investigation concluded within 4 weeks, or within a timely period. The focus is on the employee and their wellbeing, regardless of the situation or outcome, by assigning somebody neutral to offer pastoral care. Previously the policy stated, where an individual is suspended, they should not contact an employee from the organisation. This has now changed where support can be given from an employee within the organisation. The policy is to embed a 'just and learning culture' to be more supportive towards staff, not just those who are under investigation, but all those involved in the process and to provide support to all those involved throughout the process. AS commented that the policy consultation took longer than envisaged and this was due to many changes in the policy. AS thanked, all those who were involved in pulling this policy together and was in support of managers receiving the training and offered staff side support with rolling out the training, as well as the	

	facilitated conversations. The policy will be benchmarked across other local organisations to share good practice and to learn from other organisations too, as well as managing the process in a timely manner. The academy supported the recommendations set out in the paper. Thanks were given to the FL and his team for developing the policy.	
PA.1.24.12	**High Level Risk Register**	
	LP highlighted the following risks from the report, for the attention of the People Academy: • 3788 – this risk has closed, as it is reflected in other risks relating to backlog maintenance and roof issues • 3767 – this risk has been resolved, therefore the risk is now closed • 3530 – the risk score has been reduced from 16 to 12 and ETM had noted further mitigations to be put in place • 3711 - the risk score has been reduced from 16 to 12 KD advised that the Children's CSU is diligent in recording risks and there would be a review of the individual risks raised to understand if there is an overarching risk relating to workforce capacity and demand for the CSU. KD raised her concerns with the risk associated with 3788 and 3530 - these relate to estate issues and will impact staff who are based in Heaton House. This will affect staff health and wellbeing and the environment they work in, and requires some focus to address these issues. FL mentioned that there are no changes to risk number 3808, which relates to the industrial action risk. The score will only change if there is a change in the national negotiations. KD advised that in relation to risk 3767 (lone worker devices), the devices are now in use which is why the risk was closed, but an issue has since arisen in relation to the process for responding to an alert, and ensuring that the relevant staff are aware of this. Therefore, there may be a requirement to undertake a new risk assessment. **Action:** KD/LP to consider whether a new risk assessment is required in relation to confirming the process for responding to alerts raised by lone worker devices. The Academy was assured that all relevant key risks have been identified, reported to the academy, and were being managed appropriately.	(PA24005) Chief Nurse & Associate Director of Corporate Governance /Board Secretary
PA1.24.13	**Report/Minutes from Health and Safety Committee**	
	CN informed members that due to departure of the previous	

	Director of Estates and Facilities (E&F), Chris Davies, Deputy Director of E&F is the acting chair of the committee. There is currently no NED (non-executive director) for this committee, but this is being reviewed. An internal audit took place related to COSHH, which gave the outcome of limited assurance, the concerns have been reported at this academy previously these relate to the lack of a specialist adviser (COSHH Lead) in post due to maternity leave. The COSHH Group required a new Chair and a review as did the Terms of Reference and lack of Training was also an issue. An action plan has been put in place, which will be reviewed by the Health and Safety committee. The terms and reference for the COSHH groups are also under review. There are currently 93 assessors in the Trust: 73 in planned, 17 in unplanned and 3 in corporate services. The number of assessments has reduced from 5,000 to 1,770 and this continues to decrease daily. The lack of engagement from clinical areas for COSHH assessors was reported at the academy, conversations have taken place with the affected areas support is required from the clinical areas as this remains a challenge. KD noted that there is no representation from Maternity safety champion and Non-Executive Director for the committee. LP agreed to consider this and assign a NED to this committee. **Action**: Since the departure of Jon Prashar, there is no NED assigned to the Health and Safety Committee, LP agreed to investigate this and assign a NED to the committee. A discussion took place regarding the emergency planning business continuity plan, as only 10.3% of plans are completed. CN agreed to pick this up with Steven Amos, Emergency Planning Manager. FL queried if the business continuity plans were prioritised and categorised by risk and if they are will there be any risks associated to this. It was also queried what the risks are, of having no continuity plans in place and is there any mitigation, CN agreed to investigate this and agreed she will feed this back at a future meeting. **Action:** LP to review whether a risk will need to be generated on the risk register, relating to the RAG rating of services who require a business continuity plan and to bring back here for assurance. The academy was assured by the Health and Safety update.	(PA24006) Associate Director of Corporate Governance /Board Secretary (PA24007) Associate Director of Corporate Governance /Board Secretary
PA.1.24.14	**Violence Prevention & Reduction Standard**	
	BH and TB joined to the meeting to provide a presentation on the Violence Prevention & Reduction (VPR) Standard.	

	The Trust is required to review its status against the standard and provide assurance to the Board that they have met twice a year. The report highlights the work undertaken in the preceding six months, specifically the review of the existing VPR structure, required focus groups and workstreams to progress work across the Trust. Concerns have been raised that attendance at the meetings has been low. The agenda, terms of reference, membership has been reviewed to improve engagement and progress. Three distinct key areas require focus to achieve Violence Prevention and Reduction across the Trust have been identified and these were addressed in the paper. It is recommended that these three areas require significant focus and support from the senior leadership for engagement and compliance to the VPR. In addition, workstreams have been identified such as Education and Training, metrics and data validation, to support the focus groups. The Trust needs to ensure that the training delivered is targeted to the needs of the Trust and this is to be done on a risk-based approach. BH informed colleagues that the new structure and workstreams will be discussed and agreed at the next meeting scheduled for February 2024 and this will enable improved engagement and progress. A discussion took place and concerns were raised in relation to the lack of attendance at the VPR meetings - this requires a strategic oversight and additional scrutiny. It was also agreed that support is needed from an Executive lead and the risk should be escalated to the Board of Directors. **Action**: It was agreed for KW to raise the concerns in her report to the chair, which relates to VPR standards in particular additional scrutiny and engagement, as well as a named Executive Director supporting this area of work. KD agreed she would also address this issue with the Executive Team.	(PA24008) Chair and Chief Nurse
PA.1.24.15	**Industrial Action**	
	FL informed members that BMA have balloted again for renewing their mandate for junior doctor's strike action. The Consultant body has rejected the pay award which the government proposed. The Consultants have a mandate to strike and the Trust is awaiting notice on this. BMA have stated they are not planning any immediate strike action, but discussions are ongoing with the government to agree pay.	
PA.1.24.169	**People Academy work plan**	
	LP mentioned that there were a couple of items that were on the workplan for today's meeting, but these items were deferred and will be presented at future meetings.	

	FL informed colleagues that the workforce planning submission will be presented at the next meeting. The Trust have been asked to submit their draft submission plan and the deadline for this has been extended until 19th February, where the Trust will amend the draft submission and submit a final submission by mid-March.	
PA.1.24.17	**Any other business**	
	KW thanked Jon Prashar on behalf of this academy for his contributions at this meeting, the board and all the other meetings he attended. JPs term of office has now concluded.	
PA.1.24.18	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.1.24.19	**Matters to escalate to the Board of Directors**	
	KW agreed to share the risk highlight, Risk number ID3732 – in view of the vacancy position for Nursing and Midwifery staffing (reduction from 16 from 20) with the Board of Directors, in her report to the Chair. It was agreed for KW to raise the concerns in her report to the chair, which relates to VPR standards in particular additional scrutiny and engagement, as well as a named Executive Director supporting this area of work. KD agreed she would also address this issue with the Executive Team.	(PA24004) Chair (PA24008) Chair and Chief Nurse
PA.1.24.20	**Date and time of next meeting**	
	28 February 2024 – 11.00 - 13.00	
PA.1.24.21	**Internal Audit Reports relevant to the Academy – BH/17/2024 Control of Substances Hazardous to Health (COSHH) report**	
	There was nothing to report on this agenda item.	
PA.1.24.22	**Update on CSU to Academy delivery programme – March 2024 to March 2025**	
	The Academy was asked to refer to the circulated paper for updates.	

ACTIONS FROM PEOPLE ACADEMY – 31 January 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
PA24001	31.01.2024	PA.1.24.5	**Staff Story – Outstanding Theatre Services -** JS to share a copy of the review undertaken in theatres for the leadership protected time.	Jade Stephenson, Matron, Theatres	28.02.2024	
PA24004	31.01.2024	PA.1.24.10	**Workforce Report:** KW agreed to share the risk highlight, Risk number ID3732 – in view of the vacancy position for Nursing and Midwifery staffing (reduction from 16 from 20) with the Board of Directors, in her report to the Chair.	Chair	February 2024	Included in the Chairs report for January's meeting. Action closed.
PA24005	31.01.2024	PA.1.24.12	**High Level Risk Register:** KD/LP to consider whether a new risk assessment is required in relation to confirming the process for responding to alerts raised by lone worker devices.	Chief Nurse & Associate Director of Corporate Governance / Board Secretary	February 2024	Update included in HLRR report. Action closed.
PA24008	31.01.2024	PA.1.24.14	**Violence Prevention & Reduction Standard:** It was agreed for KW to raise the concerns in her report to the chair, which relates to VPR standards in particular additional scrutiny and engagement, as well as a named Executive Director supporting this area of work. KD agreed she would also address this issue with the Executive Team too.	Chair and Chief Nurse	February 2024	KW Included her outstanding action in the Chairs report for January's meeting. Action closed.
PA24002	31.01.2024	PA.1.24.7	**Workforce Civility update:** FL to present the triangulation of data, for FTSU, staff survey etc.	Interim Director of HR	March 2024	

PA24006	31.01.2024	PA.1.24.13	**Report/Minutes from the Health and Safety Committee: Since the departure of Jon Prashar,** there is no NED assigned to the Health and Safety Committee, LP agreed to investigate this and assign a NED to the committee.	Associate Director of Corporate Governance / Board Secretary	March 2024	To be confirmed when the new Chair is in post.
PA24007	31.01.2024	PA.1.24.13	**Report/Minutes from the Health and Safety Committee:** LP to review whether a risk will need to be generated on the risk register, relating to the RAG rating of services who require a business continuity plan and to bring back here for assurance.	Associate Director of Corporate Governance / Board Secretary	March 2024	
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	May 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. **Jan 2024. Data analysis to be completed by end March. Session to be scheduled for May 2024** Action to remain open.
PA24003	31.01.2024	PA.1.24.7	**Workforce Civility update:** FL agreed to share retention data for international nurses, to understand how this has impacted on the people's experience, as well as the STIP and tenure rates.	Interim Director of HR	November 2024	

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) - LEARNING AND IMPROVEMENT MINUTES

Date:	Wednesday 29 November 2023	**Time:**	14:00 – 16:30
Venue:	Microsoft Teams Meeting	**Chair:**	Louise Bryant, Non-Executive Director/Chair

Present:	**Non-Executive Directors:** • Louise Bryant (LB), Non-Executive Director/Chair **Executive Directors:** • Ray Smith (RS), Chief Medical Officer • Karen Dawber (KD), Chief Nurse • Paul Rice (PR), Chief Digital and Information Officer
Attendees:	• John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director • 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 • Adele Hartley-Spencer (AHS), Director of Nursing – Operations • Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary • Benjamin McKay (BM), Education Manager • Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes • Leah Richardson (LR), Patient Safety Specialist • Jane Kingsley (JK), Lead Allied Health Professional • Sarah Turner (ST), Assistant Chief Nurse Vulnerable Adults, Safeguarding Adults • Kay Pagan (KP), Assistant Chief Nurse Informatics • LeeAnne Elliot (LAE), Patient Safety Specialist • Sean Willis (SW), Associate Chief Nurse - Quality & Workforce • Emma Barnes (EB), Matron, Specialty Medicine, Unplanned Care and Respiratory • Naveed Saddique (NS), Service and Business Development Manager, in attendance for agenda item QA.11(2).23.11. • Ali Jan Haider (AJH), Director of Integrated Health and Care, BDC Partnership, in attendance for agenda item QA.11(2).23.11. • Ruth Haigh (RH), Equality, Diversity & Inclusion Manager, in attendance for agenda item QA.11(2).23.13. • Kez Hayat (KH), Head of Equality, Diversity & Inclusion, in attendance for agenda item QA.11(2).23.13. **In attendance** • Jacqui Maurice (JM), Head of Corporate Governance • Denise Stewart (DS), Quality & Patient Safety Facilitator

Agenda Ref	Agenda Item	Actions

QA.11(2).23.1	**Apologies for Absence**	
	• Jon Prashar, Non-Executive Director • Altaf Sadique, Non-Executive Director • Mohammed Hussain, Non-Executive Director • Sughra Nazir, Non-Executive Director • Jo Hilton, Deputy Chief Nurse **Absent** • Sarah Freeman, Director of Nursing – Operations • Deborah Horner, Deputy Chief Medical Officer • Sally Scales, Director of Nursing: Programme Lead for Magnet • Caroline Varley, General Manager, CMO Office • Caroline Nicholson, Head of Non-Clinical Risk • Padma Munjuluri, Associate Medical Director-Clinical Outcomes • Robert Halstead, Associate Medical Director Quality Governance, Emergency Department • Rebecca Kidd, Clinical Site Matron • Jill Clayton, Deputy Director of Nursing, Unplanned Care • Marianne Downey, Deputy Director of Nursing\Critical care, Theatres, day case and MSK, Planned Care • Kay Rushforth, Associate Director of Nursing for Children and Neonatal Services, Children's Clinical Business Unit • Kelly Young, Deputy Director of Nursing, Surgery and Digestive Diseases CSU • Karen Bentley, Assistant Chief Nurse, Patient Experience • Sarah Wood, Quality Lead Nursing & Midwifery • Michael McCooe, Associate Medical Director, Learning from Deaths • Nazzar Butt, Moving to Outstanding Lead • Grainne Eloi, Associate Director of Nursing and Quality, Bradford District and Craven Health and Care Partnership • Kavitha Nadesalingam, Rheumatology Consultant\Honorary Senior Lecturer • Abimbola Olusoga, Clinical Pharmacist Team Leader	
QA.11(2).23.2	**Declarations of Interest**	
	There were no declarations of interest.	
QA.11(2).23.3	**Minutes of the meeting held on 1 November 2023**	
	The minutes of the meeting held on 1 November 2023 were approved as an accurate record.	
QA.11(2).23.4	**Matters arising** **• Items to escalate from Chief Nurse / Chief Medical Officer**	
	RS noted that decisions are being made between Consultants and the government regarding industrial action. He added that talks continue for Junior Doctors. In addition, RS advised colleagues that a new strain of Swine Flu had been reported on the news. RS noted that one individual had been affected so far in the UK, who had made a full recovery.	

	KD added an escalation from Maternity Services, noting that the unit was very busy and delayed discharges were increasing. It was acknowledged that this would be addressed in detail under agenda item QA.11(2).23.10.	
QA.11(2).23.5	**High Level Risks**	
	From the report, RS highlighted the following: • 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. • 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: o Risk ID 3732 – nursing and midwifery staffing levels. o 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. There was a query regarding whether Risk ID 3696 – Aseptic unit, was still awaiting sign off. DS confirmed that it was, due to some damage caused to the unit. LP to update the register with this information. **Action: LP to update Risk 3696 to reflect delays to sign off.** The Academy were assured that all relevant key risks have been identified, reported to the academy, and were being managed appropriately.	**Associate Director of Corporate Governance**
QA.11(2).23.6	**Infection Prevention and Control Quarterly Report**	
	YM presented the Infection Prevention and Control (IPC) Quarter 1 Progress Report, covering July – September 2023. YM explained that there are 6 mandatory organisms that must be reported on. Data on quality, performance and benchmarking was shown on the slides. YM shared monthly data of each of the organisms individually: • MRSA Bacteraemia • C. diff • Pseudomonas Bacteraemia • MSSA Bacteraemia • Klebsiella • E. coli YM shared that the IPC Board Assurance Framework (BAF), demonstrates a high level of compliance. He explained in detail any gaps in compliance for the revised IPC BAF, noting that all	

	were being addressed. Improvements to the service over the quarter were shared as below. • Improvements regarding c. diff infections can be seen following intervention in July 2023. • The average time for blood culture samples from ward to lab has reduced, following intervention in September 2023. YM gave the following assurances to the Academy, with details included on the slides. • The Bacteraemia reduction measures that are in place across the Trust. • CDI reduction measures that are in place. • Mitigating actions to assure compliance to IPC BAF. • Changes to IPC activities in neonatal unit. YM outlined the plan for the service to move to PSIRF, in line with the Trust policy. A flow chart demonstrating the IPC PSIRF process was shared. Finally, some pictures were shared of International Infection Prevention Week on October 9 – 13, 2023. YM shared that there were stalls, awards and staff dressing up to celebrate and spread information about IPC. YM thanked staff and Executive Directors for participating. RS commented that it was good to see work being developed in the neonatal unit. RS queried whether growth in Klebsiella infections were due to antibiotic misuse, or another factor driving Klebsiella to increase. YM explained a number of ways in which patients can develop klebsiella, giving the details of four main reasons and assuring that improvements are being addressed concerning all factors. KD commended the IPC team for making the work they do fun and reinforcing positivity. KD queried what has been put in place to address MSSA Bacteraemia numbers increasing. YM identified that the primary factor of this would be an increase in the community, noting that the increase is evident across the UK. YM also identified some other factors that are out of the Trust's control but gave assurance that the IPC team is working towards continual improvement. The Academy were assured by the Infection Prevention and Control Quarterly Report.	
QA.11(2).23.7	**Research Activity in the Trust – update**	
	RS highlighted the projects outlined in the report circulated with the papers. The projects included research into early years of life, and an update regarding the Academic Unit for Ageing and Stroke Research. The Academy noted the Research Activity in the Trust update.	

QA.11(2).23.8	**Patient Experience – Six monthly report**	
	This item was deferred to January 2024.	
QA.11(2).23.9	**Serious Incident Report (Focus on learning)**	
	LH highlighted the following information from the serious incident (SI) report circulated with the papers: • There have been no duty of candour breaches from 1st – 31st October 2023. • The number of SIs declared by the Trust between November 2022 and October 2023 has remained within normal cause variation, except for January 2023. • The Trust's PSIRF plan has been approved by the Board of Directors. • The Trust SI reports and action plans continue to be accepted by Bradford District and Craven Health and Care Partnership • 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. Further to this, LH shared the following information regarding Serious Incidents covering 1st October – 31st October 2023: • There has been one SI declared within this period, details of which can be found in the report. • Currently 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. • There are 7 investigations, 3 of which are HSIB investigations, with extensions in place. • One SI has concluded within the period; lessons learned can be found at section 3.7 of the report. • Lessons learned are included within the report. Of the Serious Incidents reported from 1st November 2022 to 31st October 2023 there were 21 Trust investigations (one of which was de-logged), 8 HSIB investigations (2 of which were de-logged) and 3 Safeguarding system investigations. In addition, one of the Trust investigations related to a Never Event. LH noted that target timeframes are displayed within the report and suggested that there would be improvements to timeframes as the Trust transitions to PSIRF. RS queried how PSIRF will affect the nominal 60-day time limit for completion of SIs currently in place. LH clarified that it will still be expected that investigations do not take longer than 60 days, though a reasonable and appropriate timescale will be set out by the organisational. The process of this is currently being set out. Regarding an incident reported in the documents regarding	

	multiple electronic patient records, KP commented that it would be helpful to know what the findings were from this. LH noted that the reports shared in the appendices address the findings and offered for the Quality and Patient Safety Facilitator to contact KP to provide more detail. LB queried the process of the action plan within the report at Appendix 2. LH explained that once the final action is completed the assurance and regulatory teams will approach the CSUs and actions will be taken through the Safety Event Group and Quality and Safety meetings, so CSUs are aware of their actions. JC added that as the framework will be different, the terms of reference for the Safety Event Group, Quality of Care Panel and Patient Safety Groups are being addressed. JC explained that ways to track the actions are being explored, with consideration of the approach being different with PSIRF. Additionally, JC advised that a Complaints, Litigation, Incident & PALS (CLIP) report will be developed to ensure that the Board of Directors have assurance that the learning has been embedded, and the actions have been completed. The Academy were assured by the Serious Incident Report.	
QA.11(2).23.10	**Maternity and Neonatal Services Update**	
	SH provided an update on Maternity and Neonatal Services from October 2023. The October 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 October cases, in which 4 stillbirths were summarised. Additionally, SH shared that there were two Cases of HIE, one Level 1 incident, and two completed investigations in October. The details of the HIE cases and completed investigations, which included learning and recommendations, were shared on the slides. LB noted that in the Avoiding Term Admissions Into Neonatal Units (ATAIN) plan some staffing concerns had been identified, and queried how this was being addressed. SH explained that the staffing issue will primarily be led by the neonatal team but will be a combined approach with maternity. It was shared that work is planned for early 2024 and assurance was given that there are no immediate harms, though it was noted that opportunities for improvement has been identified. LB noted that on page 7 of the report there are some areas which it was suggested may require Board level support and queried if any needed to be discussed at the Academy. SH explained that the three-year plan was discussed at the last meeting of the Board of Directors, and commented that this was noted in the report to be wary that the Board may need to address any problems if required, clarifying that there was nothing particular to escalate. SH recognised that November 2023 had been a challenging	

	month and discussed some of the contributing factors: • Staffing issues. • Emerging challenges regarding point of care testing, as a result of participation in research project for Streptococcus B. • Changes to NICE guidance around timing of the offer of induction of labour, causing an issue with beds. SH explained that the unit has a significant backlog of inductions and shared the details of a recent case of harm, in which an intrauterine death occurred as a result of delayed induction of labour. SH assured the Academy that a lot of work is being done to address this issue. This includes mutual aid from neighbouring trusts. SH also shared that there is a regional induction of labour deep dive on Monday 4 December 2023 which she is involved in. SH praised the staff on the unit for their hard work and commitment. KD noted that within 48 hours of the incident occurring, it had been escalated to the ICB Chief Nurse Beverley Geary, who has escalated to Tracey Cooper, Chief Midwife for the North East and Yorkshire, NHS England. Additional actions were put in place, with additional on-call senior midwives available to get through the volume of inductions of labour. It was recommended that this issue was escalated to the Board of Directors at the next meeting in January 2024. The Academy were assured by the Maternity and Neonatal Services Update.	
QA.11(2).23.11	**Update on Health Inequalities**	
	AJH shared a presentation updating on Health Inequalities. The following information was highlighted from the presentation circulated with the papers. • Some national and regional context to Health Inequalities were addressed. • BTHFT Health Inequality workstreams. • Progress update, including progress of Health Equity Assessment Tool (HEAT) training. • Improvements being made to access, outcomes, and patient experience. • Next steps, including the development of HEAT. AJH asked the Academy whether the detail and content of the presentation provides the level of information, detail and depth required by the Academy. KD commented that an improvement would be to bring to life the initiatives that are making a difference. AJH agreed that stories that would provide positive narratives as well as some learning would be helpful; and noted that the Palliative Care team is doing a lot of work to address Health Inequalities, which would be beneficial to share. KH commented that at the moment there is a lot of focus on what	

	Health Inequalities are and what creates Health Inequalities. KH recommended that the Trust needs to celebrate and showcase the work that is being done to address Health Inequalities, and share the impact, learning and the outcomes of what is being done. It was agreed that there are some great examples of how BTHFT is overcoming some of the challenges in this area trustwide. LH reflected on how this links to the Trusts movement to InPhase, noting that if there is available data it can be linked together to make positive improvements. There was a discussion regarding practically addressing Health Inequalities, such as extended visiting policies or care of staff during Ramadan. KD recognised that there is a lot of work done in the Trust to recognise equality and diversity, but it is not captured in a quantifiable way. KH acknowledged that there is work to do in this area, but shared that there is a lot being done to empower staff and help them be aware of cultural competency, by creating the psychological safety for these conversations to happen. It was agreed that sharing learning and celebrating innovation is very important to ensure the Trust continues to grow with its work on Health Inequalities. The Academy noted the Health Inequalities update.	
QA.11(2).23.12	**Patient Safety Incident Response Framework**	
	LR shared the Patient Safety Incident Response Framework (PSIRF) slides, providing an update for the Trusts current position in the transition to PSIRF. LR highlighted that the recruitment of Patient Safety Partners at Trust Level is underway. Further to this, LR provided an update on the Compliance with Enduring Patient Safety Standards. LR explained that these are standards published by the national patient safety agency, highlighting actions that are relevant and unlikely to change. The organisation was asked to ensure we are compliant with the enduring standards. LR highlighted a Never Event in March 2022 regarding a misplaced NG tube, which demonstrated that the organisation was not compliant. LR shared the learning and actions from this incident, as shown on the slides. AHS commented that it was good to hear that the Trust is working towards standardisation with other organisations. It was agreed that this would be beneficial for Junior Doctors who will undoubtedly find it difficult to work to different standards as they move around organisations. The Academy noted the Patient Safety Incident Response Framework.	
QA.11(2).23.13	**Equality Delivery System 2022**	
	KH and RH shared a presentation about the NHS Equality Delivery System 2022 (EDS22) framework. KH explained that it is	

	a system which helps NHS organisations focus on their responsibilities regarding the Equality Act 2010. A review was undertaken in 2022, bringing to light some of the learning taken from Covid-19. KH provided some further detailed background regarding EDS22 explaining that there are three different domains, and highlighted how the Trust will address the domains: • Domain 1: Commissioned or Provided Services. BTHFT and the Bradford ICB office will be exploring Respiratory Services • Domain 2: Workforce health and wellbeing • Domain 3: Inclusive Leadership KH gave an overview of the nine protected characteristics which have been identified under the Equality Act 2010. KH added that it was also important to have the views of other inclusion health groups, giving examples of these type of groups on the slides. Some information regarding local evidence and insight was shared, noting that there was a lot of data available about the local community. KH explained that work for Domain 1 will be carried out first, and outlined the potential sources of evidence and the key requirements for Domain one which will be presented at a community engagement event, to be graded against the areas outlined within the domains. KH explained the Trust's approach, noting the importance of the engagement and involvement of stakeholders, and shared the next steps of how this framework will be implemented in the future. JC highlighted to the Academy that this is an area that is being worked on within the Quality Account. It was also recognised that health inequalities is an area of focus within the National Patient Safety Strategy; JC commented that different areas working together was beneficial for the work the Academy does. There was a discussion regarding the local population and what that meant in terms of health inequalities amongst staff who live locally. KD commented that the more the work done within the population and the Trusts staff base is brought together, the more impact will be made. BM explained that a lot of the work which done in Education about wider participation involves going into communities to address inequalities and looking at apprenticeships and opportunities that are available. LB queried what BTHFT's strengths are regarding Equality, and where the most significant challenges are. KH commented that in Bradford there are some great practices and some firm foundations in place in terms of advancing EDI and the wider focus on tackling health inequalities. KH talked about the importance of acknowledging issues and challenges with clear focus on what action we need to take with focus on improving cultural competency across the Trust and more focus on working in partnership with the local community and managing the expectations on what can be done by the Trust. In terms of staff, it has to be recognised that our staff are also patients and service users, KH suggested that local staff have a lot to offer the Trust	

	regarding patient experience and noted that it is important to recognise how staff are utilised to move forward and make improvements. The Academy noted the Equality Delivery System 2022 update.	
QA.11(2).23.14	**Draft 2024/25 Quality & Patient Safety Academy workplan**	
	LP noted that the draft 2024/25 workplan had been distributed with the papers, explaining that it had been brought to the Academy for approval. PR reflected on visibility of all meetings across the Trust, noting discussions that have taken place at the Moving to Outstanding meeting regarding the structure and associations between the various Trust meetings. LP requested that any further comments regarding the draft 2024/25 Quality and patient Safety Academy workplan are emailed to be discussed at the next meeting.	
QA.11(2).23.15	**Any other business**	
	There was no other business.	
QA.11(2).23.16	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
QA.11(2).23.17	**Matters to escalate to the Board of Directors**	
	<u>QA.11(2).23.10 - Maternity and Neonatal Services Update</u> Changes to NICE Guidance regarding the timing of the offer of induction of labour is currently having an adverse effect on the unit causing a significant backlog. It was recommended that this matter is escalated to the Board of Directors.	
QA.11(2).23.18	**Date and time of next meeting**	
	13 December 2023 14:00-16:00	
	Annexes for the Quality and Patient Safety Academy **Annex 1 - Documents for Information**	
QA.11(2).23.19	**Patient Safety Group**	
	Noted for information.	
QA.11(2).23.20	**Clinical Outcomes Group**	
	Noted for information. LT noted that an update on the Duty of Candour Policy had been shared for information with the papers and advised that following an internal audit some changes needed to be made to the document. It was agreed that an updated document would be brought to the next meeting.	
QA.11(2).23.21	**Patient Experience Group**	
	Noted for information.	
QA.11(2).23.22	**Quality and Patient Safety Academy Work Plan**	

	Noted for information.	
QA.11(2).23.23	**Internal Audit Reports relevant to the Academy**	
	Noted for information.	

Open Actions

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	January 2024	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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						involved in the districtwide Mental Health and Criminal Justice 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	January 2024	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.
QA23032	29.11.23	QA.11(2).23.5	**High Level Risks** LP to update Risk 3696 to reflect delays to sign off.	Associate Director of Corporate Governance	January 2024	

QUALITY AND PATIENT SAFETY (QPS) ACADEMY ASSURANCE MEETING MINUTES

Date:	Wednesday, 13 December 2023	Time:	2 pm to 4.30 pm
Venue:	Microsoft Teams meeting	Chair:	Professor Louise Bryant (LB), Non-Executive Director/Co-Chair

Present:	**Non-Executive Directors:** - Professor Louise Bryant (LB), Non-Executive Director/Co-Chair **Executive Directors:** - Dr Ray Smith (RS), Chief Medical Officer (CMO) - Dr Paul Rice (PR), Chief Digital and Information Officer
Attendees:	- Ms Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing, representing Karen Dawber, Chief Nurse - Ms Judith Connor (JC), Associate Director of Quality - Ms Louise Horsley (LH), Senior Quality Governance Lead - Mrs Sara Hollins (SH), Director of Midwifery - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary
In Attendance	- Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes, in attendance for agenda item QA.12.23.6 - Ms Sarah Turner (ST), Assistant Chief Nurse Vulnerable Adults and Safeguarding Adults, in attendance for agenda item QA.12.23.12 - Ms Liz Ward (LW), Named Nurse Safeguarding Children, in attendance for agenda item QA.12.23.13 - Ms Sarah Smith (SS), Quality and Safety Patient Facilitator - Ms Jacqui Maurice (JM), Head of Corporate Governance - Ms J Kitching, Minute-taker
Observers	There were no observers.

Agenda Ref	Agenda Item	Actions
QA.12.23.1	**Apologies for Absence**	
	- Mr Mohammed Hussain (MH), Non-Executive Director/Co-Chair - Mr Jon Prashar (JP), Non-Executive Director - Mr Altaf Sadique (AS), Non-Executive Director - Ms Sughra Nazir (SN), Non-Executive Director - Professor Karen Dawber (KD), Chief Nurse (CN) - Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District Care Health and Care Partnership - Mr David Smith (DS), Director of Pharmacy **Absent** - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Dr Debbie Horner (DH), Deputy Chief Medical Officer - Dr Yaseen Muhammad (YM), Nurse Consultant/Director of Infection, Prevention and Control	

	- Mrs Sarah Freeman (SF), Director of Nursing (Operations) - Ms Adele Hartley-Spencer (AHS), Director of Nursing (Operations) - Ms Kay Pagan (KP), Assistant Chief Nurse for Informatics	
QA.12.23.2	**Declarations of Interest**	
	There were no declarations of interest.	
QA.12.23.3	**Minutes of the meeting held on 29 November 2023**	
	The minutes of the meeting held on 29 November 2023 will be presented to the meeting scheduled on 31 January 2024.	
QA.12.23.4	**Matters Arising**	
	RS discussed the proposed forthcoming Junior Doctor industrial action dates 20 to 22 December 2023 inclusive are confirmed with notification having been received from the British Medical Association. This is a full walkout so debates around 'Christmas Day' level services do not apply. Further strikes are planned from 3 to 8 January 2024 inclusive. No formal notification has been received of these dates to date, however, only two weeks' notice for strike action is required. Planning is again underway and ongoing as previously. It is expected that the strikes at this time of year will have a significant impact. Cover is being sought as previously but is expected to be more difficult due to the time of year. The Trust is hoping to be able to run as much elective activity as possible, however impact is inevitable. RS noted 600 out of 3000 planned out-patient appointments will be cancelled during the three-day pre-Christmas strike. RS described the very busy activity currently within the Trust, particularly in the Accident and Emergency Department (AED) where the weekend work had been carried through into the week noting the pressure on flow and beds. Hospital teams are working incredibly hard and rising to the challenges in this pressurised environment. Ward 9 has now been opened as a stroke rehabilitation unit in order access is improved to stroke services and this will take patients as outliers from other wards. The situation is difficult and challenging with the proposed forthcoming industrial action. RS noted Junior Doctors do not have to inform the Trust if they are striking. From previous experiences of strike action the Trust is expecting around 70% of Junior Doctors to strike and it is suspected strike rates will be quite high due to the pre-Xmas timing. A number count is undertaken on each day of the strike. The Academy noted there were no items for escalation to the Board of Directors' meeting on 18 January 2024 and was assured following the discussions.	
QA.12.23.5	**Quality and Patient Safety Academy Dashboard**	
	RS highlighted the following headlines: • Summary Hospital-level Mortality Indicator (SHMI) – This is higher than expected with a continuing upward trend with the	

	reasoning discussed recently at the Board of Directors' meeting and at the Quality of Care Panel (QuOC). Confidence was expressed this is a coding issue and is being addressed. SHMI does not reflect the quality of care and confidence was noted, as this is a statistical issue rather than deterioration in the mortality position. A paper is being presented to the System Quality Committee (SQC) at their request in order this can be explained to the wider system. An interrogative piece of work is being undertaken from a multi-disciplinary perspective for full visibility. It is expected there will be an update at the Board in January 2024. A full narrative of the detail and assurance information will be outlined in depth. • Medical Examiner's Office – Significant assurance received that the Medical Examiner's Office continues to scrutinise 100% of all deaths in the Trust, with the backlog of Structured Judgement Reviews (SJR) now cleared. The Medical Examiner's Office is now open for weekend work on Saturday and Sunday mornings for three hours each day, in line with the local Registry Office, and particularly to facilitate those members of the community who require release of a body to allow early burial. The Trust is one of six pilot sites in the region undertaking the extended hours and this trial will run until April 2024. It is expected that in April this service will become statutory. Deaths continue to be scrutinised in order the Trust can be assured that the SHMI statistics are not about a deteriorating quality of care or that increased mortality is a statistical aberration. • C difficile, MRSA and E coli – The Trust remains in a good position for cases. C difficile and MRSA were noted to be showing as 'red', but as there are virtually no cases in the Trust (there were '0' cases of C.Difficile and MRSA and approximately 6 cases of Ecoli reported for this month) this is expected to show 'green' at the next meeting. • Pressure ulcer rates – Within normal limits. • Falls – The steady improvements in falls with harm and the work undertaken over the last year demonstrates an improving picture. The Academy noted there were no items for escalation to the Board of Directors' meeting on 18 January 2024 and was assured following the discussions.	
QA.12.23.6	**Quality Oversight and Assurance Profile**	
	LH shared the highlights of the Quality Oversight and Assurance report, and the Academy's aim was highlighted as the Trust moves towards implementing the Patient Safety Incident Response Framework (PSIRF), to provide a space for staff to share insight into the quality of service and engender a culture of patient centred improvement where peer challenge and support is offered by all members. This insight will be invaluable as the Trust continues its transition and moving forward to PSIRF. The following information from the reporting period, 1 October to 30 November 2023 and the details in the presentation and appendices circulated were noted.	

	The following were highlighted: • Quality Oversight System under review as part of the transition to PSIRF demonstrating the aims of compassionate engagement and involvement of those involved, application of a range of system-based approaches, considered and proportionate responses and supportive oversight. • Thirty safety incidents have been escalated from the Clinical Support Units (CSUs) for discussion at the Safety Event Group (SEG), with fourteen of these escalated to the Quality of Care Panel (QuOC). • Four Serious Incidents (SIs) were declared. • Concerns escalated to SEG are currently being monitored at CSU/Departmental level and these will be further considered where necessary with improvements and lessons learned shared. • Ten incidents were reported externally under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), five relating to patient falls, four relating to staff injuries and one a Serious Incident (SI) of a fracture having occurred during patient transfer. • Care Quality Commission (CQC) monthly returns completed for October and November – Five ad hoc requests responded to and closed, one longstanding case of note. The Trust's new CQC Inspector has been confirmed as Hazel Parker. • Twelve ongoing SIs, four of these being led by Maternity and Neonatal Safety Investigations (MNSI)/Hospital Safety Investigation Branch (HSIB). • Three SIs closed during the reporting period. • Eight Central Alerting System (CAS) alerts were highlighted to QuOC with three requiring a formal response from the Trust. • Claim and inquest details noted with details of the Employer Liability Claim regarding the psychiatry injury noted by exception. Updates to this claim will be provided as these become available, however, this case is expected to remain ongoing for a significant length of time. • Organisational learning from multiple sources – Detailed discussion with learning from both internal and external sources shared within the organisation. LB thanked LH for the clear and concise report, noting the ad hoc CQC query raised in respect of caring for adults with a learning disability with the report highlighting issues around health inequalities of those with learning disabilities. JH noted 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. Learning disability information has been included in ST's report. JH discussed elements of exemplary care demonstrated as part of the learning disability review and the care provided. The Academy having noted the processes in place was assured following the discussions around learning, improvement and assurance.	

QA.12.23.7	Maternity and Neonatal Services Update	
	SH thanked LB for her exceptional scrutiny of these papers and for identifying an error in the report which has now been rectified in the number of neonatal deaths in November which should read as none (page 3, bullet point 3, and page 18, number 6, bullet point 5). SH described the activity in November 2023: • Verbally reported induction of labour backlog at November QPSA but formally reported in the November paper. Updated on improved position. • Successful Local Maternity and Neonatal Service assurance visit in November 2023 demonstrated extremely positive feedback and no immediate safety recommendations. An area for further improvement has been noted to increase the role of the Maternity and Neonatal Voices Partnership (MNVP). This piece of work is ongoing around more visibility by the Non-Executive Director Safety Champion and further engagement with the MNVP directly as capacity permits. • Staffing challenges acknowledged with the impact noted on the consistent availability of the Birth Centre as a choice of place of birth. As a recommendation this will be kept under constant review, as always, on a day-to-day basis. • Monthly stillbirth position of two with immediate actions/lessons learned described. • No cases of Hypoxic-ischaemic encephalopathy. • No maternal deaths in November. • Six MNSI and two Trust level SIs - Confidence was expressed that the number is expected to reduce next month due to the number of SIs in their final stages of approval. • No new neonatal SIs or ongoing neonatal SIs. • No SIs completed in November. • No MNSI reportable cases. • One reportable SI declared in November. • Ten occasions in November where the Unit needed to divert care/attempt to divert care to other organisations impacting on the provision of one-to-one care in labour, delayed induction or labour, due to the increase in inductions, however, steps are being taken to both address and manage this issue and the last few weeks have demonstrated an improved position. • Demonstration of full compliance with Safety Actions of the Maternity Incentive Scheme (MIS) as 90% of all staff groups have attended training within the required timeframe demonstrating that all staff are equipped with the safety skills required within core training. • Three Year Training Plan (Appendix 5) of core competency framework 2, to fulfil the extra training requirements covering six modules of the framework, published in early 2023 and approved by the Local Maternity and Neonatal System (LMNS) was approved by the Academy and will be submitted to the Board of Directors in January for final approval prior to submission for the Maternity Incentive Scheme. The Trust's scheme now meets the framework and is in line with the five other providers within the LMNS. Learning will be shared between the organisations. An additional two days of training	

	will be required per midwife per annum. Any risks or concerns will be raised immediately. • November unit pressures – Discussed previously and noted. • Regional deep dive into induction meeting – As a result some Task and Finish groups will be set up. The Academy recognised this is not a local problem at present due to changes in the National Institute for Health and Care Excellence (NICE) guidelines and guidelines in general. SH noted the recent ease in what have been challenging situations in the Unit. Super surge rates have now dropped to surge with the staffing situation more manageable. The request for a review, should a safety issue be identified, will be made. SH was thanked for the concise update. RS raised the three-year training plan being introduced with the challenge in staffing across the country. Bradford Teaching Hospitals NHS Foundation Trust (BTH) is currently in a good position from a vacancy perspective which was reduced in October and improvement is expected over the next few months. Further recruitment routes are being explored at present. RS questioned whether there was a plan in place should the Trust be unable to deliver the required training to staff for the MIS, due to operating safe staffing levels in the Unit. SH noted the Trust is compliant with regard the training plan for this year. Organisations may express the opinion that this is unachievable forcing the MIS to review the standard or request an action plan. Core training will, however, improve safety. LB noted the position of QPSA agreeing a plan which is considered potentially unachievable. Concerns were noted, however, the strong willingness to engage was apparent and this will be under constant review. The Academy was assured by the Midwifery and Neonatal Service update, the report was noted and the plan approved.	
QA.12.23.8	**Serious Incident (SI) Report**	
	LH discussed the key points from the SI report (1 to 30 November 2023): • The Health and Care Partnership have approved the Trust's transition to PSIRF. The journey commenced on 1 December 2023, following approval of the PSIRF Policy and Plan by the Board of Directors. • Test reporting of patient safety incidents to NHS England - Learning from patient safety events (LFPSE) platform continues through the Datix test environment. Live reporting will commence when the Trust transitions from Datix to InPhase which is expected in January 2024. • Between December 2022 and November 2023 the reporting of SIs by the Trust has remained within normal cause variation, with the exception of January 2023, this being due to delays in reporting with nothing to note of concern.	

	• The Trust continues to meet the Duty of Candour requirements and there have been no breaches during the reporting period or since August 2016. • Concerns were noted with regards to the number of SI extensions in place for some of the ongoing SI investigations and work is underway to reduce these. Timescales have, however, improved and work is being undertaken to keep timescales reduced with the aim of the last deadline being met for the final SI under investigation. The last declaration of an SI under NHS England's SI framework was 28 November 2023, therefore, the trajectory for full completion is 28 February 2024 (not 28 February 2023 as documented on page 2, paragraph 4 of the report). • Three SIs have been declared by the Trust during the reporting period, two being Trust investigations and one an MNSI investigation. The immediate findings for the three newly declared SIs were noted and discussed. • Two SIs have been concluded, one a Trust SI and one an MNSI investigation and the learning noted. • There have been no Never Events. • Current positions of Datix, PSIRF and InPhase noted. • An assurance report is being developed for the QPSA and Board of Directors to describe the new investigation arrangements under PSIRF. This will highlight the learning and assurance processes around the effectiveness of actions taken in response to safety incidents. LB thanked the team for all their efforts around the transition to PSIRF. The Academy was assured following the discussions, noting the current position, confirming sufficient assurance that the Trust has processes in place to identify, investigate, improve and learn from SIs.	
QA.12.23.9	**Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 Reports**	
	LT noted the comprehensive Quarter 1 and Quarter 2 CLIP report of 2023/24, providing a collection of data from a plethora of resources including patient experience, clinical governance, legal and non-clinical risk. LT summarised the key highlights: • 231 complaints received with the majority from the AED, however, with over 70,000 attendances during the period in relation to the number of complaints this seemed a small amount. • The Patient Advice and Liaison Service (PALS) received over 1000 concerns with the PALS teams demonstrating many cases are resolved in the first contact. No PALS issues remain open. • Litigation and claims noted 33 new claims received in Quarter 1 and forty-one new claims received in Quarter 2, this being a slight increase compared to the same period last year. Nineteen have been closed with NHS Resolution.	

	• Coroner update – 123 inquests remain open with long delays experienced for listing being monitored by both the Chief Medical Officer and the Medical Examiner's Office. During the reporting period 44 new requests have been received and seven inquests held. Any learning following an inquest is circulated and shared with the relevant teams. • Patient Safety Incidents and Safety Incidents – Over 25,914 safety incidents have been reported, of those 3,481 were patient safety incidents. The three highest frequency of reported incidents were around falls, pressure ulcers and blood transfusion. There has been a fall in the number of low harm incidents being reported. Monitoring continues. • Twelve SIs have been reported. • Thirty-one RIDDOR reportable incidents were received, more than the number received for the whole of last year. The non-clinical risk team are currently exploring to understand the reasons. The team has been challenged to look at how this report is presented to the Academy with data presented in a more meaningful way. All teams work independently, and the data needs to be considered differently particularly with the introduction of PSIRF and how this is reported both monthly and quarterly and how the intelligence is fed back. A wider discussion will be held with teams to consider investigation, interrogation and analysis of the quality metrics and thematic analysis. RS noted the excellent and concise report. Typographical errors were noted of the years in the report where 2022/23 should read 2023/24. JC noted the time taken to pull this incredibly complex report together. The new InPhase system will assist but not with analysis. Pulling out the learning is crucial.	
	During the transition period of moving from Datix to InPhase, JC requested due visibility noting that reporting has dropped off in low and no harm areas. The Academy was requested this risk is added to the Quality dashboard for the next 12 months whilst the InPhase system is embedded, and staff become more familiar, confident and comfortable with the use of PSIRF. The Academy agreed to this proposal with LB noting that puling information is a challenge in itself, and good description is essential.	QA23033 Associate Director of Corporate Governance/ Board Secretary (LP)
	PR noted the huge task of pulling together a report of this type and agreed to meet to explore possible routes with a move to thematic analysis, to include searches of words and phrases. LB noted methods available for analysing the qualitative comments used by the University of Leeds.	QA23034 Chief Digital and Information Officer (PR)
	LB raised the point that we should ask - are we doing all we can to reduce the number of incidents associated with claims, and as a result reduce costs to BTHFT while accepting that human error occurs, and patients need to be fairly compensated. LT accepted the challenge noting the regular discussions held with both the	

	Chief Medical Officer's (CMO) team and the legal team. JC noted the higher value claims particularly Maternity claims, with the amount of compensation awarded being based on the life expectancy of the individual and the impact. All claims are handled through the Trust's legal team, which is without a Solicitor, but which works closely with the Trust's solicitors having many claims settled prior to the stage where costs are incurred. A Duty of Care is considered for each case and all claims are signed off by the appropriate clinical team. Learning is evident from cases which are shared with local teams immediately and discussed at the Quality and Patient Safety meetings at Clinical Service Unit (CSU) and specialty level. The CMO is appraised of any potential professional issues/concerns around professionalism or standards in order these can be picked up through appraisal processes. LB thanked the team, and the Academy noted the content of the report, being assured following the discussions.	
QA.12.23.10	**High Level Risks**	
	RS noted no further updates since the last QPSA. The high-level risks will be considered by the Executive team at their meeting on 18 December 2023.	
QA.12.23.11	**Board Assurance Framework (BAF)**	
	LP presented an update on the BAF noting distinction between the BAF and the high-level risk register as documented. The BAF is reviewed and updated every two months and presented to the Executive team, the Academies and to the Board of Directors. Two strategic objectives aligned to this Academy relate to providing outstanding care for Trust patients delivered with kindness and being a continually learning organisation and recognised as leaders in research, education and innovation. There are three risks associated with each of these objectives. LP noted there has been no change since the last BAF review and no change made to any of the risk scores. LP discussed Risk 4.3 in relation to incident management and noted the recent introduction of PSIRF, however it is too early to reduce the risk score. Risk 3.1 relating to recruitment to vacancies was previously reviewed at the People and the Finance and Performance Academies and a point raised as to whether the Trust should consider reflecting the potential impact following the Chairman's resignation to include the negative publicity. LP has since spoken to Faeem Lal, Interim Director of Human Resources, and with no impact seen it is not considered this risk requires any further update. There has been a satisfactory number of applications for the vacant Executive roles currently out to recruitment. Following review of the risks no further information was requested around the challenges and the work in progress in the areas described. LB and the Academy noted the risks are being appropriately managed and were assured there are no matters to escalate to the Board of Directors' January 2024 meeting.	

QA.12.23.12	**Safeguarding Adults – Six monthly update**	
	The paper was taken as read and ST provided the key highlights: • The positive feedback received from the Integrated Care Board (ICB) was noted following submission of the 2022-23 Safeguarding Adults' Annual report and the Trust's self-declarations against the safeguarding and Mental Health Act standards. • The main focus over the last six months concerned the training needs analysis and refreshing of compliance levels. Level 3 compliance is due to go live in the New Year. The 2024 training programme has been devised on the back of experiences, incidents, concerns and learning reviews over the last twelve months. • A Mental Capacity Act masterclass was held in 2023 and a further masterclass is planned for January 2024. • Domestic homicide and safeguarding adult reviews have been undertaken within the district and learning implemented which will inform forthcoming training programmes. • Oliver McGowan virtual training launched in the Trust. The majority of employees will need to undertake Tier 2, a full day of face-to-face training which will take time to implement and will be a challenge due to staff numbers and the length of training. • Safeguarding and additional needs elements of work described allowing the development of clearer lines of responsibility and the establishing of more robust referral methods with greater clarity and focus on safeguarding activity and monitoring. Additional needs will be reported separately going forward, for example dementia and mental health, with both teams continuing to work closely to achieve safety. • A fixed-term additional needs navigator is now in post which will vastly assist with previous concerns raised around patients transitioning from children's services to adults for those patients with learning disabilities. Children are provided with a very comprehensive service overseen by a paediatrician, however, adult patients with learning disabilities are placed under a consultant of the appropriate specialty. • Partnership working continues with commitment continuing to all multi-agency partners district-wide. • Face-to-face safeguarding training on induction re-established. • The number of referrals continue to increase with positive engagement and feedback from partners acknowledged for the Domestic Violence Advocate role, based in the hospital. This post will cease in July 2024 and is currently funded externally from charity monies via the Local Authority supporting services in the community. The Trust is keen for this post to continue with domestic abuse being one of the highest reported concerns and the post supporting both patients and staff experiencing domestic abuse. • One of the safeguarding specialist practitioners has received Independent Sexual Violence Advocate (ISVA) training with a view to linking the work into the Sexual Safety Charter from NHS England. • Involvement noted in the Safeguarding Adults and Domestic Homicide reviews and action plans identifying learning, training	

	design and delivery. • Right Care Right Person representation provided for district and regional meetings. • Future development of the navigator role and consideration of inclusion of provision around support for patients with autism discussed. LB thanked ST for the informative presentation. ST noted the additional needs navigator post is a fixed-term six month post due to end in May 2024. It is hoped to continue this post as substantive to continue service improvements for patients with a learning disability. A case of need will be compiled. Following Joint Emergency Service Interoperability Programme (JESIP) training session undertaken on 12 December, LH noted that Police Search Advisors are keen to work with the Trust. ST noted the ongoing work in the district regarding Right Care Right Person and a statement of intent is awaited. LB noted the safeguarding assurances described in the report. The inclusion of training compliance figures in future reports around levels of compliance for mental health capacity training would improve overall assurance for both the Trust and the ICB. ST noted the absence of the figures was an oversight, however, these were submitted to the ICB. ST noted Level 2 training compliance figures are over 90%, with this level of training including information on the Mental Capacity Act. There are 27 staff in the Trust who require Level 3 training. ST will forward the figures to the Academy. ***Post-meeting note*** – *Current compliance figures are for:* *Level 1 - 96%* *Level 2 - 92%* *Level 3 - 48%* *Level 4 - 100%* *It should be noted current Level 3 consists of 27 members of staff, following re-levelling this will increase to 327 members of staff. Compliance will be achieved by self-declaration of training, to have included Prevent and Level 2 Safeguarding adults.* LB noted the plan to review the Electronic Patient Record (EPR) template and strengthen documentation around the Mental Capacity Act. ST noted the Mental Capacity Act assessment is now live in EPR as of 12 December 2023. The new best interest template is also live in EPR and has been undertaken in conjunction with Calderdale. This will allow regular audits to review the quality of the information and is a strong, powerful and legally robust tool. ST noted the quality checking of the manual audits had demonstrated these were completed to a high standard. LB thanked ST for the concise update and the Academy was assured following the discussion.	QA23035 Assistant Chief Nurse Vulnerable Adults and Safeguarding Adults (ST)
QA.12.23.13	**Safeguarding Children – Six monthly update**	
	LW presented the key highlights of the safeguarding children's update:	

	• Child and adult safeguarding teams working more closely together. • The Children's safeguarding letter from the ICB had been received with satisfactory feedback but had not been included in the report. LB requested a copy be circulated to the Academy. • Children's safeguarding training has been reviewed and all training delivered from 2024 will be multi-disciplinary. Training topics have been developed from the child safeguarding practice reviews. • Mental health attendances continue to increase. General referral figures for the safeguarding team appear to be levelling out, however, the figures reflect the numbers over the summer and not winter figures. • Recruitment to a mental health practitioner has been unsuccessful, however, there is mental health liaison within the paediatric service and the paediatric team works closely with the safeguarding team and partner agencies. Work is underway with region to review the Child and Adolescent Mental Health Services (CAMHS) crisis pathway with partners. • Increased supervision sessions with concerns, cases and themes discussed. • Increased complexity of safeguarding cases, for example domestic abuse. Training in this area remains a priority. • Data collection had identified 17,000 children were screened under the age of 18 years, presenting through the AED between April and September. • A daily duty and advice service with a designated person has been introduced. An options paper is being written around screening processes. In conjunction with this the process for the National CPiS (Child Protection Information System) checks and its links to EPR is being explored. When a child or young person attends an unscheduled care setting a check is undertaken in order to identify if there is a child protection plan in place, whether the child is a child in care or if the child has experienced Female Genital Mutilation (FGM). This check is not automated and does not easily pull on to a patient's main record. A piece of work around EPR looking at the way of automating this is underway to improve compliance and reduce risk. • Drop-in supervision sessions are being run in the AED by the team on a weekly basis. • Increased number of Paediatric Liaison forms generated for adults meaning the message 'child behind adult' is being acted on by front line staff. • The improvements above were described including the use of data to allow the team to explore new ways of working to ensure they are more visible. • Concerns were raised at the June 2023 QPSA, around EPR with its ability to communicate with other systems, highlighting this as a risk with regards to safeguarding concerns as other areas of the Trust use different record keeping systems and information may not be available. In June 2023 PR assured the Academy that Informatics understood the requirements and that this work was part of the priority list for EPR.	QA23036 Named Nurse Safeguarding Children (LW)

	• Multiagency and partnership working continues. • The workplan and audit strategy for 2023/24 is currently on track at the six-month period. • The stable and happy safeguarding team was described with dedication noted to training and the changes being introduced. • There remain not insignificant challenges for the team in terms of the maintained high activity levels and still no permanent increase in staff resources. JH thanked LW and ST for the tremendous amount of ongoing work around these complex cases presenting to the Trust and congratulated the team on the speakers who are invited to deliver the training sessions and conferences providing lived experiences demonstrating very meaningful training sessions. LB discussed the concerns raised in June 2023 regarding record keeping and the inability of Cerner to link with SystmOne. RS noted this is a long-standing problem and that SystmOne can be accessed for the information. An update will be requested from PR on the progress to date of electronic records in relation to safeguarding children. LB thanked LW for the update with the areas for improvement and assurance noted.	QA23037 Chief Digital and Information Officer (PR)
QA.12.23.14	**Electronic Patient Record (EPR) Programme update**	
	PR presented an EPR programme update acknowledging the input of the whole team, but in particular Kay Pagan, Assistant Chief Nurse for Informatics, and Steve Manns, Head of Clinical Information Systems, and outlined the key EPR activity to date whilst detailing key deliverables in 2024. The meeting received assurance on the performance of the programme reflecting on the journey towards increasing digital maturity from 2017 to 2025 and ambitions beyond this point. The highlights were noted: • Scale and diversity of the areas of development from the range of improvements to existing functionality and the addition of new services, features and scope incorporating more Trust services on to EPR. • As a measure of progress– The Healthcare Information and Management Systems Society (HIMSS) Electronic Patient Record (EPR) maturity tool was referenced. • Opportunity for Airedale to go-live and join Bradford and Calderdale on the same instance of EPR in September 2024 was detailed, with the work programme to incorporate improvements at Bradford and Calderdale up to this date also outlined. • An Airedale Foundation Trust (AFT)/BTHFT programme of work involving theatres, anaesthesia and critical care (TACC) is progressing currently to introduce new EPR functionality in line with the AFT Sept go-live – this work is focusing upon configuration of the system and the relevant education, training and quality improvement (QI) opportunities. • New workstream emerging to consider forthcoming Trust	

	priorities and colleagues invited to join the prioritisation process. • Responding to change requests on a rolling basis, working in tandem with colleagues in Calderdale and Huddersfield where appropriate and opportunities/scope for improvements are assessed on a weekly basis. • The team continues to go from strength to strength with additional skills being developed as a consequence of supporting AFT. LB thanked PR for the concise report and the in depth information provided. LB queried the EPR programme/deep dive timetable up to April 2024. PR noted some topics are at different levels of development/maturity and the team will work towards completing the plan. Two sessions have been held recently and clinical colleagues are assisting with prioritisation. RS raised the expense of handheld devices to upload data for use at patients' bedsides which could be transformative for patient care. PR discussed capital versus revenue and the number of devices with a move towards more mobile kit as a replacement for old kit. Work is in hand to understand the analysis and it is expected that further information will be available by the end of January 2024. RS noted the associated costs regarding connection of anaesthetic machines to upload data and the associated costs. PR will discuss this issue separately with RS.	QA23038 Chief Digital and Information Officer (PR)
QA.12.23.15	**Digital and Data Transformation Committee Highlight Report**	
	The paper was noted by PR for information only. If further information is required, the Academy members were asked to contact PR directly.	
QA.12.23.16	**Any Other Business**	
	There was no other business to discuss.	
QA.12.23.17	**Matters to share with Other Academies**	
	There were no matters to share with the other Academies.	
QA.12.23.18	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
QA.12.23.19	**Date and time of next meeting**	
	Wednesday, 31 January 2024, 2 pm to 4.30 pm	
	Annexes for the Quality and Patient Safety Academy **Annex 1 – Documents for Information**	
QA.12.23.20	**Bradford District and Craven Quality Committee Highlight Report/Minutes**	
	Noted for information.	
QA.12.23.21	**Quality and Patient Safety Academy Work Plan**	

	Noted for information.	
QA.12.23.22	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.12.23.23	**Internal Audit Reports relevant to the Academy**	
	None to report.	

OPEN ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 13 DECEMBER 2023

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	January 2024	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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						involved in the districtwide Mental Health and Criminal Justice 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	January 2024	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.
QA23032	29.11.23	QA.11(2).23.5	**High Level Risks** LP to update Risk 3696 to reflect delays to sign off.	Associate Director of Corporate Governance	January 2024	
QA23033	13.12.23	QA.12.23.9	**Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 Reports** During the transition period of moving from Datix to InPhase, JC requested due visibility noting that reporting has dropped off in low and no harm areas. The Academy was requested this risk is added to the Quality dashboard for the next 12 months whilst the InPhase system is embedded and staff become more familiar, confident and comfortable with the use of PSIRF. The Academy agreed to this proposal with LB noting that puling information is a challenge in itself and good description is essential.	Associate Director of Corporate Governance/ Board Secretary	January 2024	

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23034	13.12.23	QA.12.23.9	**Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 Reports** During the transition period of moving from Datix to InPhase, JC requested due visibility noting that reporting has dropped off in low and no harm areas. The Academy was requested this risk is added to the Quality dashboard for the next 12 months whilst the InPhase system is embedded and staff become more familiar, confident and comfortable with the use of PSIRF. The Academy agreed to this proposal with LB noting that puling information is a challenge in itself and good description is essential. PR noted the huge task of pulling together a report of this type and agreed to meet to explore possible routes with a move to thematic analysis, to include searches of words and phrases.	Chief Digital and Information Officer	January 2024	
QA23035	13.12.23	QA.12.23.12	**Safeguarding Adults – Six monthly update** The inclusion of training compliance figures in future reports around levels of compliance for mental health capacity training would improve overall assurance for both the Trust and the ICB. ST noted the absence of the figures was an oversight, however, these were submitted to the ICB. ST noted Level 2 training compliance figures are over 90%, with this level of training including information on the Mental Capacity Act. There are 27 staff in the Trust who require Level 3 training. ST will forward the figures to the Academy.	Assistant Chief Nurse Vulnerable Adults and Safeguarding Adults	January 2024	11.01.24: Post-meeting note provided. Completed. CLOSED.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23036	13.12.23	QA.12.23.13	**Safeguarding Children – Six monthly update** The Children's safeguarding letter from the ICB had been received with satisfactory feedback but had not been included in the report. LB requested a copy be circulated to the Academy.	Named Nurse Safeguarding Children	January 2024	05.01.24: Information circulated. Completed. CLOSED.
QA23037	13.12.23	QA.12.23.13	**Safeguarding Children – Six monthly update** LB discussed the concerns raised in June 2023 regarding record keeping and the inability of Cerner to link with SystmOne. RS noted this is a long-standing problem and that SystmOne can be accessed for the information. An update will be requested from PR on the progress to date of electronic records in relation to safeguarding children.	Chief Digital and Information Officer	January 2024	
QA23038	13.12.23	QA.12.23.14	**Electronic Patient Record (EPR) Programme Update** RS noted the associated costs regarding connection of anaesthetic machines to upload data and the associated costs. PR will discuss this issue separately with RS.	Chief Digital and Information Officer	January 2024	
QA24001						

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) - LEARNING AND IMPROVEMENT MINUTES

Date:	Wednesday, 31 January 2024	Time:	14:00-16:30
Venue:	Microsoft Teams Meeting	Chair:	Louise Bryant, Non-Executive Director / Co-Chair
Present:	**Non-Executive Directors:** - Professor Louise Bryant (LB), Non-Executive Director/Co-Chair **Executive Directors:** - Professor Karen Dawber (KD), Chief Nurse (departed at 15:56) - Dr Paul Rice (PR), Chief Digital and Information Officer - Dr Ray Smith (RS), Chief Medical Officer		
Attendees:	- Mr Benjamin McKay (BM), Education Manager - Dr Debbie Horner (DH), Deputy Chief Medical Officer/Consultant Anaesthetist - Ms Jane Kingsley (JK), Lead Allied Health Professional - Ms Jill Clayton (JC), Deputy Associate Director of Nursing - Mrs Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing - Ms Judith Connor (JC), Associate Director of Quality - Mrs Kay Rushforth (KR), Associate Director of Nursing for Children and Neonatal Services - Mr Kez Hayat (KH), Head of Equality, Diversity and Inclusion - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary - Ms Leah Richardson (LR), Patient Safety Specialist - Ms Louise Horsley (LH), Senior Quality Governance Lead - Ms Marianne Downey (MD), Deputy Associate Director of Nursing - Dr Michael McCooe (MMc), Consultant in Anaesthesia / Associate Medical Director - Mrs Sally Scales (SS), Director of Nursing / Programme Lead for Magnet - Mrs Sara Hollins (SH), Head of Nursing, Midwifery - Mrs Sarah Freeman (SF), Director of Nursing (Operations) (attended 14:53-15:33) - Ms Sarah Smith (SS), Quality and Patient Safety Facilitator - Dr Yaseen Muhammad (YM), Nurse Consultant / Director of Infection, Prevention and Control		
In Attendance	- Ms Victoria Ali (VA), Lead Nurse for Palliative Care, and Dr Clare Rayment (CR), Consultant in Palliative Care in attendance for agenda item QA.1.24.6 - Ms Carly Stott (CS), Associate Deputy Director of Midwifery in attendance for agenda item QA.1.24.7 - Ms Ruth Tolley (RT), Quality Lead for Patient Experience in attendance for agenda item QA.1.24.8 - Mr Nicholas Rushton (NR), Patient Safety Manager – Learning from Deaths in attendance for agenda item QA.1.24.9		

	- Ms Liz Melsom (LM), Outstanding Theatre Service Improvement Lead, Ms Jade Stephenson (JS), Matron – Theatres, Critical Care and Day Case, and Ms Carol Close (CCl), Outstanding Theatre Service Lead in attendance for agenda item QA.1.24.10.3 - Ms Jacqui Maurice (JM), Head of Corporate Governance - Ms Linda Preston, Minute-taker
Observers	There were no observers.

Agenda Ref	Agenda Item	Actions
QA.1.24.1	**Apologies for Absence**	
	- Mr Altaf Sadique (AS), Non-Executive Director - Mr Jon Prashar (JP), Non-Executive Director - Mr Mohammed Hussain (MH), Non-Executive Director/Co-Chair - Ms Sughra Nazir (SN), Non-Executive Director/Chair - Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes - Dr Robert Halstead (RH), Consultant in Emergency Medicine/Associate Medical Director - Ms Karen Bentley (KB), Assistant Chief Nurse, Patient Experience Absent: - Mrs Adele Hartley-Spencer (AHS), Director of Nursing (Operations) - Ms Caroline Nicholson (CN), Head of Non-Clinical Risk - Ms Caroline Varley (CV), General Manager, Chief Medical Officer's Office - Mr David Smith (DS), Director of Pharmacy - Ms Grainne Eloi (GE), Associate Director of Nursing & Quality, BDC Health and Care Partnership - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Ms Kavitha Nadesalingam (KN), Rheumatology Consultant/Honorary Senior Lecturer - Ms Kay Pagan (KP), Assistant Chief Nurse, Informatics - Ms Kelly Young (KY), Deputy Associate Director of Nursing - Dr LeeAnne Elliott (LAE), Consultant Paediatric Radiologist - Mr Nazzar Butt (NB), Moving to Outstanding Lead - Dr Padma Munjuluri (PM), Consultant Obstetrician and Gynaecologist / Associate Medical Director - Ms Rebecca Kidd (RK), Clinical Site Matron - Mrs Sarah Turner (ST), Assistant Chief Nurse, Safeguarding - Mr Sean Willis (SW), Associate Chief Nurse, Quality and Workforce	
QA.1.24.2	**Declarations of Interest**	
	There were no declarations of interest.	

QA.1.24.3.1	**Minutes of the meeting held on 29th November 2023**	
	The minutes of the meeting held on 29th November 2023 were approved as a correct record.	
QA.1.24.3.2	**Minutes of the meeting held on 13th December 2023**	
	The minutes of the meeting held on 13th December 2023 were approved as a correct record. The Academy noted that the following actions had been concluded: • QA23035 – QA.12.23.12 (13.12.23) – Safeguarding Adults – Six Monthly Update. *Training compliance figures added to minutes via post meeting note.* Action closed. • QA23036 – QA.12.23.13 (13.12.23) – Safeguarding Children – Six Monthly Update. *Children's safeguarding letter from the ICB has been circulated.* Action closed.	
QA.1.24.4	**Matters Arising**	
	There were no matters arising from the Minutes that were not already on the agenda. RS noted there have been a number of apologies received for the meeting from Non-Executive Directors, and whilst the meeting is technically quorate, the Academy needs to consider and recognise that its ability to provide necessary challenge may be impaired. RS discussed the significant pressure currently being felt by the Trust and advised we are currently at Opel 3. He continued that the full capacity protocol was enacted this morning due to the number of patients requiring admission from A&E, the level of acuity, and the lack of beds to admit those patients which is resulting in some significantly long stays in A&E. RS also advised that the Trust has been requested to submit evidence to the UK Covid Inquiry. The statement must be sent in RS' name but will include contributions from many individuals. RS expressed his thanks to all the contributors for providing the evidence, and to LP, CV and Katie Shepherd, Corporate Governance Manager for their assistance in pulling the evidence together. An extension for submission of one week has been granted and the revised deadline is now 23rd February 2024. Following submission, the statement will be considered by the Inquiry and we will be contacted for any clarifications/further information required. There is a possibility RS will be required to attend the Inquiry in person to give evidence. KD advised the Quality Improvement Group (QIG) meeting with NHS England took place on Friday 26th January 2024 where the formal written feedback report from NHS Specialised Commissioning around the visit to the neonatal unit was received which shows very high assurance. The report following the independent desktop exercise in relation to the governance processes from April 2021 onwards in relation to Serious Incidents	

	was also received, and this shows there are no issues around openness, honesty and transparency. Both these reports will be submitted to the Board of Directors. Following a question from PR in relation to the Consultant industrial action ballot, RS updated the Academy that the result of the ballot regarding acceptance of the Government's offer was negative at 51% to 49%. The turnout at the ballot was much lower than previously seen. RS understands both sides wish to return to the negotiating table rather than undertake further industrial action. Their mandate has recently been renewed for a further six months. RS continued that the position for Junior Doctors is much less clear with a resolution not currently looking achievable, but there are no more industrial action dates planned at present. He understands they are to be balloted again for another mandate. LB said the Chair of the Finance and Performance Committee had asked her to highlight the significant financial risk being faced by the Trust in 2024/25 with a predicated deficit of around £46million. Work continues in an attempt to mitigate this as much as possible, and as waste reduction proposals are not currently delivering as hoped, a new approach is being considered by the Executive team and further updates will be provided as appropriate. RS added we are currently in a more favourable position than some of our neighbouring Trusts, however the situation does present a significant challenge for the Trust, and the Academy has a role and responsibility to ensure the correct actions are undertaken for our patients, communities and staff.	
QA.1.24.5	**Serious Incident Report (Focus on Learning)**	
	LH gave an overview of the December 2023 report provided to the Academy including the one maternity obstetric incident reported via MNSI during the reporting period, and the 10 ongoing serious incident investigations. LH discussed the de-log request in relation to SI2022/25989 which was accepted by the Health and Care Partnership, and the learning for the Trust from the case as included in the report. She then discussed the two Serious Incidents and the Never Event concluded during the period and lessons learnt in relation to these. With regard to the Serious Incidents which remain ongoing, LH advised three Trust investigations have extensions in place. Work continues with the aim of closing the ongoing Serious Incidents down by the end of February 2024. The MNSI reports will continue as they are a national priority for reporting, with any identified patient safety incident investigations from our local or further national priorities being reported. The Academy noted the current position detailed in the circulated report and appendices, and confirmed their assurance that the Trust has processes in place to identify, investigate and learn from Serious Incidents.	

QA.1.24.6	**Palliative Care Annual Report**	
	Following introductions VA discussed the Palliative Care Team's Annual Report covering the period July 2022 to June 2023. VA advised that the Hospital Palliative Care Team, which covers both BRI and care of the elderly in SLH, has expanded in terms of team members and visibility with seven day working, and the increase in levels of activity seen is related to this. Whilst a reduced level of service is offered on weekends, the level of referrals and the need for support has increased quite significantly. She noted there is the ability to fast-track discharge and to facilitate assessment of and discharge to hospices. VA highlighted the levels of activity as detailed in the report which show the team is working as a responsive team. The team does not have a service which covers community hospitals at the present time; this provision was historically provided by Bradford Community Trust, but this ceased a couple of years ago, and there is therefore a proportion of the Trust not covered by specialist palliative care. This is included on the Risk Register as NHS England issued an adult service specification in January 2023 stipulating face to face assessment should be available for palliative care in all areas, and as this is currently not being provided by the Trust a business case is under discussion to provide resource to support and develop the work within the intermediate care unit (IMC). VA also discussed the end-of-life virtual ward which is where any patient recognised to be dying should be commenced on a last days of life document and referred into the service. The service saw 45% of deaths within the organisation within this reporting period, and the virtual ward triggers extra support and education for the ward staff for those patients in the final days of their lives and their relatives. VA noted staff development continues via a regional development programme with two Clinical Nurse Specialists (CNS) setting up a community of practise within the North East and Yorkshire Development Programme to support and network with other CNS teams to build local and national support. With regard to the React service and social enterprise VA gave an overview and advised the React service are not part of the hospital palliative care team but are often conflated with them. VA then covered the improvement initiatives the team are involved in. She noted the new innovative CNS role with a special interest and knowledge of South Asian culture and religious needs is currently in the evaluation stage and has had national traction and interest, is making a significant impact, and is able to provide culturally sensitive care at end of life based on the needs of our population.	

	VA provided further information with regard to the development of a Trust wide strategy for education coming out of the operational group, to map what is currently provided against the national recommendations as it was recognised that these are not always aligned. With regard to the bereavement scoping exercise, VA said this looked at the support offered to bereaved carers. Next steps are now being considered around the impact of poor bereavement care, and the ability to share when poor care is identified and linking this into quality improvement. With regard to assurance VA noted the hospital palliative care team provides specialist palliative care. It is however recognised most care provided is generalist palliative care, with the end-of-life operational group providing oversight of this and the quality of palliative care broadly across the organisation. Four key areas have been identified: education, EDI and community engagement, quality of care/quality measures, and advanced care planning and information sharing. VA also discussed the results of the National Audit for Care at the End of Life (NACEL) undertaken in 2022 as detailed in the report. The audit will be repeated in 2024 with four reporting periods throughout the period. In terms of generalist palliative care VA discussed the audit of the Gold Line system, the results of which will be considered from a quality viewpoint. VA confirmed the next reporting period in respect of palliative care will be in line with the Trust's financial year. VA also discussed the work being undertaken with the wider teams to provide quality end-of-life care. These include the InPhase team to support with incidents and complaints. LB acknowledged the work undertaken by the team and the national recognition of the research to address health inequalities in the area of palliative care. KH noted with regard to palliative care for our diverse communities, he is working closely with Jamilla Hussain, Consultant in Palliative Medicine and the SPaRC team, looking at the data element and how the information is captured, used, and plays a role in the wider improvement. LB mentioned the low return rate of the audit questionnaire from South Asian families and VA said how to address this is one of the areas which is being looked at. The national team have provided a QR code this year for relatives to scan which is then translatable. The letter also provided by the national team is in English and this is being followed up due to the issues this presents. MMc	

	suggested speaking to the Born in Bradford (BiB) team in relation to wider engagement and can provide contact details. The Academy noted the report and the work being undertaken going forward, and gave their thanks for the work done so far. Assurance was also confirmed of the work being done and the delivery of end-of-life care for our patients and communities. VA and CR then left the meeting.	
QA.1.24.7	**Maternity and Neonatal Services Update**	
	CS gave an overview of the circulated update and shared the provided presentation noting the following additional information: • In relation to stillbirths, the Trust's data is reported on the legal definition of stillbirth which is date of death. When MBRRACE do their reporting they report on date of birth and there will therefore be three additional cases on which they will report, and CS provided further details of these cases. From reviewing total deliveries based on births, there has been a reduction in stillbirths per thousand, standing at 6.6 per thousand for 2022, with an adjusted rate of 5.0 per thousand births reduced to 5.1 per thousand for 2023, with an adjusted rate of 4.2 per thousand. • In relation to the perinatal deaths the reason one surveillance case missed the one month completion deadline was due to an IT issue whereby the internal database could not be located. MBRRACE who will be performing the external review of cases and NHS Resolution have been notified. NHS Resolution asked that this is also reported to the Board of Directors with regards to the mitigation, and advised it will be taken into consideration with regard to full compliance and that the mitigation being undertaken provides assurance. • In the last two weeks there has been an increase in unit pressures which has created further unit diverts, and staff are feeling burnt out with low morale at the present time. In relation to a query from LB, SH advised the pressures were reduced in December 2023 due to less annual leave being taken and less training being undertaken. The pressures have increased again over the last two weeks as has the number of women requiring induction of labour. This is now being recognised nationally and a national maternity review has been recommended. The Trust has acknowledged advice given to women needs to be tailored to manage expectations more effectively. Alongside this staff expectations and wellbeing also need to be managed and safe staffing levels maintained, and this continues to be worked on. • With regard to the two stillbirths covered, CS advised they were both MDT reviewed with no learning identified which could have	

	led to a different outcome in either case. It was noted however women need to be made aware of the potential risks if regular care is not accessed. • With regard to the recommendations for the two reported cases covered, CS advised work has been undertaken with Estates department in relation to the birthing rooms and proposals are being worked through to change the size of the rooms. With regard to the second recommendation, additional information has been added to the electronic system to support the communication and grading of deliveries. On behalf of the Academy LB expressed thanks for the work being undertaken and noted the concerns regarding staff who are feeling burnt out. The Academy noted the information provided in the update and confirmed its assurance notwithstanding the challenges and difficulties which currently exist.	
QA.1.24.8	**Patient Experience – Six Month Report**	
	RT shared the previously circulated presentation and in addition noted the Patient Experience and Engagement Strategy is going live within the next month, and will be shared and discussed with all of the teams. LB and KD expressed their thanks for the presentation and the work being undertaken by the Patient Experience Teams. In relation to the patient stories being presented to the Board of Directors, KD asked how persons are selected to be included, if there was any bias to any particular groups being chosen, and if those selected are as inclusive as possible. RT suggested increased utilisation of the Interpreting Service and SPaRC team should be made in terms of speaking to families when complaints are received. KH added focus needs to be given to the learning from the care and experiences of our patients from diverse backgrounds, and to encourage those patients to attend the Board meetings to share their stories. It was agreed a review of the SOP for patient stories to be undertaken to include an EDI impact assessment. MMc also offered to link in with this work. The Academy confirmed their agreement to the recommendations detailed in the Patient Experience Bi-Annual Report. RT then left the meeting.	QA24001 Assistant Chief Nurse, Patient Experience (KB)/Quality Lead for Patient Experience (RT) and Head of Equality, Diversity and Inclusion (KH)
QA.1.24.9	**Learning from Deaths**	
	MMc gave the circulated presentation and highlighted: • The crude mortality data in December 2023 is entirely in line with the position two years previously. An in-depth review has been undertaken of all cases of deaths by a group of specialists	

	and whilst nothing of concern was discovered, learning points have been noted. • Celebrating good care is key especially as this is provided by teams who are usually under high pressure. • A crucial learning point identified is undertaking good communication and knowledge mobilisation, especially when dealing with some of our more complex patients. RS noted the highest ratings of poor care are seen in end-of-life care and discussion took place around the reasons for this. It was recognised teams need to be proactive in contacting the palliative care team at the correct time for their assistance, expertise and support. Following a query from PR it was acknowledged further consideration is required of processes to facilitate this.	
QA.1.24.10.1	**Quality Improvement Programme Update**	
	JC advised the Trust was invited to participate in the national collaborative 'Worry and Concern' work and is the only Trust representing West Yorkshire and Humber. She gave an overview of the circulated information and presentation. LB thanked JC for the information provided.	
QA.1.24.10.2	**Mortality Review Improvement Programme**	
	MMc commented the Mortality Review Improvement Group (MRIG) meetings are held monthly and this is a multi-speciality, multi-professional, multi-disciplinary group. The cases reviewed are generally where a concern has been raised and care has been rated overall as poor. The goal of the reviews is to establish a consensus of opinion around the quality of care given in recognition that reviews are performed by individuals, with a focus on what action is to be taken and by whom, eg the Quality Improvement Team, Medical Examiner's Office and Junior Doctor teams. Reports and learning continue to be produced and a focus for the group is for this to be disseminated appropriately. The Academy confirmed they feel assured that the programme will deliver against the strategic objective of providing outstanding care, delivered with kindness.	
QA.1.24.10.3	**Outstanding Theatre Programme**	
	LM noted the Outstanding Theatre Programme (OTS) is coming to an end today. JS shared on behalf of the Band 7s a presentation providing a summary of the sustainability plans which are being called Moving to Outstanding, and have been developed by the CSU, the OTS Programme and others. She explained the workstream leads have	

	been linked to the CQC elements and pathways with five pathways being developed, and today's presentation focussed on the Safe Pathway which is to be launched in March 2024. LB, RS and PR expressed their thanks for the work done so far and to be done going forward. PR noted CCI, JS and her colleague's continued involvement in the next stage of the theatres, anaesthesia and critical care work to deliver the Theatres, Anaesthesia and Critical Care Programme (TACC). The Academy confirmed they have been provided with assurance that the work in the OTS Programme will be sustained going forward. It was agreed LM will share the recording of the OTS Programme Celebration event on 9th January 2024 with the Academy members. LM, JS and CCI then left the meeting.	
QA.1.24.10.4	**National Patient Safety Improvement Programme Update**	
	JC advised the programmes which make up the National Patient Safety Improvement Programme (NPSIP) are: • Managing Deterioration • Maternity and neonatal work around smoking • Medicine safety (administration errors and opioids prescriptions, decreasing oral methotrexate and working with the Medicine Safety Officers) • Adoption of spread programmes (COPD discharge, care bundles, tracheostomy patients, asthma care bundles and emergency laparotomy care bundles). Whilst the Trust is not directly involved in the programmes, there are links to our quality priorities and the improvement programmes identified as part of our Patient Safety Improvement Plan. The next stage is to step into the space with the Academic Health Science Network to access the resources and support from the programmes taking place in Bradford. LB thanked JC for the information provided.	
QA.1.24.11	**Patient Safety Incident Response Framework**	
	LR presented the update circulated prior to the meeting giving an overview of the changes to the NHS National Contract and the training being undertaken. LR commented that whilst the Trust is compliant in that transition to the Patient Safety Incident Response Framework (PSIRF) took place on 1st December 2023, full implementation has not yet taken place, and she discussed the plans in place for this quarter, with a roadmap developed for the next financial year. LR also discussed the Trust's new Integrated Reporting, Learning	

	and Improvement System (IRIS) which has now replaced the DATIX system. The initial transition to IRIS was smooth with further records and documents to be transferred into the new system, and reporting is now done directly into the NHSE Learning from Patient Safety Events (LFPSE) platform. LR continued the IRIS system supports the national patient safety strategy in terms of insight and how this is gleaned from the information entered into the system, and further work in relation to extracting material which is meaningful to staff at all levels is being undertaken. JC provided her thanks to LR, Sarah Branigan, Quality & Patient Safety Manager, and Carol Firth, Incident Management Facilitator for all their work in the implementation of IRIS, and this was echoed by LB and RS. Following the presentation, the Academy confirmed their assurance from the information provided.	
QA.1.24.12	**Infection Prevention and Control Quarterly Report**	
	YM discussed the quarter 3 report presentation and highlighted: • Numbers of Covid-19 cases and hospitalisations due to Covid-19 have increased slightly towards the end of the quarter both regionally and nationally. • There are now numerous Covid-19 variants with Omicron BA.2.86 being dominant at the present time. • There was a spike in the number of 'flu cases in December 2023 and January 2024. • Of the six mandatory organisms reported on the Trust has seen a slightly reduced number of MRSA cases and is still within the trajectory. The number of C. diff cases was relatively stable with no cases in October 2023. There was a slight increase in MSSA Bacteraemia cases in the community, which was replicated regionally, and this is being discussed at a regional level. E. coli cases have reduced which may be as a result of the commencement of the hydration project in the care of the elderly. • With regard to the IPC Board Assurance Framework the Trust was compliant in 51 out of 54 standards and partially compliant in the remaining three, and YM discussed the gaps in these. • YS discussed the improvements made by the Blood Culture Improvement Group to achieve the aim of blood cultures being taken correctly to avoid contamination and improve bacteria rates. • There has been a delay with the ward one project for five negative pressure rooms and these now due to open mid-February.	

	Following a query from LB in relation to the graphs provided and the averages they contain, YM confirmed the data used is now from 2021 rather than 2015 and he will therefore request the average line shown in the graphs is corrected by the Business Intelligence team. LB and RS thanked YM for the report and presentation provided and gave congratulations on the high level of compliance achieved. The Academy provided their approval of the quarter 3 report.	
QA.1.24.13	**High Level Risks**	
	RS referred to the circulated documentation which is provided for the Academy's oversight and assurance. He noted in relation to the risk concerning EPR which is past its target mitigation date (no 3468), it has been agreed this can now be closed and a new more contextually accurate risk is to be created. He gave an overview of the new risk (no 3474), the two risks which have been closed (no 3788 and no 3767), the two risks which have changed in score (no 3530 and no 3711) and the three risks beyond their review dates (no 3696, no 3877 and no 3881). He also discussed the update in relation to risk no 3896 as detailed in the paper. The Academy confirmed they are assured all relevant key risks have been identified, reported and managed appropriately.	
QA.1.24.14	**Any Other Business**	
QA.1.24.14.1	**Bradford Neonatal Assurance Commissioning Visit Report – 7th December 2023**	
	As KD had departed the meeting early, acceptance of the previously circulated paper was provided by the Academy.	
QA.1.24.15	**Matters to Share with Other Academies**	
	There were no matters to share with the other Academies.	
QA.1.24.16	**Matters to Escalate to the Board of Directors**	
	LB noted the pressures on the Midwifery and Neonatal services is to be raised with the Board of Directors and for them to be kept apprised of the situation. There were no further matters to escalate to the Board of Directors.	
QA.1.24.17	**Date and Time of Next Meeting**	
	Wednesday, 28th February 2024, 2pm to 4.30pm.	
	Annexes for the Quality and Patient Safety Academy	
	Annex 1 – Documents for Information	
QA.1.24.18	**Patient Safety Group Minutes**	
	Noted for information.	

QA.1.24.19	**Nursing and Midwifery Staffing Data Publication Report (Discussed at the People Academy)**	
	Noted for information.	
QA.1.24.20	**Clinical Outcomes Group**	
	Noted for information.	
QA.1.24.21	**Patient Experience Group**	
	Noted for information.	
QA.1.24.22	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.1.24.23	**Update on CSU to Academy Delivery Programme – March 2024 to March 2025**	
	Noted for information.	
QA.1.24.24	**Internal Audit Reports Relevant to the Academy**	
	There were no reports relevant to the Academy.	

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 31 JANUARY 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23033	13.12.23	QA.12.23.9	**Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 Reports** During the transition period of moving from Datix to InPhase, JC requested due visibility noting that reporting has dropped off in low and no harm areas. The Academy was requested this risk is added to the Quality dashboard for the next 12 months whilst the InPhase system is embedded and staff become more familiar, confident and comfortable with the use of PSIRF. The Academy agreed to this proposal with LB noting that puling information is a challenge in itself and good description is essential.	Associate Director of Corporate Governance/ Board Secretary	February 2024	31.01.24: JC advised work being undertaken with Business Intelligence to update the Quality dashboard. Action completed. **CLOSED.**
QA23034	13.12.23	QA.12.23.9	**Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 Reports** During the transition period of moving from Datix to InPhase, JC requested due visibility noting that reporting has dropped off in low and no harm areas. The Academy was requested this risk is added to the Quality dashboard for the next 12 months whilst the InPhase system is embedded and staff become more familiar,	Chief Digital and Information Officer	February 2024	31.01.24: PR advised work continues between the Quality and Digital teams. JC said a skillset needs to be developed within the Quality team and wider Trust around thematic analysis and training is to take place in relation to this. Action completed. **CLOSED.**

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			confident and comfortable with the use of PSIRF. The Academy agreed to this proposal with LB noting that puling information is a challenge in itself and good description is essential. PR noted the huge task of pulling together a report of this type and agreed to meet to explore possible routes with a move to thematic analysis, to include searches of words and phrases.			
QA23037	13.12.23	QA.12.23.13	**Safeguarding Children – Six monthly update** LB discussed the concerns raised in June 2023 regarding record keeping and the inability of Cerner to link with SystmOne. RS noted this is a long-standing problem and that SystmOne can be accessed for the information. An update will be requested from PR on the progress to date of electronic records in relation to safeguarding children.	Chief Digital and Information Officer	February 2024	31.01.24: PR advised the AFT EPR go live in September 2024 will introduce a more robust solution for all three organisations via a direct Cerner / CPIS integration, which will return safeguarding information from CPIS at the point of registration as well as creating an indicator on the demographic banner bar. Currently, CHFT process/functionality is more mature than BTHFT and integrates an auto-generated email to the safeguarding team – this could be a short-term improvement for us but will require development work and prioritisation before the "freeze" point in late March. Action completed. **CLOSED.**

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23038	13.12.23	QA.12.23.14	**Electronic Patient Record (EPR) Programme Update** RS noted the associated costs regarding connection of anaesthetic machines to upload data and the associated costs. PR will discuss this issue separately with RS.	Chief Digital and Information Officer	February 2024	31.01.24: PR noted that following engagement with colleagues at West Suffolk we are progressing the integration as proposed with Mindray, Draeger and other devices in line with the Theatres Anaesthesia and Critical Care go-live in EPR in September 2024 with colleagues at AFT. This will make a material contribution to patient safety going forward in the context of our most vulnerable patients and patients in their most vulnerable state. Action completed. **CLOSED.**
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	March 2024	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. 31.01.24: PR advised this is currently with Procurement and the screens will be replaced before the end of the financial year. Update to be provided in March 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24001	31.01.24	QA.1.24.8	**Patient Experience – Six Month Report** With regard to patient stories being presented to the Board of Directors, it was agreed a review of the SOP for patient stories is to be undertaken and this is to include an EDI impact assessment.	Assistant Chief Nurse, Patient Experience/ Quality Lead for Patient Experience and Head of Equality, Diversity and Inclusion	March 2024	
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	June 2024	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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						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 meetings which undertaking a piece of work titled 'Right Care / Right Person'. 31:01:24: JH said ST is part of Right Care, Right Person initiative and suggested she provides an update on the work being undertaken at the next safeguarding update in June 2024.
QA24002						

BO.3.24.36 - CONFIRMED AUDIT COMMITTEE MINUTES

REFERENCES

Only PDFs are attached

Bo.3.24.36 - confirmed Audit Committee minutes - 29.11.23.pdf

CONFIRMED AUDIT COMMITTEE MEETING MINUTES

Date	Tuesday, 21 November 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) • Julie Lawreniuk, Non-Executive Director (JL)
In Attendance	• Matthew Horner, Director of Finance (MH) • Michael Quinlan, Deputy Director of Finance (MQ) • Richard Maw, Counter Fraud, Audit Yorkshire (RM) • Paul Hewitson, Deloitte (PH) • Helen Higgs, Audit Yorkshire (HH) • Karina Edwards, Internal Audit (KR) • Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) • Jacqui Maurice, Head of Corporate Governance (JM) • Dr Paul Rice, Chief Digital & Information Officer (PR) for A.11.23.12, A.11.23.23 & A.11.23.24 • Karen Dawber, Chief Nurse (KD) for A.11.23.12 • Ray Smith, Chief Medical Officer (RS) for A.11.23.12 • Caroline Nicholson, Head of Non-Clinical Risk (CN) for A.11.23.12
Observer	• Caroline Mooney, Internal Audit (CM)

No.	Agenda Item	Action
A.11.23.1	**Apologies for absence** Jon Prashar, Non-Executive Director (JP)	
A.11.23.2	**Declarations of interest** No interests were declared.	
A.11.23.3	**Minutes of the meeting held 12 September 2023** The minutes were accepted as a fair representation of the meeting.	
A.11.23.4	**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; following review of the updates provided on the action log, the Audit Committee confirmed that the following actions were closed. • A23050 – Matters to share with other committee – action closed • A23049 – Assurance – Data Quality – action closed • A23048 – Assurance: Key IT systems progress report update – action closed • A23047 - Proposed changes to Standing Orders/Standing Financial Instructions/Scheme of Delegation (standing item) – action closed	

	• A23046 - Exception reports: Schedule of losses and special payments and appropriateness of single source tenders – action closed • A23045 - Exception reports: Schedule of losses and special payments and appropriateness of single source tenders – action closed • A23044 – Follow up of Internal Audit recommendations – action closed • A23043 – Internal Audit Progress report 2023/24 – action closed • A23042 - Internal Audit Progress report 2023/24 – action closed • A23041 – Annual Internal Audit performance review – action closed • A23009 - Proposed changes to Scheme of Delegation/Standing Financial Instructions (standing item) – action closed • A23002 - BH132023 Improving Financial Sustainability internal audit report – action closed	
A.11.23.5	**Sector update and benchmarking report** PH advised that there would be no sector update or benchmarking report and confirmed that these reports would only be provided during the during the audit window. PH noted that the Trust has appointed another company to provide audit work relating to the Bradford Hospitals Charity and confirmed he had received the courtesy letter from them and will respond accordingly. The Committee noted the verbal update.	
A.11.23.6	**Annual policy review – use of external audit for non-audit purposes** MQ confirmed that the policy has been updated to be consistent with the latest guidance issued by the National Audit Office and the Financial Reporting Council. SN highlighted some errors that needed rectifying:- • Page 2 – change Audit and Assurance Committee to Audit Committee • Page 10 – Audit related services – remove this section. MQ agreed to update the policy, as per the proposed changes above, and provide BAS with a clean copy for approval. The Committee approved the policy subject to the proposed changes.	Deputy Director of Finance A23051
A.11.23.7	**Accounts delivery and external audit improvement plan** MH provided an overview of the paper to provide assurance that the Annual Reports and Accounts (ARA) will meet the deadlines in relation to the Audit Committee and, the Department of Health and Social Care (DHSC). MH reminded the Committee that for 2022/23 the Trust submitted the final accounts 10 working days late. Since, several constructive meetings have taken place with Deloitte on how both parties can improve the process of delivering the audit of the accounts. Focus remains on lessons learnt and key risks to the delivery of the audit of the statutory ARA and the external audit improvement plan. The quality of the papers (including working papers) produced are of a high standard and are not the reasons for the delay in audit of the ARA. Better communication between both parties is necessary to ensure a smooth and timely process. Due to the size of the projects this financial year, relating to capital accounting, engagement with Deloitte will take place frequently throughout	

	Q4 and a mini year-end will take place daily throughout March 2024 to ensure that the working papers and the accounting in the ledger are available and appropriately captured. JL queried if there were any points of disagreements throughout the meetings or if these had been positive. MQ said that a difficult conversation had taken place as to the assurance Deloitte were able to provide that the audit would be completed on time this year. It was noted that with the steps in place to mitigate any time delays, it was envisaged that the audit would remain on plan although it is difficult to foresee any potential hurdles. Clear focus would remain on key aspects of executing and completing the audit in a timely manner. SN queried if more detail is required in relation to the risks to accounts mitigation which notes that Deloitte will provide a verbal update of any change in timescales. She felt that further clarification was needed if there was a delay and whether there is a likelihood of an extension being required and the timescales for the verbal update to the Audit Committee. PH confirmed that discussion had taken place around the clarity of position and the status of the work to give a better understanding of the work that is ahead and where we are in the journey. PH felt that from the discussions there was a sense that the Trust felt that once the work had been passed to Deloitte then it was complete, but this was only the start of the process for Deloitte who then had to review and process the documentation. Deloitte's aim is to be more transparent on the process and progress, with the Trust, throughout the audit to ensure there are no delays. The Committee noted the report.	
A.11.23.8	**Use of External Audit to provide non-audit services (standing item)** There was nothing to report on this item.	
A.11.23.9	**Internal Audit progress report** KR provided an overview of the paper which details the progress made towards the delivery of the 2023/24 Internal Audit Plan and the results of the Recommendations Benchmarking Report. The plan is approximately 46% complete with 14 finalised reports, 2 high assurance, 7 significant assurance, 3 limited assurance and 2 which do not provide an opinion (Control Improvement Audit – advisory). BAS queried the number of audits that are still flagged as Q1/Q2 where work is still ongoing. KR confirmed there have been some delays over the summer period, including capacity issues and industrial action, that have impacted on the schedule. Each of the individual reviews are progressing and they will be reported back to the February 2024 meeting in the usual report. KR highlighted that the KPI's, apart from one, are showing 100%. At the request of the Audit Committee a list of amendments, also shown in the paper, have been circulated to Committee members via email prior to the meeting with one late addition of the 'Serious Incidents' audit. The Associate Director of Corporate Governance / Board Secretary had asked	

	for the Serious Incidents review to be added to the Internal Audit Plan for 2023/24 to assist with the work that is ongoing in relation to the board action plan. BAS felt that there had been a higher-than-normal level of changes to the plan and queried the underlying causes. KR felt that the scope and the audit briefs of the 3-year strategic plan had developed, meaning that other areas that are currently providing a higher level of risk require review. It is the intention to produce a 1-year plan for each of the 3 years to ensure that changes are current and valid. She envisaged that the plan we have in place at present will not require any further changes and will be fully delivered. BAS felt that this level of change is illustrative of a dynamic internal audit process that responds to changes and priorities within the Trust to deliver maximum assurance and value along the way. SN referred to the cover sheet which relates to risks, benchmarking and resources which has been left blank. She suggested that they need populating to correspond with the paper. BAS referred to a discussion that had taken place with LP around modifying and updating the format of the cover sheets for all high-level meetings. LP advised that the cover sheet will be aligned more closely with the template that is used across Bradford and Craven and the ICB. Views on an updated cover sheet will be sought from the Executive Team and the Board by January/February 2024. BAS noted the request for an internal audit review of the data warehouse and queried the background for this request. PR confirmed that the request was to understand the management of the new Nautilus 835 platform and the process going forward. KR confirmed she is in regular contact with Rachel Pyrah, General Manager to the CDIO Office to progress the informatics internal audit plan forward. This plan for audit is in the early stages, as the full scope of the piece of work has not yet been agreed, but conversations are ongoing to determine the work. The Committee approved the amendments to the report.	
A.11.23.10	**Follow up of Internal Audit Recommendations** KR stated that, the Trust is making steady progress compared to other organisations as shown in the benchmarking report. The completed recommendations are higher than the average, which is a positive outcome, however there are still a lot of recommendations that require input from the executive team to ensure they are delivered. HH felt that the recommendations implementation is the most crucial part of the process and need to be actioned appropriately, although it was recognised that there have been some mitigating factors hampering progress such as COVID and industrial action. SN stated that the setting of the timeline for delivery of the recommendations, in the first instance, needed to be more realistic given some of the operational issues that remain live. MH stated that overall, improvements had been made in completion of the recommendations and he continues to send out individual recommendations to the executive team monthly with support being	

	provided by internal audit although there was still scope for improvement on the position to date. He suggested that if there are mitigating factors in completing the recommendations then consideration, in some instances, should be given to stretching a timeline based on the assessment of the risk that recommendation carries. The Committee noted the report and the assurance provided.	
A.11.23.11	**Annual Internal Audit performance review** MH confirmed that questionnaires have been distributed to all Executive Directors for completion. Positive responses have been received and a summary will be reported back to the February 2024 meeting as per action A23003. The Committee noted the verbal update.	
A.11.23.12	**Internal Audit reports (limited assurance)** BH062024 – Patient Safety: Sepsis RS joined the meeting and provided an overview of the sepsis management internal audit report which received a limited assurance rating. He confirmed that the Sepsis Nurse Specialist is now back in post which should help to support improvements. Sepsis is one of our high-level quality priorities for the coming year as highlighted in the recent quality account. In terms of governance, sepsis is reviewed and discussed at the 'Recognition response to acutely unwell patient group', 'Clinical Outcomes Group' and then the 'Quality & Patient Safety Academy'. RS provided an overview of the 90% target for screening of patients for sepsis and the screening tool used on EPR for flagging sepsis. As this is a coarse instrument many more patients are being flagged as being septic who are not but have been flagged on the system due to various triggers e.g. increased heart rate. He noted that completion of the sepsis form on EPR is quite a lengthy procedure, as it takes time to justify why each patient isn't septic which can lead to the form being bypassed by staff. The CSU dashboard data shows that 50% of the time, when a patient is flagged for sepsis, the screening isn't completed which means that the screening tool is not fit for purpose. Work is under way to alter the threshold and to update the form that requires completion by clinical staff. PR added that a new build, within EPR is ongoing due to the NICE guidance relating to sepsis being updated in September 2023. Further training with junior doctors is also being undertaken. PR noted that monthly audits are being undertaken looking at a 10% sample of patients (approximately 40 per month), who were flagged as septic but not screened for sepsis. The results showed that no patient came to harm as a result. There were 10 recommendations which arose from the audit and most are now completed. However, work is still required on the trigger and screening process. PR concluded that the recommendations and the timescales in the audit report are achievable to ensure that sepsis management will be in an acceptable position going forward.	

	SN asked if best practice from other local Trusts had been gathered or is this a similar issue for others. RS confirmed that work is ongoing with Calderdale & Huddersfield NHS FT which also uses Cerner, to try to solve some of the similar problems and issues although modifications to Cerner are not always forthcoming. The Committee noted the update and the assurance provided on what is a challenging piece of work. <u>BH092024 -ReSPECT</u> KD joined the meeting and provided an overview of the ReSPECT internal audit report which has received a limited assurance rating for the second time (previously this was in January 2022). KD provided an overview of the ReSPECT tool that is used for a patient in the last year/ days of life and replaces the DNARCPR form. Work was undertaken to set up an electronic editable version of the form to ensure all parties could see the most accurate version at any one time. KD noted that there were several factors that impeded the implementation, although every effort had been made to move this forward. In response to the recommendation from the last internal audit in January 2022 all the old paper forms were removed from circulation. Findings from the most recent internal audit found issues remain with providing an electronic form along with staff using the ReSPECT paper form as a DNARCPR only and not completing the ReSPECT sections. Sarah Freeman, Director of Nursing along with Ben McKay, Education Manager - Patient Safety Training will be providing further ReSPECT education training Trust wide to staff and regular audits will continue. An enabler to this would be to make the forms electronic, which would then be a live document that can be shared throughout the care system. PR stated that we have employed an external contractor to adapt the Cerner model content to ensure delivery of the ReSPECT electronic document element in EPR by March 2024. KD stated that the initial target date for completion of the electronic solution was September 2023 with a three-month embedding period taking the completion date to 31 December 2023 as noted in the audit. Confirmation of roll out will now be March 2024 and a three-month embedding training period is required hence the position to re audit would be around July 2024. In response to SN's question on non-completion of the electronic form, PR confirmed that there will be mandated and non-mandated fields within the electronic form which will be decided using the national guidance and the paper document already in use. Because of the shared domain it is envisaged that the same product is ultimately adopted by both Calderdale, Bradford and Airedale from September 2024. The Committee felt assured that there is an appropriately timed and effective follow up exercise being undertaken to be fully implemented by July/August 2024. <u>BH312023 -Pennine Breast Screening Unit Equipment</u> MH provided an overview of the limited assurance report and noted that a paper had been presented previously at a closed board meeting identifying	

	the next steps and the replacement program. MQ has been working closely with the service to develop an implementation plan. We are currently in the process of going out to tender to re-procure the items of concern with a phased implementation approach agreed with the team. MQ confirmed that we are replacing the purchased equipment this financial year and we will replace the leased equipment next financial year. The team are all on board to ensure a smooth transition for both patients and staff to minimise any disruption to the service. MH felt that most of the recommendations, actions, and target dates, as set out in the report, have now been implemented and we are on track to meet the deadlines. MQ confirmed that we have gone through the framework for this piece of kit and provided our feedback. He confirmed it was very difficult to have a claim against a negative piece of kit, when on paper it meets the standard, and as we are the only Trust that has procured the item, we have no comparisons. SN queried if there were any plans in place, in the interim, to minimize harm to patients due to the possibility of the current machine exposing patients to higher levels of radiation. MH confirmed that he would speak with a member of the PBSU team and report back to the February 2024 meeting. MH gave his thanks to Internal Audit for their hard work and investigations into this additional requested piece of work. <u>BH172024 – Control of Substances Hazardous to Health Regulations (COSHH)</u> CN joined the meeting and provided an overview of COSHH for the organisation. She stated that during COVID COSHH wasn't a priority for the organisation and that has been our downfall as most assessments are undertaken by clinical staff in clinical areas. Prior to October 2022 the post, that was dedicated to the management of the COSSH database, was vacant. Once the post was filled there were approximately 5000 outstanding assessments which have now been reduced to 2500 over 9 months, although these will be the most difficult to complete. CN envisaged that once all the assessors are in place, we can reduce the outstanding assessments and be in a more suitable position going forward. The COSHH advisory group (CAG) has not always taken place in a timely manner nor has there been adequate attendance at the meetings which had been noted, on several occasions, at the Health & Safety Committee. CN will now Chair the COSHH advisory group which will have new Terms of Reference and an updated membership list. CN advised the Committee that we will always have some outstanding assessments, approximately 500, as the way COSHH reports is always changing and updating. Whilst the COSHH assessments are taking place the assessors are checking products for their viability and if they are still required on site. CN felt assured that we have the resources available to achieve the targets noted in the audit report within the timescale. SN queried what level of confidence do we have that we are aware of all products on site including those brought in by external contractors to ensure they have a risk assessment. CN confirmed that she works closely with the procurement team as part of the CAG. Processes are in place, generally through the Estates project manager, for external contractors coming on site	Director of Finance A23052

	to ensure all risk assessments are completed. The Committee noted the reports and the assurance provided.	
A.11.23.13	**Counter Fraud progress report** RM provided an overview of the report and drew attention to the following key points: • **INV/23/1015 – Bribery and Contract Fraud allegation re Estates** This is moving forward although there have a been a couple of holdups recently. RM is working with MQ to get hold of the relevant statistics, facts and figures to move this forward. Once the report is complete, site visits will take place with the selected tenders and contract work. • **INV/23/01825 Timesheet Fraud** There are early indications that the subject has been paid twice for work which overlapped across a considerable period. The total value of overpaid work is currently around £47k. The investigation is very much live and ongoing, and another meeting is scheduled for Wednesday, 6th December when staff, in various departments, have had the opportunity to compile the necessary documents; rosters, workplans, payment history, signed claim forms etc. There will be a paper trail to follow and review which may highlight any potential breaches. SN queried if the swipe card data only being available for two months, as referred to in INV/23/895 ICU Timesheet Fraud Allegation, would be a risk or a hinderance to the organisation in terms of the potential safeguarding concerns or matters relating to fraud in the future. RM said it was potentially a risk, but the swipe card data was held for a longer time period than most CCTV systems which was held for around 21 days. The swipe data and the CCTV evidence would generally try to be mirrored in the collation of evidence to be a contributing factor to the overall picture. MH felt that from the outcomes of the investigation, there are learnings and system weaknesses identified that need to be addressed around not complying with guidelines and procedures and the co-ordination of rosters. RM gave an overview of the timeline, steps taken to gather evidence and those involved throughout an investigation. MH confirmed that himself and MQ are fraud champions within the organisation, and they discuss the outcomes and learning from these investigations with their team. • **Inform and Involve newsletter** The NHS Counter Fraud Authority (NHSCFA) is developing how it receives information and intelligence and how it will be recorded going forward. There is a drive by the NHSCFA to try and increase the dissemination of intelligence outwards and to also accept more intelligence coming into the organisation. We may see a higher number of incidents being recorded and potentially a commensurately lower number of investigations taking place depending on how intelligence is judged and disseminated through the process. RM asked the Committee to note that there may be a slight change in the statistics at year end due to the information being recorded on the NHSCFA's data capture system, CLUE.	

	The Committee noted the report and the assurance provided.	
A.11.23.14	**Charitable Funds Annual Report and Accounts** The accounts will be audited by Moore Kingston Smith during November 2023 and early December 2023. The audited accounts along with the auditor reports will be shared at the Audit Committee virtually so that the accounts can be shared with the Charity Commission before the end of January 2024. BAS queried if the issue with the Elsie Sykes fund, which caused additional work for Deloitte at the last audit, had been resolved. MQ confirmed that a substantial amount of work had been carried out on the valuation and working paper from the fund to enable the year end information to be shared with the new auditors. SN queried the percentage of figures that were spent as a proportion of the overall on support costs and how our figures benchmarked with other hospitals or similar charities. MH confirmed the audit process won't address those issues, but they are being discussed at the Charitable Funds Committee to ensure that the appropriate proportions of fundraising are fundraising support costs. MQ agreed to update the Board of Directors term dates on page 12 of the paper. The Committee noted the report.	Deputy Director of Finance A23053
A.11.23.15	**Proposed changes to Scheme of Delegation/Standing Financial Instructions** • Schedule of high-value approvals under the scheme of delegation MH referred to a request from BAS to see that the appropriate approvals are in place for high level approvals. MH felt that we have internal mechanisms in place to determine the triggers for high value items and agreed to bring a paper to the February 2024 meeting. To provide further assurance, MH suggested that we include this in the financial transactions audit that is due to be undertaken. The Committee noted the verbal update.	Deputy Director of Finance A23054 Internal Audit A23055
A.11.23.16	**Exception reports: Schedules of Losses and Special Payments** MQ referred to the actions that arose from the September 2023 Audit Committee meeting: - A.9.23.14 – Waivers The Audit Committee requested assurance that the Standing Financial Instructions (SFIs) and Scheme of Delegation (SOD) were followed for all waivers presented and the financial input query for waiver WF44-23 for £99,792. A waiver can only take place if they are between the threshold of £15,000 - £137,00 which would need the approval of the Head of	

	Procurement. All the waivers did align to the SOD but on 2 occasions they were signed by the Operational Head of Procurement in the absence of the Head of Procurement. The Trust is currently working with the ICS to review and potentially amend SFIs and SOD, so they are aligned and consistent for tenders below PCR threshold. <u>A.9.23.14 – Overseas Debt</u> The Audit Committee requested an update on the overseas debt recovery once the internal audit review has been completed. MQ confirmed that the audit field work is currently underway however the audit has not been completed. A further update will be provided, once the audit is completed, to the February 2024 meeting. BAS asked for clarification on some of the signatory names particularly on WF23048, MQ confirmed that they are senior procurement staff authorised to approve the waivers. SN queried what the parameters are for coding of items in the 'other' section in the ex-gratia payments and special payments listed in the summary of Appendix A Summary of Losses and Special Payments. Last year's total was for £11,779.05 compared to this year's total of £801. MQ confirmed that last year's payment related to a compensation payment made to one individual. The Committee noted the report and the assurance provided.	Deputy Director of Finance A23056
A.11.23.17	**Appropriateness of Single Source Tenders** Item discussed as part of A.11.23.16.	
A.11.23.18	**Trust compliance with Standing Orders, Standing Financial Instructions/Scheme of Delegation (standing item)** There was nothing to report on this item.	
A.11.23.19	**Suspension of Standing Orders/Standing Financial Instructions (standing item)** There was nothing to report on this item.	
A.11.23.20	**Other assurance functions (standing item)** There was nothing to report on this item.	
A.11.23.21	**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. The Committee noted the verbal update.	

A.11.23.22	**Monitoring compliance with regard to the 'Policy for the Development and Management of Trust Policies' and compliance with Trust Policies** In presenting the report LP stated that the annual audit compliance rate for 2023 is 81%, the same as that reported in 2022 which is a good result. All policy holders whose policies were audited have been contacted to ensure the appropriate amendments are made. A generic communication to all policy holders has been circulated with the findings and the common themes that arose. The two lowest scoring areas, questions 3 and 5, is to ensure all the sections from the policy template and the monitoring criteria is include within their policy. LP will also ensure that the process for approval of policies is clarified with end users and is also updated in the Policy on Policies. The Committee noted the report and the assurance provided.	Board Secretary A23057
A.11.23.23	**Assurance: Key IT systems progress report update** BAS referred to the recent Board meeting where discussion took place in relation to poor performance in 'depth of coding' on 'Summary Hospital-level Mortality Indictor' (SHMI) data - and a significant risk on the high-level risk register relating to members of staff not using or knowing how to use EPR correctly. PR stated that from the Board discussion, there will be a strong focus on SHMI because of the potential financial implications and staff not using EPR to its full extent. MH confirmed that he had confirmation from NHSE that commissioners are accusing organisations of upcoding again. Fortunately, the Trust is not in that situation due to the waiting list model we currently use. PR provided a verbal update on progress to date on the assurance regarding the key IT systems and confirmed that they continue to have a series of internal audit reports that speak positively of the position of those systems. PR felt that the focus remained on the human element of EPR and how people are using our major systems. Airedale NHS FT is due to go live next September which will provide the Trust with an opportunity to undertake an EPR review in 2024. All education and training resources will also be revised - both online and in person training. The plan is to review the work ongoing in Airedale to reuse as many of those resources as practically possible and to brand those resources accordingly to have a rollout programme in support of that. As part of a wider WYAAT programme, we are part way through replacing the LIMS system and the education and training is progressing with the role out of the system which is currently at the halfway stage. A further two elements of the system are scheduled to go live next spring and education and training will continue. PR referred to the high-level risks on the risk register that are reviewed by the CSUs led by Sajid Azeb, Chief Operating Officer who has a leadership responsibility in the organisation to ensure that a program of this nature is supported by them. He noted that the go live in Maternity has proven that maternity colleagues are now increasingly using the system to the best effect.	

	In relation to data quality one of the resources identified by the Executive Team is data quality improvement resources matched to maternity. The response has been incredibly positive with updates being provided at Board meetings. The same model will be adopted at the Trust for the theatres, anaesthesia and critical care module in September 2024 alongside Airedale. The opportunity will be taken throughout 2024 to re remind colleagues on the education and training for EPR to ensure bad habits are not passed on. In response to BAS's question on assurance that our systems operate correctly, PR noted that the various tests that we adopt, and our internal audit reports provide the various assurances. Vast quantities of data are provided to NHSE on a routine and regular basis and if we were seen to be serial outliers in relation to that then that would provide cause for challenge. A set of internal controls, verifications and validations are a consequence of our relationship with wider system partners and ultimately the regulator and NHSE. In response to BAS's question on our journey towards consistent data quality across the Trust, PR referred to the creation of the Insights Centre app in which users can test the correlation between metrics with easy to produce self-service dashboards and a one stop shop to access more detailed insight and intelligence. The Insights Centre allows colleagues to triangulate the conversations that happen in the separate Academy meetings in relation to budgetary and staffing positions and key quality markers and indicators. This is a data quality resource that allows colleagues to have conversations to challenge, revalidate and revisit their data. PR confirmed that we are in a much healthier position as our data warehouse solution had moved on significantly and, twinned with the Insight Centre. work the next 12 months will be about colleagues owning their data to a much greater degree. PR suggested that the Insights Centre is discussed at a future board development session. JL queried where data quality sits within the governance structure below Committee/Academy level. PR advised that there is a Digital and Data Transformation Committee which generates a Chair's report that goes to the Quality & Patient Safety Academy. New working groups look at data quality for maternity, waiting lists, activity, finance, Urgent and Emergency Care (UEC) and discharge returns. A steering group sits above this work to coordinate capacity and prioritise actions. PR confirmed that he will discuss with the Executive Team the viability of a standalone meeting focusing on data quality. In summary BAS felt it was valuable for the Audit Committee to continue to monitor and focus on the developments in these two areas through assessments from time to time to be satisfied that progress is being made. The Committee noted the verbal update.	Board Secretary A23058
A.11.23.24	**Assurance: Data Quality** Item discussed as part of A.11.23.23.	

A.11.23.25	**Estates Project Management Quality Manual Assurance** MH provided an overview of the paper which relates to the Trust receiving Public Dividend Capital Funding from government to complete NHS 'improvement' works, with monies required to be expended in the 20/21 financial year. This was under the banner of 'use it or lose it' allocation by the 31 March 2021. The Trust submitted a number of pandemic mitigation opportunities using the national framework provided by the national team. MH felt that we weren't geared up to manage such a step change in our capital programme. Tilbury Douglas were awarded the tender for a 2-year programme. The Trust subsequently highlighted a substantial budget overspend as the 7 projects progressed with a final figure significantly in excess of the original planned sum. On completion, Avison Young were appointed to undertake an independent Project Audit to identify the factors driving the difference and to establish a range of recommendations for future learning. The learning outcome was that there were clearly gaps in our capacity as a team and gaps in our governance in terms of how we manage such a big scale programme. The paper details the response to the Avison Young audit action plan and our ability to demonstrate that we have appropriate project management regimes and controls in place although the challenge remains on the resource perspective to the capital estates team. MH noted that the context of the report was missing from the paper and agreed to provide this, to the February 2024 AC meeting, to provide assurance that we have strengthened our management controls and processes. JL suggested that MH includes reference to this in his capital paper to F&P Academy to close the loop. The Committee noted the report.	Director of Finance A23059 Director of Finance A23060
A.11.23.26	**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.11.23.27	**Any other business** The Committee members expressed their gratitude to BAS for his exemplary chairing of the Audit Committee and for his unwavering personal support to his colleagues. He has brought the Audit Committee through a huge evolution to where it is now, and he is a great Audit Chair role model to his successor Bryan Machin. The Committee wished him well in his future endeavours.	

A.11.23.28	**Matters to share with other committees** • The limited assurance reports to be shared with the appropriate Academies • Estates Project Management Quality Manual Assurance to F&P Academy	
A.11.23.29	**Matters to escalate to the Risk Register** There were no matters identified to escalate to the high-level operational risk register.	
A.11.23.30	**Matters to escalate to the Board of Directors** There were no matters identified to escalate to the Board of Directors.	
A.11.23.31	**Items deferred to subsequent meetings** There were no items deferred to subsequent meetings.	
A.11.23.32	**Attendees for subsequent audit committee meeting**	
A.11.23.33	**Review of meeting** BAS suggested that more time is allocated to any limited assurance reports that are presented to the Committee.	
A.11.23.34	**Date and time of next virtual meetings:** • 6 February 2024 • 16 April 2024 • 21 May 2024 • 20 June 2024 (extraordinary meeting accounts sign off) • 10 September 2024 • 19 November 2024	

Action log from the Audit Committee Meeting held 21 November 2023

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
21.11.23	A.11.23.25	**Estates Project Management Quality Manual Assurance** JL suggested that MH includes reference to this in his capital paper to F&P Academy to close the loop.	**Director of Finance A23060**	February 2024	Added to January F&P agenda. Action closed.
21.11.23	A.11.23.25	**Estates Project Management Quality Manual Assurance** MH noted that the context of the report was missing from the paper and agreed to provide this, to the February 2024 AC meeting, to provide assurance that we have strengthened our management controls and processes.	**Director of Finance A23059**	February 2024	Added to February agenda. Action closed.
21.11.23	A.11.23.23	**Assurance: Key IT systems progress report update** PR suggested that the Insights Centre is discussed at a future board development session.	**Board Secretary A23058**	February 2024	This has been added to the list. Board development sessions are to be confirmed with new Chair once in post (early March 2024). Is the Audit Committee content for this action to be closed?
21.11.23	A.11.23.22	**Monitoring compliance with regard to the 'Policy for the Development and Management of Trust Policies' and compliance with Trust Policies** LP will also ensure that the process for approval of policies is clarified with end users and is also updated in the Policy on Policies.	**Board Secretary A23057**	February 2024	A flow chart is being produced and the policy is being updated to include the chart. The flow chart and the revised policy are expected to be published by the end of February 2024. Is the Audit Committee content for this action to be closed?
21.11.23	A.11.23.16	**Exception reports: Schedules of Losses and Special Payments** The Audit Committee requested an update on the overseas debt recovery once the internal audit review has been complete. MQ confirmed that the audit field work is currently underway however the audit has not	**Deputy Director of Finance A23056**	February 2024	Added to the February 2024 agenda. Action closed.

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		been completed. A further updated will be provided, once the audit is completed, to the February 2024 meeting.			
21.11.23	A.11.23.15	**Proposed changes to Scheme of Delegation/Standing Financial Instructions - Schedule of high-value approvals under the scheme of delegation** To provide further assurance, MH suggested that we include this in the financial transactions audit that is due to be undertaken.	**Internal Audit A23055**	February 2024	Item included in the Financial Transaction review. Action closed.
21.11.23	A.11.23.15	**Proposed changes to Scheme of Delegation/Standing Financial Instructions - Schedule of high-value approvals under the scheme of delegation** MH felt that we have internal mechanisms in place to determine the triggers for high value items and agreed to bring a paper to the February 2024 meeting.	**Deputy Director of Finance A23054**	February 2024	Added to the February 2024 agenda. Action closed.
21.11.23	A.11.23.14	**Charitable Funds Annual Report and Accounts** MQ agreed to update the Board of Directors term dates on page 12 of the paper.	**Deputy Director of Finance A23053**	February 2024	Annual Accounts were updated and have been audited. Term dates are accurate as at 31 March 2023. Action closed.
21.11.23	A.11.23.12	**Internal Audit reports (limited assurance)** SN queried if there were any plans in place, in the interim, to minimize harm to patients due to the possibility of the current machine exposing patients to higher levels of radiation. MH confirmed that he would speak with a member of the PBSU team and report back to the February 2024 meeting.	**Director of Finance A23052**	February 2024	
21.11.23	A.11.23.6	**Annual policy review – use of external audit for non-audit purposes** • Page 2 – change Audit and Assurance Committee	**Deputy Director of Finance A23051**	February 2024	Policy has been updated and shared with BAS for approval. BAS has approved the policy. Action closed.

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		to Audit Committee • Page 10 – Audit related services – remove this section. MQ agreed to update the policy, as per the proposed changes above, and provide BAS with a clean copy for approval.			
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. Item is included on the agenda. Action closed.
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. Item is included on the agenda. Action closed.
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**	February 2024	21.11.23 - MH confirmed that questionnaires have been distributed to all Executive Directors for completion. Positive responses have been received and a summary will be reported back to the February 2024 meeting. Item is included on the agenda. Action closed.
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. 21.02.24 - Awaiting the publication of the

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
					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 21 November 2023

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
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 audit. We are liaising with Steve Moss in terms of financial checks, financial

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.			transactions and payroll in particular for any anticrime aspects that need including and any key risks flagged. This will continue going forwards - action closed
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. Email sent to Committee prior to the meeting – 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

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
					notified that a follow up on the actions is 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.

BO.3.24.37 - CONFIRMED CHARITABLE FUNDS COMMITTEE MINUTES

REFERENCES

Only PDFs are attached

Bo.3.24.37 - Confirmed Charitable Funds Minutes - 7 November 2023.pdf

CONFIRMED MINUTES - CHARITABLE FUNDS COMMITTEE

Date:	Tuesday 7th November 2023	**Time:**	15:30-17:00
Venue:	Via Microsoft Teams	**Chair:**	Altaf Sadique, Non-Executive Director (AS)
Present:	**Non-Executive Directors:** - Karen Walker, Non-Executive Director (KW) - Julie Lawreniuk, Non-Executive Director (JL) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer (SA) - Matthew Horner, Director of Finance (MH)		
In Attendance:	- Michael Quinlan, Deputy Director of Finance (MQ) - Laura Parsons, Associate Director of Corporate Governance (LP) - Sharon Milner, Charity Director (SM)		
Minutes:	- Mel Lomas, Executive Assistant		

No.	Agenda Item	Action
C.11.23.1	**Apologies for Absence** Apologies were received from Mohammed Hussain, Non-Executive Director and Helen Hirst, Interim Chair.	
C.11.23.2	**Declarations of Interest** No interests were declared.	
C.11.23.3	**Minutes of the Meeting Held on the 4th of July 2023** The minutes were accepted as an accurate record of the meeting and the action log was reviewed and updated.	
C.11.23.4	**Matters Arising** AS reiterated the purpose of the Committee and welcomed SA to his first meeting in his capacity as Executive lead for charity operations. SM queried if the charity accounts audit had started. MQ replied that it hasn't and the team are engaging with the external auditors and Procurement. The audit is due to start shortly and the team are on-track to complete the account within the national deadline of the end of January 2024. Delays have been experienced this year and it is hoped that this will be completed more quickly next year.	

	SM asked if Moore Kingston Smith LLP had been formally appointed as the external auditors and MQ confirmed that the Foundation Trust has engaged them, but a formal appointment has not yet been made.	
C.11.23.5	**Investment Report** MQ summarised this report, which was written by Rathbones (the charity's investment managers). • The report provides an update on the performance of the charity investments during the first 6 months of the financial year. • Bonds and UK equities have fallen, bonds by 5.1%. Overseas equities have performed better, rising by 5.4%. • Performance of the investments remains under pressure from high interest rates. Although Rathbones are of the opinion that the rising cycle of interest rates is nearing an end. • The overall portfolio has risen by 0.7%, which is a positive result against the benchmark of -0.1%. Longer term, the portfolio has risen by 15.2% versus a benchmark of 5.2%. AS queried if the Finance Team were comfortable with the investments and strategy being followed. MQ responded that the portfolio and risk profile were chosen by the Charitable Funds Committee and went through the appropriate due diligence. Investments just below medium risk were chosen, with longer term capital growth to balance with income. The team are comfortable that Rathbones are investing in line with the risk return portfolio approved by the Committee. It was agreed to explore this when Rathbones next attend the meeting. SA stated that the whole investment portfolio is due for review in 2024 and SM suggested meeting with Rathbones twice yearly. MQ stressed the need to agree the Committee requirements first. The Committee noted the report.	**All** **C23004**
C.11.23.6	**2023/24 Finance Report – Month 6** MQ summarised the key points of the report: • The plan was to raise £1 million for the Neonatal Unit during this financial year, but this has been delayed largely due to finalisation plans. • At Month 6, the total value of the fund was £2.1 million, £600,000 less than planned due to the Neonatal Unit delay. • A lower than planned return on investment of £131,000 has been reported. • An overall reduction in the total value of the fund by the end of the financial year by £240,000 is predicted (£1.3 million less than planned). • A key risk is the charity not forecasting sufficient headroom to support the predicted income and expenditure. • The target fundraising rate of investment was 25%, which was agreed through Gifted Philanthropy, has not been met. Around	

	70% fundraising rate of investment is expected by the end of the year. More is due to be invested in the fundraising team and it is hoped that the rate of return will improve. JL mentioned the Neonatal Unit delay and asked if large schemes needed to be up and running to generate income. SM shared that initially there was no fully costed plan for the Neonatal Unit and a deep dive resulted in a price of around £4.6 million. A £3 million limit was subsequently set and work is ongoing to reduce this further. The Sick Children's Trust are also involved, who have pledged £1.5 million, reducing the overall fundraising target to £1.5 million for the Foundation Trust. MQ confirmed that the Estates Team will manage the build, with the charity paying the Foundation Trust. It is anticipated that the latest design will fall within the targeted envelope. SA highlighted the importance of projects being able to demonstrate good value for money to their benefactors and considering the reputational impact of fundraising for an amount that is not achievable. The Committee noted the report.	
C.11.23.7	**Charitable Funds Committee Terms of Reference** LP presented this item. The Committee was asked for approval to recommend the following changes to the Board: • The Chief Operating Officer to be added as a member to replace the Director of Strategy and Integration. • The term Chairman to be changed to Chair. • The internal auditor recommended that the Committee review the frequency of its meetings. There are three meetings a year at present, in line with the Terms of Reference and four are diarised for 2024. The Committee agreed to recommend the above changes to its Terms of Reference for approval by the Board.	
C.11.23.8	**Operational Committee Report** SA highlighted the areas of focus of the meeting on 24th October: • Lisa Williams, new Head of Fundraising, attended her first meeting. • A grant has been secured from NHS Charities Together to improve the green spaces on-site, totalling £46,000. • Work around rebranding the charity is now complete. • The Neonatal Unit scheme is being reassessed with the Estates and Facilities team. • The charity has been featured on the Look North television programme and is about to receive a £5,000 donation from the local Amazon office.	

	• Meetings to discuss the independence option are occurring fortnightly and the proposal will go to the January Board for approval. Jennifer Lindsay, General Manager, has been employed to assist SM with this. SM has written a 3-5 year strategy, but there is further work to do around finances. Infrastructure and GDPR work are also ongoing. AS asked if there should be a separate register for risks relating to the charity. SA confirmed that this will be included in the case for change and agreed to update the Committee at the next meeting. AS queried if the Finance Team were involved in the discussions regarding recruitment of finance support to the Charity. SA confirmed that this was the case and conversations have taken place around whether to recruit immediately or wait until the independence decision is made. SM is liaising with HR to ensure that any new employees understand what an independent status entails. MQ stated that the finance strategy is to establish income of around £1 million per year and if the charity is to grow, a more ambitious target is required. Once the plan been agreed, it will be presented to the Committee. JL queried if the plans would have an impact on the national expectations around financial controls. MH stated that the charity is being treated separately, so does not face the same controls. The Committee noted the update.	**SA/SM C23005**
C.11.23.9	**Bradford Hospitals Charity Policy** MQ presented this item and shared that it was agreed by the Charity Operational Committee last month. The aim of the policy is to ensure that there are clear procedures to follow and it is consistent with charity law and good practice. There have been a few minor changes made to make the policy to make it more transparent in terms of where the funds can and cannot be spent. And the Terms of Reference will be updated now they have been agreed. AS queried if there was a fund that the team could use for hospitality expenses. MQ confirmed that there is a policy which states that petty cash can be used to purchase small items, but this will need to be aligned to the Charity Commission guidance and agreement is required by the Committee how it will be used. SM expressed concern about staff potentially leaving if they can claim those sorts of expenses elsewhere. MP stated that policies can be changed if they are restrictive. Pre-booking refreshments for donors and fundraisers was suggested, but SM pointed out that this is restricted to a maximum of 12 people and not all individuals are local to Bradford.	

	SA commented that once a decision has been made around independence that will allow the creation of different policies for the charity in comparison to what is in place for the rest of the staff in the organisation. It was agreed that SA, MH and SM would discuss this matter further outside of the meeting and agree a way forward. It was agreed that any required policy amendments could be implemented as necessary without seeking further approval from the Committee. The Committee approved the amendments to the policy.	**SA/MH/SM C23006**
C.11.23.10	**Expenditure Policy** MQ shared that this policy has already been agreed by the Charity Operational Committee and relates to ensuring clear guidelines are in place around expenditure. Minor changes have been made. The Committee approved the amendments to the policy.	
C.11.23.11	**Charitable Funds Committee Work Plan** LP highlighted that lines have been added to the workplan for charity strategy updates and the independence recommendation will be discussed in January. The workplan will be reviewed at every meeting going forward given the pending independence decision. The Committee approved the work plan.	
C.11.23.12	**Any Other Business** AS mentioned the three items which were approved via e-mail; the appointment of an external auditor for the 2022/23 accounts and annual report, the unaudited draft of the Bradford Hospitals Charity annual report and accounts 2022/23 and the Bradford Hospitals Charity Investment and Treasury Management Policy. The Committee noted the approval of the above items.	
C.11.23.13	**Date and Time of the Next Meetings - all 3.30-5pm** • 11 January 2024 • 30 April 2024 • 2 July 2024 • 5 November 2024	

Actions From the BTHFT Charitable Funds Committee 7th November 2023

Action ID	Date	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
C23002	4.7.23	C.7.23.14	**Committee Effectiveness Review** LP to provide an update at the next meeting in November 2023.	Associate Director of Corporate Governance/Board Secretary	November 2023	Item on the February agenda – action closed 04.07.23 - A verbal update will be provided at the meeting. 07.11.23 - It was decided that the Academy questions were not relevant for this Committee.
C23004	**07.11.23**	**C.11.23.5**	**Investment Report** To discuss the portfolio and returns in detail when Rathbones are next in attendance.	All	TBC	
C23005	**07.11.23**	**C.11.23.8**	**Operational Committee Report** SA/SM to update on the proposal for a separate charity risk register.	SA/SM	March 2024	20.12.23 – LP has advised to use the new app, which will be installed in the New Year.
C23006	**07.11.23**	**C.11.23.9**	**Bradford Hospitals Charity Policy** It was agreed that SA, MH and SM would discuss the expenses matter further outside of the meeting and agree a way forward. It was agreed that any required policy amendments could be implemented as necessary without seeking further approval from the Committee.	SA, MH & SM	March 2024	20.12.23 – work on the expenses policy has been started, but further is required to fall in line with the NHS paper.

Appendix 1: Actions Closed at Previous Meeting

Action ID	Date	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
C23001	4.7.23	C.7.23.7	**Draft 2022/23 BHC Accounts and Annual Report** MQ advised that he would circulate the draft 2022/23 BHC Accounts and Annual Report to members of the Committee at the end of July 2023 via email for their review.	Deputy Director of Finance	November 2023	Action closed
C23003	4.7.23	C.7.23.15	**Investment and Treasury Management Policy** MQ would liaise with Rathbones on the wording required for inclusion within the Investment and Treasury Management Policy relating to the exclusion of gambling from the Charity's investment portfolio.	Deputy Director of Finance	November 2023	Action closed