Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS OPEN

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9 May 2024

09:30 GMT+1 Europe/London

Conference room, Field House, BRI

AGENDA

AGENDA - 9.5.24

REFERENCES

Only PDFs are attached

Bo.5.24.0 - Open board agenda 9.5.24.pdf

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	Thursday, 9 May 2024	**Time:**	09:30 – 12:45
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair

- 09:40 - 10:00 - Emma Clinton, Matron A&E – Bo.5.24.5 – Patient Story
- 10:10 - 10:25 - Sara Hollins, Director of Midwifery – Bo.5.24.7 - Maternity and Neonatal Services Update
- 10.25 - 10.35 - Rosie McEachan, Born in Bradford (BiB) Director– Bo.5.24.8 – Research Activity in the Trust
- 11:20 - 11:35 - Carl Stephenson, Associate Director of Performance – Bo.5.24.13 – Health inequalities & waiting list analysis

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.5.24.1	Apologies for Absence	Chair	For information	Verbal
Bo.5.24.2	Declarations of Interest	Chair	For information	Bo.5.24.2
Bo.5.24.3	Minutes of the meeting held on 14 March 2024	Chair	For approval	Bo.5.24.3
Bo.5.24.4	Matters arising • Plans to improve depth of coding	Chair Chief Digital & Information Officer	For information For assurance	Verbal Bo.5.24.4
09:40 Section 2: Patient Care				
Bo.5.24.5	Patient story	Chief Nurse	For information	Bo.5.24.5
Bo.5.24.6	Report from the Chair of the Quality and Patient Safety Academy - March & April 2024 - Guardian of safe working hours quarterly report	Chair of the Quality and Patient Safety Academy	For assurance	Bo.5.24.6
Bo.5.24.7	Maternity and Neonatal Services Update	Chief Nurse	For assurance	Bo.5.24.7
Bo.5.24.8	Research activity in the Trust	Chief Medical Officer	For assurance	Bo.5.24.8
Bo.5.24.9	Paediatric Audiology Service	Chief Medical Officer	For assurance	Bo.5.24.9
10:45 Section 3: People				
Bo.5.24.10	Report from the Chair of the People Academy - March & April 2024 - Gender pay gap reporting – March 2024	Chair of the People Academy	For assurance	Bo.5.24.10
Bo.5.24.11	Equality & Diversity Council update	Chief Executive	For assurance	Bo.5.24.11

BREAK 11.05 – 11.15

11:15 Section 4: Finance and Performance				
Bo.5.24.12	Report from the Chair of the Finance and Performance Academy - March & April 2024	Chair of the Finance and Performance Academy	For assurance	Bo.5.24.12
Bo.5.24.13	Health inequalities & waiting list analysis – access focus	Chief Operating Officer	For assurance	Bo.5.24.13

11:35 Section 5: Audit & Assurance				
Bo.5.24.14	Report from the Chair of the Audit Committee - February 2024	Chair of the Audit Committee	For assurance	Bo.5.24.14
Bo.5.24.15	Report from the Chair of the Charitable Funds Committee - April 2024 - Draft Charitable Funds TOR	Deputy Chair of the Charitable Funds Committee	For assurance For approval	Bo.5.24.15

11:50 Section 6: Business Reports				
Bo.5.24.16	Report from the Chair	Chair	For information	Bo.5.24.16
Bo.5.24.17	Report from the Chief Executive - Integrated Dashboard - Finance Report - Performance Report	Chief Executive	For information	Bo.5.24.17

12:20 Section 7: Governance				
Bo.5.24.18	High-level risks	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.5.24.18
Bo.5.24.19	NED Academy/Committee membership and champion roles	Chair	For approval	Bo.5.24.19
Bo.5.24.20	Bradford Hospitals Charity – supplemental deed	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.5.24.20
Bo.5.24.21	Data security & protection toolkit	Chief Digital & Information Officer	For approval	Bo.5.24.21

12:40 Section 8: Board Meeting Outcomes				
Bo.5.24.22	Any other business	Chair	For information	Verbal
Bo.5.24.23	Issues to refer to Board Committees/Academies or elsewhere	Chair	For approval	Verbal
Bo.5.24.24	Review of meeting	Chair	For information	Verbal
Bo.5.24.25	Date and time of next meeting: • 11 July 2024 – 9.30am	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 9 May 2024

Annex 1: For Information				
Bo.5.24.26	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.5.24.26

Annex 2: For Information: Board Committee/Academy Governance				
Bo.5.24.27	Confirmed Academy minutes: • Quality & Patient Safety Academy – 28 February & 27 March 2024 • People Academy - 28 February & 27 March 2024 • Finance & Performance Academy 28 February & 27 March 2024	Chairs of Academies	For information	Bo.5.24.27
Bo.5.24.28	Confirmed Audit Committee minutes – 6 February 2024	Chair of the Audit Committee	For information	Bo.5.24.28
Bo.5.24.29	Confirmed Charitable Funds Committee minutes – 7 March 2024	Chair of the Charitable Funds Committee	For information	Bo.5.24.29

BO.5.24.1 - APOLOGIES FOR ABSENCE

BO.5.24.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.5.24.2 - 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	2020/21,2021/2	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/2	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 NGI	ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08/12/2021	2021/22,2022/2	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01/09/2022	2022/23,2023/2	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
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/2	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/2	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	2019/20,2020/2	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	2020/21,2021/2	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/2	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Netwwork nationall	0
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/2	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
James Rice	Chief Digital & Information Officer	28/02/2024	2023/24	Hospitality		Meal for NHS Trusts Chairs, CEOs and CDIOs following an learning event in Manchester.	Agilisys	45
James Rice	Chief Digital & Information Officer	12/03/2024	2023/24	Hospitality		Meal at Rewired event.	Penpole Consulting	27.5
James Rice	Chief Digital & Information Officer	11/03/2024	2023/24	Hospitality		Meal at Rewired event.	Meditech	27.5
Julie Lawreniuk	Non-Executive Director	11/03/2021	2020/21,2021/2	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		board member	Incommunities housing association	0
Julie Lawreniuk	Non-Executive Director	01/07/2022	2022/23,2023/2	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	University of Lahore	0
Karen Dawber	Chief Nurse	14/03/2024	2023/24	Loyalty Interests		Mind in Bradford is a local mental health charity that provides free mental health support to everyone living in Bradford District and Craven. Trustee post.	MIND in Bradford	0
Karen Walker	Non-Executive Director	01/07/2022	2022/23,2023/2	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
Mark Hindmarsh	**Director of Strategy & Transformation**	**15/04/2024**	**2023/24**	**Nil Declaration**				
Matthew Horner	Director Of Finance	12/07/2017	2017/18,2018/1	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	2017/18,2018/1	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	2019/20,2020/2	Outside Employment		Director of Pet Food Manufacturer (Family Business)	E&S Feeds	0
Matthew Horner	Director Of Finance	01/04/2018	2018/19,2019/2	Outside Employment		Board Member of Audit Yorkshire (Consortium)	Audity Yorkshire	0
Matthew Horner	Director Of Finance	03/01/2021	2020/21,2021/2	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	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	2019/20,2020/2	Outside Employment		Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/2	Outside Employment		non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/2	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
Renee Bullock	**Chief People and Purpose Officer**	**08/04/02024**	**2023/24**	**Nil Declaration**				
Raymond Smith	Medical Director	10/10/2018	2018/19,2019/2	Clinical Private Practice		Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/2	Clinical Private Practice		Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	01/12/2019	2019/20,2020/2	Clinical Private Practice		Anaesthetics within scope of normal clinical practice	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	2021/22,2022/2	Outside Employment		Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/2	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	2016/17,2017/1	Outside Employment		Various roles including:Deputy Head of Internal Audit – Department of Health & Social CareHead of Internal audit for the NHS Counter Fraud AuthorityHead of Internal audit for the NHS Health Research Authority	Government Internal Audit Agency	0

BO.5.24.3 - MINUTES OF THE MEETING HELD ON 14 MARCH 2024

REFERENCES

Only PDFs are attached

Bo.5.24.3 - Unconfirmed Minutes of the meeting held on 14 Mar 2024.pdf

Bradford Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday 14 March 2024	**Time:**	09:30 – 14:00
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair
Present:	**Non-Executive Directors:** - Sarah Jones (SJ) - Bryan Machin (BM) - Julie Lawreniuk (JL) - Karen Walker (KW) - Louise Bryant (LB) - Zafir Ali (ZA) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - Professor Karen Dawber, Chief Nurse (KD) - Dr Ray Smith, Chief Medical Officer RS) - Matthew Horner, Director of Finance (MH)		
In Attendance:	- Faeem Lal, Interim Director of Human Resources (FL) - Dr Paul Rice, Chief Digital and Information Officer (PR) - Laura Parsons, Associate Director of Corporate Governance & Board Secretary (LP) - Jacqui Maurice, Head of Corporate Governance - Arshad Mohammed, SPaRC team (MA) for item Bo.3.24.3 only - Rubina Yasin, SPaRC team (RY) for item Bo.3.24.3 only - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) for item Bo.3.24.16 only - Sara Hollins, Director of Midwifery (SH) for item Bo.3.24.20 only - Sam Wallis, - Annesha Archyangelio, Chief Nurse for Specialised Commissioning, NHS England (AA) for item Bo.3.24.20 only - Sharon Milner, Charity Director (SM) for item Bo.3.24.23 only - Michael Quinlan, Deputy Director of Finance (MQ) for item Bo.3.24.23 only - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- Helen Wilson, Staff Governor - Mark Hindmarsh, Incoming Director of Strategy and Transformation - CQC Inspector colleagues		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.3.24.1	**Apologies for Absence** Apologies were received as follows: - Altaf Sadique, Non-Executive Director - Sughra Nazir, Non-Executive Director	

No.	Agenda Item	Action
	- Mohammed Hussain (authorised absence), Non-Executive Director	
Bo.3.24.2	**Declarations of Interest** There were two declarations of interest noted from SJ who declared that she was Chair of an apprenticeship business, and her brother is a current NHS Director in Cheshire and Merseyside. KD is pending confirmation of her appointment as a trustee for Mind in Bradford. It was agreed that future versions of the declarations of interest report would include highlights of any changes since the previous version.	**Associate Director of Corporate Governance / Board Secretary Bo24006**
Bo.3.24.3	**Spiritual, Pastoral and Religious Care (SPaRC) Team – Ramadan Allies** AM and RY joined the Board to provide an update on the Ramdan Allies Project which had been developed by the SPaRC team and had won the HSJ Award for 'Staff Wellbeing Initiative of the Year 2023'. AM provided a brief overview of Ramadan, which is one of the five pillars in Islam and sees Muslims fasting from dawn until sunset for 29 to 30 days. AM highlighted that during this period, there is an increase in the use of prayer facilities for work, increased requests for annual leave and flexibility in working hours, and an increase in Ramadan related queries from managers. The presentation highlighted that during Ramadan, colleagues would value more flexible shift patterns, their team members understanding the significance of Ramadan to individuals, annual leave being granted for the final days of Ramadan, and nearly half of staff would value reduced hours during this time. The SPaRC team's vision was to make BTHFT a Ramadan Friendly Employer which led to the development of the Ramadan Allies project, and the request for colleagues to become a Ramadan Ally. As an ally, colleagues pledge to be committed to positive action to create the 'Ramadan Experience'; a Ramadan inclusive ethos in the workplace; a pro-active approach around Ramadan dialogue; champion the right for all to bring themselves to work fully and unconditionally, and create a culture of acceptance and support. The project is run in collaboration with a number of internal teams including OD, HR, Bradford Hospitals Charity, and communications. The SPaRC team also provide managers with Ramadan 'PROP' packs upon request which include all the materials needed to create a prayer room at any place in the hospital and staff have access to 'FAST' packs. Over 1,300 FAST packs, and 1,300 PROP packs have been handed out thus far.	

No.	Agenda Item	Action
	AM highlighted some key results from the project including the recruitment of 120 Ramadan allies, 98% staff engagement in the project, and the project being featured in an NHS England publication. The presentation also shared extracts of feedback and positive outcomes received by the team, and how best practice has been shared externally. RY also provided an overview of the Ramadan Roadshow which shared information with colleagues about the Trust's flexible workforce policy, distributed PROP packs for managers, recruited more Ramadan allies and allowed for staff across sites to meet the Ramadan project ambassadors. MP thanked RY and MA for their hard work on the project and the sharing of it with other organisations. She reflected that there are also areas of good practice in other Trusts, such as the extension of visiting hours, which BTHFT has adopted to enable better support for patients and their families. JL echoed her thanks to SPaRC colleagues and noted that the Trust was lucky to have such a creative and passionate SPaRC team. She welcomed the encouragement to have open conversations about Ramadan that previously she may have lacked the confidence to have. FL recognised the difference this initiative made as a Muslim member of staff. He invited MA to share the support provided to staff for their evening prayers, and MA advised that for staff on evening and night shifts who cannot attend the local mosques, evening prayer has been implemented at the place of worship in the Trust to enable staff to attend. SA referenced the 'Pause for Peace' initiative that the SPaRC team had started and commented that this had enabled difficult conversations to happen amongst managers and staff where previously they may have felt uncomfortable. This confidence to speak openly starts from top down, and the conversations help broaden understanding and knowledge about Ramadan. This understanding also helps day to day outside of the Ramadan period as there is a wider understanding of the Muslim faith and that makes a difference to the community we serve. RS welcomed that this is not solely a Muslim project as it encompasses all those across the organisation. He queried if benefits from the initiative are seen all year round and RY advised that relationships seem much improved as a result of this, and teams such as pharmacy feel able to have more open conversations in a more relaxed manner. However, she recognised there was still further room for improvement. KW asserted that the work of the SPaRC team will have contributed to the good improvement scores reflected in the staff survey and hoped that there would be an opportunity for the initiative to be shared even more widely, particularly given the passion of SPaRC colleagues.	

No.	Agenda Item	Action
	The Board thanked the SPaRC team for their time.	
Section 2: Business From Previous Board Meeting		
Bo.3.24.4	**Minutes of the Meeting held on 18 January 2024** The minutes of the meeting held on 18 January 2024 were approved as a true and accurate record.	
Bo.3.24.5	**Matters Arising** The following actions were reviewed, and the outcomes confirmed. • Bo23016 Corporate Strategy: An update had been circulated via email on progressing amber areas to green. Action closed. • Bo24001 Declarations of Interest: The declarations of interest document was amended and re-published to include all Board Directors. Action closed. • Bo24002 Board Assurance Framework (BAF) and High-Level Risks: ETM reviewed and confirmed the revised narrative for risk 3810 at their meeting on 19 February – so that it better reflected the current position. Action closed. • Bo24003 Maternity and Neonatal Services Update: Zafir Ali has temporarily been appointed as NED Maternity Champion following the term end of Jon Prashar. Action closed. • Bo24005 Review of Meeting: The finance report, performance report and integrated dashboard report remain as separate items on the agenda. Action closed.	
Section 3: Business Reports		
Bo.3.24.6	**Report from Chair** SJ stated that this was her first Board meeting at the Trust and her first opportunity to meet some colleagues in person. She thanked them for their warm welcome and acknowledged that whilst there are challenges within the Board, she had noted that the Board was committed to overcoming these and working together. She advised there were some changes she wished to make to the Board structure and ways of working, but she would share these with the Board in the coming weeks and a longer-term board development plan would be put in place to strengthen the Board as a team. The report was taken as read and SJ invited further comments from the Board, of which there were none. The Board noted the report.	

No.	Agenda Item	Action
Bo.3.24.7	**Report from the Chief Executive** MP advised that the Trust is in the middle of an unannounced CQC inspection which began on 12 March relating to medicine services. The Trust has also been notified of an inspection into the well-led domain which will take place mid-April 2024. MP highlighted the following key points from the report in relation to the Quality Improvement Group (QIG) meeting that took place on 26 January 2024: • Following the meeting, a letter was received by the Trust advising that on the matters relating to the care of babies in the neonatal unit, the reporting and learning from incidents, and the board governance and transparency related to this area; the QIG has received significant assurance and now closed this line of enquiry. • The letter and the findings on which it is based finally provides external validation that the neonatal service is safe and high quality and contrary to allegations, clearly chronicles that the Board and the Quality and Patient Safety Academy were fully sighted throughout on all matters subsequently raised as concerns. • MP expressed her thanks to clinical teams on the neonatal unit for their cooperation and professionalism during this difficult period which was also commented on by the QIG team. The Board noted the report.	
Section 4a: Delivery of the Trust's Corporate Strategy		
Bo.3.24.8	**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: • There have been no material changes to the risk scores. • All target scores remained at amber except for strategic objective five in relation to partnerships which was rated green. • The highest risk areas relate to finance, recruitment to vacancies and governance. Regarding the high-level risk register, the following information and amendments were shared: • There were currently 17 risks in total on the high-level risk register. • There has been one new risk proposed for addition to the HLRR in relation to the risk of 'Harm to children referred to paediatric service as new patients from a relay in initial diagnosis and initiation of appropriate investigation and therapy.' The Executive Team had discussed this and agreed that this would be a focus for discussion at the next Children's 'Executive to	

No.	Agenda Item	Action
	CSU meeting' before a decision is made on whether to include this as a high-level risk. • One new risk has been added to the risk register (3309 – delays in processing histopathology samples), currently scoring at 16 with a target score of 4. • Risk 3877 (operational pressures resulting in delays to treatment) had been discussed at the Finance and Performance Academy and the score had been reduced to 12 which is the current target score. Therefore, the target score would be reduced. • Risk 3896 (specifically relating to gynaecology histopathology delays) had been discussed at the Quality and Patient Safety Academy and reduced to a risk score of 12. SJ advised that she would discuss risk 3468 (correct recording of activity on EPR) offline with SA as she had some queries relating to this. BM referred to the overall risk relating to 'backlog maintenance resulting in the closure of risk 3788' which was a specific risk around roof leaks in Heaton House. He queried how these specific issues would be monitored through the wider risk, and LP advised this would be through risk assessment routes and teams monitoring this. SJ reflected that there were six risks past their review date and queried if this was the norm. LP advised this is higher than usual, but they do get reviewed on a regular cycle. It was agreed that future iterations of the report would include a trend analysis of whether the number of risks past their review date had increased or decreased in comparison to the previous report. There had been a number of minor changes to the risk management strategy which the Board approved. 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. The Board approved the revised Risk Management Strategy.	**Associate Director of Corporate Governance / Board Secretary Bo24007**
Section 4b: Finance and Performance		
Bo.3.24.9	**Report from the Chair of the Finance and Performance Academy (January & February 2024)** JL provided an overview of the report highlighting the following items: • The January meeting highlighted an alert to the Board in relation to the risks to delivering the 2023/24 plan. This would be discussed further by MH under item Bo.3.24.10.	

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	• The Academy also discussed the significant underlying financial position; the actions being taken to minimise this risk and the significant deficit being carried into the 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 Academy received an update in relation to Intermediate Care at the February meeting 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. The Board was assured by the report.	
Bo.3.24.10	**Operational and Financial Plan 2024/25** MH introduced the 2024/25 draft operational and financial plan and highlighted the following: • This had been a particularly challenging year in terms of process. • The plan included realistic and plausible but stretching plans. It would be helpful for the Board to further understand how the plans triangulate and this could potentially be a topic for an extraordinary update session. • In relation to workforce, FL noted the following assumptions: - Reductions in temporary staffing across the year (substantive staff growth tracked against temporary staffing reduction) - No further Industrial Action in 2024/25 - Turnover target of 9.75% - Sickness absence target of 5.2% • Key headlines relating to the workforce plan included a planned growth of 3.89% of substantive staff, and a planned reduction of 12.44% of bank staff and 68.94% agency staff. • In relation to activity and performance plans, SA advised there is no formal guidance issued as yet, so 2023/24 priorities and NHSE locality team insight has been used to inform plans. • It was anticipated that activity plans will inform elective recovery fund (ERF), which would work in a similar way to payment by results (PbR). • Key performance targets were: - no 65-week RTT waits by September 2024 - 77% Faster Diagnosis Standard and 70% 62-day cancer - 77% Emergency Care Standard performance - 92% bed occupancy - The DM01 target was believed to be set to 95% but this was not yet confirmed. • In relation to activity and performance, SA noted the following assumptions: - Waste reduction programme has no negative impact on current levels of activity and performance (or Clinical Service	

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	Unit (CSU) plans supported by already approved business cases) - Capital programmes complete on time (particularly St Luke's Hospital Day Case Unit) - 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 Getting it Right First Time (GIRFT) further faster can be realised. • An ambitious stretch target has been set to reduce outpatient follow ups to create capacity for new patients which is in line with the national ask of NHS England. • The ambition is to meet zero 65 week waits by August ahead of the September targeted time frame. • Against the 92% bed occupancy levels, it was expected that the Trust occupancy would average at 93.5% due to the limited bed capacity with an aim of >95% during Winter. • In relation to cancer and diagnostics, the Trust was aiming to be fully compliant with cancer targets with an additional stretch target to exceed these. • It was believed the opening of the Community Diagnostic Centre would help with the increased growth in diagnostic demand but there would be a balance of performance improvement against realistic financial opportunities. • MH updated on the draft plan for finance in 2024/25 highlighting the underlying challenging from 2023/24 that will be taken forward into 2024/25 and the increasing costs in relation to inflation. • Key headlines included the £54.6m deficit before the Waste Reduction Programme (WRP) which would reduce to a net deficit plan of £28.3m if the WRP target of £26.3m is achieved. In relation to inflation, the realistic assessment in excess of the NHS nationally published assumptions is £3.7m for utilities, £1.6m for drugs and £3.4m for non-pay uplift. • The majority of WRP plans were rated high or medium risk and scrutiny on credibility of WRP delivery is to be expected. • There has been a revised approach to WRP for 2024/25 including the introduction of a corporate project management structure to oversee the delivery of WRP led by the Director of Strategy via a Waste Reduction Programme Board (WRPB). Each CSU would have an executive sponsor to help them reach their target. • Key messages for the Board in relation to the plan included: - Recognition of the scale of challenge (9.4% of turnover to remove the £54.6m deficit) - The need to submit a plausible/ realistic but very stretching plan with robust quality impact assessment processes in place. - There are unpalatable options that will need to be considered. - There are opportunities at place and across the West Yorkshire Association of Acute Trusts (WYAAT), and	

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	discussions are ongoing to address these at a place and Integrated Care System (ICS) level. • There were a number of next steps including to continue to embed the updated governance arrangements and communicate the 'financial recovery' position to the organisation. There would be a need to establish a strengthened financial reporting and delivery framework and recalibrate the non-financial productivity KPIs triangulating performance and waste reduction. He welcomed a dedicated Board session on the Operational Plan to discuss this further and it was suggested that this takes place in April. SJ queried the aspiration of apprentice growth of 7% and how many apprenticeships are currently in the Trust. FL confirmed currently around 370 apprentices but still some room in the apprenticeship levy to grow this further. KW recognised the challenge faced by the Trust and reflected that the challenge needed to be carefully communicated to staff in a more positive manner to involve people in helping decision making and identify opportunities for financial improvement, and making changes that may also improve service as well as save money. KD recognised the step change in challenge and welcomed a more focused Board session to discuss this in more detail. There will be tough decisions to be made but the Board needed clear oversight of this to help inform the decision-making process. SJ echoed that the Board would need to consider how the Non-Executives can also support with the WRP process. MP recognised that as an organisation we sit within a place, within an ICS, and these discussions are replicated at each of those levels. A 'closing the gap' workstream had been developed to try identifying financial opportunities at place and she recognised the need for the draft plan to link in with this. She also reflected that all acute providers were having these same discussions, the Trust was not an outlier in the challenges faced. The Board noted the update.	
Bo.3.24.11	**Capital Programme 2024/25** MH introduced the paper and highlighted the following: • Current funding available for the 2024/25 capital programme is £42.1m (as at March 2024). • To fund the ICS capital allocation the Trust will need to use £10.8m of its own internal cash as the allocation is higher than the level of cash generated by the Trust through depreciation. • Outstanding Maternity Services (£4.9m), SLH Day Case Unit (£3m) and Endoscopy Transformation Programme (£15.1m) are material 2024/25 capital schemes with risks to deliverability.	

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	• It is likely to be challenging to deliver the exact level of spend in the year to match available resources. The current position for 2024/25 suggests little flexibility for new schemes. • Planning work is underway to review the capital programme and determine priorities for subsequent years. • The key risks were around deliverability, slippages, and financial sustainability. KD reflected that it would be good to have a portfolio of capital decisions made and the rationale for these. MH would provide this in preparation for the well-led review. The Board noted the update and delegated the final approval of the 2024/25 capital programme to the Finance and Performance Academy.	**Director of Finance Bo24008**
Supporting Reports		
Bo.3.24.12	**Integrated Dashboard** MP presented the integrated dashboard which provides a single view of quality and performance across the Trust for Board oversight and challenge. She advised that this would be refreshed to include updated metrics and targets and the revised version would be available for the next Board meeting. The Board was assured by the report.	
Bo.3.24.13	**Finance Report** MH noted the finance report which was taken as read. The Board was assured by the report.	
Bo.3.24.14	**Performance Report** SA noted the performance report which was taken as read. The Board was assured by the report.	
Section 4c: People		
Bo.3.24.15	**Report from the Chair of the People Academy (January & February 2024)** KW introduced the report. The following key items from the report were highlighted. • The Academy had noted that ZA had temporarily stepped into the role as maternity champion to fill the vacancy left by the departure of NED, Jon Prashar.	

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	• At the January meeting the Academy received an update on the Violence Prevention and Reduction Standard, which was introduced in 2021. The Trust is required to assess itself against the standard twice yearly. 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. • The Academy also received an update on the Workforce Civility programme at the January meeting. 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. • The Outstanding Theatres Programme has ended, but the team have devised a new 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 updated disciplinary policy and procedure was shared with the Academy in January which was also supported by Amandeep Singh (staff-side representative). The Academy approved the policy. • At the February meeting, RS challenged recruitment to the 16 bed Intensive Care Unit (ICU) where only 7 beds are currently open due to lack of staff. RS and KD are working together on addressing these issues. • The February meeting also included an update on Freedom to Speak Up (FTSU). 31 concerns were raised in Q3, the highest number since reporting began, which could be explained by the release of the Lucy Letby findings and October being Speak Up month. The National Guardian's Office (NGO) has 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 and KW advised that she had the privilege of representing the Trust in London on 4 March to share her experience of FTSU and the strength of the relationship with the Guardian. • There had been good news in relation to staffing, with average fill rates over the last 3 months having 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 Academy also received a thorough presentation on recruitment at the February meeting. Board was assured by the report.	
Bo.3.24.16	**EDI Strategy annual update / Equality, Diversity & Inclusion update (WRES, WDES)** KH joined the meeting to provide an annual update on the Trust's approach and progress to EDI, including our future direction, and progress on the EDI Strategy.	

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	KH summarised the approach to EDI in the Trust which included a dedicated and committed EDI team whose role is to facilitate and advance the EDI agenda Trust-wide, including the 5 key strategic objectives identified in our EDI Strategy. There is a strategic equality and diversity council, chaired by the CEO, which helps identify and align workforce and population health inequalities priorities. There is now a wider focus on inclusion and belonging, and an increased focus on engagement and involvement with both communities and workforce. There are regular equality impact assessments which identify impact on the nine protected groups. KH also highlighted the five EDI strategy and objectives for 2023-25: • 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. • Build community and staff trust and confidence through effective community engagement and involvement. • Tackle health inequalities and strengthen the system approach to population/place-based health and care management. • 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. • Develop and enhance our approach to recruitment, selection, and promotion to positively attract, retain and support the progression of diverse staff across the Trust. KH referred to the progress made by the EDI team over the last 12 months including continuing to ensure annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions with up to date action plans, the launch of the Trust's first EDI strategy, inclusion of EDI strategy discussions at Executive to CSU meetings, the launch of both the EDI and Workplace Civility training for managers, a review and refresh of the harassment and bullying policy, and the championing of the Health Inequalities agenda. KH highlighted a number of key achievements of the EDI team including: • Exceeding the 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" • 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 raising 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. • Establishing Support for Staff aligned to the Workplace Civility agenda	

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	KH advised that the Equality Delivery System for 2022 (EDS2022) was an accountability and improvement tool for NHS organisations and a contractual requirement. The Trust has received a rating of 'achieving' on the 11 outcome measures across three domains. KH referred to the NHS EDI Improvement plan and the high-impact actions to address the widely known intersectional impacts of discrimination and bias. This would be a key focus for the team over the next 12 months. KH reflected that there had been great progress over the last 12 months, with staff networks now thriving and influencing change at a strategic level. There is a clear focus on tackling health inequalities as an acute hospital and more clarity around role as an anchor organisation. These efforts are reflected in some of the external recognition received, but also in the latest staff survey results. Next steps for the EDI team included proactive work towards improving WRES and WDES performance, continuing to develop the approach to civility and respect in the workplace, a proactive focus on the national EDI plan and the six high impact actions, a renewed approach to 'Root Out Racism', a focus on cultural competence, improved staff experience and retention and a renewed effort to improve gender equality in the Trust. The team would continue to work with local partners and ensure the EDI agenda is aligned to local, regional, and national priorities, and it was hoped that an EDI conference would be held in late 2024 to showcase EDI across the district. SJ thanked KH for his energy and enthusiasm in raising and progressing the profile of the EDI agenda. SJ advised that she would check that EDI objectives are included in the Board objectives. MP referred to the 'Thrive' conference scheduled to take place in September which would focus on the theme of diversity. This may be a showcase opportunity as mentioned by KH. ZA queried if there was a local EDI plan similar to the national EDI plan, and KH confirmed that the EDI strategy objectives align with the national plan. KH further advised that the ICB are also developing an EDI strategy which will have clear alignment with the national plan. LB commented that EDI terminology always changing and contested and queried the difference in the bullying and harassment policy. KH reflected that bullying and harassment is negative language and confrontational hence the intention of shifting away from that to more positive words such as respect and resolution. LB also queried if staff would be confident in the escalation routes if people were feeling bullied or harassed. KH advised that the work around civility training is helping to support this, and the hope is that all staff will receive civility training in the next two years.	**Chair Bo24009**

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	The Board was assured by the update.	
Bo.3.24.17	**Staff survey results** FL introduced the presentation which provided an overview of the 2023 staff survey results. FL reminded colleagues that the staff survey was conducted during a time of pressure for the Trust during ongoing industrial action and at a time of negative media attention following the resignation of the former Chairman. He cautioned that it was important to consider this context when reviewing the results. FL highlighted that the results demonstrate the Trust is achieving above the national average on almost all metrics which was extremely positive particularly given the context previously mentioned. There are two areas lacking in comparison to the national average, around support for work/life balance and work pressures. In relation to WRES, there were two areas which have seen improvement compared to previous years, in relation to experience of bullying and harassment from staff and equal opportunities for career progression or promotion. The strong results reflected the ongoing culture work across the Trust, and SJ thanked FL for his leadership throughout this challenging period. KW highlighted increased year on year performance against all dimensions but recognised the need to continue to encourage staff to respond as the response rate is still low. As FTSU Champion, KW reflected there could still be a lack of confidence around people feeling that if they speak up, there will be a follow up process and so this still needed to be addressed. ZA noted that it is still worrying that twice as many ethnic minority staff experience discrimination in comparison to white staff and this still required significant focus. FL recognised this would be an area for improvement in the action plan which is scheduled to be presented to the People Academy for approval and shared with the Board for information. KW suggested that there be a breakdown of demographics of those who completed the survey. FL would look to obtain this information to share with colleagues alongside the action plan. The Board was assured by the report.	**Interim Director of HR Bo24010**
Bo.3.24.18	**Looking after our people** FL advised of a new initiative introduced for bank staff, whereby they can access 50% of bank shift pay immediately (InstantPay). This adds another financial product offer which would be welcomed in the current cost of living crisis.	

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	The Board noted the update.	
Section 4d: Quality and Patient Safety		
Bo.3.24.19	**Report from the Chair of the Quality and Patient Safety Academy (January & February 2024)** LB introduced the report and drew particular attention to the following items: • The pressures on Midwifery and Neonatal services in the last two weeks that have created further unit diverts. Staff feel 'burnt out' and report low morale. Similar pressures are being experienced nationally and a national maternity review has been recommended. • 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. • The Academy received the palliative care annual report and noted that 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. • In January there were 2 stillbirths. The Academy was advised that both were reviewed by an MDT(multi-disciplinary team). There was no learning identified which could have led to a different outcome in either case. • The Academy received the patient experience six-monthly report. A question was raised as to potential bias in groups being chosen for Patient Stories and the need for inclusive selection criteria. It was agreed that a review the SOP for patient stories would be undertaken along with an Equality Impact Assessment. • The Infection Prevention and Control (IPC) Quarterly report in January indicated that the Trust was compliant in 51 out of 54 standards of the IPC Board Assurance Framework and partially compliant for the remaining three. • Following the February meeting, the Academy wishes to alert the Board 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 from the Academy that it should remain at 16. If, following the reassessment, it is deemed to be rated 12, the Academy noted that it would not be included in future reports to Executives or Academies, as it would be managed locally.	

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	• A comprehensive presentation was received in relation to the NHS Trust Mortuary Independent Inquiry. The inspection undertaken by the Human Tissue Authority (HTA) in 2023 found that the Trust was meeting the majority of HTA standards, with two major and one minor shortfall regarding consent training and fridge capacity. Work is ongoing work to rectify the shortfalls. • A report was received on the latest round of ward visits for the '15 steps' assurance programme. The structure of each visit is aligned to the CQC standards and regulations. LB has put her name forward as a NED volunteer for the programme and encouraged other NEDs to do the same. MP referred to the 'Reach In, Reach Out' initiative being rolled out more widely across the organisation. She advised that she would be recommending that it uses the 15 steps approach to provide a structure to the programme. The Board was assured by the report.	
Bo.3.24.20	**Maternity and Neonatal Services Update** KD introduced SH, SW, and AA whom she had asked to join the meeting to provide an update on maternity and neonatal services. AA provided an overview of the report in relation to the Commissioning Quality Assurance Review visit to the Neonatal Unit. AA and colleagues met with various staff on the unit, and there was clear safety culture demonstrated with good response to incidents with clear processes to follow. The department also had processes in place to act on previous learning. The staff were enthusiastic about their care, and happy to share the good practice they were doing within the unit, such as induction programme for new staff joining the unit. The unit was clean, tidy, and welcoming, with clear evidence of complying with infection control procedures. Following the visit there were three areas for improvement, all of which the Trust were already addressing, these are: • 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. • It was acknowledged 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. It was recommended that the Consultant Neonatologist lead/Head of Department continue to attend the Executive Board to directly present a regular report on behalf of the department.	

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	SH gave a more detailed update on stillbirths, highlighting the reduction in the 2023 stillbirth rate to 27 from 32. National data collection is taken from Perinatal Mortality Review Tool (PMRT) who use date of birth as opposed to the date that the 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. MP referred to the outcomes of the Quality Improvement Group (QIG) as part of her Chief Executive Update earlier in the agenda and she thanked SW and SH for their commitment and support in attending these meetings and helping to assure the QIG. The Board was assured by the update and approved the recommendations as detailed in the paper.	
Section 4e: Audit & Assurance		
Bo.3.24.21	**Report from the Chair of the Audit Committee (February 2024)** BM introduced the report which was taken as read however he asked the Board to note the importance of following up on Internal Audit Recommendations. The Audit Committee had also discussed 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. BM advised that 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 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. The Board was assured by the report.	
Bo.3.24.22	**Report from the Chair of the Charitable Funds Committee (March 2024)** SJ introduced the report, which was taken as read, recognising the bulk of the meeting focused on the Bradford Hospitals Charity – Case for Change which would be discussed further by the Board as a separate agenda item. She also noted that the annual report and accounts were approved by the Committee and subsequently the Board in early January (via email). SA highlighted the Neonatal Unit (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	

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	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 Board was assured by the report.	
Section 5: Governance		
Bo.3.24.23	**Bradford Hospitals Charity – Case for Independence** SA introduced SM and MQ who had been invited to the meeting to present the Bradford Hospitals Charity – Case for Independence. The paper shared with colleagues puts forward an outline Business Case for the consideration to transfer Bradford Hospitals Charity from its current corporate trustee model to an Independent Charity, launching in April 2025. The case provided an in-depth overview of the risks and benefits of each option. The key non-financial benefits of independence were: • Autonomy: to focus solely on the needs of the beneficiaries and to be released from Department of Health oversight/authority • Governance: work to a legal framework aligned to the Charity Commission, supported by an independent Board of Trustees • Fundraising: access to a wider range of funding streams and fundraising activities. • Workforce: agile and fit for purpose for fundraising activities, not bound to Agenda for Change; market-aligned terms and conditions. • Agile and focussed: being released from the demands of hospital operations/performance provides the ability to adapt quickly to charitable needs. SM had worked with financial colleagues to draft up a base model financial summary and it was suggested that by 2025/26, moving to an independent model would begin to see a greater return on investment. If the Board were to approve the case for independence, the next steps would include development of a project plan with a timeframe of 9-12 months for transfer, commencement of the recruitment for Chair and Trustees, agree key objectives and principles with the Trust Executives, undertake all due diligence processes and hold monthly progress review meetings with key senior colleagues to assess progress and discuss any risks/concerns. The potential date for go live would be 1 April 2025. SJ has previously worked with an independent charity and could clearly see the difference it made. However, it was important to	

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	ensure continuous strategic alignment of the Trust and the Charity, and all would need to be committed to getting this right. FL queried how the Board would be assured of good governance around employment of staff should the move to independence be supported. SM confirmed there are external companies that can be used that can ensure the HR perspective is managed legally and appropriately and these would be used for recruitment purposes. There would also be an intent to have a trustee with a HR background on the Board for additional assurance. KD recognised the investments into long term investments and if this would transfer over if the Charity moved to independence. MQ confirmed investments could be transferred. ZA sought clarity on the number of independent charities already working in Trusts and SM advised that there were 30. Based on both the financial and non-financial benefits described above and the recognition of risks and commitment to their mitigation, the Board approved the conversion of Bradford Hospitals Charity to an independent charity.	
Bo.3.24.24	**Fit and Proper Person Test** LP introduced the paper which provided an update in relation to the Fit and Proper Person Framework and associated guidance which has been published recently. LP highlighted the 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 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. LP further highlighted that 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 Board is asked to note that NHSE plans to introduce many 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. The Board noted the update.	
Section 6: Board Meeting Outcomes		
Bo.3.24.25	**Any Other Business** No other business was discussed.	

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Bo.3.24.26	**Issues to Refer to Board Committees/Academies or Elsewhere** LP advised she would arrange the dedicated Board session on the financial plan to take place in April, and that the Operational and Financial Plan would be referred to the Finance and Performance Academy for approval on behalf of the Board.	**Associate Director of Corporate Governance / Board Secretary Bo24011**
Bo.3.24.27	**Review of Meeting** SJ welcomed any feedback from Board colleagues on the structure of the meeting including the agenda and the structure, and the ability to contribute.	
Bo.3.24.28	**Date and Time of Next Meeting** 9 May 2024 – 09:30am	

ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 14 March 2024

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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.
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. Update included on the May Board agenda under matters arising. Action completed.
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 April 2024 . This was discussed as proposed at the Academy. Action completed.
Bo24006	Bo.3.24.2	**Declarations of Interest:** It was agreed that future versions of the declarations of interest report would include highlights of any changes since the previous version.	Associate Director of Corporate Governance and Board Secretary	May 2024	Any changes will be highlighted on the register of interests. Action completed.
Bo24007	Bo.3.24.8	**Board Assurance Framework and High-Level Risks:** It was agreed that future iterations of the report would include a trend analysis of whether the number of risks past their review date had increased or decreased in comparison to the previous report.	Associate Director of Corporate Governance and Board Secretary	May 2024	Trend analysis added to the 'risks on a page' appendix. Action completed.

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo24008	Bo.3.24.11	**Capital Programme 2024/25:** KD reflected that it would be good to have a portfolio of capital decisions made and the rationale for these. MH would provide this in preparation for the well-led review.	Director of Finance	May 2024	Information provided as part of preparation for the well led review. Action completed.
Bo24009	Bo.3.24.16	**EDI Strategy annual update / Equality, Diversity & Inclusion update (WRES, WDES):** SJ would check that EDI objectives are included in the Board objectives and include these if not.	Chair	May 2024	NED objectives to be reviewed and agreed during May 2024.
Bo24011	Bo.3.24.26	**Issues to Refer to Board Committees/Academies or Elsewhere:** LP advised she would arrange the dedicated Board session on the financial plan to take place in April	Associate Director of Corporate Governance and Board Secretary	May 2024	Session took place on 18 April 2024. Action completed.
Bo24010	Bo.3.24.17	**Staff Survey Results:** FL would bring the action plan to the People Academy for approval and then share with the Board for information.	Chief People & Purpose Officer	July 2024	The draft Staff Survey Action Plan was presented and discussed at the People Academy on 24 April 2024 and wider engagement is in progress. To be presented to the Board in July 2024.
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	

BO.5.24.4 - MATTERS ARISING

PLANS TO IMPROVE THE DEPTH OF CODING

REFERENCES

Only PDFs are attached

Bo.5.24.4 - Plans to Improve Depth of Coding.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.4

Plans to Improve the Depth of Clinical Coding

Presented by	Paul Rice, Chief Digital & Information Officer	
Author	Nick Dodds, Operational Lead, Business Intelligence	
Lead Director	Paul Rice, Chief Digital & Information Officer	
Purpose of the paper	To update the Board on clinical coding discrepancies in HED	
Key control		
Action required	For assurance	
Previously discussed at/informed by	Executive Team Meeting 22.04.24	
Previously approved at:		**Date**

Key Options, Issues and Risks

Concerns were raised at the Foundation Trust Board meeting in November 2023 that the most recent update to the Healthcare Evaluation Data (HED) dashboard showed a low Average Depth of Coding metric for the organisation. HED allows Trusts to monitor the quality of care provided to patients. By analysing outcomes and comparing them against benchmarks and standards, Trusts can identify areas for improvement and implement measures to enhance patient safety and satisfaction.

Average Depth of Coding analyses the comorbidities and diagnoses of finished consultant episodes to review admission patterns and clinical coding quality compared to peers.

This reported figure was less than expected and placed the Foundation Trust second from bottom when ranked against peers on coding depth nationally.

Analysis

Upon review, it was identified the data presented on the HED dashboard in November does not reflect the Trusts actual position on Depth of Coding, particularly in relation to the Summary Hospital-level Mortality Indicator (SHMI).

A notable discrepancy was identified with the presence of an unexpected diagnosis code, R69.X – Unknown and unspecified causes of morbidity. This code, which diverges from our established coding norms, signifies nonspecific 'illness' exclusively and is discouraged when more detailed information is available.

Further investigation noted that this code, R69.X, has not been appropriately used in primary diagnosis fields between the specified dates, indicating its erroneous inclusion. Discussions with HED revealed that R69.X is automatically assigned as a filler code for data cleansing purposes, triggered by incomplete or blank diagnosis fields.

As part of updating the Admitted Patient Care (APC) Commissioning Dataset (CDS) from v6.2 to v6.3 in June/July 2023 there were data processing issues which had not been escalated. This resulted in some records not being updating with clinical coding hence the application of R69.X. The Data Warehouse team have provided assurance that this issue was resolved shortly after it was identified, and any affected data was resubmitted in December 2023. Checks have been introduced to prevent re-occurrence of this issue going forward.

This unanticipated application of R69.X mis-represented the depth of coding metric and consequently influenced SHMI and Charleson Co-Morbidity Index scores. HED have confirmed that resubmitted data will be refreshed into HED as part of normal data refreshes.

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Those that have already occurred show depth of coding more reflective of our clinical coding practice (increase to 5.12 from 1.2) and benchmark more consistently against peers and national expectations re good practice.

[It is important to note SHMI is not merely a metric; it reflects our commitment to patient care and safety. Over-coding, as highlighted in NHS data, can skew SHMI values and compromise the integrity of our healthcare standards. However, our recent Data Security and Protection Toolkit (DSPT) audit has demonstrated that our coding team maintains a commendable balance, neither over-coding nor under-coding to a concerning extent.]

To mitigate issues such as this arising in future we have taken proactive measures to empower team members with HED access and dedicating monthly analysis sessions to discuss coding-related metrics, both of which are yielding positive outcomes and driving improvements in our data related to SHMI. This is most evident in Charlson comorbidity coding and the accurate capture of palliative care, with the implementation of comprehensive internal guidance on Charleson comorbidity coding and the implementation of local policy for accurate capture of Palliative care intervention. (see Appendix One)

Another issue negatively impacting our SHMI score in relation to clinical coding is the number of finished consultant episodes (FCE's) generated in our EPR. Current configuration means a new FCE is generated each time a consultant transfer takes place. A new FCE should only be generated when there is a change in service/speciality, SHMI methodology will only interrogate diagnoses on the first two FCE's of a completed hospital stay, initially the first, and if this does not contain a definitive diagnosis (for example, a symptom code), will move to the second. The number of FCE's currently being recorded means that a definitive diagnosis is not given in many instances until the third FCE or later during treatment. Consequently, we find that patients are allocated to inappropriate comparator clusters for benchmarking purposes and that this negatively impact the Trusts SHMI score. For example, a patient may be admitted as 'off legs.' In the third FCE cycle their definitive diagnosis could be that a stroke event has occurred. Where the patient to die, based on the first two recorded FCEs, this death would be recorded as a consequence of 'connective tissue diseases.' This would be highlighted as an unexpected death. This is clearly an error, with significant consequences in terms of our external reporting metrics.

As the causal factors here are multifarious, we are tackling the issue going forward within the scope of a wider EPR Optimisation programme. This initiative will require the participation of colleagues working on quality improvement, EPR training, clinical coding, data quality, and wider Ops. In the interim we continue, with the help and support of colleagues such as Dr Mike McCoo, Clinical Director at the Improvement Academy in BIHR, and the wider learning from deaths programme to articulate the ways in which, recognising the inferences that could be mistakenly drawn from SHMI metrics, patient safety and quality care delivery are paramount.

Recommendations

- Continue to monitor HED data from a perspective of accurate representation of coded data. Any data quality issues with future SUS submissions will be flagged with KPI's comparing SUS+ data with EPR extracts. Discrepancies will be rectified with resubmission as necessary.
- To reduce the number of unnecessary slices (FCE's) generated within EPR the rule setting in the encounter slice builder will be changed to only trigger a new slice when the service, rather than when the clinician, changes.
- Continue to work closely with Clinical/Quality colleagues to improve accuracy of coding relevant to SHMI through better documentation and performance management of adherence to the rules.
- Develop, consult upon, and resource a comprehensive EPR Optimisation Programme, with multi-disciplinary input and leadership from across the Trust. Its focus will be on ensuring the digital transformation tools at our disposal are used to best effect consistently.

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This activity will be positively reflected in our data, intelligence and insight informed activities within, and communications outside, the organisation.

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Appendix One – Palliative Care Local Policy

Bradford Teaching Hospitals Foundation Trust

Local Policy

ICD-10

Any input from specialist palliative care team including advice, irrespective of if it is in person or via phone, including use of the REACT template (A&E) and Last Days of Life document with specialist palliative care team review, **will be coded as Z51.5.**

Please ensure Z51.5 is coded following the condition leading to specialist palliative care, or within the first 15 diagnoses.

Please read the documentation carefully – for those documented to be "inappropriate referrals" or "service not required", Z51.5 should not be coded.

In cases when patients are discharged from specialist palliative care service but remain an inpatient and are then transferred (new slice), **they will be coded to Z51.8 on the new slice.**

A Last Days of Life document without specialist palliative care team review, or documentation of "Goldline," "fast track discharge," "F/T discharge" or "meets fast track criteria," **will be coded to Z51.8.**

For patients that are admitted and documentation states that the patient is "known to Goldline"/"eligible for fast track"/"on a fast track" etc, or if a Patient is documented as being "palliative" without specialist palliative care team involvement, **Z51.8 will be coded in a secondary diagnosis position.**

Signed

Consultant Anaesthetics/ICM

Nick Dodds Clinical Coding Manager

Victoria Ali Lead Nurse for Palliative Care

Date: 27/03/2024

BO.5.24.5 - PATIENT STORY

REFERENCES

Only PDFs are attached

Bo.5.24.5 - Patient story (video link).pdf

Find below the new link for the updated patient story – Rebecca Latz May 24

https://vimeo.com/941611934/b153d52185?share=copy

BO.5.24.6 - REPORT FROM THE CHAIR OF THE QUALITY & PATIENT SAFETY ACADEMY

MARCH & APRIL 2024

REFERENCES

Only PDFs are attached

Bo.5.24.6 - Report from the Chair of the Quality and Patient Safety Academy - March 2024.pdf

Bo.5.24.6 - Report from the Chair of the Quality & Patient Safety Academy - April 2024.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.6

Committee/Academy Escalation and Assurance Report (AAA)

Report from the Quality and Patient Safety Academy (QPSA)

Date of meeting: 27 March 2024

Key escalation and discussion points from the meeting
Alert:
Nothing to escalate to the Board.
Advise:
1. Achieving safe staffing levels in Maternity services remains a challenge. The current vacancy against the safe staffing establishment is 7.04 WTE, the majority within the Labour Ward establishment. Combined with vacancies and long-term sickness within the Maternity Theatre Scrub Team, is compromising safe staffing levels, as midwifery staff are required to provide emergency scrub cover. In addition, any short-term sickness and absence not picked up by bank, is backfilled by labour ward to maintain minimum safe staffing levels. The service experiences staffing pressure on a regular basis. A contributory factor is that 125 midwifery shifts per month are required for mandatory training, in line with the 3-year plan. This will be discussed at the March Bi-monthly Maternity and Neonatal Safety Champion meeting and any recommendations/escalations provided to the April QPSA. The Board will remain updated via the QPSA Chair. 2. There is an ongoing Pharmacy cover shortage for Maternity & Neonatal Services and no designated Pharmacist (although some cross cover). The longstanding Senior Pharmacist in neonatal has left the Trust. There have been several medication incidents recently, which may be related. A deep dive will now take place addressing the medication incidents and an update provided at April's Academy meeting. This has been logged as an Action for the QPSA.
Assure:
The Trust is in a period of transition from the national Serious Incident (SI) Framework (2015) to the national Patient Safety Incident Response Framework (PSIRF, 2022) which formally began on 1st December 2023. There are a total of 10 investigations on-going, 5 are Trust Legacy serious incidents, 2 are Healthcare Safety Investigation Branch (HSIB)/ Maternity and Newborn Safety Investigations (MNSI) and there are 3 newly reported Trust Patient Safety Incident Investigations (PSII). <u>Legacy Serious Incidents</u> The final legacy SI was recorded on 29/11/23. The target date for completion of all SIs was 21/2/24. All investigations have taken place but target not met in terms of writing up SIs and associated action plans, due to availability of clinical staff (Industrial action,

winter pressures). Two SIs were closed during the reporting period. 5 legacy SI investigations remain with approved extensions in place beyond the 60-day deadline.

Patient Safety Incident Investigations (PSII)
It was confirmed that the number of PSIIs reported through the new system is within normal variation, providing assurance that patient safety incidents continue to be recorded appropriately. A Never Event (radiology wrong site kidney biopsy) was turned around very quickly using the new After Action Review process. Five learning points were identified and this PSII was closed in the period. This was used as an example of how PSIRF is providing benefits in approach.

The Patient Safety specialist updated the Academy on the implementation of PSIRF, linkage with Improvement Programmes such as the Medicines Safety programme, progress on developing evaluation metrics for PSIRF, the need to develop and recruit to the Patient Safety Partner role and actions to address.

The Academy noted the current position and confirmed they feel assured that the Trust has processes in place to identify, investigate and learn from serious incidents and patient safety incident investigations.

Maternity and neonatal services

From the report the Academy noted the position for February
- 2 stillbirths (1 butterfly baby)
- 0 neonatal deaths
- 0 maternal deaths
- 2 cases of HEI (Hypoxic-ischemic Encephalopathy)
- 0 new neonatal SIs
- 0 ongoing neonatal SIs.
- 6 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level
- 1 MNSI reportable case and 0 reportable Serious Incidents (SI) declared
- 3 occasions in the period where the unit was assessed as needing to divert women to other organisations.

These numbers are within normal monthly figure.

1 HSIB/MNSI investigation is beyond the 120-day deadline Extensions to the original deadline under the SI Framework continue to be agreed by Bradford District and Craven Health and Care Partnership

Visiting times were increased significantly during the Ramadan/Eid period. This is having a positive outcome and consideration is being made to making the Ramadan/Eid changes permanent.

The annual Maternity CQC Survey results were made available to the Academy. There were 5 questions where BTHFT performed below average and five above average. The 36% response rate was a 5% improvement on 2022: 59% of women responding were

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Asian or Asian British. The 5 worse performing responses have formed the basis of the co-produced improvement plan.

The final NHSE report in relation to Neonatal Incident Timelines was noted. It provides good assurance that the Board were aware of all incidents within 10-14 days of occurrence.

The Academy confirmed they feel assured they have sufficient information and oversight on maternity and neonatal safety.

Zafir Ali will be the Interim NED Perinatal Safety Champion until further notice.

Acute Liaison Psychiatry Service (ALPS)

ALPS presented their Healthy Minds strategy and the challenges of meeting the Core 24 requirement for 24-hour emergency psychiatry cover. The Liaison model at Bradford is a consultant led fully compliant Core 24 service, but challenges delivering cover to all sites and patient groups. The reduction in 2023 performance from 2022 was raised (% referrals seen within one hour and four hours has reduced). ALPS believe this is due to colleagues being more aware of the service, which has increased referrals. Ways to improve performance are being discussed at the Urgent and Emergency Care Board

High Level Risks

No new risks have been added and no risk scores have reduced in the period. It was proposed that risk 3810 (haematology) be reduced from a score of 16 to a 12, however the Executive Team did not accept the reduction pending further improvements in outcomes. The improvement work and action plans were noted. It was noted 2 risks: age and condition of the Pharmacy aseptic unit and inadequate accommodation in Pharmacy, were beyond their review dates. No significant changes in relation to the risks were noted, and the review dates would be updated as soon as possible. Continued focus on these risks remains within the QPSA remit.

A new risk will be added to the Risk Register in relation to patient experience in the Emergency Department. While our performance against the 4-hour target is very good patient experience is less positive, especially for those waiting for a bed. In some instances, there has been a need to transfer mental health patients out of region.

On 18th March 2024, the ETM reviewed risk 3468, relating to the EPR system, and agreed that this risk would be reviewed and rescored. A new risk assessment will be undertaken in relation to the accuracy of clinical systems.

The Academy reported they were assured by the management of risks within their remit on the High-Level Risk Register and noted the matters raised by the Executive Team at its meeting in March.

Draft Internal Audit Plan 2024/25

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Academy were asked to note the draft Audit Plan and confirm that the draft Plan includes the appropriate audits. The Plan is intended to be flexible to allow changes to be made throughout the year, and these are transacted via the Audit Committee.

The Academy provided their assurance regarding the draft Internal Audit Plan.

Report completed by:

Louise Bryant
Academy Co-Chair and Non-Executive Director

18 April 2024

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.6

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Q&PS Academy

Date of meeting: Wednesday 24th April 2024

Key escalation and discussion points from the meeting
Alert:
The Academy did not identify any items to escalate to the Board.
Advise:
1. The Quality and Patient Safety dashboard is being redesigned and the full dashboard was not available prior to the meeting. The Academy were however of the view that the partial presentation suggested the new dashboard would offer improved insight and be better able to support the work of the Academy. It was accepted there was a gap in assurance due to the reduced data available at the meeting. The Execs were therefore asked to advise of any significant changes in data in the reporting period that needed further discussion. The Academy were assured that no such changes had occurred. 2. In the Academy report for March, the Board were advised of possible medication incidents in Maternity and Neonatal services. This issue has been investigated by the matron for Neonatal Services and no incidents have occurred. The action is therefore closed. 3. High level risk register: Risk 607 (risk of harm to patients and the organisation from delays in processing histopathology samples, with potential of having an impact on delayed diagnosis and pathways) has increased in score from 16 to 20. A Histopathology improvement programme has started, with the CMO as Lead Director. The programme aims to deliver sustainable improvement over time due to the multiple factors (external & internal) impacting on the service including the difficulties of recruiting amid a national shortage of histopathologists.
Assure:

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The Quality & Patient Safety Academy Annual Report 2023/24 was signed off by those present as accurately reflecting the Academy's business over the past 12 months.

High level risks

Two new risks have been added.

- 2549: A risk that the current NSO (non-surgical oncology) workforce within BTHFT and WYAAT cannot continue to support the model of care within the region, which will delay cancer treatment causing harm to patients (Score 16, also with the People Academy
- 2566: Delayed discharges to Adult Social Care (Score 16, also with F&P Academy)

448: 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 has been closed as the risk no longer reflects the current context (note Digital Report in Assure section). A new risk assessment to be completed (also with F&P Academy)

Three risks have changed, only one specific to the QPSA as highlighted in the Advise section (607 Histopathology).

The Academy confirmed there was sufficient assurance that all relevant key risks have been identified, reported to the Academy and are being managed appropriately.

Quality Oversight and Assurance Profile
Serious Incident Report (PSII and Legacy SIs)

Three safety events have been reported to the Safety Escalation Group this month.
- Several glaucoma patients lost to follow-up.
- Use of single-use/single-patient insulin pens on multiple patients
- The ongoing review of a Colorectal cancer patient follow-up following SI.

Updates on external reporting were provided and learning from an internal MNSI reported. Details of claims and inquests were included in the monthly report.

There are a total of 8 on-going investigations: 4 are legacy Serious Incident, 2 HSIB/MNSI investigations, and 2 Trust PSIIs (under PSIRF (Patient Safety Incident Response Framework)). All 4 legacy Trust serious incident investigations have approved extensions in place beyond the 60-day deadline. Both HSIB/MNSI investigations are beyond the 120-day deadline with extensions agreed by Bradford District and Craven Health and Care Partnership.

No Never Events have been identified during the reporting period. Two patient safety investigations were concluded in this period.

The Academy confirmed that there is sufficient assurance that BTHFT has processes in

place to identify, investigate, and learn from patient safety investigations.

Maternity and neonatal services

From the report the Academy noted the position for March 2024

- 0 stillbirths
- 0 cases of HEI (Hypoxic-ischemic Encephalopathy)
- 2 neonatal deaths (1 associated with congenital abnormality, 1 extreme prematurity)
- 1 late maternal death (7 months post-partum, case not yet reviewed)
- 0 new neonatal SIs or ongoing neonatal SIs.
- 6 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level (same as for February 2024, 0 completed investigations this month)
- 0 MNSI reportable case and 0 reportable Serious Incidents (SI) declared.
- There was 1 occasion in the period (66 hours) where the unit was assessed as needing to divert women to other organisations: 2 women were diverted.

- Safe staffing in Maternity stays a priority:
  - Staffing gaps are closely monitored using the amber risk assessment and escalation processes as needed. A daily system-wide safety huddle is in place to assess the need for mutual aid and support across the 6 West Yorkshire and Harrogate Local Maternity and Neonatal System.
  - 1:1 care in labour continues to be just below the locally accepted 90% mark.
  - There are significant areas of extra strain on the obstetric consultant body summarised on the local risk register with mitigation activities in place.
  - Two positive open days for newly qualified midwives in March were reported.

- Neonatal staffing:
  - Junior medical staffing a challenge due to various rota gaps with plans to employ more trust grade doctors.
  - Update on nursing staffing including specialist training completion, a good level of promotions including 3 BAME colleagues appointed to senior positions.

The Perinatal Mortality Review Tool Quarterly report confirms that the required standard with Safety Action 1 of the MIS has either been met or is on a trajectory to meet the standard in the timeframes required. An action plan related to learning and improvement (improved recording of previous pregnancies at booking, and lack of carbon monoxide screening) is with relevant teams.

It was noted that the number of homebirths has declined significantly since Covid and there are plans to promote to appropriate women.

The Academy noted the reports and confirmed that they were receiving information related to perinatal quality and safety issues and associated learning and improvement activity in good time to provide assurance.

Digital Report

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Date	9 May 2024	Agenda item	Bo.5.24.6

The Academy noted the report provided to offer oversight and assurance on the Informatics function as discussed at the Digital and Data Transformation Committee (DDTC), and to provide broader digital updates.

An update on in-depth work to understand the Trust's SHMI data (second 'worst' nationally) was provided. SHMI data is at odds with our standardised mortality ratio analysis and wider assurance and improvement activities as part of the learning from deaths programme, which confirms a high quality of care is provided.

Issues associated with accuracy, depth and consistency of coding have been found. SHMI data are showing signs of improvement, but it will be some months before changes in the rolling figures become evident. These data continue to be reported to the Academy as part of the standard dashboard, enabling oversight. An update on EPR optimisation work was provided along with information on an enhanced governance and assurance model.

The Academy confirmed they were assured by the Digital report in terms of the investigation around SHMI data and ongoing work to continue improvement in the digital performance of the Trust.

The Academy recognised the significant work of the Digital team and thanked them.

The Chair noted the documents for information appended to the Academy papers and drew attention to the Internal Audit Reports relevant to the Academy.

Report completed by:

Louise Bryant
Academy Chair and Non-Executive Director

29 April 2024

GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT

REFERENCES

Only PDFs are attached

Bo.5.24.6 - Guardian of Safe Working Hours Quarterly Report.pdf

Meeting Title	People Academy		
Date	24th April 2024	Agenda item	PA.4.24.12

GUARDIAN OF SAFE WORKING HOURS DOCTORS AND DENTISTS IN TRAINING QUARTER 4 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 assurance	
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 Jan – 31 March 2024.

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 4 there were 41 exception reports. All of these were related to hours/working patterns. In addition, 2 reports were flagged as an immediate safety concern.

In total, 41.75 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 JDF.

The highest number of additional hours claimed this quarter was from Foundation doctors in General Medicine.

2 of the 41 reports were flagged as an immediate safety concern. These were from Foundation doctors on General Medicine.

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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: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS Improvement Effective Use of Resources: Choose an item.
Other (please state):

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

QUARTER 4

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 Jan – 31 March 2024. 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 41.75 additional hours claimed this quarter. The highest number of hours came from General Medical Foundation doctors mostly due to busy on-calls and reduced staffing. The next highest hours came from General Surgical Foundation doctors quoting similar reasons.

There were 2 immediate safety concerns this quarter. Both came from the same foundation trainee in Medicine/Care of the Elderly. These were both due to staying late whilst looking after unwell patients.

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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 Jan – 31 March 2024.

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 4 there were 41 exception reports. All 41 were related to hours/working patterns. This is 35% increase in reports compared with Quarter 3. 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. Both reports came from a Foundation trainee on Medicine / Care of the Elderly who had to work late on their ward due to staying to look after a sick patient with no one to hand over to (at St Luke's).

The highest number of additional hours was from Foundation doctors on General Medicine. 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 General Surgical Foundation doctors stating similar reasons to their medical colleagues. The other trainees claiming additional hours came from OMFS, Obstetrics and Gynaecology, ENT and Orthopaedics.

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 January – March 2024.

Exceptions by Speciality	Hours/work pattern	Educational	Service support	Patient safety
General Medicine	14	0	0	2
O+G	9	0	0	0
General Surgery	7	0	0	0
OMFS	6	0	0	0
ENT	4	0	0	0

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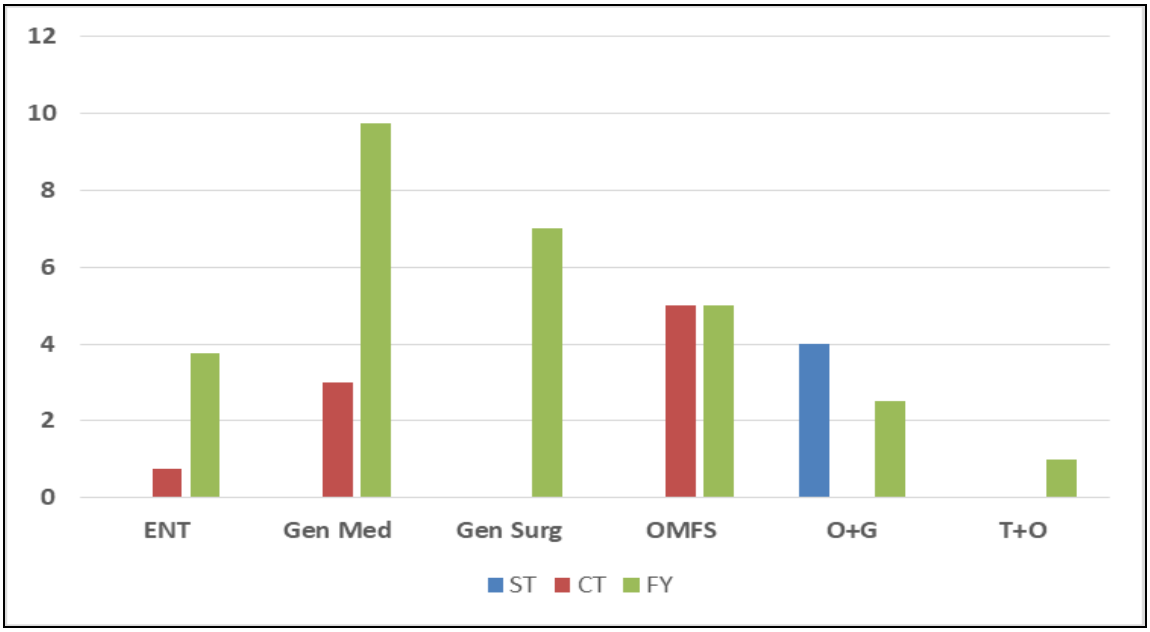
Fig 1: Exception reports (hours) by specialty and training grade January – March 2024

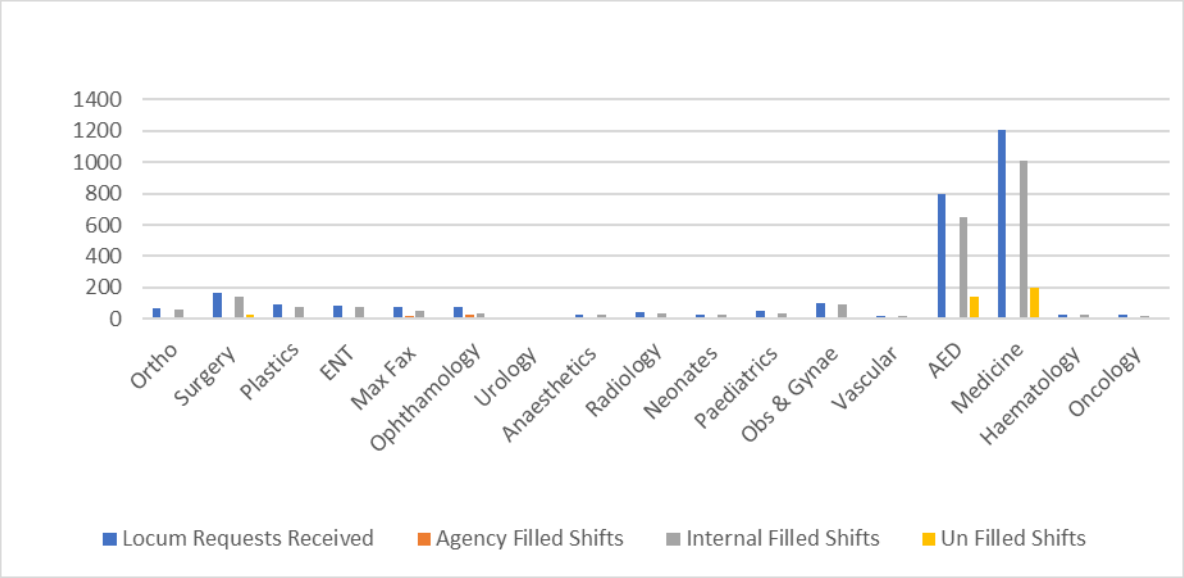


Work schedule reviews
Every trainee agrees a work schedule with their educational supervisor. A work schedule review takes place when changes are needed to ensure safe working hours or to provide better training opportunities. There were no work schedule reviews this quarter.

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 2887 requests which is an increase of 54% on the previous quarter. 15% of the shifts remained unfilled compared with 8% in quarter 3. 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 January – March 2024



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 both General Medicine and General Surgery. The most common reason was staying late due to busy shifts and reducing staffing. There were 2 patient safety reports from one Foundation trainee who stayed late on 2 occasions due to looking after unwell patients. The introduction of the hospital at night team should relieve some of the workload of the Foundation trainees in particular.

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 41 exception reports in Quarter 4 compared with 31 in Quarter 3.
- The highest reporting group of doctors were Foundation doctors from General Medicine. This was mostly due to staying late after busy shifts. There were only 2 immediate safety concerns and they have been reviewed.

Meeting Title	People Academy		
Date	24th April 2024	Agenda item	PA.4.24.12

- The highest amount of overtime is from General Medicine Foundation trainees at 9.75 hours.

- There was a 54% increase in locum requests this quarter with around 15% 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.5.24.7- MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

Only PDFs are attached

- Bo.5.24.7 - Maternity and Neonatal Service May (presentation).pdf
- Bo.5.24.7 - Maternity and Neonatal Services FebMar2024 (cover).pdf
- Bo.5.24.7 - App1.MatandNeoServicesUpdate.(PERINATAL).February2024.pdf
- Bo.5.24.7 - App2. MatandNeoServiceUpdate.(PERINATAL)March2024.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors
May 2024

Maternity and Neonatal Update
February and March 2024

Sara Hollins, Director of Midwifery

Together, putting patients first

Highlights February and March

Bradford Teaching Hospitals
NHS Foundation Trust

- The February and March perinatal update papers were presented to March and April 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 were shared and are also available to Trust Closed Board for information
- April Academy received the Internal Audit report of the Maternity CQC Improvement Plan with Significant Assurance
- April Academy received the quarterly PMRT report and actions, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme

Discussion Points

Bradford Teaching Hospitals NHS Foundation Trust

- **Perinatal Mortality Review Tool Quarterly Report**
  - Required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme
  - Report demonstrates that the service has either met or is on trajectory to meet the required standard within the required time frame
  - The report includes the review of deaths from 8 December 2023 to 31 March 2024, meaning that there has been no break in reporting between Year 5 submission and the commencement of reporting compliance for the Year 6 scheme
  - The report also includes a number of improvement actions identified from the reviews. To note that none of the concerns contributed to the outcome for the baby but are required to improve antenatal care:
  - Improved documentation of previous pregnancies and risk factors at booking to ensure women are on the correct pathway
  - Lack of carbon monoxide screening due to faulty equipment- improved documentation and flagging of the need to repeat at the next appointment

Discussion Points

Bradford Teaching Hospitals NHS Foundation Trust

- **Internal Audit of the Maternity CQC Improvement Plan**
  - **Significant Assurance received**
  - **There was a minor recommendation regarding the extension of completion dates, particularly around actions which are complete but require ongoing monitoring, and for actions where closure depends on completion of building work or recruitment.**
  - **The service believes that extending the dates was entirely appropriate, and internal audit acknowledged that regular review of the plan and board reporting could be evidenced.**

Questions?

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.7

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – FEBRUARY AND MARCH 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	March and April 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.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.7

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 February and March 2024 activity, was presented and key elements discussed including:

- The number of harms occurring in February and March, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of MNSI and SI cases were discussed.
- There were no completed MNSI and internal investigations/SI reports in February or March.
- March QPSA received the results of the 2023 CQC National Maternity Survey and the subsequent co-produced action plan.
- April QPSA was provided with a copy of the Maternity CQC improvement plan, Internal Audit report, which was rated as significant assurance.
- April QPSA approved the Quarterly PMRT report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme.
- The report presented to April QPSA included that the Perinatal Leadership Quad joined the March bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.

Recommendation

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the February and March Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.7

- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in February and March 2023/24 and both newly reported and ongoing investigations.
- Trust Board is asked to note the rating of 'significant assurance' following the internal audit review of the Maternity CQC Improvement Plan.
- 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.
- Trust Board is asked to note that the contents of the February update paper have been discussed at the April Perinatal Oversight Group, attended by representatives from the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board. The March update paper will be presented and discussed in May.

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?	☒	☐	☐

Meeting Title	Board of Directors		
Date	9 May 2024	**Agenda item**	**Bo.5.24.7**

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	9 May 2024	Agenda item	Bo.5.24.7

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.

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 February and March 2024 (Appendices 1 and 2):

The February and March updates and associated appendices were respectively discussed at the March and April QPSA.

The key elements of the papers discussed included:

- The number of harms occurring in February and March, 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 0 completed Internal/MNSI reports to share for February and March.
- March QPSA was informed of the impact of the increase to midwifery mandatory training requirements on midwifery staffing. To meet mandatary maternity training requirements as nationally recommended, 125 midwifery shifts are required every month which contributes to clinical shift shortfalls. This issue will be discussed in more detail with the Chief Nurse at the next Bi-Monthly perinatal safety champion meeting.
- March QPSA noted the appointment of Zafir Ali, as the interim Non-executive Director Perinatal Safety Champion. The Perinatal Safety Champions welcomed Zafir to the group at the March bi-monthly meeting, and Zafir has undertaken an introductory walk round the Women's and Newborn unit.
- Results of the 2023 National CQC Maternity Survey and the action plan co-produced with the Maternity and Neonatal Voices Partnership (MNVP) were shared with March Academy. Academy was informed of the slight improvement in response rate and that overall, the service is comparable with other maternity service providers. There were 5 questions where the Trust performed better than the national average, including signposting regarding mental health changes in the postnatal period and antenatal information regarding how to feed their baby. The key focus of the co-produced action plan is around the 5 questions scoring below the national average, including appropriate advice provided at the start of labour and not being asked about mental health during antenatal appointments. Progress with the action plan is monitored at Perinatal Services Forum, which is attended by the MNVP leads.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.7

- April QPSA received the final Internal Audit report of the Maternity CQC Improvement Plan, which was rated as providing 'significant assurance'. There was a minor recommendation regarding the extension of completion dates, particularly around actions which are complete but require ongoing monitoring, and for actions where closure depends on completion of building work or recruitment. The service believes that extending the dates was entirely appropriate, and internal audit acknowledged that regular review of the plan and board reporting could be evidenced.
- April QPSA reviewed and approved the Quarterly PMRT report and actions required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme.
- April QPSA was asked to note that the Perinatal Leadership Quad joined the March bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- March and April 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 February and March 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 February and March 2023/24 and both newly reported and ongoing investigations.
- Trust Board is asked to note the rating of 'significant assurance' following the internal audit review of the Maternity CQC Improvement Plan.
- 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.
- Trust Board is asked to note that the contents of the February update paper have been discussed at the April Perinatal Oversight Group, attended by representatives from the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board. The March update paper will be presented and discussed in May.

4 Appendices

- Appendix 1 - Maternity and Neonatal Services Update Paper, February 2024
- Appendix 2 - Maternity and Neonatal Services Update Paper, March 2024.
- Appendix 3 - Closed Board Harms February.
- Appendix 4 - Closed Board Harms March 2024.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	27.03.24	Agenda item	QA.3.24.8

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE FEBRUARY 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.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	27.03.24	**Agenda item**	QA.3.24.8

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)		
Date	27.03.24	**Agenda item**	QA.3.24.8

Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, February 2024.
- Academy is informed that to meet mandatary maternity training requirements, 125 midwifery shifts are required every month which contributes to clinical shift shortfalls. This will be discussed in detail at the March Safety Champion meeting.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 2, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that there were 2 cases of HIE reported in February.
- There were 0 neonatal deaths in February.
- There were 0 maternal deaths in February.
- There are 6 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 0 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for February.
- Quality and Patient Safety Academy is asked to note that there was 1 MNSI reportable case and 0 reportable Serious Incidents (SI) declared in February.
- Academy to note that there were 3 occasions in February 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.
- To note that Zafir Ali, will be the Interim Non-Executive Director (NED) Perinatal Safety Champion until further notice.
- Academy is asked to note Appendix 5, results of the 2023 Maternity CQC Survey, the associated headline narrative, and that a draft improvement plan has been co-produced with the Maternity and Neonatal Voices Partnership Leads.

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	

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	27.03.24	**Agenda item**	QA.3.24.8

The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**	**Moderate**	**High**	**Significant**
	Risk (*)			
Explanation of variance from Board of Directors Agreed General risk appetite (G)				

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

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

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

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

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	27.03.24	Agenda item	QA.3.24.8

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

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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 initial pilot was sent to 20 women with 45% commencing the PCP and 30% completing it.
The next steps are:

- To understand why women did not start/complete.
- To amend the form based on feedback received.
- Pilot 2 to be sent to >300 women.

East Kent Report/Three Year Delivery Plan for Maternity and Neonatal Services:

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

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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.

The plan was updated in January and is provided as appendix 1 for information. Some areas are complete and are 'business as usual'. Progress is described for other areas which are identified as being in progress. There are no 'red' areas requiring escalation and overall the plan is on track.

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.

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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,

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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 7.04 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. A contributory factor to the ongoing fill rate gaps is that 125 midwifery shifts per month are required for mandatary training, in line with the 3 year plan. This will be discussed in more detail at the March Bi-monthly Maternity and Neonatal Safety Champion meeting and any recommendations/escalations will be provided in the subsequent QPSA report in April.

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 32.46 WTE.

Maternity leave is currently 13.26 WTE.

Open days for newly qualified midwives are planned for March, prior to centralised recruitment starting in May.

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.

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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 Obstetrics 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.

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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.

Neonatal Staffing

Medical:

Consultant starting in April which should result in a full complement.
Junior – A number of gaps on the new rotation from March. Have appointed 2 x Clinical fellows on Tier 1 and 1 x Tier 2. Some upcoming Maternity cover needed and the service is looking to see if a further fellow can be recruited to Tier 2.

AHPs – Ongoing Pharmacy cover shortage. No SATO and no designated Pharmacist (although some cross cover). There have been a number of medication incidents recently, which may be related, so this area does need to be addressed.

Otherwise, the general AHP position is good.

Nursing:

Nurse staffing continues to improve and staff turnover remains strong. No recent leavers.

Current band 5 vacancy = 10.03 WTE 4.84 of these are recruited and awaiting start dates.
This leaves 5.19 WTE with interviews pending. By September we will subsequently be fully recruited.

An Executive team meeting (ETM) paper has been submitted to request over recruitment.

Confident that vacancy will be filled with newly qualified nurses in October due to the number expected to qualify and apply

Governance Nurse appointed-starts in April.

2 WTE band 6 vacancies due to promotion.

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-

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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 February and shared at the February Women's CSU Core Governance meeting.

Progress continues on target and includes the positive outcome of a business case for the uplift in medical staffing to achieve the 'must do' action regarding medical staffing in MAC which was approved and staff have now been appointed and will commence in July and September.
The improvement plan is currently subject to internal audit review and the outcome will be shared in next month's paper.

Stillbirth Position

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

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
February	2	6	1	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 2 babies diagnosed with HIE in February, details in Appendix 3.

- 1 baby born with congenital abnormalities and a poor prognosis. This case does not meet MNSI criteria but has been accepted due to parental concerns.
- 1 baby born by elective caesarean section in unexpected poor condition. This case does not meet MNSI criteria as mum was not in labour, and will be reviewed through the ATAIN and Maternity Safety Investigation Response Framework (MSIRF)

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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 February (HIE baby as described), and 0 internal SIs.

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

There are 6 ongoing maternity PSIIs/Level 1 investigations, 3 MNSI and 3 Trust level.

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

Neonatal Deaths (NND)

There were 0 neonatal deaths in February.

Please see Table 2:

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)
February	0	2	0	0

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Maternal Deaths

There were 0 maternal deaths in February.

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 February based on family concerns.

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 February.

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 did not meet in February and are next due to meet in March. No safety escalations were received outside of the bi-monthly meetings.

An interim Non-Executive Director, Zafir Ali, has kindly agreed to undertake the role of NED Perinatal Safety Champion until further notice.

Monthly staff feedback from Safety Champions and walk-rounds

Judith Connor, Associate Director of Quality Governance, chaired the February Ward to Board Safety Champion meeting. The group discussed the ongoing challenges with the issue of car parking permits, which was escalated to People Academy.

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Quality and Safety Lead midwife updated that the inconsistencies regarding guidance on the management of babies of Group B Strep positive mother's, has been resolved.

Maternity Unit Diverts

There were 3 partial/attempted units diverts/escalations in February recorded on the closure log.

1 woman was diverted to a neighbouring organisation for care during 1 attempted divert, but system wide pressures prevented any further mutual aid on that occasion.

2 other 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)
FEBRUARY	0	1(then attempted)	2	1
Total	0	4	7	4

Midwifery Continuity of Carer (MCoC) Action plan

The MCoC lead is due to meet with the Chief Nurse in April to discuss the plan. An update will be provided following the discussion.

Maternity Dashboard

The dashboard has not been updated since the last paper.

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Training Compliance

Unfortunately the Professional Development Midwife is off for an extended period therefore an update on training compliance, PROMPT and Fetal monitoring training will be provided in the next report.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 4 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 February. Next main meeting planned for March.

The annual Maternity CQC Survey results are available as Appendix 5.

The survey results have been reviewed jointly with the MNVP leads and a draft improvement plan has been co-produced in response to the areas demonstrating lower than expected scores. The improvement plan will be formally agreed at Perinatal Services Forum, which is attended by the MNVP leads.

In brief, the headlines are:

- 36% response rate, slight improvement on 31% in 2022.
- 59% of women responding were Asian or Asian British.
- Of the 54 questions:
    - 1 question demonstrated a ‘Better than expected’ response compared to other Trusts.
    - 51 questions were about the same compared to other Trusts.
    - 1 question ‘somewhat worse than expected’.
    - 1 question ‘worse than expected’.
- There were 5 questions where the Trust performed better than national average.
    - Maternity service users being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
    - Midwives providing service users with relevant information, during their pregnancy, about feeding their baby.
    - Maternity service users discharge from hospital not being delayed on the day they leave hospital.
    - Midwives or doctors appearing to be aware of the medical history of the service user during labour and birth.

  - Midwives or the doctor appearing to be aware of service users' medical history during antenatal check-ups.
- There were 5 questions where the Trust performed worse than the national average.
  - Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
  - Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
  - Maternity service users feeling they were given appropriate advice and support when they contacted a midwife or the hospital at the start of their labour.
  - Maternity service users (and/or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
  - During antenatal check-ups, service users being asked about their mental health by midwives.

The 5 worse performing response have formed the basis of the co-produced improvement plan.

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.

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6 RECOMMENDATIONS

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, February 2024.
- Academy is informed that to meet mandatary maternity training requirements, 125 midwifery shifts are required every month which contributes to clinical shift shortfalls. This will be discussed in detail at the March Safety Champion meeting.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 2, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that there were 2 cases of HIE reported in February.
- There were 0 neonatal deaths in February.
- There were 0 maternal deaths in February.
- There are 6 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 0 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for February.
- Quality and Patient Safety Academy is asked to note that there was 1 MNSI reportable case and 0 reportable Serious Incidents (SI) declared in February.
- Academy to note that there were 3 occasions in February 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.
- To note that Zafir Ali, will be the Interim NED Perinatal Safety Champion until further notice.
- Academy is asked to note Appendix 5, results of the 2023 Maternity CQC Survey, the associated headline narrative, and that a draft improvement plan has been co-produced with the Maternity and Neonatal Voices Partnership Leads.

7 Appendices

- Appendix 1 - Three Year Delivery Plan version 2.
- Appendix 2 - Maternity CQC Improvement Plan version 4.
- Appendix 3 - Maternity and Neonatal Harms February 2024.
- Appendix 4 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.
- Appendix 5 - Maternity CQC National Survey Results BTHFT.

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MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE MARCH 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.

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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.

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

Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, March 2024.
- Quality and Patient Safety Academy is asked to acknowledge appendix 1, Internal Audit report regarding progress with the Maternity CQC Action Plan, and the rating of 'Significant Assurance'.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 0.
- Academy is asked to note that there were 0 cases of HIE reported in March.
- There were 2 neonatal deaths in March.
- There was 1 late maternal death in March.
- There are 6 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 0 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for March.
- Quality and Patient Safety Academy is asked to note that there were 0 MNSI reportable cases and 0 reportable Serious Incidents (SI) declared in March.
- Academy to note that there was 1 occasion in March 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 Academy is asked to note appendix 3 Perinatal Mortality Review Tool, quarterly report and associated action plan, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme.

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				g		

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recognised as leaders in research, education and innovation						
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

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

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

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

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

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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 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

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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 initial pilot was sent to 20 women with 45% commencing the PCP and 30% completing it.
The next steps are:

- To understand why women did not start/complete.
- To amend the form based on feedback received.
- Pilot 2 to be sent to >300 women.

East Kent Report/Three Year Delivery Plan for Maternity and Neonatal Services:

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

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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.

The plan was updated in January and shared with February QPSA. The next update will be provided to May QPSA.

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.

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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. This is currently being progressed and engagement with teams will start in April.

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 May 2024 People Academy followed by July Board. This paper will include the analysis from the November 2023 Birth Rate Plus full review,

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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 9.56 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. A contributory factor to the ongoing fill rate gaps is that 125 midwifery shifts per month are required for mandatary training, in line with the 3 year plan. This will be discussed in more detail at the May Bi-monthly Maternity and Neonatal Safety Champion meeting, having been deferred in March due to the unannounced CQC inspection.

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 34.98 WTE.

Maternity leave is currently 13.26 WTE.

There were 2 extremely positive open days for newly qualified midwives in March, prior to centralised recruitment starting in May.

The last Internationally Educated Midwife following International recruitment funding is due to join the organisation in April.

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.

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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.

1 Fully funded Obstetric only consultant post gap– previously advertised and not recruited to. We have advertised for a locum Obs and Gynae 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. Interview for a cost neutral combined obstetrics and gynaecology post on 9/4/2024 resulted in offering a conditional offer for a substantive post with a tentative start date of 1st of August 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.

Further consultant activity review and reshuffling of skills to meet colposcopy demands is in progress.

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 now 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 interviewed and offered 1 post.

As part of our aim to meet the CQC must do ask of covering maternity triage, we have interviewed and offered 3 fix terms 12 month SAS doctor posts. 2 have withdrawn their

applications due to change in circumstances. We have re-advertised and shortlisted with a view to interview the week starting 29th of April 2024. Escalated rates to cover the gaps have been continued and agreed by HR until end of March 2024. Further approval of current escalated rates is urgently needed to enable the department to cover gaps.

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

Neonatal Staffing

Medical:

- New consultant starting in April.
- Junior medical staffing has been a challenge due to various rota gaps. Plan is to employ some additional trust grade doctors.

Nursing:

- 3 nurses qualified in speciality (QIS).
- 11 nurses start the Neonatal Foundation programme (NFP) with the Y&H ODN – biggest intake ever. This is the gateway course for QIS.
- 2 RN complete NFP.
- 4 learners started QIS.
- We had approx. 5 new starters in March.
- Lots of internal promotions – 3 BAME colleagues have successfully been appointed to senior positions. Lots of work and liaison with the Equality Diversity and Inclusion team to help open gateways to support opportunities for BAME colleagues.
- We have just completed interviews for NQN's which means if all pass their HR checks we will be at Establishment in September 2024.

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.

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The Improvement plan was updated in February and shared at the February Women's CSU Core Governance meeting. The next update will be provided in May.

Progress continues on target and includes the positive outcome of a business case for the uplift in medical staffing to achieve the 'must do' action regarding medical staffing in MAC which was approved and staff have now been appointed and will commence in July and September.

The improvement plan was subject to an internal audit review in March, which returned a rating of significant assurance. See Appendix 1. There was a minor recommendation regarding the extension of completion dates, particularly around actions which are complete but require ongoing monitoring, and for actions where closure depends on completion of building work or recruitment. The service believes that extending the dates was entirely appropriate, and internal audit acknowledged that regular review of the plan and board reporting could be evidenced.

Stillbirth Position

There were 0 stillbirths in March.

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
February	2	6	1	0
March	0	6	0	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies diagnosed with HIE in March.

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).

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There were 0 MNSI reportable cases occurring in March and 0 internal SIs.

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 2 includes a position summary of ongoing maternity SIs. There are 0 completed reports) for the attention of Quality and Patient Safety Academy and Closed Board this month.

There are 6 ongoing maternity PSIIs/Level 1 investigations, 3 MNSI and 3 Trust level.

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

Neonatal Deaths (NND)

There were 2 neonatal deaths in March. See appendix 2 for details.

1 baby, born in February, died as a result of a congenital abnormal in March. This case is being investigated by MNSI due to HIE, which was not a contributory factor to the baby's death.

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)
February	0	2	0	0
March	2	4	2	1 (MNSI)

Maternal Deaths

There was 1 late (after 42 days but within a year following pregnancy) maternal death in March. (See Appendix 2).

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

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

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 March.

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 in March. The group welcomed Zafir Ali, as the new Interim Non-Executive Perinatal Safety Champion. The standard agenda items were discussed and there were no safety issues from the meeting or from the Perinatal Quad Leadership team, requiring Board level escalation. Zafir raised a question regarding terms of reference for the meeting. Currently there are no terms of reference but further to the meeting a draft version has been circulated.

Monthly staff feedback from Safety Champions and walk-rounds

The March meeting was well attended and the majority of the discussion was around car parking safety, with members of the security team in attendance to provide responses and assurances regarding actions in place to improve security in the Women's and Newborn unit carpark. A further action was for a member of the maternity team to join the Trust wide car parking steering group, to escalate specific issues and concerns.

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Maternity Unit Diverts

There was 1 partial/attempted unit diverts/escalations in March recorded on the closure log. However, the attempted divert lasted for 66 hours, due to high levels of activity and complexity. Despite the duration of the pressures, only 2 women were able to be diverted to neighbouring organisations for care as system wide pressures prevented any further mutual aid on that occasion.

Table 3:

MONTH	Full Divert	Partial divert	Attempted Divert	Number of women diverted
JANUARY	0	3	5	3 (1 returned to BTHFT to birth)
FEBRUARY	0	1(then attempted)	2	1
MARCH	0	1 (then attempted)	0	2 in 66 hours
Total	0	5	7	6

Perinatal Mortality Review Tool (PMRT) Quarterly Report

Appendix 3 is a copy of the PMRT quarterly report, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme. The service has continued to follow the Year 5 guidance, until the Year 6 scheme is published in April.

The report confirms that the required standard has either been met or is on trajectory to meet the timeframes required.

The report also includes an action plan in response to concerns identified as part of the PMRT review process. To note that the concerns were not relevant to the outcome in all cases, but are areas requiring action and improvement, including improved documentation regarding previous pregnancies recorded at booking, and lack of carbon monoxide screening due to faulty equipment. The relevant teams are aware of the actions required.

Midwifery Continuity of Carer (MCoC) Action plan

The MCoC lead is due to meet with the Chief Nurse in April to discuss the plan. An update will be provided following the discussion.

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Maternity Dashboard

Appendix 4 is a copy of the maternity dashboard which has not been presented for a number of months due to the protracted recruitment of the Digital Midwife. The successful applicant is due to join the Trust in May.

The Head of Midwifery has brought the dashboard up to data, although there are a number of incomplete data sets for March which require further validation.

Of note:

- The number of Home Births has declined over the last 12-18 months after an increase during the pandemic. It is thought that this in part is due to the resumption of 2 birth support partners in labour, which was limited during the pandemic. The Home Birth team are actively promoting their service in an attempt to improve the uptake.
- 1:1 care in labour continues to be a metric of concern, and is hovering just below the locally accepted 90% mark. This is thought to be as a result of staffing challenges combined with high levels of acuity and activity across the unit, impacting on flow. The service is about to commence training on the Birth Rate Plus acuity app, which will support labour ward co-ordinators and shift leaders in accurately assessing the acuity of women in their areas, and support allocation of staff. This is expected to 'go live' in June/July.

Training Compliance

There has been a delay in presenting training compliance data due to the long term absence of the Professional Development Midwife. However, they have now returned to work and appendices 5a and 5b show the current maternity specific mandatary position for March and the cumulative data for January to March 2024.

The Maternity specific training days are on trajectory to meet compliance with the Maternity Incentive Scheme standards, despite some cancelled sessions due to faculty absence. This position will be closely monitored.

Trust wide mandatary training has 6 areas below 75% compliance:

- Fit Testing dropped due to challenges with appointments. This has been addressed by the Matron team and now two staff members are booked to attend appointments every day. This has resulted in a progressive increase in compliance and now stands at 71.43% and will continue to improve.
- 3 of the competencies relate to Blood Transfusion practical assessments. Do to clinical acuity and a shortage of blood transfusion assessors these have been difficult to assess

in practice. This started to be addressed by provision of a session to train more assessors in each clinical area. A number of new assessors are now in place so this will allow more scope for these practical assessments to increase.
  - Organising Receipt of Blood
  - Preparing to Administer/Administering Blood
  - Collecting Blood
- Moving and Handling - Level 2 - 3 Years was been targeted by the Moving and Handling lead and line managers and staff were been booked on. However, a shortage of course availability has made this challenging. This has been addressed by the Matron team and the plan is for additional dates for midwives to be explored or for midwives to potentially attend the weekly session delivered in the Trust.
- The Oliver McGowan mandatory training for staff was only added in Feb 2024 and compliance has increased from Feb to March 2024.

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 first main MNVP meeting of 2024 was held in March.

The service shared an update and improvement report with the group, and provided a brief presentation of the 2023 Maternity CQC survey results and the initial co-produced action plan. The service also acknowledged feedback received from Bradford Doula's, and the plan to incorporate this into the overarching action plan.

The Parent Education team are in the process of organising a unit open event for service users and families. This will be an opportunity to share the services on offer in the unit, and to receive and respond to first hand feedback. The event is planned for May.

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.

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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, March 2024.
- Quality and Patient Safety Academy is asked to acknowledge appendix 1, Internal Audit report regarding progress with the Maternity CQC Action Plan, and the rating of 'Significant Assurance'.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 0.
- Academy is asked to note that there were 0 cases of HIE reported in March.
- There were 2 neonatal deaths in March.
- There was 1 late maternal death in March.
- There are 6 ongoing maternity SIs/Level 1 investigations, 3 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 0 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for March.
- Quality and Patient Safety Academy is asked to note that there were 0 MNSI reportable cases and 0 reportable Serious Incidents (SI) declared in March.
- Academy to note that there was 1 occasion in March 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 Academy is asked to note appendix 3 Perinatal Mortality Review Tool, quarterly report and associated action plan, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme.

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7 Appendices

- Appendix 1 - Maternity CQC Action Plan Internal Audit report.
- Appendix 2 - Maternity and Neonatal Harms February 2024.
- Appendix 3 - PMRT Quarterly Report.
- Appendix 4 - Maternity Dashboard.
- Appendix 5a and 5b - Mandatary Training Report March 2024, Mandatary Training Compliance January-March 2024.
- Appendix 6 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.

BO.5.24.8 - RESEARCH ACTIVITY IN THE TRUST

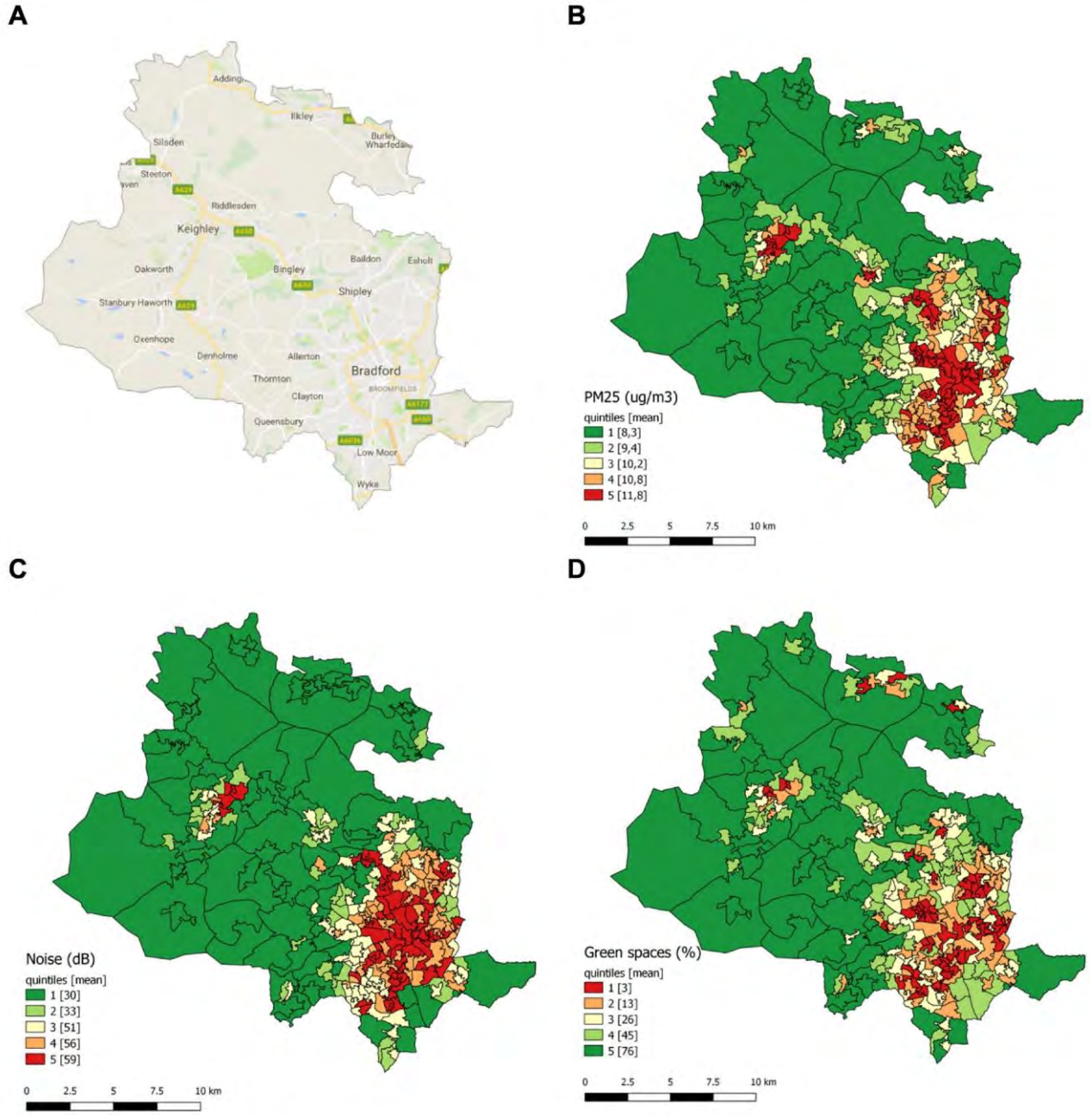
REFERENCES

Only PDFs are attached

- Bo.5.24.8 - Research activity in the Trust (presentation).pdf
- Bo.5.24.8 - Research Activity in the Trust (Cover).pdf
- Bo.5.24.8 - Research Activity in the Trust.pdf

10 miles

10 years



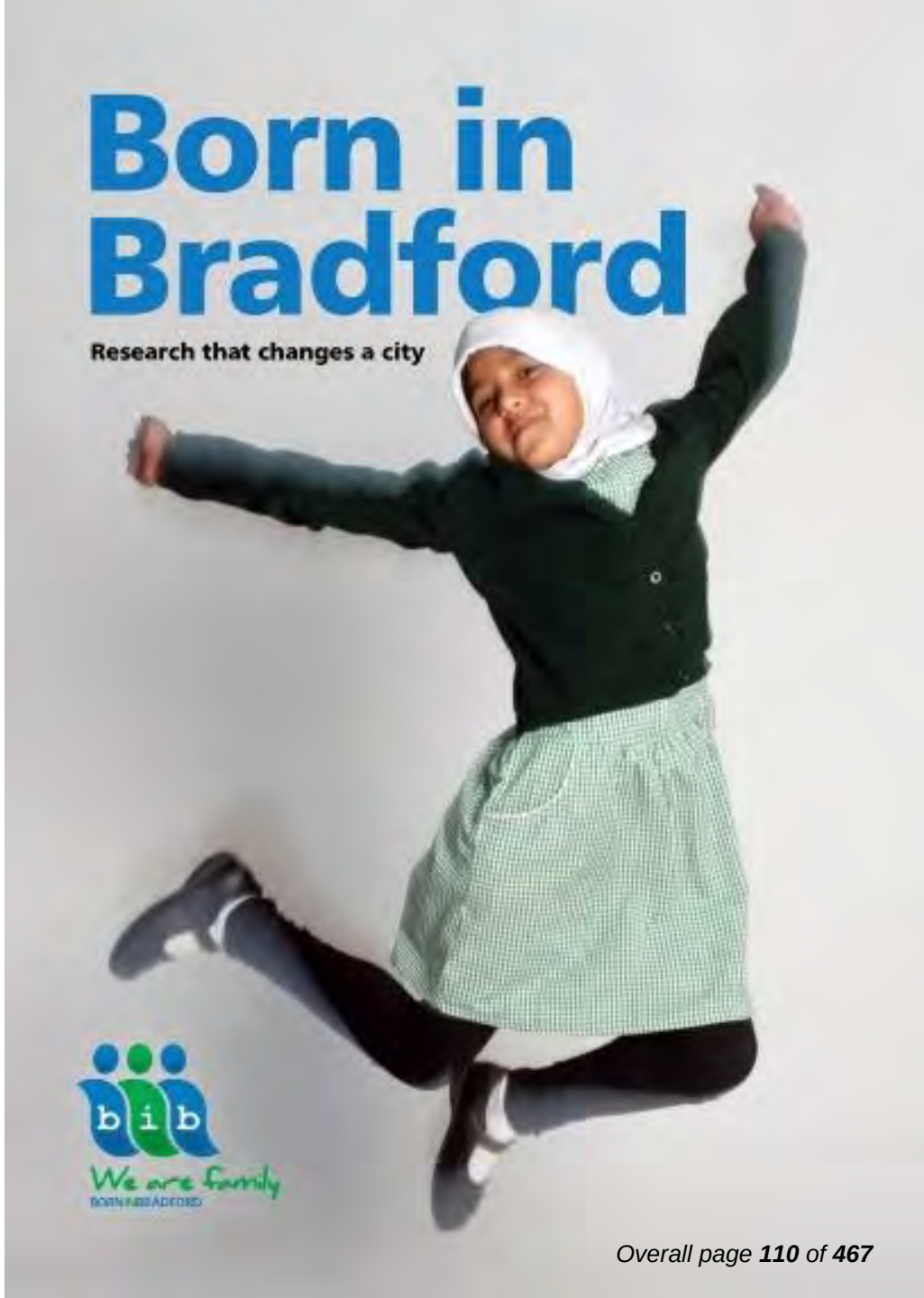
A=Major road network of the Bradford district.
B=$PM_{2.5}$ concentrations (2009/ 2010) at LSOA level.
C=Noise levels L_{den} (2006) at LSOA level.
D=% green space (2012) at LSOA level.

Born in Bradford's: Research that changes a city

Professor Rosie McEachan

@drrosiemc

8th May 2024



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CHILDHOOD OBESITY TRAILBLAZER PROGRAMME

RIC Reducing Inequalities in Communities

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OUR TIME
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2025

Key priorities for 2024

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NORTH
HEALTHY URBAN PLACES

Our **vision** is to promote a **healthier, fairer future** for children and families: Are you in?

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@drrosiemc

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.8

RESEARCH ACTIVITY IN THE TRUST

Presented by	Dr Ray Smith and Dr Michael McCooe	
Author	Professor John Wright (Director of Research) & Dr Tracy Watson (Director of Research Operations) & Research Department Heads	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	To provide information on some of the key research activities in the Trust	
Key control	NA	
Action required	For assurance	
Previously discussed at/ informed by	*NA*	
Previously approved at:	*e.g. Academy / ETM / CSU group*	**Date**
	Quality and Patient Safety Academy (QA.3.24.24)	27.03.24

Key Options, Issues and Risks

This report for research describes some of the main areas of work and progress over the last few months; these include:

- Applied Health Research Activity
- Clinical Research Activity

Analysis

As above.

Recommendation

This report is for assurance and highlights how important research activity is for healthcare and treatment improvement.

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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	Other (please state)
☐	☒	☐	☐

Bradford Institute for Health Research

Research in the Trust

Report for Quality Academy

March 2024

This report provides an update on research in the Trust, highlighting some of the activities of our research teams and provides information on some of the developments that are happening.

RESEARCH ACTIVITY AND PERFORMANCE

At the end of Quarter 3 the Trust's recruitment into research studies was 17,469 and was the 5th highest recruiter in the NIHR league table for portfolio recruitment.

In order to improve research experience and as a requirement of the NIHR, we take part in the PRES- Participant Research Experience Survey. The Trust's target for 2023/24, as set by the NIHR Y&H Clinical Research Network, is 514; at end of February 569 surveys have been completed (111% of target).

RESEARCH INFRASTRUCTURE

Work is now well underway on the new entrance extension for the Bradford Institute for Health Research. Due to be completed late May, the new extension will enable improved way finding for our research participants with a dedicated reception area as well as providing additional informal and formal meeting spaces, a new waiting area and an additional research clinic room.

APPLIED HEALTH RESEARCH

ACTEARLY

ActEarly is a UKPRP funded collaboration between Bradford and Tower Hamlets in London. The ActEarly vision is to create City Collaboratory's in areas of high child poverty that provide research ready, people-powered, and data-linked test beds to co-produce, implement, and evaluate multiple early life interventions to prevent disease and reduce inequalities. Highlights since our last update:

New citizen science project in Tower Hamlets will see local residents design and deliver research investigating ActEarly themes

Tower Hamlets Council and UCL's Citizen Science Academy are joining forces to train local residents to become social scientists in their own neighbourhoods. Around 10 residents will be employed part-time while they are trained and supported to design their own research along the ActEarly themes and that will be also relevant to Tower Hamlets Council. Communities involved in ActEarly are keen to have a more central role in research – identifying local priorities, setting research questions, and carrying out research and analysis. This project will explore how citizen science can bring new insights about lived experiences and concerns of local communities to ActEarly themes, and the Council's new Health Determinants Research Collaboration (HDRC). It will also demonstrate a more bottom-up implementation of the ActEarly Co-Production strategy.

Join Us Move Play: a whole system approach to tackling children's physical inactivity.

As an integrated implementation and research programme, JUMP, as part of ActEarly, has been undertaking a process evaluation designed to understand what is working (or not), how and in what context. A range of methods are utilised across the process evaluation including, but not limited to, observations of key meetings and events, interviews, focus groups, ripple effects mapping, balanced score cards and surveys. Data is fed back into the workstreams and programme development to continuously improve JU:MPs work. There is also a full-scale control trial of JUMP which aims to explore whether JU:MP is effective at increasing physical activity for children aged 5-11 years. Data was collected at baseline from 1500 children, prior to JU:MP implementation. Two-year follow-up data is currently being collected until March 24, and a 3-year follow-up will also be conducted in September 24 – March

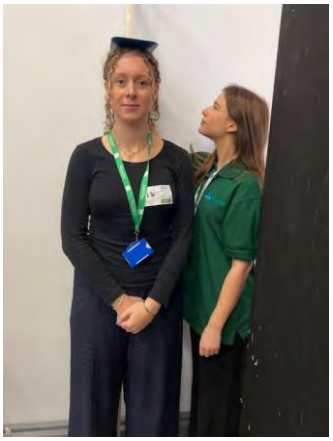
25. Watch this space in Autumn 2024 for findings from the control trial and process evaluation!

ActEarly is also holding their first in person conference this Spring. Titled 'Tackling the Wider determinants of Health: Research into Policy' at Bradford City Football Club on the 18th of April 2024.

More details are available on the site which also includes a link to sign up for our monthly newsletter **here.**

Born in Bradford

Born in Bradford (BiB) aims to understand why some families fall ill and why others stay healthy. We are a people powered research project, and together with our communities and stakeholders aim to make positive changes to improve the lives of families living in our city and beyond. We host three birth cohort studies (the Born in Bradford Family Cohort, Born in Bradford's Better Start and BiB4All) encompassing over 60,000 Bradford residents, in addition to a range of other initiatives including the Better Start Bradford Innovation Hub, Bradford Inequalities Research, the Healthy Childhood theme of the Yorkshire and Humber Applied Research Collaboration, Connected Bradford, Join Us: Move Play, the LEAP, the Centre for Applied Education Research and various other externally funded applied health research studies. We have over 100 members of staff all working to make Bradford communities healthier and happier. You can find out more about our research programme here: www.borninbradford.nhs.uk.



Age of Wonder: Exploring the journey for adolescence into young adulthood

Funded by the Wellcome Trust, Age of Wonder (AoW) is a seven-year project capturing the journeys of up to 30,000 Bradford teenagers during adolescence, using quantitative and qualitative methods. Since September, we have already recruited 23 schools for this academic year, over 3800 young people have completed questionnaires, and over 1300 Year 9 students have taken part in the physical health measures. We launched an online data dashboard for schools in November, reporting descriptive statistics at the aggregate level, with the aim to empower schools with insights into their populations. Our work was highlighted in a BBC Radio 4 documentary in November 2023.

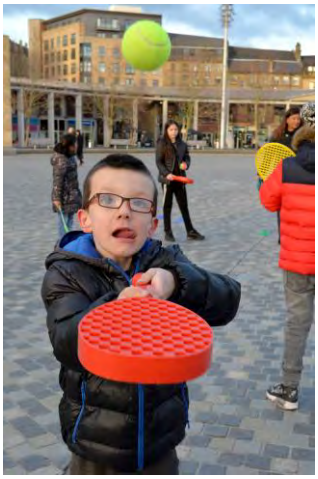
Within the qualitative longitudinal research arm of AoW, we have conducted 27 in-depth interviews with young people, collected 30 creative expressions from young people on their hopes, dreams, and fears on growing up. We have held 32 portrait sessions with our artist-in-residence. Young people describe different aspects of their health and wellbeing by producing creative expressions through videos, poetry,

drawing, voice notes, written expressions, memes, and through artistic use of video games, online edits.

Ibraaheem, aged 15:
"My hobbies include gaming, martial arts, running, high intensity interval training, video production, photo making, cycling […] My hopes for the future are I go college and I go uni, and from there do my PhD in whatever subjects I'd like to get, and my masters or whatever. Something to do with cars and technology, for example. Engineering. Open my own garage and petrol station and stuff like that […] When I am an adult I'd like to buy my dream car and I'd like to become a footballer."

Physical activity Research

Evaluation of JU:MP



The BiB physical activity research team have been continuing to evaluate the JU:MP (Join Us: Move Play) whole system approach to tackling children's physical inactivity. The team have been working with schools and children in Bradford and across Yorkshire to conduct the first follow-up of a world leading control trial to assess the effect of the intervention on health outcomes, including physical activity levels, body mass index, social, emotional, and behavioural health. Baseline data was collected in 2021-22 from 37 schools and over 1400 children. The team have now completed the 1st follow-up (September 2023-February 24). Data has been collected from 34 schools and over 1200 children. Data will now be cleaned, processed, and analysed. Alongside the control trial there is an in-depth process evaluation designed to understand what is working (or not), how, and in what context. The strategic and neighbourhood process evaluations and the children and families process evaluations are entering their final rounds of data collection. Data from previous rounds continues to be coded into the JUMP framework for analysis and interpretation. Process evaluation findings are fed back into the JUMP Programme to continuously improve the programme.

Bristol BRC projects

The physical activity research team are embarking on new discovery science projects in collaboration with the Bristol NIHR Biomedical Research Centre. Two new senior research fellows have joined the team and will be working on projects on young people with Type 2 diabetes, physical activity in children with disabilities, the impact of school PE kit policies on girls perceptions of body image and experience of

PE, and understanding the relationship between movement behaviours and eating disorders.

Play in Urban Spaces for Health

Finally, the physical activity research team are working on a project called Play in Urban Spaces for Health (PUSH). This project is in collaboration with University College London and is about designing play into urban spaces, moving away from traditional play equipment, and thinking more about the design of the landscape and incorporating playable features. The team intend for children and families to influence the design of two spaces in Bradford and two in Tower Hamlets, with activation of the sites being facilitated through early years centres and primary schools. The aim is for schools to take children to the site once a week for child-led free reign play and physical activity, so that playing in those type of spaces becomes familiar and habitual. Using an NIHR programme development grant, the research project is currently scoping the feasibility and acceptability of this concept to develop a theory of change, with the aim to apply for further funding to test and refine the intervention.

Healthy Places: Understanding how indoor and outdoor air pollution impacts on health

The BiB Breathes team works with Bradford Council and academic colleagues to track the impact of the Clean Air Zone (CAZ) implemented in September 2022 on air pollution levels and health outcomes. A survey was deployed in Summer-Autumn 2023 to examine attitudes towards air pollution, the CAZ, and any changes to travel behaviours and will help us understand whether public perception and behaviours have changed following the implementation of the CAZ. We are continuing to progress research on how the CAZ has impacted on levels of air pollution in the city and changes in numbers of A&E and GP visits for respiratory, cardiovascular, and birth outcomes.

Our EU project, ATHLETE, which seeks to assess and understand how our exposome – all non-genetic exposures – impacts on our health, has recently completed a workshop in Bradford with 33 local stakeholders including Bradford Council staff, local community organisation/social enterprise/community interest companies, and those working in the education and academic sectors. The workshop aimed to prioritise the interventions identified from our Delphi consensus study as effective on reducing exposures or improving health outcomes as well as acceptable to communities, feasible to implement, and impacting many people. All interventions reaching

consensus focussed on changing the structural environment to improve health rather than relying on individual behaviours and were ranked in order of priority: (1) affordable and improved public transport; (2) green infrastructure improvements; (3) cycle route improvements; (4) improving indoor air quality through building regulations. A policy briefing note was created combining the Delphi survey findings, workshop prioritisations and discussions of barriers and enablers, and recommendations for policymakers and will be disseminated.

Our indoor air quality project, INGENIOUS (Understanding the sources, transformations, and fates of indoor air pollutants) is nearing the end of its recruitment period where 300 BiB families install non-invasive air quality monitors to develop our understanding of what the key sources of indoor air pollution are and how occupant behaviours (e.g. cleaning, cooking, and ventilation) can affect levels of air pollutants. A related EU project, INQUIRE (Improving indoor air quality and health: Identification of chemical and biological determinants, their sources, and strategies to promote healthier homes in Europe) has completed recruitment of 25 BiB families for more intensive monitoring of indoor air pollutants; a subset of these families have kept the air quality sensors in their homes for long-term monitoring.

The Better Start Bradford Innovation Hub (BSBIH)

The BSBIH is a centre for research and evaluation working in partnership with the Better Start Bradford programme to develop the evidence base of what works to give children the best start in life. Since 2015, the team have worked alongside both statutory, and voluntary and community sector stakeholders to develop a robust and pragmatic approach to integrating research and evaluation into practice. Using a range of methods, we are evaluating multiple early years interventions delivered to families with children aged 0-4 years in three wards of the district.

Funded by the National Lottery Community Fund, Better Start Bradford is a 10-year programme moving into its final year. In recent months learning from the BSBIH has been used to support local decision making about the future of Better Start Bradford interventions and further roll out. The team are currently working to collate all learning to date, delivering comprehensive and accessible evaluation reports to our partners with recommendations to support future successful implementation and sustainability. Effectiveness evaluations, which will use data from our **BiBBS birth**

cohort, are underway for a number of interventions and we aim to establish their impact on maternal and child outcomes. The team have also continued to deliver workshops and training to partners with the aim of building capacity for good quality evaluation in Bradford.

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

This is the 2nd birth cohort within the BiB cohort family and is recognised internationally as the world's first interventional cohort, designed to evaluate interventions delivered as part of the Better Start Bradford programme.

Following the success of recruiting 5,000 pregnancies last summer, the BiBBS team continued their celebrations out in the community during Bradford Baby Week in November. They engaged families in a range of activities at events across the district, taking the opportunity to encourage eligible families to sign up to the study. As we enter the final year of Better Start Bradford, the community research team have been focused on ensuring that every eligible family has the opportunity to be part of the BiBBS before recruitment ends this summer. This has involved contacting families previously missed through our normal recruitment process, as well as a huge amount of community outreach and billboard campaigns across Bradford.

Bradford Inequalities Research Unit (BIRU)

BIRU are celebrating some incredible achievements as their work comes to an end with the Reducing Inequalities in Communities programme (Bradford District & Craven CCG and West Yorkshire integrated care board) to evaluate the impact of interventions delivered to reduce health inequalities in central Bradford. The final report summarising all of the learning and evaluations of this research can be found here:
https://borninbradford.nhs.uk/wp-content/uploads/BIRU-Final-Report_v2.0_Jan24.pdf

The major impacts from this work are that BIRU have provided evidence that two of the interventions have had a large impact on unplanned hospital admissions:

1. The Pro-Active Care team (PaCT), run by BDCFT, which provides proactive, holistic short-term care and support for vulnerable individuals. For patients who received PaCT, the odds of an **unplanned hospital admission** was **31% lower**, and the odds of an **A&E attendance** was **41% lower**, compared to the matched control group.

2. The Bradford Central Locality Integrated Care Services (CLICS) intervention, which integrates social prescribing and general practice). For those who

received **CLICS**, the odds of an **unplanned hospital admission** was **17% lower** compared to the matched control group.

We're now working with colleagues in the Improvement Academy and across the ICB to disseminate this learning and see how we can work together to ensure the implementation of these effective interventions.

Health Promotion through Faith Settings in Bradford

BiB's health promotion programmes using faith settings harness the potential of place based community groups affiliated with faith settings to implement hyper-local childhood obesity prevention plans. Thirty Islamic faith settings in Bradford are planning and implementing promotion of healthy behaviours such as physical activities and healthy diet. We coproduced a toolkit with placed based groups and community organisations that enables faith settings such as mosques and madrasas in Bradford to deliver sessions and workshops on healthy diet & physical activity for ethnic minority children, particularly those from South Asian background.

BiB Youth Resilience Programme

BiB research facilitated production of a neighbourhood plan in Barkerend, Bradford that builds capacity of grassroots local organisations to prevent young people from the harms of violence, drugs and anti-social behaviour. Our Youth Resilience Programme invited diverse group of young people from the neighbourhood to identify youth priorities on what young people would like community groups to deliver for them. The BiB Youth Forum prioritised activities that enable community groups to ensure support for role modelling mentoring, and career pathways is available for young people in the neighbourhood.

Centre for Applied Education Research

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

CAER is now overseen by the Education Alliance for Life Chances (EALC), a multi-agency partnership that brings together senior leaders from public services across Bradford, to empower education settings with evidence-based approaches, and identify and remove barriers to learning.

CAER works with EALC to implement Act Locally, an initiative with convening partnerships in 3 localities of Bradford, Holme Wood, Manningham & Girlington, and Keighley, all areas of multiple deprivation. The convening partnerships are built around and led by local schools, and bring together policy makers with residents,

front line professionals, and researchers. CAER provides the Research & Development support for these partnership groups, which aim to improve outcomes for children and young people within 3 priority areas – crime & antisocial behaviour (Holme Wood), mental health (Manningham & Girlington), and Food Insecurity & Nutrition (Keighley).

Following the successful launch of a CAER-coordinated commissioned report for the Child of the North All-Party Parliamentary Group, CAER, in collaboration with the Centre for Young Lives and the N8 Research Partnership (research intensive universities across the North of England), has been asked to produce 12 parliamentary reports over 2024. These reports will be part of a campaign for a government that puts children first, and each will focus on a topic deemed to be one of the greatest challenges currently facing children and young people. In January 2024, the first report was released, focused on recommendations around improving the current autism assessment and support crisis in the UK. The report has already received significant media coverage and has been well-received by stakeholders. Currently, 3 more reports are under development, on the topics of addressing childhood poverty through schools, connecting and coordinating public services through education settings, and improving mental health in education settings. For the remainder of 2024, CAER and partners hope to influence policymaking through this series of 12 reports.

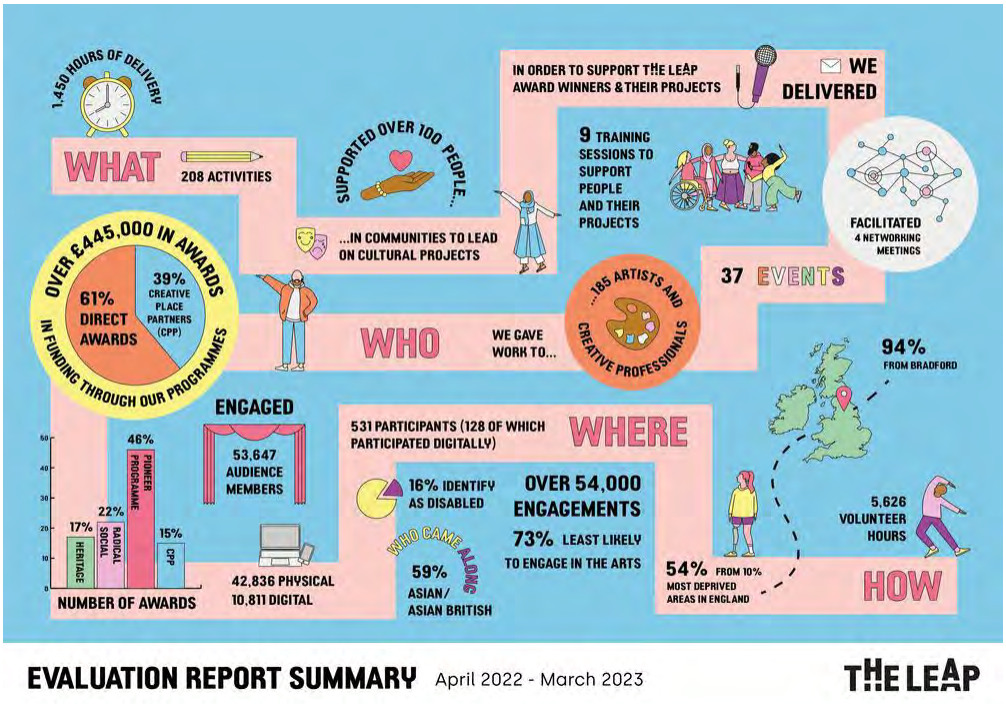
CAER realises its vision through a community of practice, and demonstrates the strength of partnership working within Bradford and beyond. CAER now has Child Health Outcomes Research at Leeds (CHORAL) as a sister organization. CHORAL officially launched in February 2024 and is a children's health research partnership based at University of Leeds/Leeds Children's Hospital, that aims to tackle key areas where research can improve outcomes for young people. In 2024 and beyond, CAER and CHORAL will work together, to tackle education and health inequalities with and through education systems, and establish West Yorkshire as a trailblazing site.

Healthy families' theme of the Yorkshire and Humber ARC

The healthy families theme continues to support nearly 60 active research projects across the Yorkshire and Humber region. The Mental Health Navigators project won a national Public Participation, Involvement and Engagement 'Dialogue and Change' award for their patient and public involvement and engagement. People reported how involvement in the project had made them feel valued, listened to and helped aid their mental health recovery. The theme also drew on experiences and learning of Bradford projects, delivering a popular lunch and learn session on theories of change and logic models. To support the adoption, scale-up and spread of proven interventions the BRUSH project also launched their supervised toothbrushing toolkit.

The Leap

The Leap is an Arts Council programme focused on increasing leadership and participation in arts and culture for people and places that are the least engaged in Bradford District. Born in Bradford is a member of the Consortium providing oversight and governance for The Leap, and acts as it's accountable body. The Leap to date, through various innovative interventions has supported hundreds of people to deliver community led projects, as well as training and networking sessions to support people and their projects. Projects have included the BD3 Living Wall with The Leap continuing to work across Bradford and Keighley.



Connected Bradford

Connected Bradford is an innovative research database that demonstrates the utility of linking healthcare data across multiple healthcare providers not only across the Yorkshire & Humber region but also expands data linkages with non-healthcare data for up to 5 million individuals. We foster collaborations between the general public, academia, healthcare organisations, education and the local authority to demonstrate positive change.

Connected Bradford is playing a significant role in the NHS England Secure Data Environment led by Bradford Teaching Hospitals for Yorkshire & Humber. The aim of this project is to develop a new platform that ensures the safety and protection of sensitive and confidential data from unauthorized access, theft, modification, or destruction. The Secure Data Environment platform is designed to provide researchers with access to anonymised data while maintaining its security and protection. Furthermore, the platform is adaptable and flexible, allowing researchers

to access data across different locations and the Yorkshire & Humber region. Existing work already undertaken by Connected Bradford will provide significant opportunities in the development of the SDE.

Examples of the insights we are able to demonstrate are below:

Associations of exposure to air-pollutants and respiratory illness :
This study examines the relationship between air pollutant exposure and respiratory illness visits to General Practice (GP) and Accident & Emergency (A&E) services. The study found that for every 10 µg/m^3 increase in these pollutants above WHO thresholds, there was a significant immediate and delayed increase in the risk of respiratory visits to GP and A&E services. Notably, a considerable proportion of these visits (a third to GP and half to A&E) were attributable to exposure to NO2 levels beyond the WHO recommended threshold, indicating a strong link between high pollution events and increased healthcare utilisation for respiratory issues. The study highlights that the burden of respiratory illness related to air pollution may be much higher than previously estimated.

Associations between early school readiness, Autism, and ADHD:
Previous work has shown that there is an association between an early measure of school readiness, the Early Years Foundation Stage Profile, and later Autism diagnoses. This work extends that to also look at ADHD, and whether they are differentially associated with the components of the indicator.

Performance on the EYFSP, in the form of the Good Level of Development, predicted later diagnoses of both Autism and ADHD. In both cases males were more likely to be diagnosed than females, and White children were also more likely to be diagnosed than their Asian counterparts.

This adds to a growing body of evidence suggesting that the EYFSP is a powerful indicator of later disadvantage across a variety of measures. It shows that later Autism and ADHD diagnoses are signalled at an earlier point by performance on the EYFSP, and that if combined with other indicators it should be possible to allocate resources earlier to those likely to require additional support through the education system. The de-identified Bradford autism patient tracking data provided to Connected Bradford has prompted changes to the way mental health services record patient data, leading to an increased need for collaboration. As a result, a new streamlined clinical SystmOne module has been developed to support these improvements.

Bradford Genes & Health
The Bradford Genes & Health study aims to learn how genes vary in adult Bangladeshi & Pakistani communities. The study is also recruiting in East London and Manchester with the view to including 100,000 people from these communities

in the research study. In order to better understand why heart disease, diabetes and stroke occur in higher levels in these groups, it is important to know what is normal when searching for genes that may cause inherited diseases.

Participants are asked to complete a short questionnaire, consent form and provide a saliva sample. One in four participants will be asked to attend stage two clinic visits where further consent is obtained, blood samples and a second short questionnaire is completed. We have extended our recruitment activities to Kirklees and Calderdale and Leeds, working closely with research partners across the West Yorkshire region, engaging with GP practices and community settings including Mosques. To date we have over 5350 participants to the study locally.

The BaBi Network

In 2019 Born in Bradford launched BiB4All (Born in Bradford 4 All), a study that aims to approach all pregnant women in Bradford to join a data linkage cohort study. The study, supported by the NIHR Applied Research Collaboration Yorkshire & Humber aims to make use of routinely collected data from health, education, social care and other sources to build up a rich picture of families lives over time. This data can then be used to help us understand what helps to keep families happy and healthy.

BiB4All currently has 17,856 mothers and babies in the study, and over 90 of Bradford midwives are trained to take consent for the study.

Following the success of BiB4All, BiB established the Born and Bred in (BaBi) Network (https://www.babinetwork.co.uk/) in 2022, and there are now 12 BaBi sites across the country; Bradford, Leeds, Doncaster, Wakefield, East London, Tameside, Warwick, York, Scarborough, Harrogate, Hull and Nottingham. These sites are likely to be joined by Calderdale, North Lins & Goole, Sheffield and East Lancashire in 2024. The BaBi Network has over 32,000 mothers and babies in the study, and over 800 midwives and other clinical staff are trained to take consent for BaBi across the country.

Each BaBi site is its own data controller and has been supported by the central BaBi team at Bradford to work with local partners and stakeholders such as service users, community groups, clinicians, local authority and policy advisors to explore local priorities to use its data locally. This prioritisation engagement method was developed by BaBi Network Research Fellow Hollie Henderson who recently completed a PhD exploring how linked routine data from the BaBi studies can be used as a local health intelligence for child and maternal health.

The BaBi coordinating team based in Bradford is working on producing a common data model for the BaBi Network that will assist with creating a shared dataset to answer research questions using data from across the BaBi Network. It has also submitted an application for a Programme Development Grant, which if successful

will explore using the BaBi study to look at infant growth and obesity, paying particular attention to inequalities in experience, detection and service use.
You can watch a short video that we co-produced with community members about how the study works here https://www.babinetwork.co.uk/info-for-participants

The Bradford Centre for Qualitative Research

The Bradford Centre for Qualitative Research (BCQR), established in 2023 by Born in Bradford, aims to deliver high quality, impactful and innovative qualitative research. Supported by a Steering Group of members from across Bradford Institute for Health Research, BCQR works to connect and build capacity amongst a dynamic collective of researchers. Over the last 12 months we have designed and delivered bespoke training sessions, including: an introduction to Qualitative Research and Philosophies, Ketso, Ethnography, Interviewing and focus groups, Thematic Analysis, Ripple Effects Mapping, and Creative Communication. We also host a bi-monthly 'Quali-Tea Time' to encourage peer support, where researchers come and share ideas, difficulties, and solve their problems together.

ALPACA

Led by University of Bristol, the ALPACA project aims to develop, pilot and evaluate an intervention that uses novel methods to get real-time feedback about patient experiences of shared decision-making during surgery. Born in Bradford is a research partner in an NIHR Programme Development Grant which aims to explore the views of members of underserved groups (ethnic minority, economically disadvantaged, older age) to inform the development of an inclusive intervention. Since November 2023, 15 in-depth interviews have been conducted.

COPPER

The Centre for Co-production and Peer Research (CoPPeR) Network are currently delivering an NIHR programme development grant, aimed at creating energetic and sustainable community research partnerships. We have built relationships with community co-ordinators from four diverse community organisations who are currently in the process of recruiting peer researchers who will together design, implement and analyse a citizen science research project.

Supporting Young Bradford

The Supporting Young Bradford study is one of four projects in a programme from the Health Foundation looking into emotional support for young people. Since it began in November 2023, the project has explored the impact of families' working lives on the quantity and quality of emotional support young people aged 12 -15 experience at home. We have facilitated 5 community workshops with parents/caregivers and young people across the city, and conducted 40 interviews

with parents and young people from 20 diverse households from the BiB cohort. By taking an Appreciative Inquiry approach, we have been able to understand the key enablers for emotional support for young people in their families, using this as a springboard to understand what barriers exist in relation to families' working lives. We are now planning a final round of community workshops to complete the Appreciative Inquiry by working with parents/caregivers and young people once again to consider what we have learned from the data and what needs to change going forward. The research team is Ruth Webber, Bridget Lockyer and Shahid Islam, along with Co-Investigators Rosie McEachan and Kate Pickett.

Improvement Academy

Based within the Bradford Institute for Health Research, the Improvement Academy undertakes implementation and improvement projects nationally, provides training across many areas, including Quality Improvement and Behaviour Change, and hosts one of NHS England's Patient Safety Collaboratives. The Improvement Academy is also the implementation arm of the Yorkshire and Humber Applied Research Collaborative. Below details some of the work in which we are currently involved.

Involving Patients and Families in Proactive Patient Safety Initiatives

One of the central aims of the Patient Safety Incident Response Framework (PSIRF) is to ensure we have compassionate engagement with patients and families, doing this well has been something that organisations have struggled with for years. To support the engagement of patients and families and understand their perceptions of safety we decided the Patient Reporting for a Safe Environment (PRASE) tools could be used.

PRASE is an evidence-based and validated data collection and reporting tool based on the Yorkshire Contributory Factors Framework. The tool was developed by the Yorkshire Quality and Safety Research Group and has been used on over 30 wards, several Emergency Departments, and a care home group. Through this we have learnt that:

- Patients and service users can tell us about safety and provide information about when safety failures are more likely to occur.
- The information collected from patients and service users differs from other forms of safety intelligence already collected, e.g. case note review, staff incident reporting and patient complaints, and therefore does not duplicate effort.
- Staff are extremely positive about the use of PRASE feedback for making ward improvements and that the information provided is suitable to support effective action planning.

By asking about contributory factors PRASE aims to identify things that could lead to harm before the harm occurs so staff and patients/service users can take action. As Trusts implement PSIRF, we are looking to support them via our newly developed training and through existing tools, such was PRASE.

Quality Improvement Training

As well as developing our training offer around PSIRF, the team has been updating our Quality Improvement training to bring it in line with PSIRF and the draw on the new skills and expertise within the team. Our Quality Improvement training now consists of 5 levels – from QI beginner to QI Leader – supporting colleagues at all stages of their QI journey. The new courses are due to go live early in the new financial year.

Artificial Intelligence in the Real-World

Funding from The MPS Foundation was awarded in 2022 to support a new collaboration between the Improvement Academy at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and the Assuring Autonomy International Programme (AAIP) at the University of York. The funding is being used to understand how Artificial Intelligence (AI) might be used in the real world with clinicians and patients. Different human-machine interaction models for shared decision-making in healthcare will be tested and their ethical and legal implications considered. We recently completed the first stage of recruitment for the study and have published the first paper: Lawton, et al. (2024). Clinicians risk becoming 'liability sinks' for artificial intelligence.

Academic Unit of Ageing and Stroke Research

Grant Successes

The ASR has continued to work with partner organisations and public members to develop new research proposals addressing key health and care questions relevant to ageing and stroke. In financial year 23/24, we have successfully won over **£6M** new research grant funding. This includes the following recent grant awards:

We have been awarded a **£2.3M** research grant by National Institute for Health and Care Research (NIHR) Health Technology Assessment. Collaborating with University of Leeds, Exeter and Liverpool, and Liverpool University Hospitals NHS Foundation Trust,

the project aims to establish whether comprehensive geriatric assessment (plus usual care) is a clinically and cost-effective intervention to sustain independence in activities of daily living (IADL) for older people with heart failure with preserved ejection fraction and frailty when compared with usual care alone. The project has commenced on 1st March 2024 for a duration of 58 months. We aim to recruit 17 sites across the North West, Yorkshire & Humber and South West regions.

We are also delighted to have won **£1M** research grant from NIHR Health and Social Care Delivery Research. The research aim is to improve quality and accessibility of structured medication reviews (SMRs) to reduce overprescribing for older people with severe frailty living in the community and care home residents, informed by intersectional characteristics and experiences. The project brings together interdisciplinary expertise through collaborating with University of Bradford, Leeds and Liverpool, University College London and NHS West Yorkshire Integrated Care Board.

We have received new funding from The Dunhill Medical Trust for a Reimagine Ageing Doctoral Research Programme. The programme will create **3 PhD opportunities** - focused on sustaining the independence and well-being of older people through cross-disciplinary research.
In relation to existing PhD studies, we are pleased to announce three of our PhD students have successfully passed their viva.

Congratulations to Dr Oliver Todd who has been appointed **as Clinical Associate Professor in Geriatric Medicine & Honorary Consultant Geriatrician** at University of Leeds and Bradford Teaching Hospitals NHS Foundation Trust. This caps off an excellent year for Oly, following a **successful NIHR Advanced Fellowship** application and **British Geriatrics Society's Rising Star award**, alongside other successes.

Successful completion of the Community Ageing Research 75+ (CARE75+) original pathway

The Community Ageing Research study was established in 2015 with the aim of creating a national cohort of older adults (≥ 75 years) to provide observational data for analysis and potential participants for research studies with older adults. (https://bmjopen.bmj.com/content/9/3/e026744.abstract)

Between 2015 and 2020, **1325 participants were recruited to CARE75+ Original**, and the last 4-year follow-up assessment was completed in February 2024. A huge thanks to the general practices for the hundreds of invitation letters they have posted, to the researchers for their skills, patience, and dedication to recruitment and assessments, but most of all to the participants that were willing to share their time so generously. Over the 4 years that individuals participated in the study, they underwent 5 detailed assessments where they were measured, questioned and tested, and researchers often reported that it was an absolute privilege to be a part of their research journey.

CARE75+ has generated a huge amount of data on a diverse range of outcome measures including health conditions, medication, quality of life, mood, independence, resilience, self-efficacy, vision, hearing, blood pressure and frailty. CARE75+ has captured over 4 million items of data and the rich dataset has been resourceful in supporting a range of research projects across the UK. This includes topic areas in pain and pain impact, depression, quality of life, social care costs, cognitive frailty, falls, frailty measures and perceptions of independence.

NIHR | Applied Research Collaboration Yorkshire and Humber

In December, the ARC Yorkshire and Humber (YH ARC) received excellent feedback from the National Institute for Health and Care Research (NIHR) on our annual report and successfully achieving our objectives for the last financial year. Work has now begun preparing for this year's annual report which includes working towards adding a summary of all our live projects (over 160) to a public facing NIHR database.

We have had confirmation that the NIHR has approved our business plan for the 18 month extension period. The ARC extension will run from September 2024 to March 2026.

We hope to launch the brand new YH ARC website at the end of March, which will include a searchable list of projects and publications, bite sized research summaries, and more emphasis on how YH ARC can help implement our findings with organisations such as NHS Trusts and Local Authorities. The new website will help to provide a clearer understanding of YH ARC and what it does, to support this we have also produced an interactive infographic and animation which will be added the website. We will share the links to these resources in the next update.

Our series of Lunch & Learn webinars continue to grow in popularity, and we have a full schedule for the next 6 months on a wide variety of topics. All upcoming Lunch & Learns can be viewed here and past events are recorded and added to our growing You Tube platform, as a resource for the region.

Our quarterly newsletter was relaunched in December, rounding up all the latest YH ARC news, publications, blogs and events, you can view it here. We also plan to have special editions throughout the year and you can sign up to receive the newsletter here.

We continue to build partnerships with the Yorkshire & Humber ICS and ICBs. YH ARC has been asked to chair communities of practice in the region and will be leading a series on prioritisation events for the ICBs to set regional research priorities and agendas.
So YH ARC has:

- leveraged over £62million of external funding to support our work
- recruited over 50,000 participants into our research
- collaborated with 41 member organisations
- worked on over 300 research projects
- supported over 70 PhD students
- published over 200 research papers

During the extension period we hope to focus on knowledge mobilisation and building regional links and partnerships to increase dissemination of our work to decision makers. We will increase face to face events and raising the profile of YH ARC as a source of high quality evidence that drives change.

Yorkshire Quality and Safety Research Group

Over the last few months, the team have been working to complete studies, produce final reports and ensure that our work is impacting national policy and local safety practice.

Our Learn Together project has come to an end and the final report has now been submitted to NIHR. This project which investigated how to support patients and their families to be involved in safety investigations has allowed for the production and testing of resources that focus on restorative justice and ensuring that investigations, at the very least, do not result in compounded harm for staff and patients. For more information about and access to the resources, please follow this link https://learn-together.org.uk/ The findings have already been integrated into the first version of the NHS England guidance to support engagement and involvement in incident responses (that appends the PSIRF). The team are currently working with NHS England to support the revision of this guidance, to incorporate the full findings of the Learn Together evaluation, which will be published in 2024/2025.

Another project that has finished in the last few months, with a final report (synopsis) submitted to NIHR in January 2024 is the Partners At Care Transitions (PACT) project. Here, we used a large (39 wards) cluster RCT to evaluate an intervention (Your Care Needs You) that encouraged older people to know more, move more and practice taking medicines while they were in hospital and know what to look out for and how to respond when things don't go as planned after they returned home. The intervention didn't reduce readmissions at 30 days post-discharge but we did find a significant impact at 90 days with readmissions being 13% lower in the intervention group. We also found that 30 days after leaving hospital, patients reported a better experience and fewer patient safety incidents if they had been part of the intervention group. The intervention was also cost-effective. These positive findings indicate this might be worth rolling out further and we are currently in discussions with the Improvement Academy about how best to do this. Huge congratulations are due to the PACT team, particularly Jenni Murray (programme manager), the researchers (Ed Breckin and Lubena Mirza) and the team of research nurses and practitioners – Jayne Marran, Sally Moore, Jacqui Elliot, Jane Schofield and Rachel Swingler who all did an amazing job of getting this up and running at a very challenging time. Thanks also to the teams across the Trust who took part.

The team have also been working closely with the NHS England Worry and Concern group and our Policy Research work (commencing shortly) will focus on an early evaluation of the implementation of Martha's rule.

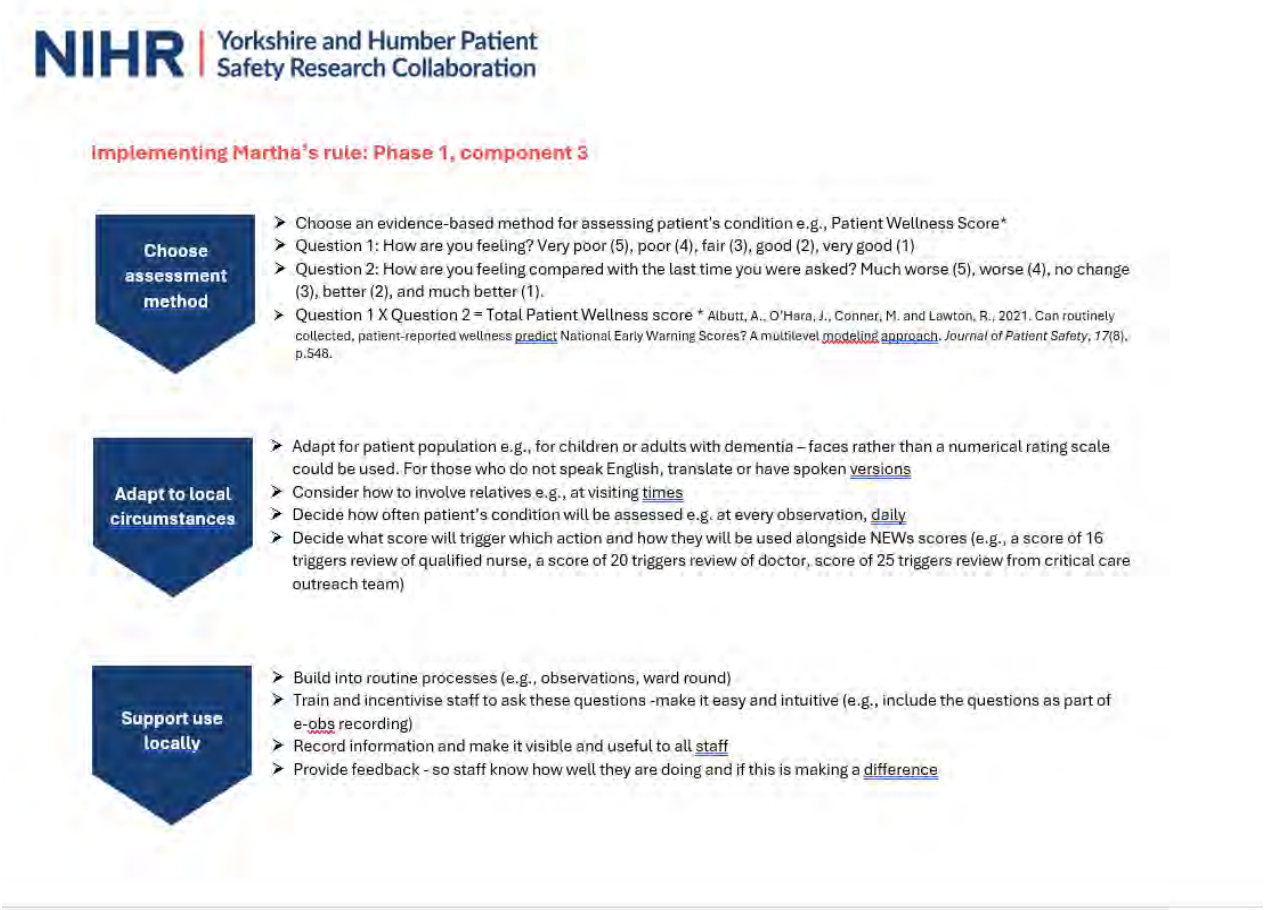
The 3 proposed components of **Martha's Rule** are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, which they can contact should they have concerns about a patient.

2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition. This is Martha's Rule.

3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

We have produced a document, based on research we have conducted over the last few years to understand how patients and families can best provide information on their condition. The Patient Wellness Questionnaire which we designed with patients, family members and staff is a useful tool for collecting this information. Guidance about how to use this measure can be found on the YQSR resources page and is shown below:



Clinical Research

Clinical Research Delivery Workforce

The Clinical Research Workforce are continuing to work together as a centralised team and the Senior Research Nurses and Midwife meet with R&D teams on a monthly basis at their strategic operations meeting.

The centralisation of the workforce has highlighted discrepancies in training and development for the staff so training is being investigated with the intention of providing a training matrix and guidance for the clinical research workforce. The Research Matron is working with the training team to collate a training record and plan for the workforce. A number of "sweeper days" for research specific training were organised through the Yorkshire and Humber Clinical Research Network alongside Leeds Research Academy and was offered to all clinical research staff. There were 200+ sessions attended by the wider team.

Trust Research Unit Council

The unit council continues to work with the team to address the issues raised in their staff survey. They are currently working on various projects including:

- Organising quarterly connection events for the whole workforce
- New project "Let me Introduce You" to introduce teams to each other's staff and workloads, to foster collaboration and sharing best practice etc.
- New Research Support circle started which meets monthly for all admin/support staff in clinical research.
- Archiving project – to address current state of archiving and develop guidance to ensure the Trust can meet the legal and regulatory requirements regarding this.

The Council's hard work led to them being featured in the Trust shared governance newsletter.


February 2024, Newsletter 13

TOGETHER IS BETTER

The BTHFT Newsletter of Shared Governance

Supporting Nurses & Midwives to be at the centre of decision-making through sharing responsibility and accountability

February saw the councils hold their first meetings of 2024. There's a lot of exciting activity planned for this year. Keep reading to find out more

Clinical Research Unit Council

The clinical research nurses and midwives set up a unit council for their team last summer. The council is led by Susan Shorter (pictured). Since starting their shared governance journey they have undertaken several projects. They identified the team's priorities for action and support quarterly 'connection cuppa' events to promote team building and networking. Also, a survey of clinical research nurse & midwives highlighted archiving of clinical research records as a key challenge across the department. As a result, the unit council ran an archiving current state process mapping event, facilitated with OD support , to start their journey into addressing the archiving challenges.

Clinical Research Specialty News

News and highlights from some of the research specialties this quarter include:

Anaesthetics

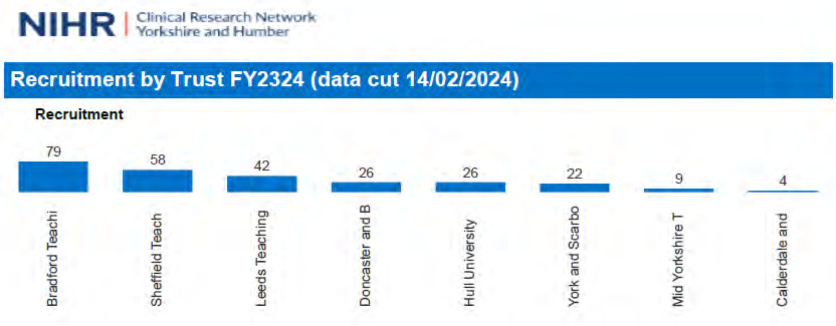
'Patient reported Outcomes, Postoperative pain and Pain relief after daY case surgery' (The POPPY study).

The POPPY study is under the umbrella of RAFT (https://www.raftrainees.org/) to engage future Consultant Anaesthetist's in research. Principal Investigator, Dr Bret Claxton supported the study with Associate Principal Investigators Dr Helen Stanworth and Dr John Dereix leading and engaging with many other doctors for the week to swell the 'research team' to be able to undertake the necessary processes on the day; with the support of the Anaesthetic Research Nurses. The clinical areas of Wards, 14, 20 and ENT Day Case were incredibly engaged and supportive, thanks to the work of all, even to the extent of identifying potential recruits or those meeting exclusion criteria.

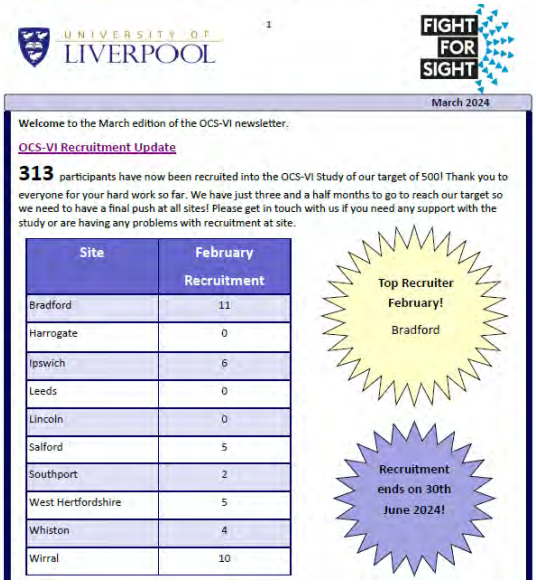
This fast moving, intense recruiting study required preparation to enable smooth processes. In the time between admission for day surgery to going to theatre, the 'research team' had to work alongside all the necessary clinical teams and not cause any delays to care.

It is with thanks and great working relationships of all, (including the support of Consultants to enable junior doctors to be released to participate in recruitment) that the POPPY study recruited 71 participants over the allowed five consecutive days.

Stroke



The stroke specialty staff remain the highest recruiting site in Yorkshire and Humber – allowing more research participants to take part in research here in the Trust than in any other regional site.



March 2024

Welcome to the March edition of the OCS-VI newsletter.

OCS-VI Recruitment Update

313 participants have now been recruited into the OCS-VI Study of our target of 500! Thank you to everyone for your hard work so far. We have just three and a half months to go to reach our target so we need to have a final push at all sites! Please get in touch with us if you need any support with the study or are having any problems with recruitment at site.

Site	February Recruitment
Bradford	11
Harrogate	0
Ipswich	6
Leeds	0
Lincoln	0
Salford	5
Southport	2
West Hertfordshire	5
Whiston	4
Wirral	10

Top Recruiter February!
Bradford

Recruitment ends on 30th June 2024!

They have also successfully collaborated with the Orthoptic Research specialty staff to open a new study OCS VIA 02-Jan-2024. The trial is investigating the Oxford Cognitive Screen (standard V enhanced) and Vision tests. This is a very successful venture, despite the staff from the two specialties only being able to work together 1 day per week. They met trial target by the end of January and were the highest recruiters in February. Current recruitment is 19, trial target 9. Recruitment ends in June 2024.

Rheumatology

Professor Phillip Helliwell, Rheumatology Consultant and Principal Investigator at Bradford Teaching Hospitals NHS Foundation Trust and a Senior Lecturer in Immunology, has been nominated for the Outstanding Lifetime Contribution to Healthcare award in the 2024 'Our Health Heroes' awards. He has dedicated his career to advancing research and patient care in the field of psoriatic arthritis. Over several decades, he has made ground-breaking contributions that have transformed our understanding and treatment of this challenging autoimmune condition. Through his visionary leadership, he has pioneered studies redefining clinical concepts of the disease, leading to improved diagnosis and management globally.

As Chief Investigator of the influential Classification of Psoriatic Arthritis (CASPAR) study, Prof Helliwell spearheaded the development of widely adopted classification criteria for psoriatic arthritis. His work creating validated disease activity measures and screening tools also continue to impact patient outcomes today.

Two new studies have opened in Rheumatology recently:

Moose is a portfolio study with a target of x10 patients with a diagnosis of Rheumatoid arthritis who will be randomised to the gold standard Disease Modifying Antirheumatic Drug (DMARD) cytotoxic medication Methotrexate in either oral or subcutaneous injections. The cost of both drugs is the same, and the study aims to

see which of the 2 methods of drug administration is the most effective, given the high incidence of adverse effects with the oral route.
BaXics is a portfolio observation study aimed at patients with Psoriatic Arthritis who have evidence of Axial spondyloarthritis (axSpA) a type of arthritis characterised by affected joints in the axial skeleton of spine, chest or pelvis. The pain and stiffness of this type of arthritis can be quite debilitating, and drugs which specifically target this sub-type are limited currently as many are still in the early stages of research.

Dermatology
Dermatology had a very difficult to recruit to study Pustular psoriasis: eLucidating Underlying Mechanisms (PLUM) extended for recruitment as they've done incredibly well getting 26 recruits overall out of 30 planned. Patients are extremely rare in Dermatology clinics with approximately 5 patients seen over the course of a year, and Research Nurse Jenny Ott has worked especially hard on this study. The study is observational in collaboration with Guys and St Thomas's and is looking at better ways to help us understand the condition pustulosis psoriasis, which will help with the development of drugs to treat the disease and give better treatments for patients with the condition.

Rheumatology
The RESOLVE study is rapidly moving forward, approx. 300 recruits and cluster randomisation are due in the next couple of weeks. This study with its high recruitment over a short period of time has been supported by staff from all the research teams based at St Luke's. RESOLVE is a large NIHR study which is looking at the amount of sodium in dialysate fluid for dialysed patients. The whole dialysis unit of patients with the exceptions of a few opt outs (mainly for clinical reasons), are opted in to be randomised to the same amount of sodium either 137 or 140 mmols of sodium over a 5 year period. The aim is to see whether or not this makes a difference to haemodialysis patients' cardiovascular system, in terms of incidence of heart attacks and strokes during the 5 year surveillance period.

Welcome to new staff

Rebecca Leon has joined our Maternal and Child Health Research Team as Senior Research Midwife. She is an experienced research midwife who has joined us from a neighbouring trust and is also the Regional Reproductive Health and Childbirth Research Champion.

BO.5.24.9 - PAEDIATRIC AUDIOLOGY SERVICE

REFERENCES

Only PDFs are attached

Bo.5.24.9 - Paedatric Audiology service (cover).pdf

Bo.5.24.9 - Appendix 1 - Paediatric Audiology service.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.9

Quality Assurance of Paediatric Audiology

Presented by	Dr Ray Smith, Chief Medical Officer	
Author	Rob Gardner, Head of Audiology Rob Guest, Senior General Manager, Surgery & Digestive Diseases CSU	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	To enable a Board response to the CQC that there is oversight and assurance in relation to the safety, quality, and accessibility of children's hearing services at BTHFT.	
Key control	N/A	
Action required	For assurance	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Meeting**	**Date**
	N/A	

Key Options, Issues and Risks

Background

In 2021 an Independent Review of Paediatric Audiology Service at NHS Lothian found systemic failings which led to some babies and children being undiagnosed or significantly delayed in diagnosis and appropriate treatment.

As a consequence of this, and to try and identify any issues in England, the Newborn Hearing Screening Programme reviewed the data of every newborn baby born in England (2018-2023) and identified four Trusts who had diagnosed significantly fewer babies with a permanent childhood hearing impairment (PCHI) than expected following initial hearing screening assessment.

The review of these Trusts identified root causes that led to poor service delivery and outcomes. Subsequently more Trusts came forward to indicate that they are actively reviewing or pausing their services and it was therefore believed there may be other services where quality improvements need to be made and some babies/young children recalled for further testing.

National Paediatric Hearing Improvement Programme (PHIP)

Recognising the system wide nature of the issues identified, a National Paediatric Hearing Improvement Programme (PHIP) was established by NHS England in April 2023 to support providers and ICBs to improve the quality of services with a set of system recommendations for immediate action being developed.

These included an assessment template for ICBs to work with their providers to complete and gather evidence of compliance. This evidence was then sent to regional teams and reviewed by Audiology Subject Matter Experts, in order to risk rate the services.

The outcome of this review in a letter issued to BTHFT from the North East & Yorkshire Medical Director (Appendix 1) was that it did not identify significant concerns within the service at BTHFT, but there were some issues of note to improve the service, namely the need for departmental documentation to be reviewed and version control added to ensure consistency, and that the service should continue to embed the British Academy of Audiology (BAA) paediatric quality standards into practice.

BTHFT was one of only two services within WYAAT where no significant concerns were found.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.9

The West Yorkshire ICB has subsequently established a West Yorkshire Paediatric Audiology Oversight Group, the aim of which is to manage all highlighted areas of concern from the reviews to monitor improvement to 'green' level of assurance. There is medical director oversight to this group from Dr James Thomas, and Bradford is represented on this group by Rob Gardner, Head of Audiology.

All services are required to submit action plans to this group, addressing any concerns/improvements that were identified in the review. BTHFT's Action plan was submitted to this group on 12 April 2024.

Board assurance to the CQC about Improving quality in physiological services (IQIPS) accreditation

More recently on the 8 April 2024 the CQC wrote to CEOs of all Trusts providing paediatric audiology services asking that it considers the assurance that they have about the safety, quality, and accessibility of its children's hearing services and whether services are accredited by IQIPS.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care.

Following that, a board signed off report should be shared with the CQC that makes clear:

- *Whether the Paediatric Audiology service has achieved IQIPS accreditation, including whether there were any improvement recommendations made.*
- *Whether you are working towards IQIPS accreditation.*
- *What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.*
- *The expected timeline for gaining accreditation.*
- *The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.*

Additionally, if the service is not IQIPs accredited then.

- *It should formally register this as a quality risk in their quality reporting system.*
- *An external evidence-based assessment of the service provision should be conducted which should be included in the response to CQC.*
- *Additional reviews of assurance are conducted at subsequent board meetings and follow up reports provided to CQC.*

Analysis

Assessment of BTHFT service to update CQC

With regard the questions asked in the letter from the CQC:

- The paediatric audiology service at BTHFT is not IQIPS accredited. As pointed out in the letter from the CQC, only 23% of services nationally are.
- The service would like to actively work towards achieving accreditation by registering with IQIPS, with a target of achieving accreditation within 2 years.
- The service has had no reported safety incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

As the service is not IQIPS accredited, a risk will be entered onto the CSU risk register as per the ask in the CQC letter.

Meeting Title	Board of Directors		
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Whilst not working towards IQIPS accreditation prior to this, the service has engaged in a number of quality programmes to assure the level of quality provided.

The service has actively engaged in the national/regional Paediatric Audiology Service Improvement programme including the participation in an independent desktop review of the service by Subject Matter Experts.

As previously stated, this did not identify any significant concerns regarding the department but has led to the development of an action plan that has been submitted to the ICB for sign off and oversight. Additionally, the service has been working on gaps identified by the Professional Bodies British Academy of Audiology (BAA) Quality assurance tool, however this work has been inhibited significantly by staffing shortages and will require significant resources.

A copy of the action plan and an analysis of the present state of the department with regard to these quality standards is available on request from the corporate governance team for any board members who would like further detail.

Other IQIPS accredited services

It is worth noting that the IQIPS accreditation applies to all physiological services. At present no BTHFT services are accredited although there are plans in place to achieve accreditation at part of the cardiorespiratory service at the Community Diagnostic Centre (CDC). It is known that in other WYAAT organisations, a number of services are either IQIPS accredited or are working towards accreditation. NHS England and the CQC have confirmed their commitment to, and strongly endorse, participation in accreditation schemes for diagnostic services. The CQC considers the accreditation status of diagnostic services as part of their assessment of NHS Trusts.

Options

1. Do nothing. Do not pursue IQIPS accreditation and continue to work towards actions in PHIP.

Advantages – no additional cost

Disadvantages - The service will have no further external quality assurance. The service is at reputational risk in particular if other local regional services achieve accreditation but BTHFT does not which could lead to commissioning and consequently funding issues. This could also impact the regional Cochlea Implant service hosted by BTHFT.

2. Work towards IQIPS accreditation by registering with IQIPS at a cost of £1,685 + vat and use the recommended external UKAS benchmarking tool to undertake an options appraisal over the next 3 months. This will then inform a further paper to board/executive team to determine whether to pursue full IQIPS accreditation once the gap analysis has been completed.

Advantages – having UKAS external benchmarking would provide external, independent analysis of present state of the service vs IQIPS standards. External validation will support future business cases.

Disadvantages – the UKAS benchmarking exercise can cost between £4k for a desktop exercise and £16k for the full onsite visit. It has the potential to identify areas where a service doesn't meet standards, but may not indicate how to meet standards, or what resources are required.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.9

3. Work towards IQIPS accreditation by registering with IQIPS at a cost of £1,685 + vat and commence formally working towards the standards required for IQIPS accreditation using the UKAS self-assessment gap analysis tool to identify resources and systems that will be required in order to achieve accreditation.

Advantages – no cost of UKAS benchmarking tool identified in option 2.

Disadvantages - time and resource required to do the self-assessment work and unknown whether this is achievable from existing resources. No formal external validation of work required to achieve accreditation.

Recommendation

This paper recommends to progress with option 2 as described above, to use the UKAS benchmarking tool in order to fully understand and produce a review of the current service against IQIPS accreditation. A further paper will come to the Board/ETM once the gap is fully understood and the cost of achieving this has been costed.

The Board is also urged to consider that no other service at BTHFT is either accredited, or working towards IQIPS accreditation, at present.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.9

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: Safe
Care Quality Commission Fundamental Standard: Safety
NHS England Effective Use of Resources: Clinical Services
Other (please state):

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

NHS England

To: Dr Ray Smith
Chief Medical Officer
Bradford Teaching Hospitals NHS
Foundation Trust

cc. Rob Gardner
Service Lead
Bradford Teaching Hospitals NHS
Foundation Trust

NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

13 December 2023

Dear Dr Smith

Paediatric Audiology Hearing Service Review

Thank you for the information you and your colleagues submitted for the Paediatric Hearing Services Improvement Programme. As you will know, these data were as requested by the '*Quality Improvement in Paediatric Hearing Services: recommended actions for immediate implementation'* letter from Professor Dame Sue Hill on the 31st of August this year.

We are now ready to share the results of the exercise. A letter has been sent to the ICB Medical Director with the combined results for services within the ICB patch. This letter is to share the results for the service at your Trust.

Review results for Bradford Teaching Hospitals NHS Foundation Trust

Audiology experts across the Region carried out a desktop analysis of responses and a validation exercise has taken place for all services. The outcome of the review is shown in the table below. The weighted review process provides a risk per category as follows:
A (no significant risk), B (low risk), C (moderate risk) or D (significant risk).

These are combined into an overall score, which is weighted towards the Auditory Brainstem Response (ABR) and Visual Reinforcement Audiometry (VRA) domains.

Bradford Teaching Hospitals NHS Foundation Trust	
Audit domain	**Score**
Calibration	**D**
Documentation	**B**
Visual Reinforcement Audiometry (VRA) rooms	**B**
Audit	**A**
Incidents/risks	**A**
Staffing	**A**
Auditory Brainstem Response (ABR)	**A**
Overall rating	**B**

In summary, the review did not identify significant concerns within this service. There are, however, some issues to note to improve the service for which an action plan should be developed to address the following:

- There is no evidence of version control on the documentation and some documents need to be reviewed. It is recommended that documentation is reviewed and version control added to ensure consistency.
- The service should continue to embed the BAA paediatric quality standards into practice.

The team should be congratulated as there are no significant concerns with the service. The ICB will be in touch regarding an action plan and timeline to address the issues above. We do expect services that have no significant concerns to offer support and provide mutual aid to other services that have been found to have risks. We are grateful for the support that staff from your service have already provided and look forward to continuing to work with you. We also expect all services in the region to engage with a region-wide ABR peer review process and we ask you to ensure your services participate fully.

Thank you again for the time taken to complete the review and your work to continue to develop and improve paediatric audiology services. We will continue to share the wider regional and national learning with all ICBs.

If you have any further questions, please do not hesitate to contact Dr Michelle Foster (michelle.foster10@nhs.net).

Yours sincerely

Dr Yvette Oade CBE
Regional Medical Director
North East & Yorkshire

Dr Michelle Foster (PhD)
Healthcare Scientist and Head of Audiology Service at Leeds Teaching Hospitals
Regional Lead Healthcare Scientist – North East & Yorkshire

BO.5.24.10 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY

REFERENCES

Only PDFs are attached

Bo.5.24.10 - Report from the Chair of the People Academy - 27 March 2024.pdf

Bo.5.24.10 - Report from the Chair of the People Academy - 24 April 2024.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.10

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 27 March 2024

Key escalation and discussion points from the meeting
Alert:
Dashboard – following a sustained month on month drop in turnover since June 22, February saw a very slight increase to 9.55% from 9.48% in January. Absence also saw a slight increase from 5.77% in January to 5.79% in February. Not significant but metrics to keep an eye on. **Gender Pay Gap (GPG)** – of the 6869 Trust employees, 76.4% are female. Whilst there has been progress made in both the mean and median pay gaps, women continue to earn less than men and are under-represented at more senior levels, with over-representation in supervisory and middle management roles. Men are significantly under-represented in Nursing and Midwifery roles and other typically female roles. The mean GPG has reduced from 26.1% to 24.4% and the median GPG has reduced from 7.7% to 5.2%. The Gender Equality Reference Group will be chaired by the new Chief People and Purpose Officer and will create a refreshed action plan, aligned to the overall Equality, Diversity and Inclusion plan, to ensure progress is made in reducing the gap and improving representation of females into senior roles and men into Nursing and Midwifery roles.
Advise:
Staff Story – Faeem shared a recent example of a mum about to return from maternity leave who needed to attend training at the Trust. The Trust weren't supportive of her need to breastfeed her baby or express milk which made it difficult for the mum to attend. As a result of her feedback, Faeem has now established a working group to ensure people understand that the Trust is supportive of breastfeeding, that managers understand this and speak to pregnant team members ahead of them taking their maternity leave to ensure they feel welcome and valued on their return and that the right facilities are available for breastfeeding staff.
Assure:
NHS Staff Survey Results – against a backdrop of sustained industrial action and media attention following the previous Chair's resignation at the time the survey was open, the Trust increased their response rate to 43% and have improved across most categories of the survey, achieving above the national average on all 9 of the People Promise questions. Notably, compassion and inclusion at 7.37 and engagement at 7.02 are nearing some of the best results nationally. Diversity and equality scores 8.26 and inclusion scores 7, people experiencing discrimination at work has dropped and advocacy has increased. People feeling safe in raising concerns has increased but there

has been a slight drop in confidence that their concern would be addressed. Burnout and work related stress have improved but still need further work. Overall, a very promising set of results that the Trust should be proud of with some clear work ons to be addressed through the survey action plan which will be presented at a future academy.

Outstanding Pharmacy Services – a year into the 2-year programme, the Pharmacy team returned to update the Academy on progress, with a new Programme Manager and 6 very active workstreams. They shared their highlights around culture and engagement, process mapping and the increase on their wellbeing score, up from 1.8 in February 23 when the programme started, to 3.1 in Feb 24 on a scale of 1 to 5. They are drafting a patient voice survey and piloting stay interviews. The team shared a fantastic initiative they've implemented following a complaint from a patient's wife that has improved the delivery of time critical Parkinson's medication to patients. A collaborative effort between the patient and his wife, a specialist Parkinson's nurse, Assessment Medical Unit, Emergency Medical Unit and the Pharmacy team. Another great example of how the programme empowers people to improve their experience of work and the patient experience.

Staff progression – Karen Dawber shared the Staff Progression report charting the progress of the work done to support and attract local employment. The turnover rate has reduced and whilst there is still work to do to grow the workforce, retain talent and attract the best candidates to BTHFT, the data from 2017 to date shows a strong improvement in the number of ethnic background staff in the medical workforce (now 46%) and across each grade in the admin and clerical workforce. There is still work to do to further improve ethnic background representation in Band 6 and above in the admin and clerical workforce and the Trust is focused on positive action to develop the pipeline they have built over the last 7 years.

A good meeting with a crammed agenda that meant some items were pushed for time. Those who contributed challenged and supported in good measure but it would be great to see contributions from more attendees.

Report completed by:

Karen Walker
Academy Chair and Non-Executive Director

27 March 2024

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.10

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 24 April 2024

Key escalation and discussion points from the meeting

Alert:

Sexual Safety Charter – The Assistant Chief Nurse for Vulnerable Adults, Safeguarding Team presented the 10 standards that Trust has signed up to and shared her plan to implement these across the Trust by July 24. The Trust reports lower than average in the NHS Staff Survey on unwanted behaviour of a sexual nature from patients, service users, their families, the public or their colleagues with 93 cases reported. It is suspected this is under-reported. Support is offered through Thrive, FTSU, OH, Safeguarding and HR and the Trust are raising awareness of reporting, support and resources available to encourage people to come forward.

High Level Risk – The Director of HR shared a new risk relevant to the Academy; 2549, the risk that the current Non-Surgical Oncology workforce in BTFHT and WYAAT can't continue to support the model of care required, delaying treatment and causing harm to patients.

Advise:

Dashboard – a draft new version dashboard was presented that shows staff turnover at 9.81%, a slight increase from February's 9.73%. Absence is at 5.88% and work is underway to explore how local health inequalities impact BTHFT staff and breakdown the staff groups to better understand where the issues are. It was suggested that the Trust could do more to promote Thrive wellbeing initiatives. The non-medical appraisal completion rate at 76.31% vs 85% target has been reducing since the start of the year, following an upward trajectory from August 23, and was discussed in detail. The Partnership Lead (Unison) shared his observations that people perceive appraisals are no longer meaningful and the Chief People and Purpose Officer shared her plan to review how the Trust makes them worthwhile through focusing on the wellbeing, support, development and enabling of people.

National Education and Training Survey – the 2023 results were shared, with 308 responses received representing a diverse range of students and trainees, an increase of 40% on last year. 7 of the 9 indicators have improved year on year and the 4 quality domains (Learning Environment and Culture, Educational Governance and Leadership, Supporting and Empowering Learners, Delivering Curricula and Assessments) exceed the national average and those of neighbouring Trusts. Theatres is a positive outlier in

teaching and Learning, likely driven by the Outstanding Theatres project. The lower scores in Surgery and, Obstetrics and Gynaecology are being explored. Staffing levels continue to be called out and the cost of living is impacting the retention of learners.

Assure:

Education Service Annual Report – the Head of Education shared the highlights of her team's performance over the last 12 months. They have won external recognition for the Apprenticeship team, the quality mark for Preceptorship and the Clinical Teaching Excellence Award from Leeds Teaching Hospital. There has been an expansion of the team in mandatory and statutory training roles, a locally employed Doctor tutor and more Clinical Fellows in response to the changing needs of the workforce. Student training placements have increased and feedback is positive which could lead to future recruitment but there are challenges in the capacity and state of the estate, budget cuts and a high workload that need to be overcome.

People Academy Annual Report – I shared a brief summary of the Academy's work in learning and improvement evidenced by staff telling their stories of the positive impact of the outstanding programmes, how the Trust is looking after our people, the impressive improvements in the various survey results, the growth of FTSU, EDI and the kindness and civility work. The hard work on recruitment and retention has paid off with turnover now below 10%. We've taken assurance from the dashboard, workforce reporting and planning, delivery of the NHS People Plan and Civility In The Workplace initiatives, and the Guardian of Safe Working Hours and Medical Appraisals and Revalidation reports. We've learned and grown as a team, the challenge between attendees has been constructive and valuable. Everyone around the Academy table has made a difference to our people and our patients, and I called out two particular people who have made a significant difference over this last twelve months – the Director of HR for his leadership in the absence of the Chief People and Purpose Officer and the Partnership Lead (Unison) for his support, contribution and fair challenge.

Report completed by:

Karen Walker
Academy Chair and Non-Executive Director

24 April 2024

GENDER PAY GAP REPORTING - MARCH 2024

REFERENCES

Only PDFs are attached

Bo.5.24.10 - Gender pay gap reporting - March 2024.pdf

Meeting Title	Board of Directors		
Date	9th May 2024	Agenda item	Bo.5.24.10

GENDER PAY GAP REPORTING MARCH 2024

Presented by	Renee Bullock, Chief People & Purpose Officer	
Author	Kez Hayat, Head of Equality, Diversity & Inclusion/ Asst Dir HR and Ruth Haigh, Equality, Diversity & Inclusion Manager	
Lead Director	Renee Bullock, Chief People & Purpose Officer	
Purpose of the paper	The purpose of this report is: • To inform the Board of the Trust's Statutory Gender Pay Gap Report that was approved at People Academy on 27th March 2024 and published for 30th March 2024 deadline in line with our contractual and legal obligations.	
Key control	To be in the top 20% of NHS Employers	
Action required	For assurance	
Previously discussed at/ informed by	People Academy (27th March 2024)	
Previously approved at:	People Academy	27th March 2024

Key Options, Issues and Risks

The 6th April 2017 saw the introduction of the Government regulations setting out the requirement for public sector bodies in England with 250 or more employees to publish their gender pay and bonus gap. The Equality Act 2010 (specific Duties and Public Authorities) Regulations 2017 bring in the gender pay gap reporting duty as part of the existing public sector equality duty (PSED).

It is a legal requirement for all relevant employers to publish their gender pay data and report within one year of the 'snapshot' date. The 'snapshot' date is 31 March 2023. The publishing date for data as at 31st March 2023 is 30th March 2024. All employers must comply with the reporting regulations for any year where they had a headcount of 250 or more employees on the 'snapshot' date.

As an NHS Trust we have been submitting and publishing our gender pay gap data to the Government for five consecutive years, i.e. 31 March 2017 and 31 March 2018, 31 March 2020, 31st March 2021 and 31st March 2022 (N.b. data collection as at March 2019 was paused in 2020 as a result of the Covid-19 pandemic). For the benefit of this report, we have included both the 2021 and 2022 data for comparison reasons where appropriate. This will be our 6th publication against the standard.

Gender pay reporting is different to equal pay. The gender pay gap is the average difference between the gross hourly earnings for all men and women which is expressed as a percentage of men's earnings (as set out in the explanation below). Equal pay refers to men and women being paid the same for like work; work rated as equivalent, or work of equal value as set out in the Equality Act 2010. It is unlawful to pay people unequally purely because they are a man or a woman.

Gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations and any subsequent analysis may help to identify what those issues are.

Our mean ordinary pay gap as at March 2023 was 24.4%. Since we began to report our Gender Pay Gap in 2018 (as at March 2017) when our mean gender pay gap was 31.34%, there have been fluctuations in this figure, but we have seen an overall improvement of 6.9% which is positive. However, we recognise that there is still work to do to reduce the gap and other gender equalities that exists within the workforce.

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We have included an analysis of the March 23 data comparing our data to other local acute NHS Trusts. This shows that we are not outliers in terms of ordinary pay gap. However, other Trusts within WYATT have now managed to achieve equity in their median bonus pay gap. Although we have moved to an 'equal shares' payment for the new style bonus payment to medical and dental staff this is still skewed for us by a number of staff remaining on the 'old style' bonus payment or in receipt of additional national payments.

Analysis

On 31 March 2023 our workforce comprised **6,869 staff**, of which; 5,250 **(76.4%) were women** and 1,619 **(23.6%) were men.**

Who is included in the data: The Regulations state that an employee, for the purposes of the headcount, is a person who is employed by the Trust on the snapshot date. Some bank staff are included if they are employed and have worked on an assignment as at the snapshot date of 31 March. Agency staff are not included.

There has been a slight decrease in all the reported data over the last 12 months, which is positive (with the exception of an increase in the mean bonus pay gap).

An overview of key highlights, which demonstrate an improvement since our last report (as at March 2022) include:

- A **1.7%** decrease in the mean gender pay gap (from **26.1%** in **2022** to **24.4%** in 2023).
- A **2.5%** decrease in the median gender pay gap (from **7.7%** in 2022 to **5.2%** in 2023).
- A **20.5%** decrease in the median average bonus pay gap (from **42.4%** in 2022 to **21.9%** in 2023). This is a significant difference from previous years and is caused by a slight reduction in the number of people receiving the 'old style' (higher value) CEA and a slight increase in the number of people getting the new style (equal shares) CEA - which means the central (median) point has shifted.

Women continue to make up a significant proportion of our workforce (**76.4%**), but with a slight (**0.5%**) increase in men since 2022 and an encouraging **5.8%** increase in men in AHP roles over the last 12 months).

Progress is being made with our gender pay gap since 2017. However, when it comes to pay; although there are more women employed in the organisation, women continue to earn less than men. There is still work to do to address the issues in the following key areas:

- Women continue to be under-represented at more senior levels and over-represented at supervisory and middle management levels.
- Men continue to be significantly under-represented in Nursing & Midwifery and some other traditionally female professions.

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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: Well Led			
Care Quality Commission Fundamental Standard: Staffing			
NHS England Effective Use of Resources: People			
Other (please state):			
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality &Patient Safety	Finance & Performance	Other (please state)
☒	☐	☐	☐

Meeting Title	Board of Directors		
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1 PURPOSE/ AIM

The purpose of this report is to provide detail of our mandatory gender pay gap data and reporting.

2 BACKGROUND/CONTEXT

2.1 Gender Pay Gap Indicators – Overview

The legislation requires employers to publish the results of six calculations and this report provides information on:

- **Mean gender pay gap in hourly pay –** adding together the hourly pay rates of all male or female full-pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.

- **Median gender pay gap in hourly pay –** arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of range.

- **Mean bonus gender pay gap –** add together bonus payments for all male or female employees and divide by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.

- **Median bonus gender pay gap –** arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

- **Proportion of males and females receiving a bonus payment –** total males and females receiving a bonus payment divided by the number of relevant employees.

- **Proportion of males and females in each pay quartile –** ranking all our employees from highest to lowest paid, dividing this into four equal parts (‘quartiles’) and working out the percentage of men and women in each of the four

The median helps to show where the mean value has potentially been skewed by an outlier (a few individuals at the very top or bottom of the range).

2.2 BTHFT Gender Pay Gap Data – 31st March 2023 (snapshot)

The following data was collected on 31 March 2023 when our workforce comprised **6,869 staff**, of which; 5,250 **(76.4%) were women** and 1,619 **(23.6%) were men.**

Throughout this report, where appropriate, data for March 2021 and/or March 2022 has been included to show a comparison and evidence our position and progress over the last three years.

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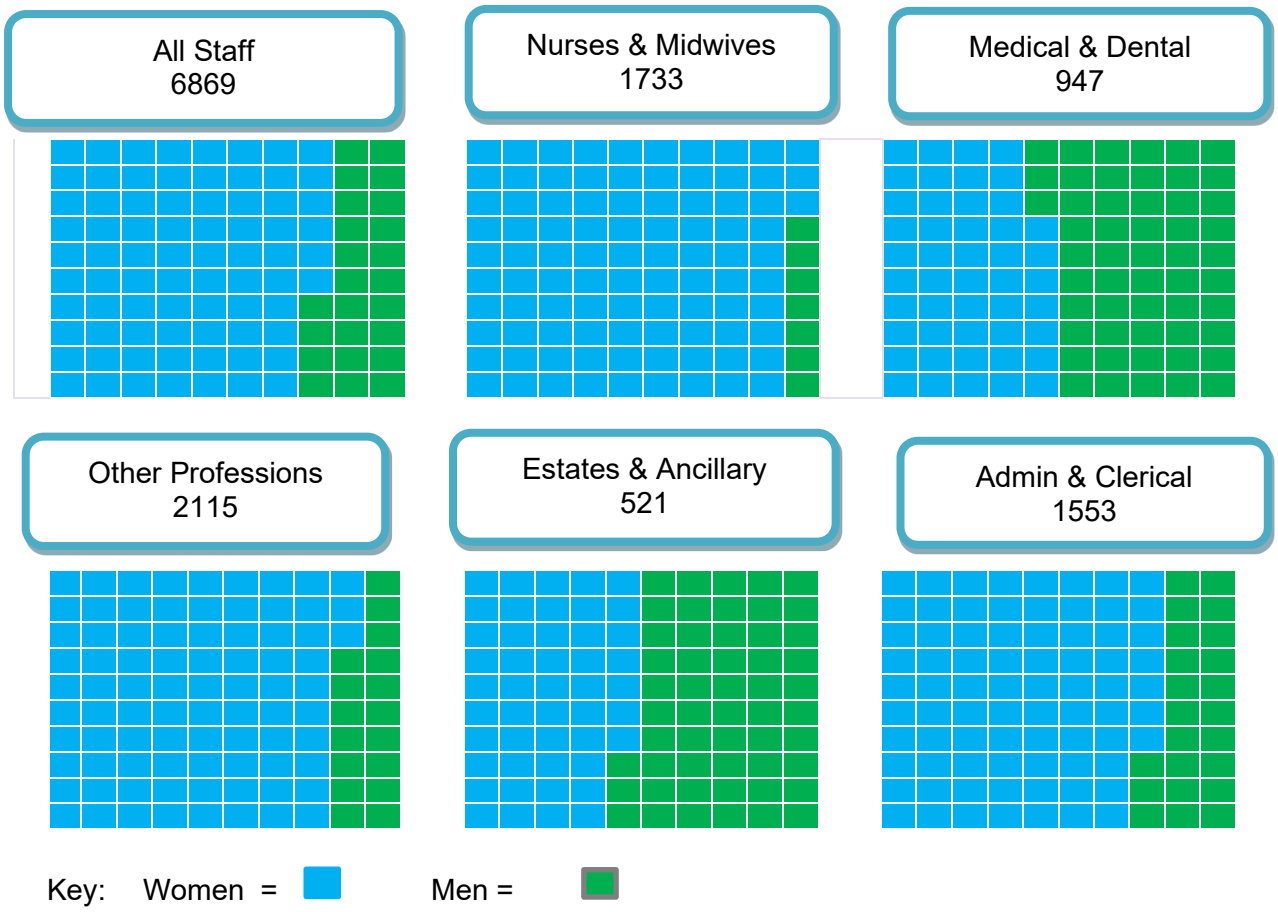
Workforce by Gender

The table below illustrates how our workforce was made up by gender as at 31st March 2023.

The green squares represent men, and the blue squares represent women. Women make up a significant proportion of our workforce (76.4%). *There has been a slight increase (0.5%) of men in the workforce as a whole over the last 12 months.*

Men continue to be significantly under-represented in Nursing & Midwifery roles and some other traditionally female professions. However, it is worth noting there has been **a 5.8% increase in male AHP's over the last 12 months** with the representation of men in AHP roles now being proportionate with the representation of men in the workforce as a whole.



Quartile Reporting

The pie charts below show the proportion of males and females when divided into four groups ordered from lowest to highest pay. The data below ranks our whole-time equivalent employees from highest to lowest paid, divided into four equal parts (quartiles). The lower quartile (red) represents the lowest salaries in the Trust and the upper quartile (green) represents the highest salaries.

In March 2023 there were proportionately more women employed by the Trust (76.4%) than men (23.6%). If we are to have gender pay equality, the same proportion of men and women should be

represented at all levels of the organisation. The following analysis shows that this is not the case at BTHFT and **women continue to be under-represented at the most senior levels and over-represented at supervisory and middle management levels. There has been little change in this metric since March 2021:**

- **At 64.2%; Women continue to be proportionately under-represented in the Upper quartile (higher paid staff) by 12.2%** (compared to 76.4% women in the organisation overall).

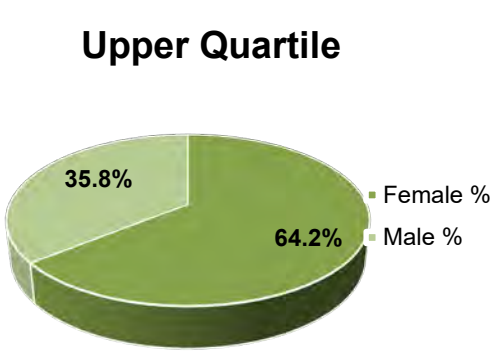
The proportion of women in the upper quartile has fluctuated over the last three years. After an encouraging 1% increase in March 2021**, we have now seen a further reduction in the proportion of women in the upper quartile again this year (down 1% to 64.2%).**

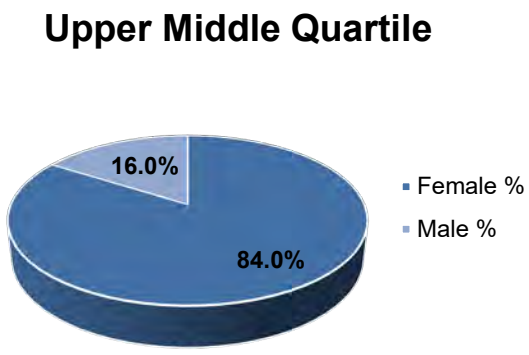
Women continue to be proportionately over-represented in the Upper Middle quartile (84%) with no real change from last year.

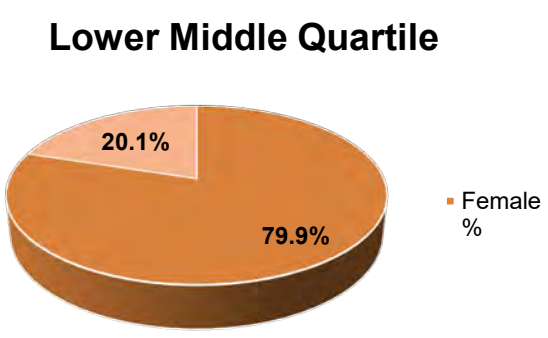
Women continue to be proportionately over-represented in the Lower Middle quartile (79.9%), although representation of women in this quartile has decreased again this year by 1.7%.

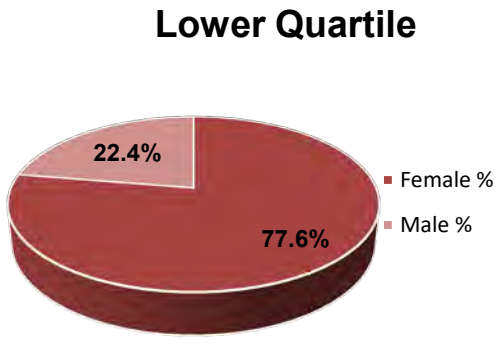
Women are now just slightly over-represented in the lower quartile (lowest paid staff) at 77.6% after an increase of 1.6% this year.

The charts below show the percentage of males and females who fall into each quartile:









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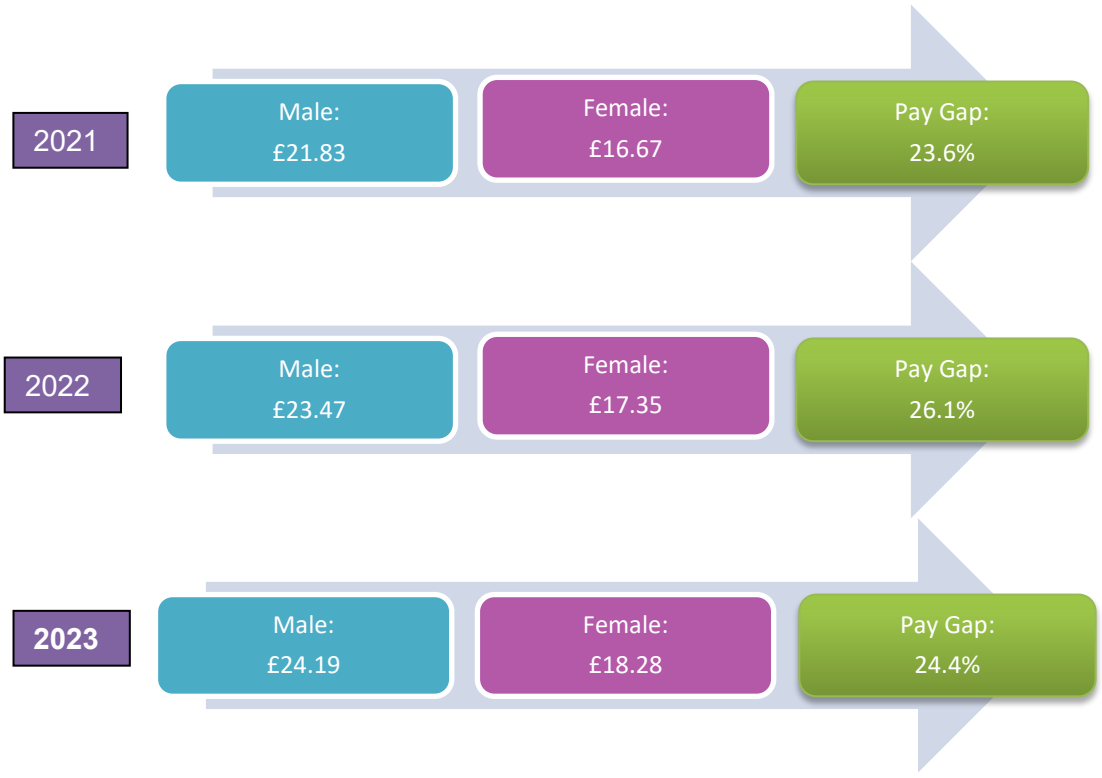
Average Gender Pay Gap as a Mean Average

The mean is calculated as the sum of all values (hourly pay rate) divided by the number of staff.

Table 1

Average Hourly Rate	2021	2022	2023
Male	£21.83	£23.47	£24.19
Female	£16.67	£17.35	£18.28
Gap	**23.6%**	**26.1%**	**24.4%**

When it comes to pay, although there are more women employed in the organisation; women earn less. The mean average pay gap has fluctuated over the last few years. However, this year we have seen a slight increase in women's mean average hourly rate of pay between March 2022 and March 2023 which has resulted in a **slight decrease (of 1.7%) in the mean gender pay gap from 26.1% to 24.4%**



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Average Gender Pay Gap as a Median Average

Median is calculated by separating each pay list by gender and then putting each list in order from lowest to highest. The Median is the middle number in each list.

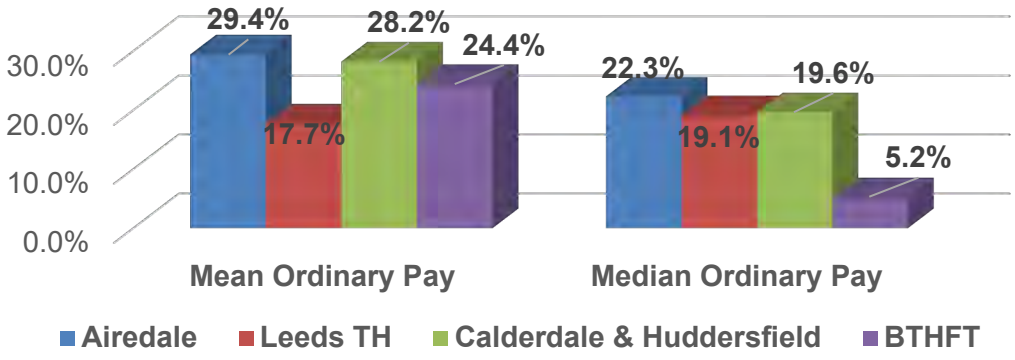
Table 2

Median Hourly Rate	2021	2022	2023
Male	£15.78	£16.82	£17.33
Female	£14.69	£15.54	£16.43
Gap	**6.9%**	**7.7%**	**5.2%**

There has been a year-on-year increase in women's median average hourly pay rate for the last 3 years and despite a slight increase last year, **the median average pay gap has decreased again this year by 2.5% (from 7.7% in 2022 to 5.2% in 2023)**

Comparison of Gender Pay Gap (ordinary pay) – March 2023 data

This shows that we are not outliers in terms of ordinary pay gap.



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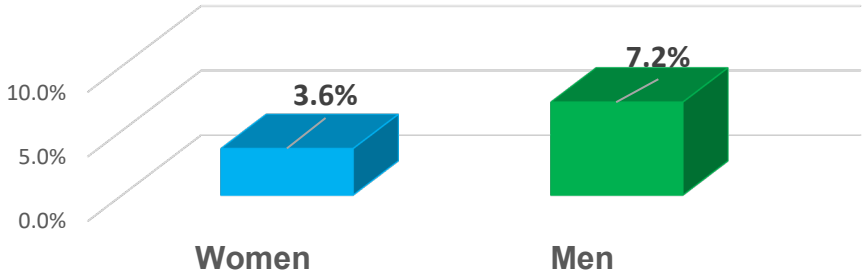
Percentage of Men and Women receiving a Bonus Payment at BTHFT

3.6% of the women at BTHFT and 7.2% of the men at BTHFT received a bonus payment in March 2023. This shows a slight improvement from the proportion of men/ women paid bonus payments in 2022 (when 2.2% of women and 11.9% of men were paid bonus payments).



For the purposes of the gender pay gap requirements this data is calculated as a proportion of the workforce as a whole. However, the only bonus payments made in the Trust are clinical excellence awards (CEA) paid to medical & dental consultants.

As at 31st March 2023 the consultant workforce was made up of 125 (39%) women and 193 (60.7%) men. 304 staff were paid bonuses, 117 (38.5%) women and 187 (61.5%) men. **The number of bonus payments is therefore roughly proportionate with the number of men and women in the Medical Consultant workforce.**

For the 2022 Clinical Excellence Award (which is paid to eligible consultants in their March 2023 pay); eligibility for the award was assessed in April 2022 and an equal share of the total award was paid to all those who were eligible (without requirement to submit an application). Payment was made in full, irrespective of someone's hours of work. **This has been the case since 2020 and has created greater equity for female consultants going forward who are more likely to work part-time hours. The proportion of consultants receiving the CEA is now also directly related to the proportion of eligible consultants employed, rather than limited to a selection of those who have made an application for the award.**

It is worth noting that, from previous analysis of this data; the bonus pay gap is primarily due to there being a higher number of male consultants in the workforce historically, with a higher length of service and seniority which were previously success factors in successfully receiving the existing local CEA (which is an award that is paid in varying amounts). As at March 2023 there also continued to be some consultants (all male) who were in receipt of a national award for clinical excellence (a national application process that is renewable every 3-5 years, but potentially generates much higher bonus payments dependent on the level of the award). We are aware that as of April 2023 one of our female consultants has been successful in attaining a national award.

New arrangements for CEA have been in place since 2020. There is no longer opportunity for anyone to apply for the 'old style' CEA and this award will be subject to a formal review in the future in agreement with the Local Negotiating Committee. In the interim this means that year-on-year the numbers linked to the 'old style' CEA may only change as people retire or leave the organisation for other reasons.

Therefore, whilst the overall proportion of consultants now receiving a bonus payment is now roughly proportionate with the number male/ female consultants over-all; due to the variety of payments still being made, male consultants still earn on average (mean average) 38.1% more in bonus payments than female consultants.

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Average Bonus Gender Pay Gap as a Mean Average

Men continue to earn on average 38.1% more in bonuses than women. This is an increase of **7.3%** from last year and is closer to the bonus pay gap reported in 2020, which was **37.22%).**

Table 3

Average Bonus Pay Per Annum	2021	2022	2023
Male	£11,110.12	£10,898.68	£8,142.16
Female	£7,910.34	£7,546.68	£5,041.58
Gap	**28.8%**	**30.8%**	**38.1%**

Since 2020 the Trust has agreed to pay bonuses only to eligible Medical Consultants on an 'equal shares' basis (based on national eligibility criteria). As at 31st March 2023 the consultant workforce was made up of 125 (39%) women and 193 (60.7%) men. 304 staff were paid bonuses, 117 (38.5%) women and 187 (61.5%) men. **Therefore, in terms of numbers this is roughly proportionate with the number of men and women in the Medical Consultant workforce.**

However, the mean average bonus payment values made to men and women continues to be higher for men (see table 3). Whilst CEA payments are now equal shares (which is more equitable), due to the increase in eligible consultants taking an equal share, the total amount of each payment has reduced this year across the board for men and women. In combination with this, there have been increases (pay awards) to both 'old style' CEA payments and national awards (disproportionately paid to males for historical reasons – see page 9). The difference in the mean bonus pay gap continues to be wholly attributable to variations in the 'old style' CEA payments/ national awards.

It is anticipated that, over the next few years we will see an improvement in the mean bonus pay gap data as 'old style' CEA payments are gradually phased out and more women potentially achieve some of the higher paid national awards.

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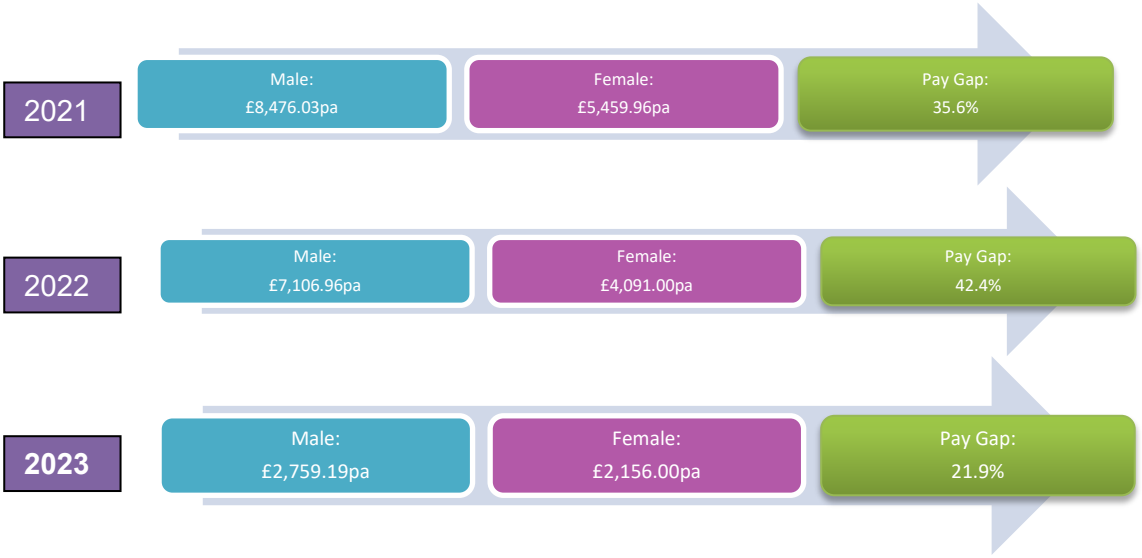
Average Bonus Gender Pay Gap as a Median Average

As a median average (mid-point of all payments for men compared to the mid-point of all payments for women)**: men earned 21.9% more than women in bonuses in March 2023**. This is a decrease of **20.5%** in the bonus pay gap over the last 12 months.

Table 4

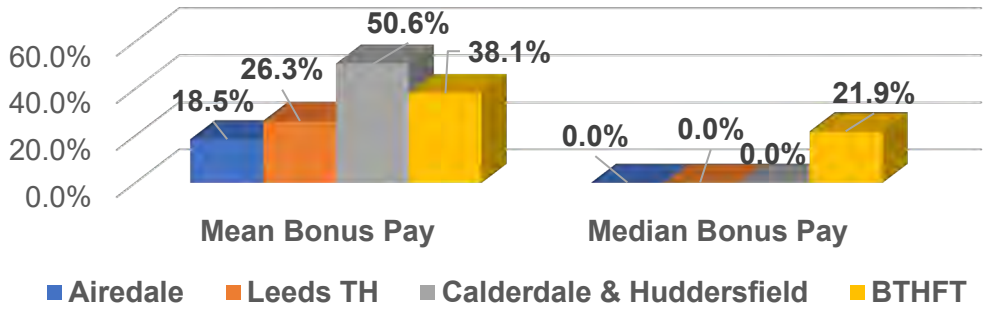
Average Bonus Pay Per Annum	2021	2022	2023
Male	£8,476.03	£7,106.96	£2,759.19
Female	£5,459.96	£4,091.00	**£2,156.00**
Gap	**35.6%**	**42.4%**	**21.9%**

The Trust has paid bonuses only to eligible Medical Consultants (of whom there are more men than women). Whilst we know there is a higher number of men in receipt of 'old style' CEA and national pay awards (which are potentially much higher in value), there has been an increase in the number of men who are in receipt of the new (equal shares) CEA award and a slight reduction in the number of consultants receiving the 'old style' CEA award, shifting the mid-point of all awards paid to a lower value. This can be seen in table 4 where the difference between the mid-point/ median value for men and women has decreased from a difference of £3015.96 in 2022 to a difference of £603.19 in 2023.



Comparison of Gender Pay Gap (bonus pay) – March 2023 data

Although we have moved to an 'equal shares' payment for the new style bonus payment to medical and dental staff this is still skewed for us by a number of staff remaining on the 'old style' bonus payment or in receipt of additional national payments.



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3 PROPOSAL

3.1 Progress to date on Gender Equality

The Trust has made some progress over the last 12 months around gender equality. The following are examples of some of the positive activity that has been taking place:

3.2 **Flexible Working:** According to our People Promise Manager; the largest demand for flexible working comes from younger age groups (linking to working parents and working mothers), and with 56,000 people having left the NHS since 2011 (citing work-life balance as the primary reason) flexible working forms a crucial part of creating modern and inclusive employment practices.

The Trust recognises that more action is needed to increase the uptake of flexible working across BTHFT to allow us to recruit and retain diverse talent and ensure that we are an employer of choice and to improve the working life for our (predominantly female) workforce.

Our staff survey results tell us that 58.16% of BTHFT staff feel they have been provided opportunities for flexible working, but we are keen to ensure that a shift in the organisation culture ensures that everyone has the opportunity for some form of flexible working. This includes focus on changing the way that managers think about the provision of flexible working and what this might entail, including making the formal process simpler and considering informal options such as swapping shifts, time off in lieu, staggered start/ finish times and self-rostering.

There has been particular focus over the last 12 months to facilitate flexible ways of working for front-line staff. We have updated our flexible working policy, circulated practical guidance and toolkits on how to make flexibility work for everyone, including specific guidance for managers, developed flexible working workshops for managers, looking at their specific flexible working challenges and how to overcome them and held 1:1 surgeries for all staff.

There is scope to develop this work further as we endeavour to move to a culture which promotes flexible working at a team level, and we propose to work with the People Promise manager to ensure this is captured as part of our gender equality action plan for the coming year.

3.3 **International Women's Day 2024:** On 12th March 2024 we held our first ever International Women's Day celebration event in the Sovereign Lecture Theatre. The event was hosted by Karen Walker, Non-Executive Director and with closing remarks made by Karen Dawber, Chief Nurse. The event featured a diverse range of guest panellists and speakers who shared their inspirational leadership journeys and experiences of working for BTHFT, including Mel Pickup, Chief Executive and Sarah Jones, Chairperson. Presentations provided delegates with an overview of the Trust position and direction of travel in relation to gender equality and the progress that the Trust has made over the last 12 months around areas of work such as flexible working and menopause support (becoming a menopause confident employer). The event was well attended and well received, and served as a catalyst for both gender equality, including trans equality and allyship.

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Delegates also learned more about the Gender Equality Reference Group which was established in 2021 to review the progress and agree priority areas for action around gender equality. The Gender Equality Reference Group was led by the Director of HR, Pat Campbell (who became the Gender Equality Champion). With the departure of Pat Campbell in 2023, this role will be taken over by the Chief People & Purpose Officer and membership of the group will be refreshed and expanded with new members being invited to join.

3.4 **Menopause Friendly Employer:** Research has shown that Menopausal symptoms can result in women losing confidence and they may consider leaving work. All Trust staff will experience menopause in some way, shape or form, be it themselves, a friend, a loved one or a colleague. However, with 4022 females at BTHFT over the age of 30, that is potentially 62% of our workforce who may personally experience symptoms of varying levels in the next few years.

The Trust has developed a Menopause Network; A group of staff who are dedicated to providing education and support to BTHFT employees with the aim of creating an environment where staff can talk openly about the menopause and where managers are empowered to provide appropriate support for their staff.

A whole range of activity has taken place over the last 12 months including face-to-face events, video's, webinars, menopause café's, the provision of the "Balance App" and a dedicated page on Thrive. The Trust has also developed the role of Accredited Menopause Advocate, a group of staff who provide signposting and supporting and helping colleagues to gain understanding about the menopause and think about different ways of managing symptoms. The Trust is also about to introduce a new, lighter weight uniform which should be more comfortable for women during perimenopause/ menopause and have launched a new "Menopause Guidance" document for managers and staff. This fantastic work has resulted in the Trust being recognised and accredited as a "Menopause Confident Organisation".

3.5 **The NHS EDI Improvement Plan,** launched in 2023, was co-produced through engagement with staff networks and senior leaders. It sets out six high impact actions targeted at addressing the prejudice and discrimination (direct and indirect) that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The EDI Improvement plan builds on the NHS People Promise and the People Plan, which sets out the priorities for improving the sense of belonging experienced by our diverse NHS workforce.

Each of the six high impact actions includes SMART (specific, measurable, achievable, realistic and time-bound) objectives, which we as a Trust are required to implement. One of these high impact actions includes the need to "**Develop and implement an improvement plan to eliminate pay gaps".**

As a Trust we are taking steps to complete the following actions:

- Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024).

- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.

- Continue to implement an effective flexible working policy including advertising flexible working options on organisations.

3.6 Next steps

3.7 The Trust gender pay gap data was published by 30th March 2024 in line with our legal requirements.

3.8 The Trust is required to report this information annually on its website by the data deadline and the refreshed data set has now been published.

3.9 We will be working with our Gender Equality Reference Group to review and refresh our gender equality action plan, aligning this to the EDI Improvement plan, considering new actions and look at developing existing actions further.

3.10 The action plan will continue to be developed around three key themes with an overall aim of ensuring we recruit, retain and support the right staff and develop excellent leaders who have the skills to empower our people and create a positive culture where our people feel valued, can take responsibility for their actions and flourish. The main focus of our action plan to reduce our gender pay gap will be:

- **Women in Leadership:** Increasing engagement with aspiring females and representation of women in senior management roles, including development and talent management. Exploring potential "blockers" for women progressing

- **Further developing a culture of flexible working** focussing on front line roles

- **Addressing the under-representation of men in Nursing & Midwifery** and challenge traditionally female role stereotypes.

We will continue to work with other NHS Trusts and partners at place level to learn from best practice and explore opportunities to develop joint activities.

4 BENCHMARKING IMPLICATIONS

Benchmarking data is now published and available for the March 2023 data (as at 2.2 above) and will be shared with People Academy with our next gender equality update.

5 RISK ASSESSMENT

N/a

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6 RECOMMENDATIONS

It is recommended that the Trust Board:

1. Note the contents of the report and Gender Pay Gap data submissions
2. Support the next steps to reduce the Trust's Pay Gap (Section 3.6 – 3.10)

7 Appendices

N/a

BO.5.24.11 - EQUALITY & DIVERSITY COUNCIL UPDATE

REFERENCES

Only PDFs are attached

Bo.5.24.11 - EDC Update May 2024 V2.pdf

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Strategic Equality and Diversity Council May 2024 Update

Presented by	Mel Pickup – Chief Executive Officer	
Author	Ruth Haigh, EDI Manager	
Lead Director	Renee Bullock, Chief People & Purpose Officer	
Purpose of the paper	The purpose of this report is to: Update the Trust Board on the work of the Equality and Diversity Council and provide an overview of the key areas of focus since our last update in January 2024.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Academy/Group**	**Date**
	N/A	

Key Options, Issues and Risks

The Trust's Equality and Diversity Council (EDC), chaired by CEO, has a remit for both workforce and wider health inequalities in the district and continues to meet quarterly.

This report provides an update on the key highlights from the last EDC meeting which was held on 29th April 2024.

Analysis

The following key items were discussed at December EDC meeting:

- Staff Equality Network Updates on progress and future plans
- Health Inequalities – Self Assessment
- Findings of the Too Hot to Handle Report and Next Steps

Recommendation

It is recommended that the Trust Board:

1. Note the contents of this report
2. Support the proposed areas of work identified in section 3.1

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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 one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				G		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					G	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

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

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

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

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

Meeting Title	Board of Directors		
Date	9th May 2024	Agenda item	Bo.5.24.11

1 PURPOSE/ AIM

The purpose of this report is to:

- Update the Trust Board on the work of the Trust' Equality and Diversity Council and provide an overview of the key areas of focus since our last update in January 2024.

2 BACKGROUND/CONTEXT

2.1 EDC has been in place since January 2021 and continues to meet every quarter, providing strategic direction, leadership and support to the Trust EDI agenda, including the Trust's approach in tackling population health inequalities.

2.4 EDC Membership

2.5 All EDC members are encouraged to attend each meeting and EDC is usually very well attended. Where attendance is not possible members are asked to send a representative on their behalf.

2.6 Chairs of each of the Trust's staff equality networks are included as members of EDC with dedicated agenda time at each meeting. This enables staff networks to have a voice where they can actively influence EDI across the Trust.

3 Highlights of the EDC Meeting – Monday 29th April 2024

3.1 EDC continues to be well attended and generates lots of useful discussion, with 26 people attending the April meeting, including Renee Bullock the new Chief People & Purpose Officer and Mark Hindmarsh the new Director of Strategy & Transformation. This section provides a summary of agenda items and actions arising from EDC since the last Trust Board update provided in January 2024.

The table below captures some of the key discussions from the meeting which took place on 29th April 2024.

Staff Network Updates
General Update (from all Networks) <u>Exec Champions for Staff Equality Networks:</u> Saj Azeb is the Exec Sponsor for RESIN and Karen Dawber is Exec Sponsor for the LGBT+ Network. Mark Hindmarsh volunteered to sponsor the Enable Network. The offer remains open for any of the Non-Exec Directors to get involved where they feel they can add value. Karen Dawber talked about the event she attended organised by NHSE around how Execs can support staff equality networks and how she is currently supporting LGBT+ network core group members to gain agreement from their line managers around ensuring protected time for network activity. <u>CQC Staff Networks Listening Event:</u> There was excellent attendance and participation from across all 3 networks at the recent CQC Staff Network Engagement session which took place on 17th April. This was a great opportunity to share

some of the positive progress that has been made for networks in the last couple of years (including recognition with a Nurisng Times Worforce award), but also some discussion around some of the challenges that remain. Network members felt the enthusiasm and commitment around the role and remit of networks really came across in this discussion.

People Promise Event:
Network members also participated in the People Promise event which took place on 18th April allowing us to showcase all the fantastic work that is taking place across the Trust centred around each of the People Promise pillars and which CQC inspectors were also able to attend.

Engagement with networks around Staff Survey Action Plans:
Staff Survey action plans have been developed in response to our 2023 Staff Survey results and these have been shared with each of the 3 networks for their feedback and to generate discussion around how these can influence the work plans for each network.

Upcoming EDI events involving Staff Networks:

8th May is *National Day for Staff Networks* which will involve a celebration event on the main concourse at BRI and an opportunity for colleagues to share their views on EDI priorities at the Trust.

Equality, Diversity & Human Rights week (13th – 17th May) will also provide an opportunity to showcase the three staff equality networks on the main concourse, but also with guest speaker and Inclusivity Champion Fatima Khan Shah joining an event in the Sovereign Lecture theatre via livestream to share her experiences and lead a discussion around creating a fairer and more inclusive NHS for both patients and staff.

Enable Staff Network Update

Membership and recent activity:
Sonia Sarah, Co-chair of Enable provided an update for the network. There has been a quieter period for the network following the activity that took place in December 2023 around *Disability History Month*, and with some members leaving and others joining there continues to be a real focus on driving up network membership to ensure there is the capacity to focus on developing the network work plans.

Sonia advised EDC of a new member joining the Enable Core Group and hopes that this will provide an opportunity to re-energise Core Group activity.

Enable marked *Neurodivesity Celebration week* in March, which is a worldwide event focussed on challenging the stereotypes and misconceptions around neurodiversity. They shared an informative article via global comms which included a number of webinars on key topics, raising the profile of neurodiversity.

Wider Enable network meeting: A wider Enable network meeting took place on 16th April which provided an opportunity for a wellbeing check-in for members, with lots of discussion around the Trust Disability Equality policy and sharing lived experience on how staff are navigating their own personal journeys in the Trust. The role of carer was a topic of conversation for the last meeting. Despite lower membership for the Enable network compared to other networks, Sonia emphasised the important role they play in supporting staff with long term health conditions and caring roles as and when they need that additional support and guidance. Meetings continue to be virtual only as this allows more network members (who may be working remotely) to attend.

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RESIN Staff Network Update

Membership and recent activity:
With RESIN network membership expanding further (around 300 members to date), Raquel Licas reinforced the commitment of the network in nurturing a sense of belonging and driving forward change. She recognised and welcomed the support of BTHFT Charities and the Senior Leadership team and shared a number of slides with photographs of recent network activity and celebration events which included:

- Chinese New Year
- Holi
- Supporting the Ramadan Roadshow (getting out to community locations)
- Easter
- Supporting the EDS2022 Staff Engagement event
- Supporting International Women's Day (with network members sharing their lived experience)
- Vaisakhi (with excellent feedback coming from the Sikh community)
- Supporting 'Pause for Peace' which is proving beneficial to many RESIN members and Rubina Yasin highlighted this is providing a safe space for colleagues to share some of the emotional challenges they are facing)

Current Focus:
The network are exploring with the SPaRC team re-establishing a monthly Catholic Mass for staff.

The Core group are also looking to work with comms to ensure their intranet pages are update and there is a regular comms update shared across the Trust and Renee Bullock offered to facilitate a meeting with network chairs and comms to support this ambition.

They also have plans to develop a survey to understand the needs of network members around e.g. learning and development and application and interview skills and Renee Bullock offered her support around developing a training needs analysis for network members to inform plans for the coming year (perhaps confidence skills).

Emma Fleary provided an update on the recent listen events taking place in maternity in which they are looking to shape activity to support staff going forward. There is particular focus on the experience of Internationally recruited colleaguesand also on the development of ethnically diverse staff to higher banded roles. Kez Hayat highlighted the alignment of this work to the national EDI Improvement Plan (high impact action 5). Renee and Karen Dawber thanked those involved and, along with the EDI team, offered to support this fantastic work going forward.

LGBT Staff Network Update:

Membership and recent activity:
Karla Pawlowski was introduced as the new comms officer for the LGBT+ staff network and provided an update on activity from the last 3 months and plans going forward. She confirmed, despite challenges with a number of key members leaving recently (including secretary and network chair Abbie Wild) the Core Group continue to meet regularly and provide a safe space for wider members, encouraging interactivity.

The network have also celebrated LGBT+ History month in February, including an event on the main concourse, and have contributed to other Equality related events that have taken place over the last 3 months, including the International womens day, and recent CQC feedback session and People Promise event.

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Current focus:
Due to current challenges the network have paused some of their plans including, the Rainbow Badge training. Instead, current focus is around recruiting and re-establishnig core group members and re-energising network participation and contribution to forthcoming plans and activities and they are looking to gather feedback from existing members on their proposed prioities in the coming weeks.

Renee and Karen offered their support in re-energising and re-focussing members and there was discussion around some of the challenges that members experienced in getting more involved with network activity and how these might be overcome. They also discussed the need for more information and signposting for LGBT+ staff and allies (who may have LGBT+ or questioning family members whom they wish to support). Proposals which are being explored such as the wellbeing hub and the Rainbow Garden could really help with this.

Challenges aside, network members are already discussing plans for Pride month which takes place in the summer.

Health Inequalities – Self Assessment

Naveed Saddique provided an overview of a new Health Inequalities Self Assessment Tool which has been published as part of a government good practice guidance document around how NHS Trust Board members can act on health inequalities and to recognise "what good looks like".

The tool allows Trust to assess their performance and assign maturity ratings against 4 domains (from Not started through to Thriving):

1. Building Public Health capacity and capability (rated Emerging)
2. Data, insight, evidence, and evaluation (rated Maturing)
3. Strategic leadership and accountability (rated Developing)
4. System partnerships (Maturing)

Naveed presented the Trust outcomes from this assessment, and the ongoing activity which has allowed us to achieve that progress, along with next steps, which include:

- Focus on the improvement opportunities across the 4 domains.
- Detailed action plans to be drafted for ratification at Quality & Patient Safety Committee.
- Follow up assessment in 12-months time

Naveed asked EDC to consider if there is anything else we should have included in the assessment and whether there are any other area's we could focus on to close the gap/ improve our score?

Mel provided some additional context in how the Trust has developed its approach to tackling Health Inequalities over the last few years and emphasised the Trust commitment to addressing this challenge and Mark Hindmarsh echoed his support and thanked Naveed and the team for all their hard work. He also communicated the need for everyone across the Trust to recognise the part they play in addressing population health inequalities. Paul Rice also highlighted the need for an equality impact assessment approach in individual areas across the Trust and Kez Hayat re-affirmed the need to consider access, experience and outcomes and within that approach and supported the idea of setting up a small focus group and to bring ideas back to EDC for further discussion.

Findings of the "Too Hot to Handle" Report and Next Steps

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Kez Hayat provided an overview the the "Too Hot to Handle" report which was published in 2024 in response to a number of high-profile Tribunal cases relating to allegations of racism in the NHS and the observation that talking about racism continues to cause fear and concern and elicits "performative" (what we are seen to be doing) rather than "effective" responses to address the situation.

Roger Kline and brap (a charity transforming the way we think and do equality) carried out a survey which elicited 1,327 responses relaying experiences or raising allegations of racism within their respective organisations.

The report is not about proving that racism exists in the NHS (we already know this is the case). It aims to identify key learning points to support the NHS to respond more fearlessly with allegations of race discrimination.

Some of the findings included:

- UK staff more likely to raise a concern than international staff.
- Concerns of believing nothing would change, being seen as a "troublemaker", not being taken serious or dealt with satisfactorily
- The most common outcomes of race discrimination concerns were "nothing happening", generic responses (such as mediation), the complainant themselves being disciplined.
- 41.8% of respondents left their jobs as a result of their treatment.

Survey respondents reported experiencing denial, reluctance/ refusal to acknowledge race as an issue, harm minimisation and lack of empathy. Many were subjected to a protracted investigation process and an unrealistic burden of proof. There was a general lack of confidence in receiving a fair response to any complaint of racism.

Recommendations included:

- Focus on leadership and role modelling behaviours.
- Developing an appetite and psychological safety to talk openly about race.
- Training and empowerment for staff in "anti-racist" practice
- Recognising early warning signs of racism and nipping it in the bud informally, at an early stage.

Kez asked EDC to consider what tangible actions the Trust can take to develop and "anti-racist" culture, how we can align this with the Root out Racism movement and how we can adopt/ adapt the place level approaches to anti-racism that are currently being developed?

Samia Hussain (HR) shared an update on the refreshed disciplinary policy, harassment & bullying policy and the Just Culture approach that the Trust is adopting, along with training and support for managers and staff to achieve this.

Kez reminded EDC about the EDI training which is really empowering managers in inclusive approaches, dignity, respect, kindess and compassion.

Kez challenged members to think about how we can create psychological safety for colleagues to have challenging conversations that may allow them to change their perspective.

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Sue Franklin (FTSU) talked about her learning from an annual FSTU guardians refresher and a reflection tool that was shared to take us through the required development steps, and a TEDEX talk about "Calling it in" rather than "Calling it out" – asking curious questions to start an open and educational discussion (with the power of forgiveness) rather than making an accusation. She talked about "listening in good faith" and leaders listening and being more aware.

Mel challenged EDC to think about how we might bring in those "quieter voices" to share their thoughts on this.

Rubina Yasin highlighted the role of SPaRC and Staff Advocates in these approaches (linking in with FTSU).

Karen Dawber highlighted the need to increase confidence for people to be more receptive to conversations about race and Mel agreed that there needs to be more confidence raising stories shared that demonstrate positive outcomes where people have been listened to and appropriate action taken.

EDC discussed the development of a place level anti-racist approach under Act-as-One and how we can adapt and adopt this strategy to meet our own organisational focus.

3.2 Next EDC is due to take place on Wednesday 17th July 2024.

4 RECOMMENDATIONS

It is recommended that the Trust Board:

1. Note the contents of this report
2. Support the proposed areas of work identified in section 3.1

5 Appendices

N/A

BO.5.24.12 - REPORT FROM THE CHAIR OF THE FINANCE AND PERFORMANCE ACADEMY - MARCH & APRIL

REFERENCES

Only PDFs are attached

Bo.5.24.12 - Report from the Chair of the Finance and Performance Academy - March 2024.pdf

Bo.5.24.12 - Report from the Chair of the Finance & Performance Academy - April 2024.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.12

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 27th March 2024

Key escalation and discussion points from the meeting
Alert:
Financial Plan Update -. At this stage in the planning process there is a deficit forecast for 2024/25 before delivery of waste reduction plans of £54.6m. A waste reduction plan of £26.3m has been agreed which will reduce the net deficit to £28.3m. The Academy was assured that the governance arrangements for the management of waste reduction are being strengthened and asked for consideration of how we strengthen reporting through the Academy going forward.
Advise:
Monthly Finance Report – The Trust is forecasting to deliver a £4.4m surplus for 2023/24, this is higher than last month's breakeven forecast due to two non-recurrent allocations that have been received from the West Yorkshire (WY) Integrated Care Board. **RTT Operational Improvement Plan –** The Deputy Director of Planned Operations took the Academy through the continuing actions being taken to maintain and improve referral to treatment performance. It was pleasing to listen to her feedback on the communications across teams within the Trust that support delivery of these improvements. **Performance Highlight Report** – The Academy received and reviewed the monthly comprehensive performance report. Our performance remains strong in comparison with our WY peers. **Health inequalities and Waiting List Analysis –** The Academy received a report on actions being taken within the Trust to reduce health inequalities, improve access, outcomes and experience. **Clinical Service Unit (CSU) to Academy Engagement Event** – The Academy received the slides from the CSU to Academy event that took place in March. **Procurement Update** – The Academy received an update on work undertaken, noting the savings that have been delivered in this area.
Assure:
High Level Risks Relevant to the Academy - The Academy was assured that all relevant risks had been identified, reported to the academy and were being appropriately managed. No new Finance and Performance Academy risks had been included on the risk register, none had changed in score, and none had been closed. **Internal Audit Plan** – The 2024/25 internal audit plan was shared with the Academy. **Emergency preparedness Resilience and Response Update** – the Academy reviewed the progress made on the work plan for 2023/24 and the work plan for 2024/25 and

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approved a number of supporting documents. The Trusts compliance rating will now increase to 50%. The Academy was assured on the work that has been undertaken. 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
April 4th, 2024

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.12

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 24th April 2024

Key escalation and discussion points from the meeting

Alert:

Financial Plan Update -The Academy reviewed the current operational and financial plan submission for 24/25 following on from the board development session the previous week. The net deficit in the plan has improved to £22.6m but is reliant on delivering a waste reduction plan of £32.3m.

The Academy was assured that the governance arrangements for the management of waste reduction are being strengthened and that the new Director of Strategy and Transformation will be attending future meetings to update on progress and delivery of the 'Closing the Gap' programme.

The plan is still subject to the NHSE assurance process.

Advise:

Monthly Finance Report – The Trust is forecasting to deliver a £4.6m surplus for 2023/24 (subject to external audit). The Academy congratulated the finance team and organisation on delivering the surplus.

Capital Report – The Trust has delivered its capital plan for 23/24 spending £55m on capital projects, another pleasing result.

Cancer and Diagnostic Operational Improvement Plan – The Academy were pleased to see the work underway to improve performance across cancer and diagnostics. The three-month trend data for cancer performance shows improved performance across 4 of the 5 cancer targets. The presentation included an update on the histopathology service and work underway to improve turnaround times.

Performance Highlight Report – The Academy received and reviewed the monthly comprehensive performance report. Our performance remains strong in comparison with our West Yorkshire (WY) and national peers. Urgent Care performance was 82.67% in March, this performance is in the upper decile of Acute Trusts in England.

Finance team – The Academy was delighted that the finance team has been reported as being the most improved finance team in the country in the national staff survey.

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Assure:

High Level Risks Relevant to the Academy - The Academy was assured that all relevant risks had been identified, reported to the academy and were being appropriately managed. A new risk on delayed discharges to care has been included on the risk register, this has been discussed through the Academy on several occasions. No risks had changed in score but the risk about missing or incorrect data on EPR has been closed and incorporated into a new data quality risk.

F and P Academy Annual Report – The annual report that summarised the business of the Academy over the last 12 months was approved by members.

Report completed by:

Julie Lawreniuk
Academy Chair and Non-Executive Director
April 29th, 2024

BO.5.24.13 - HEALTH INEQUALITIES & WAITING LIST ANALYSIS ? ACCESS FOCUS

REFERENCES

Only PDFs are attached

Bo.5.24.13 - Health Inequalities - Access Focus - May 2024.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Health Inequalities and Access to Care

Context

Bradford Teaching Hospitals
NHS Foundation Trust

- National guidance for 2022/23 focussed on **improving the use of data** to help us better understand health inequalities
- Guidance for 2023/24 has shifted focus to **coordinated action** to improve access, outcomes and experience
- In November 2023, NHS England published a Health Inequalities Statement setting out the data gathering and reporting requirements for NHS bodies

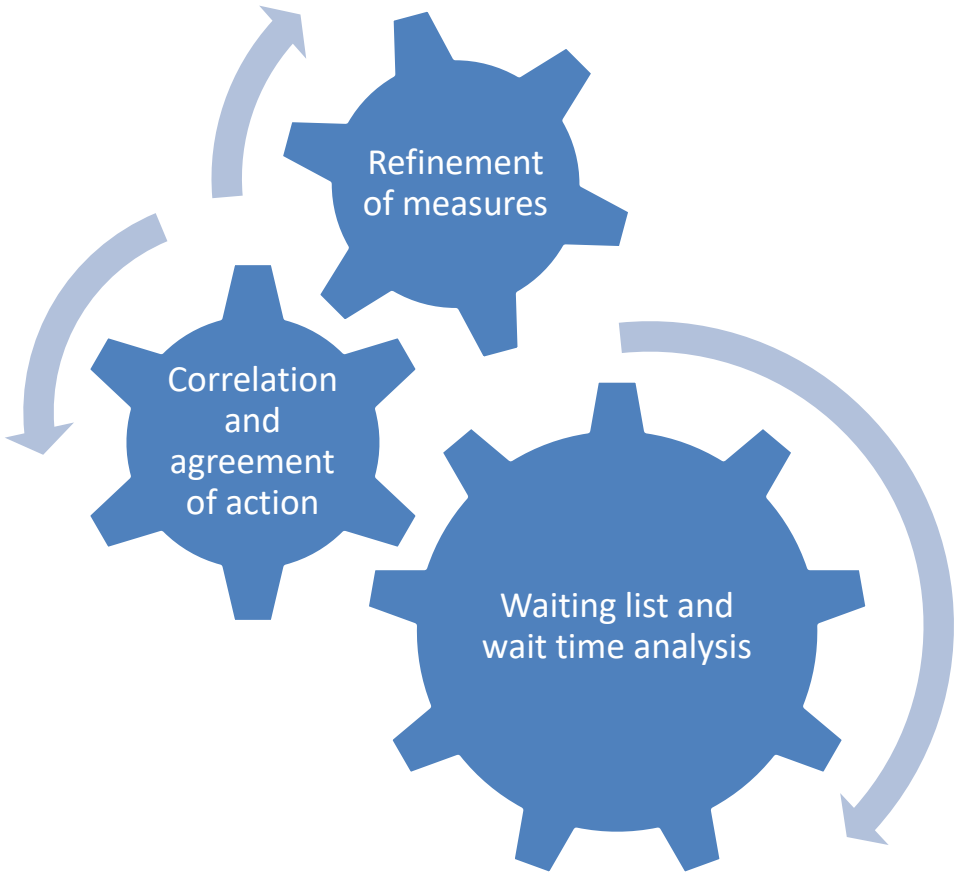
Access Data

Bradford Teaching Hospitals NHS Foundation Trust

- **Indices of Multiple Deprivation (IMD), ethnicity, age, sex and LD data items** were added to a master patient index and joined to all existing waiting list data
- The CORE20 cohort (**20% most deprived nationally**) has been identified from national data providing this lens on analysis
- Outputs from this **analysis** shared with internal groups and partners across the place footprint – this is now a reciprocal process but still needs streamlining to improve frequency
- Weekly **access meetings** include the ability to use IMD, ethnicity, age, sex and LD data items
- A dashboard specific to **reducing DNA rates** is available in support of the work several parties are progressing relating to this objective
- Bespoke analysis aligned to national or local priorities now possible

Using this data

Bradford Teaching Hospitals
NHS Foundation Trust



This is an iterative process whereby the analysis of any data will need careful consideration by operational and clinical colleagues.

When action is agreed and progress tracked we will then be able to refine the measures and provide further analysis in support of continuous improvement.

Ongoing Learning

Bradford Teaching Hospitals NHS Foundation Trust

- Approaches to analysis discussed with partner organisations including the BIHR
- Conversations to discuss approaches and findings are also in place at a West Yorkshire level with interest in work at CHFT
- Regular attendance at national sessions on reducing health inequalities and inclusive recovery
- Replication of national studies and NHSE analysis as part of our approach to using data
- Within the NHS Providers “What Good Looks Like, Guidance for Boards acting on Health Inequalities” self-assessment we scored ourselves as maturing for Data, insight, evidence and evaluation

Referrals and OPA

Bradford Teaching Hospitals NHS Foundation Trust

- Waiting lists are c.50% from CORE20
- Patients from CORE20 **more likely to be routine priority** (55% are CORE20) and **less likely to be Fast Track** (40% are CORE20)
- CORE20 patients now wait slightly less time than non CORE20 for first OPA having previously waited longer
- Routine activity has increased with growth exclusively in CORE20
- Routine waiting list has reduced for CORE20 as a result
- These changes may relate to post-COVID recovery of routine services taking longer than urgent and cancer services
- Outpatient metrics by TFC and by referral priority are similar for all patients except for DNA rates

DNA rates

Bradford Teaching Hospitals
NHS Foundation Trust

- Patients from CORE20 **remain twice as likely to DNA** despite improvement in some specific areas
- At an aggregate level there is no correlation between DNA rate and ethnicity within the CORE20 cohort by referral priority
- At a specialty level there was some correlation between DNA rate and ethnicity in a couple of instances
- There is a **strong correlation between DNA rate and age** (younger population more likely to DNA) and this is repeated for almost all specialties we looked at
- Focussed action to reduce DNA rates for younger patients in the lower IMD areas would have the best impact
- Findings shared with Act-As-One programme and Operational colleagues within BTHFT to inform actions to improve attendance

Treatment

Bradford Teaching Hospitals
NHS Foundation Trust

- Fewer referrals from the CORE20 cohort result in an admitted treatment (elective ordinary or day case spell)
- For routine and urgent referrals CORE20 are less likely to be admitted but for FT referrals they are equally as likely (when viewed as a percentage of completed pathways)
- Analysis by treatment priority shows once given a clinical priority the **time to TCI correlates more with TFC than IMD** (but some delays for CORE20 were observed for routine pathways)
- Routine referrals are often higher for CORE20 and patients who are admitted are more likely to be P3 and less likely to be P2
- Replicating analysis as per the November 2022 Nuffield report we observed lower drop-off rates for BAME patients compared to white patients (opposite to national trends) for all the procedures included except for Cataract and Dental

Cancer demand

Bradford Teaching Hospitals NHS Foundation Trust

- Skin cancer referrals are significantly less likely to be CORE20 (only 20%) with similar diagnosis and treatment per referral rates
- During summer 2023 referrals increased for skin cancer which resulted in a 13% increase in diagnosed cancer and a 26% increase in diagnosed cancer for the CORE20 cohort
- Without skin cancer included demand is 47% CORE20 (much closer to the 50% overall waiting list distribution)
- Breast cancer is at 49% for referrals but only 43% of treatments are for CORE20 (suggesting cancer is more prevalent in the referrals received from non CORE20 patients)
- Breast cancer referrals are increasing following national awareness campaigns

Updated Findings

Bradford Teaching Hospitals NHS Foundation Trust

- CORE20 patients are **more likely to be on routine pathways** which have a longer wait time and higher DNA rates
- Although there is no real difference within referral priority (FT, Urgent, Routine) for CORE20 and other patient wait times
- CORE20 **DNA rates are higher** than other patients across all referral priorities
- CORE20 patients seem **less likely to be referred for cancer** and cancer treatment
- **No evidence of variance in clinical prioritisation** of surgical waiting lists for CORE20 patients and treatment dates are given fairly within priority grouping
- Fewer referrals from the CORE20 cohort result in an admitted treatment

Improvement

Bradford Teaching Hospitals
NHS Foundation Trust

- Linking with Act as One and BIHR colleagues to discuss next steps in analysis and use of the findings
- Link findings to patient experience data and feedback from services as the actual experience of service users may be different to what the aggregated analysis can show
- Utilise population health data to support CSU insight and improvement activity
- Elective recovery, operational improvement plans, and implementation of policy are being considered with the positive impact they should aim to have on this agenda in mind
- Increasing referrals and improving OPA attendance (reducing DNA) require targeted work to support priority cohorts, this is being built into our operational excellence plans

Thank you

BO.5.24.14 - REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE

-FEBRUARY 2024

REFERENCES

Only PDFs are attached

Bo.5.24.14 - Report from the Chair of the Audit Committee - April 24v2.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.14

REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE FEBRUARY 2024

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 22 April 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	9 May 2024	Agenda item	Bo.5.24.14

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

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

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

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

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

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.14

REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE FEBRUARY 2024

1 PURPOSE/ AIM

To provide an update to Board regarding key matters covered in and relating to the Audit Committee meeting held on 22 April February 2024.

2 BACKGROUND/CONTEXT

The agenda of the meeting was driven by and derived from the Audit Committee 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	9 May 2024	Agenda item	Bo.5.24.14

REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE FEBRUARY 2024

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 22 April 2024.

2. Key Matters discussed

- **External Audit Annual Plan**
  The Committee received and noted a report from Deloitte on their planning for the year end audit. The auditors advised of the "significant" risks for the Accounts that they would be paying particular attention to accounting for capital spend, the vesting of assets, and the management of financial journals. The auditors informed the Committee of the materiality thresholds they would be applying to their audit.

  The audit plan also included the approach to the value for money opinion in which particular attention would be paid to financial sustainability/efficiency planning and any governance risks from reduced stability of Board membership during 2023/24. The Committee felt the auditor's planning document was not wholly accurate on this matter and the Senior Independent Director agreed to follow that up with Deloitte outside the meeting.

- **Internal Audit progress report**
  Internal Audit reported that continued good progress was being made in executing the 2023/24 Audit Plan with 13 reports having been received since the last meeting.

  Internal Audit reported that 8 audit reviews had been completed since the Audit Committee meeting in November:
    - 2 High Assurance
    - 10 Significant Assurance
    - 1 Low Assurance

  The low assurance rating was given to a report on 'Medical Records – Deletion and Destruction of Electronic Patient Records'. The auditors recommended that the Trust needs to do more to meet the requirements of the NHS England Records Management Code of Practice. The report also recommended greater clarity on the governance of medical records and improvements in the coverage of required policy documents.

  The Chief Digital and Information Officer said that because of the length of time EPR has been in place it doesn't fall under the responsibilities that a strict interpretation of GDPR would require us to apply. He said there were general issues across the country in terms of how to deal with digital footprints and the scrutiny of the preservation of data beyond a particular timeframe. He said he would work with internal audit and colleagues in other organisations on areas of good practice in response to the recommendations in the report.

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- **Follow up on Internal Audit Recommendations**
  The Audit Committee had expressed concern at the previous meeting about whether sufficient assurance could be taken about the follow up of internal audit recommendations. Having considered a paper from the Director of Finance on revised arrangements the Committee was assured about the proposed future process.

- **Draft Internal Audit Plan 2024/25**
  The Audit Committee received the draft plan and noted the consultative process that had informed its preparation. The Committee requested more information at its next meeting on the last 3 years' audits to ensure there was no gap in audit coverage. The Committee agreed progress can commence on the plan whilst aiming for final approval at the May meeting.

- **Counter Fraud progress report**
  Counter Fraud provided a report on progress since the last Audit Committee meeting which the Committee noted. The Trust should receive a green overall assurance rating on the functional standards. Standard 3 is currently the only amber score that we will return across the 12 different standards which relates to fraud risk descriptors and fraud assessments. Proactive work will take place throughout the year with the aim of achieving the green standard for Standard 3.

- **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. The Committee noted that the majority of losses related to write offs of overseas visitors. Whilst being advised that the Trust's approach to the issue was in line with good practice, the Committee will invite the Senior Healthcare Contracts and Overseas Manager to its meeting in September.

- **Annual Accounts 2023/24 Update**
  The Committee received an update on progress against the timetable and liaison with the external auditors. The Committee noted the assurance provided.

- **Policies and procedures for ensuring acceptable data quality for all key Trust data**
  The Chief Digital and Information Officer provided an overview and confirmed that the Trust has a series of steps, mechanisms and processes in place to ensure data quality across the Trust. It was felt, from the detail contained within the paper, that there was general positivity around data quality and processes within the Trust. As the CQC had raised the issue of Summary Hospital-level Mortality Indicator (SHMI) data the Committee sought to understand how the general positivity contrasted with this example. The Chief Digital and Information Officer confirmed that a separate piece of work is ongoing, through the Board, relating to the collection of SHMI data specifically around coding accuracy and the steps being taken to remedy those. He confirmed that an EPR optimisation programme, relating to the quality of data being captured, is being planned primarily for clinical care and also coding. This will ensure further assurance in relation to the quality of coding as data will be captured more accurately at the start of the process.

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- **Compliance with NHS provider licence and, code of governance**

  Provider Licence and, Good Governance and Collaboration

  The Associate Director of Corporate Governance reported that a revised provider licence was published by NHS England in March 2023 in line with the publication of the Health and Care Act. The licence now includes an assessment of the Trust's compliance with the guidance on good governance and collaboration which was published last year. The Trust has no areas of non-compliance, so the proposal is to declare full compliance against the provider licence.

  Code of Governance for NHS Provider Trusts

  The Associate Director of Corporate Governance noted that given the resignation of the Chair, part way through the year, has led to more partially compliant areas this year than normal. She confirmed that the Trust is required to either 'comply' or 'explain' with the requirements of the code of governance. The Committee felt assured with the explanations provided for the areas of partial compliance. A final position paper will be presented to the May Board.

- **Deficit Financial Plan**

  The Director of Finance advised that if the Trust posted a deficit plan the Audit Committee (or the Chair on its behalf) would need to review a template identifying a number of rapid actions and governance actions.

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

29 April 2024

BO.5.24.15 - REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

REFERENCES

Only PDFs are attached

Bo.5.24.15 - Report from the Chair of the Charitable Funds Committee.pdf

Board of Directors			
Date	**9 May 2024**	**Agenda item:**	**Bo.5.24.15**

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) • Julie Lawreniuk, Non-Executive Director • Karen Walker, Non-Executive Director • Sajid Azeb, Executive Lead for Charitable Funds • Mel Pickup, Chief Executive • Matthew Horner, Director of Finance In attendance: • Michael Quinlan, Deputy Director of Finance • Jacqui Maurice, Head of Corporate Governance Apologies were received from: • Sarah Jones, BTHFT Chair • Mohammed Hussain, Non-Executive Director • Sharon Milner, Charity Director • Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Observers	• Bryan Machin, Non-ExecutiveDirector/Audit Committee Chair • Raquel Licas, Staff Governor	
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 30 April 2024. High-level summaries of the key items discussed are presented below. The next meeting is scheduled for 2 July 2024.

High-level summary of key items discussed.

1 2023/24 Finance Summary

The Committee noted the year end position (subject to confirmation following the final external audit). Income was reduced by £922k against plan, of which £895k related to the Neo Natal Unit (NNU) appeal. The Committee noted that there has been a delay in fundraising for the NNU as this has been subject to a detailed re-review in year. Other areas impacting on the year end position are the increase in pay costs and the 57% rate of return which has resulted from the investments made in-year for the future benefits of the charity.

2 Investment report

The fund performance benchmarked well against other charities with a similar profile to our Trust. Year to date the fund was up by 3.5% and since inception there had been overall strong performance with a return of 24.9% against benchmarking of 11.2%.

Board of Directors			
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3 Five Year Plan (2024/25 – 2029/30)

Key points to note from the plan which was approved by the Committee.

- The increase in staffing in the lead up to and following independence (expected in 2025/26).
- The need to liquidate some shares to reimburse the Trust for the costs of the DaVinci Robot.
- The expected rate of return-on-investment set at approximately 35% in the next year (2024/25) and 45% in the year following (2025/26). Improved rates of return were expected following the long-term improvements in fundraising.

The key significant risk noted by the Committee was around 'people'. The Director of the Charity would be leaving the Trust shortly which meant that there was a risk to the delivery of the plan in terms of fundraising, the appointment of new team members and, the work required for the move to independence. A new Charity Director was being sought.

.

4 Supplemental Trust Deed

This was approved by the Committee. It is presented for the Board's subsequent approval at agenda item Bo.5.24.20.

5 Charitable Funds Committee annual report

The report was approved and will now be presented to the Audit Committee for review prior to its submission to the Board in July so that the Board is sighted on the activities of submission to the Board for approval.

6 Committee Effectiveness Review – feedback & review of terms of reference

The Committee noted the positive outcomes from the review of its effectiveness. The Committee has reviewed the Committees Terms of reference and there are no changes resulting from the effectiveness review; there are some other minor amendments proposed which the Board is asked to approve.

- Under section 7 Membership and attendance at the Charitable Fund Committee and relate to a change from '*up to four NED members'* to say, *'three Non-Executive Directors, one of whom will be appointed as Chair of the Committee'*.
- Under section 10 Chair; where the change indicates that, *'General meetings shall be chaired by the Non-Executive Director appointed as Chair of the Committee'.*

The Terms of Reference which are attached for review by the Board at Appendix 1 (with track changes). The changes are on page 4 of the document.

7 Operational Committee report

Committee received a comprehensive report from the operational committee and noted in particular the progression towards the recruitment of a new Chairty Director and, the work undertaken, with the support of estates colleagues, to bring the costs of the new Neo Natal Unit down to approximately £3m of which the Sick Children's Trust will fund £1.5m. New members of the 100 club had been confirmed and a number of existing members had renewed their membership which was good news.

8 Charitable Funds Committee Work plan

One change was agreed to the workplan related to the Charitable Annual Accounts. The draft accounts would be ready and presented to the Committee in July however the ISA 260 would not be received until November 2024 because of staffing changes within the finance team which meant that more time was required to work with the external auditor.

Matters escalated to the Board

There were no matters to escalate to the Board of Directors.

Board of Directors			
Date	**9 May 2024**	**Agenda item:**	**Bo.5.24.15**

New/emerging risks

The Committee asks the Board to note the discussion around the five-year plan and the identification of the significant risk identified regarding 'People' and the expansion of the fundraising team which poses a risk to the Charity should the planned income generation not be achieved in the longer term. The Board is asked to note that to safeguard against a potential loss of funds due to loss of income, the Charity has a reserves policy that ensures at least 1 year of running costs are always held back.

Recommendations

- The Board of Directors is requested to note the discussions and outcomes from the Charitable Funds Committee meeting held on 30 April 2024.
- **The Board is asked to approve these changes to the Charitable Funds Committee Terms of Reference.**

CHARITABLE FUNDS COMMITTEE DRAFT TOR

REFERENCES

Only PDFs are attached

Bo.5.24.15 - Appendix 2 - Charitable Fund Committee TOR - draft.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

BRADFORD HOSPITALS CHARITY
CHARITABLE FUND COMMITTEE
TERMS OF REFERENCE

Bradford Hospitals Charity

Version:	Draft
Executive Lead:	Director of Finance
Approval Committee:	Board of Directors
Date approved:	
Review date:	

CHARITABLE FUND COMMITTEE – TERMS OF REFERENCE

1. Status and overall purpose of the Charitable Fund Committee

The Charitable Fund Committee ("the Committee") is a Committee of the Board of Directors. Its purpose is to give additional assurance to the Board 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 Board 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.

The Board Members of the Committee shall act as Trustees of the Charity and in this Terms of Reference are together called "the Trustees".

2. Scope of Authority

The Committee is authorised by the Board of Directors to monitor all aspects of charitable activity within Bradford Teaching Hospitals as set out within its governing document registered with the Charity Commission.

The Committee is authorised by the Board of Directors to obtain as and when required external independent professional advice through normal business processes and to secure the attendance of outside parties with relevant experience and expertise if this is considered to be appropriate.

3. Scope and Objects of the Charity

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 Charity seeks to achieve this objective, giving consideration to general guidance on public benefit, by two main routes.

Firstly, 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.

Secondly, there are hundreds of staff working at a sub-fund level to identify small but valuable differences where Charitable Fund monies can deliver benefits to patients / staff, such as attendances at extra training courses or conferences.

4. What is Public Benefit?

To be charitable, spending must demonstrate sufficient public benefit in what it aims to achieve.

Patient focused expenditure within the NHS (unless directed mainly towards private patients) will generally meet this public benefit test.

5. Corporate Strategy

To achieve the strategic objectives of the Charity, the Trustees' priorities should be:

1. To provide outstanding care for patients, delivered with kindness
2. To deliver our financial plan and key performance targets
3. To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion
4. To be a continually learning organisation and recognised as leaders in research, education and innovation
5. To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals

6. Powers of Trustees and their responsibilities

Trustees have and must accept ultimate responsibility for directing the affairs of a Charity, and ensure that it is solvent, well-run, and delivering the charitable outcomes for which it has been set up. Bradford Teaching Hospitals NHS Foundation Trust is a corporate body and is the Corporate Trustee of the Charity, acting through the Board of the Foundation Trust. Members of the Board of Directors and the Committee must act in accordance with the responsibilities and duties of charity Trustees.

Compliance – Trustees must:

- Ensure that the Committee complies with charity law, and with the requirements of the Charity Commission as regulator; in particular ensure that the Committee prepares reports on what it has achieved and annual returns and accounts as required by law.

- Ensure that the Committee does not breach any of the requirements or rules set out in its governing document and that it remains true to the charitable purpose and objects set out there.

- Comply with the requirements of other legislation and other regulators (if any) which govern the activities of the charity.

- Act with integrity, and avoid any personal conflicts of interest or misuse of charity funds or assets.

Duty of prudence – Trustees must:

- Ensure that the charity is and will remain solvent.

- Use charitable funds and assets reasonably, and only in furtherance of the charity's objects.

- Avoid undertaking activities that might place the charity's endowment, funds, assets or reputation at undue risk.

Duty of care – Trustees must:

- Use reasonable care and skill in their work as Trustees, using their personal skills and experience as needed to ensure that the charity is well-run and efficient.

- Consider getting external professional advice on all matters where there may be material risk to the charity, or where the Trustees may be in breach of their duties.

7. Membership and attendance at the Charitable Fund Committee

The Charity and its property shall be managed and administered by a Committee comprising Board Members elected by the Board of Directors.

The Committee membership shall comprise;

~~The Chairman~~
~~Up to four~~Three ~~other~~ Non-Executive Directors, one of whom will be appointed as Chair of the Committee
The Chief Executive
The Director of Finance
The Chief Operating Officer
The Deputy Finance Director and Trust Secretary will be in attendance.

8. General Meetings

The Committee shall meet four times per year unless the Committee agrees a different meeting schedule.

A minimum period of notice is required to hold any general meetings of the Committee of at least fourteen calendar days.

9. Quorum

No business shall be transacted at any general meeting unless a quorum is present. A quorum is a minimum of three Trustees including at least one Executive and one Non-Executive Director.

10. Chair

General meetings shall be chaired by ~~the Trust Chair~~the Non Executive Director appointed as Chair of the Committee.

If there is no such person or he or she is not present, a Non-Executive Director nominated by the Trustees shall chair the meeting.

11. Adjournments

The Trustees present at a meeting may resolve that the meeting shall be adjourned.

12. Votes

Each Trustee shall have one vote but if there is an equality of votes the person who is chairing the meeting shall have a casting vote in addition to any other vote he or she may have.

13. Duties of the Committee

The duties of the Committee are to:

- Ensure that the Charity complies with current legislation;
- Review new legislation and its impact on the Charity;
- Set and review an investment policy for the Charity;

- Appoint brokers to manage the Charity's funds if required;
- Review the performance of the Charity's investments as managed by its brokers;
- Set and review an investment policy including the use of investment gains;
- Review individual fund balances within the overall Charity on a regular basis;
- Seek expenditure plans from individual fund holders where funds are currently not being used;
- Agree guidance and procedures for fund holders;
- Review audit recommendations;
- Review the Annual Accounts for the Charity; and
- Review the Annual Reports for the Charity.

14. Financial Controls

Financial controls are an essential part in assuring all stakeholders that a charity's property is safeguarded, is managed efficiently and that sound governance arrangements exist.

The Director of Finance is responsible for implementing an internal control system which clearly shows areas of responsibility and lines of authority. These are set out in the following internal documents set by the Committee in the governing document.

- Expenditure policy
- Investment policy
- Reserve policy

15. Disqualification and removal of Trustees

A Trustee shall cease to hold office if he or she;

- Ceases to be a Director of the Charity
- Resigns as a Trustee
- Is disqualified from acting as a Trustee by virtue of section 178 of the Charities Act 2011

16. Delegation

The Trustees may delegate any of their powers or functions to a subcommittee of two or more Trustees but the terms of any such delegation must be recorded in the minute book. The Trustees have the power to delegate all investment decisions to the appointed investment broker.

17. Minutes

The Trustees must keep minutes of all:

- proceedings at meetings of the Charity;
- meetings of the Trustees and committees of Trustees including the names of the Trustees present at the meeting;
- the decisions made at the meetings and where appropriate the reasons for the decisions;
- the draft minutes as agreed with the Chair of each Committee will be presented to the next Board of Directors meeting. Any amendments to those minutes agreed at the subsequent Committee will also be reported to the next Board of Directors meeting.

18. Annual Report and Return of Accounts

The Trustees must comply with their obligations under the Charities Act 2011 with regard to;

- the keeping of accounting records for the Charity;
- the preparation of annual statements of account for the Charity;
- the auditing, or independent examination, of the statements of account of the Charity;
- the preparation of an annual report and the sending of it together with the statements of account to the Charity Commission; and
- the preparation of an annual return and its transmission to the Charity Commission.

Accounts must be prepared in accordance with the provisions of any Standard of Recommended Practice (SORP) issued by the Charity Commission.

19. Review of Terms of Reference

The Committee shall review the terms of reference annually, and any amendments required shall be put before a meeting of the Board of Directors for approval.

BO.5.24.16 - REPORT FROM THE CHAIR

REFERENCES

Only PDFs are attached

Bo.5.24.16 - Report from the Chair.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.16

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 in March 2024	
Key control	N/A	
Action required	For Information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Council of Governors meeting scheduled for 25 April 2024

As you are aware, the Council meeting scheduled for 25 April was postponed. We will shortly be seeking to reschedule this meeting and the corporate governance team will be in touch with a revised date.

There were however two items of time-limited business that the Council has dealt with via email (in line with the Council of Governors standing orders and its ability to deal with items via email approval if required).

Appointment of the Lead Governor. The Council of Governors has approved the appointment of Mark Chambers, Patient Governor as Lead Governor. The roles and responsibilities of the lead Governor are available on our website here. Mark's term of appointment runs from 1 May 2024 to 30 April 2026 (subject to Mark being re-elected as a governor at the end of his current term).

Membership of the Governors and nominations Remuneration Committee. Mark Chambers and Dermot Bolton, Public Governor have been reappointed to the Governors Nominations and Remuneration Committee. Mark's and Dermot's tenure will run for further three-year terms from 1 May 2024 to 30 April 2027 (or, until their period as Governor comes to an end (whichever occurs first)). The terms of reference for the Governors Nominations and Remuneration Committee are available on our website here. They rejoin the following members of the Governors Nominations and Remuneration Committee which is chaired by me.

David Wilmshurst	Public Governor
Professor Alastair Goldman	Partner Governor
Helen Wilson	Staff Governor
Raquel Licas	Staff Governor
Dr Farzana Khan	Staff Governor

2. Changes to Council Meetings Schedule

I would also like to advise the Board of the change to the format of our Council of Governors meetings moving forward which I have already confirmed with the Council members. Our new format will reflect the typical way of holding to account that most other Trusts operate. As such there will no longer be a closed Governor only session nor un-minuted sessions with the Non-Executive Directors. My aim is that this will

provide better transparency and discussions will benefit from being formally recorded at the main Council meeting.

3. Feedback to the Council following Board of Director meetings

Our last Board meeting on 14 March and the recording from that meeting alongside access to the agenda and papers are available here. I did meet with some of our Governors to provide feedback on the items covered. In particular I drew attention to the exceptional presentation delivered by the SPaRC team on our 'Ramadan Allies' initiative. Two other items I have signposted Governors to, in the report prepared for the April Council of Governors meeting, are the presentations received on the Equality, Diversity and Inclusion Strategy and, the Staff Survey results. I have arranged for the Council of Governors to receive its own update on the Staff Survey at the next Council meeting.

I would ask the Board to note that I will shortly be convening routine feedback sessions following our Board of Director meetings to provide updates to Governors on items we discuss.

4. Elections to the Council of Governors launch 7 May 2024

Our next election process will launch on 7 May 2024 (ensuring there is no conflict with the local authority elections that are underway in line with NHSE guidance).

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.

5. Invites to Executive led sessions / Operational activities

In recent months Governors have attended the following sessions:

- Operational Planning: This session took place on Monday 11 March providing Council members with the opportunity to discuss and comment on the draft Trust proposals, with Sajid Azeb, Chief Operating Officer and Matthew Horner, Director of Finance, in advance of the submission of the draft plan to the ICB. As those who attended were made aware, the difficulty was that the NHSE Planning guidance was still awaited. Our final submission was approved by the Board on 18 April. As a reminder, a joint plan will be submitted to NHS England.

- Freedom to Speak Up (FTSU): On 19 March this session took place and was delivered by members of the Chief Nurse's team who provided a briefing on FTSU in response to questions raised by Governors, prompted by the Lucy Letby case.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.16

- A small number of governors attended the CSU (Clinical Service Unit) to Academy event on 8 March where three of our CSUs (Musculoskeletal (MSK) and Therapies; Theatres, Critical Care and Day Case and, Women's) presented to an audience comprising of NEDs, Executives and staff from across the Trust their learning and improvement work, plans for continuous improvement and, reflections on how this impacts on quality, people, performance, and finance. This event was arranged as part of the work programme of the Quality and Patient Safety Academy.

Governors have been invited to the next 'CSU to Academy' session scheduled for 4 June provisionally from 9.30 to 2.15. The CSUs presenting are Medicines Management, Access, and Specialist Medicine. A meeting invite will be sent to you shortly. I have also requested that Governors put a hold in their diary for the following two activities:

- Strategy Workshop Thursday 18 July, 1pm to 2.15pm. This session will be delivered by Mark Hindmarsh, our new Director of Strategy and Transformation.

- Patient Experience 'Back to the Floor' Visits, 18 July, 2.15pm to 3.30pm. To encourage our Governors to get involved in a series of 'back to the floor' visits; I have asked for an initial programme to be put in place for 18 July which will take place immediately prior to our Council meeting on that day. The visit will focus on patient flow and is currently under development with the support of Sajid Azeb, Chief Operating Officer and Sarah Buckley, Clinical Lead for Patient Flow & Command Centre.

6. Key communications

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 will be circulated following the rescheduled Council meeting.

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.5.24.17 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

Bo.5.24.17 - Report from the Chief Executive.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.17

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 March 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

NHS Oversight Framework Segmentation Review, Q4 2023/24

Each quarter, NHS England (NHSE) undertakes a review of the 'segmentation' status of each NHS Trust and NHS Foundation Trust within the NHS Oversight Framework (NOF). The purposes of placing an organisation in one of four segments are: to provide an overview of the level and nature of support required; to inform oversight arrangements; and to target support capacity as effectively as possible.

The NHSE regional team have advised the West Yorkshire Integrated Care Board (ICB) that following a recent internal review for Q4, 2023/24 the segmentation status for Bradford teaching Hospitals NHS Foundation Trust (BTHFT) will remain unchanged at Segment 2. This is the 'default' segment to which all trusts will be allocated unless the criteria for moving into another segment are met. It signals that the Trust has plans that have the support of system partners to address areas of challenge and that targeted support may be required to address specific identified issues.

The regional team have not advised the ICB of any change to the issues that were highlighted in Q3 as contributing to the Trust's segmentation.

NHSE will shortly launch a consultation on proposed changes to the scope of the NHS Oversight Framework. The ICB will work closely with us, and partners across West Yorkshire to address the outcomes of this consultation.

Planning Guidance 2024/25

The formal 2024/25 priorities and operational planning guidance was received on the 28th March 2024. In anticipation of the guidance, which was significantly delayed this year we had already commenced developing our operational, finance and workforce plans based on the information available to us. Plans have been updated to reflect any changes and have been presented to closed Board on 18th April 2024 where delegated authority for sign off for the final plan was given to the F&P Academy. The Academy considered the latest plan and confirmed its approval for submission of the plan on the 24th April 2024.

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Date	9 May 2024	Agenda item	Bo.5.24.17

We are committing to meet the expectations set out and have developed a plan which would see the delivery of improved activity levels when compared to 2023/24: Outpatient first +2%; Outpatient Procedures (OPPROC) +11%; day cases +18%; elective ordinary +26%; outpatient follow ups -5% (trajectory to -10.0% for Quarter 4 2025). Overall we anticipate elective recovery fund (ERF) related activity will be at 107.8% of 2019/20 baseline (before tariff adjustment). Patient Initiated Follow-up (PIFU) increases to 5% of outpatient activity to meet target. 52-week waits reduce to no more than 426. For Urgent & Emergency Care (ECS at 78% and ambulance turnaround <30 mins), Cancer Waiting Times (Faster Diagnosis Standard (FDS) at 77% and 62 Day First Treatment (FT) at 70%), and Referral to Treatment (no 65 week waits by September 2024) whilst also increasing activity and improving diagnostic waiting times to deliver a c.90% DM01 performance (this refers to the collection of monthly diagnostics waiting times and activity data).

Further triangulation between Finance, Workforce and Operational plans has been 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 (West Yorkshire Association of Acute Trusts), Regional and National level. Our current position is in the upper decile of Acute Trusts in England. From March 2024 we will commence to include Type 2 activity in our monthly data submission following agreement with the ICB and NHSE on a standardised approach to reporting. 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, delays for patients requiring intermediate care beds or packages of care has meant occupancy has continued to increase. As a result, some patients do continue to have an extended length of stay in the Emergency Department (ED) whilst awaiting a bed. This has been escalated to system partners and we continue to engage in an attempt to address this issue.

We have an agreement to work Yorkshire Ambulance Service colleagues (YAS) to improve the accuracy of handover data reporting given there is a variance in our actual handover time achieved versus that reported by YAS. The discrepancy has occurred as a result of a change in the YAS ambulance process with the handover clock starting earlier based on the global positioning system (GPS) and a drift in compliance with the electronic sign out that concludes the process. The YAS Hospital Ambulance Liaison Officer (HALO) service concluded at the end of March and is currently undergoing an evaluation. There may be an opportunity for the role to be reintroduced ahead of the winter peak pressure.

Work to reduce elective waiting times has continued to make good progress and at year end we had managed to get this to only 24 patients waiting beyond 65 weeks. This is an excellent achievement given the pressures experienced including the impacts of winter and repeated industrial action disruption throughout 2023/2024. We have seen an increase in this figure more recently but work is underway to reduce this in line with the operational planning submission. Any subsequent or ongoing

industrial action has the potential to disrupt our progress in achieving the aspiration of no waits longer than 65 week by the end of August 2024.

Elective activity will increase in 2024/25 with the opening of the St Luke's Hospital (SLH) Day Case Unit which is expected to be handed over to us on the 17 July 2024. This will provide us with two theatres dedicated to undertaking high volume day case procedures. The Community Diagnostic Centre (CDC) has continued to have a positive impact on providing additional diagnostic capacity since its official opening on the 27/02/2024.

We have experienced some histopathology delays impacting on our cancer pathways an improvement programme is in place which will address the underlying issues of concern. 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 17 July 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.

2. People

Gender Pay Gap

The Trust reported its 31st March 2023 Gender Pay Gap data prior to the deadline of 30th March 2024 in line with our legal and contractual requirement. The report identified some encouraging improvements in this years' data and also identified key areas of focus for the next 12 months, which will help to not only improve our pay gap going forward but support gender equality for everyone. The Gender Pay Gap report is included in Trust Board agenda.

Workforce Planning

Our annual 2024/25 workforce plan has been generated and recruitment to these positions is underway.

We are leading on several recruitment events including a focus on Newly Qualified Nurses and other temporary clinical roles. This activity is resulting in increased recruitment that is positively impacting on staffing levels and ultimately leading to enhanced patient care. We are expecting approximately 100 newly qualified colleagues to start at BTHFT over the next 6 months and are developing an improved induction process to support engagement and development of these new colleagues. We are also now almost fully recruited for all posts (60) for the St. Lukes Day Case Unit.

Health & Financial Wellbeing

Our improved Employee Assistance Programme (EAP) is now providing not only counselling and a confidential space for all colleagues, but also debt advice and support with financial concerns.
We have also achieved the Menopause Friendly Employer Accreditation and are continuing to work with our colleagues to build further health and wellbeing initiatives to support enhancing a menopause friendly workspace.

We are also holding several events and activities during Mental Health week in order to raise awareness of the support available for our colleagues during the 13th – 19th May. Healthy eating week on 10th – 15th June will also have a number of activities that will include external providers, charities and colleagues across the Trust.

Inclusion

On 12th March 2024, we celebrated **International Women's Day** to raise the profile of gender equality at BTHFT. We focused the day on raising awareness against bias, celebrating the unique experiences and career journeys of some of our most inspirational women at BTHFT and shared initiatives that we have implemented that are making a positive difference towards achieving greater gender equality at BTHFT. The event was very well received and served as a catalyst for establishing a new gender equality staff network in the Trust.

The EDI team are working with a range of colleagues both internally and externally to arrange initiatives for the **National Staff Equality Networks Day** on 8th May and to celebrate **Equality and Human Rights Week**, taking place between 13th -17th May.

3. Place

National updates

Death certification reform and the introduction of medical examiners

On Monday 15 April 2024, the Government confirmed that legislation to reform the death certification process will be implemented from September 2024, rather than April 2024, as had originally been proposed.

The legislation means that from 9 September, medical examiners will look at the cause of death in all cases that have not been referred to the coroner. From that date, it will not be possible to register a death without medical examiner scrutiny, unless it has been referred to the coroner.

Medical examiners will look at the care received around the time of death, confirming that the cause of death is valid. They will also consult with families or representatives of the deceased, providing an opportunity for them to raise questions or concerns with a senior doctor not involved in the care of the

person who died. This process will help safeguard future patients by learning from death and being supportive to families and healthcare professionals.

We are still awaiting guidance on the details of the legislation. In the meantime, medical examiners in West Yorkshire continue to work with colleagues across health and care to ensure that the new arrangements are working smoothly so as to minimise disruption to bereaved families.

For more information, please see the DHSC announcement.

Overview and scrutiny statutory guidance updated

This statutory guidance for councils, combined authorities and combined county authorities, has been updated to take account of deeper devolution and the creation of combined county authorities through the Levelling Up and Regeneration Act 2023. This guidance was published on 22 April 2024 and replaces guidance published on 7 May 2019.

First ever national clinical director for women's health

The NHS has appointed Dr Sue Mann, a consultant and lead for women's health in City and Hackney, North East London, as its first ever national clinical director for women's health. In her new role, Dr Mann will help implement the Women's Health Strategy alongside supporting the roll out of women's health hubs across England. She will also work on the development of a network of Women's Health Champions, made up of senior leaders in every local care system to drive forward work to improve women's health.

Health Foundation research predicts 700,000 more workers projected to be living with major illness by 2040

The report focuses on inequalities in major illness in England, notably among working-age people. It reveals that growing ill-health will continue to significantly impact people's lives and the economy. On current trends, 3.7 million working-age adults will be living with major illness by 2040—up from 3 million in 2019. The report warns that 80% (540,000) of this increase will be in the more deprived 50% of areas, further entrenching health inequalities and having considerable implications for local and regional economies.

Place updates

Ministerial visit to hear more about proactive care

Helen Whately, Minister for Social Care, visited our district on 7 March to hear more about the reducing inequalities programme across Bradford and Craven that proactively targets health inequalities. The Minister heard about three integrated services that bring together specialists across health, care and voluntary organisations, and the positive impact of their work. The Proactive Care Team brings together a wide range of skills and experience to support adults at home and avoid unnecessary GP and hospital appointments. This service is proving successful, showing a 41% reduction in Accident and Emergency (A&E) attendances so far.

The Minster also heard about two mental health initiatives from Healthy Minds. The Cultural Adapted Therapies service supports individuals with depression in Muslim communities and is showing positive outcomes for those involved. While the Specialist Early Adaption and Development service – just one of three across the UK – and its multidisciplinary team within the Child and Adolescent Mental Health

Service (CAMHS), is providing therapeutic support for 0–6-year-olds and their families. This is also having a positive impact and showing lasting change for the families involved. Thank you to all those involved in the visit who showcased the innovative work across our place.

Bradford featured in Partnerships for People and Place: learning and evaluation report

The Department for Levelling Up, Housing and Communities has published Partnerships for People and Place: learning and evaluation report which includes learning from case studies from across the country, including Bradford. The Partnerships for People and Place (PfPP) programme was delivered by the Department of Levelling Up, Housing, and Communities between February 2021 and March 2023. The programme aimed to test whether closer working between different parts of central and local government can bring measurable benefits to local communities and people.

Closing the gap: 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 us. 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.

Visit our webpage to find out more about the work we're doing to meet this challenge, our focus on maintaining our vision to 'Act as One' to keep people happy healthy at home and access all our briefings. We will continue to keep you updated on progress.

Countdown to Bradford 2025 UK City of Culture has begun

On Tuesday 19 March around 400 people from across our district came together at the official countdown event for Bradford 2025 UK City of Culture. The even included some exciting new developments, read on for more information

- A new brand was unveiled including the new logo. Show your love for Bradford District by downloading and displaying the new Love Bradford 2025 logo
- Zayn Malik was announced as the brand ambassador for Bradford 2025. Throughout 2025, Zayn, along with the people of Bradford, will celebrate the district as the UK City of Culture.
- If you can't wait for the Bradford 2025 UK City of Culture to kick off next year, you can get a flavour through three special events announced for 2024.

Stay connected and find out more by visiting the Bradford 2025 website, you can sign up to receive regular updates.

RIC: What works in reducing inequalities

To address inequalities in central Bradford, the Reducing Inequalities in Communities (RIC) programme was set up in 2019 as a five-year programme to test out various interventions. The programme has been overseeing the delivery of 21 projects, involving a range of partners and has benefitted over 16,000 people. This learning has been captured in a final RIC learning report, there's also a short video, blog and recordings from a RIC Learning Week available from our partnership website www.bdcpartnership.co.uk/RIC

School transforms classroom into flat to teach life skills

A special education needs school has turned one of its classrooms into a furnished flat to teach pupils essential life skills. High Park School in Heaton, Bradford, appealed for donations of furniture and appliances to kit out its flat to help prepare pupils for independent living. Parents, staff and pupils attended the opening of the flat last week. Assistant principal Sarah Tollemache said it was about preparing older students for adulthood.

Students enter the Dragons' Den to pitch for health project

Prototype medical devices created by students at the University of Bradford won praise from a panel of health experts during a Dragons' Den-style assessment. Seven groups of second-year BSc (Hons) Clinical Sciences students were tasked with inventing a new digital medical device, which they pitched to a group of seven industry and healthcare experts from Pharmacy2U and Health Innovation Yorkshire and Humber.

JogOn to female runner harassment

Safer Bradford is clamping down on the harassment and abuse of female runners by telling perpetrators to JogOn. A national survey by Runner's World magazine has found that 60 per cent of female runners experience some form of harassment, particularly from men in cars. The Safer Bradford partnership (which includes Bradford Council, West Yorkshire Police and the NHS) wants to stamp out the problem. It leaves many women feeling scared and intimidated, looking for alternative running routes or changing the times they go out to avoid cat calling, offensive comments and, occasionally, physical harassment.

Working in partnership to get people Home FAST!

Colleagues within Airedale NHS Foundation Trust and City of Bradford Metropolitan Council have been working in collaboration to deliver a Home First Assessment Support Team (Home FAST) Pilot. Adapted using the principles from the East Lancs Home First model, the pilot aims to discharge people within 24 hours and undertake an assessment (over a period of up to 3 days) within the individual's own home to determine their ongoing care and support needs.

Starting with a soft launch early March 2024, discharging one person per day, the pilot has already seen 12 people safely return home and remain home with H FAST which equates to approximately 60 bed days saved. The pilot is part of the system wide work taking place to implement our Intermediate Care Blueprint that aims to improve outcomes for our population, maintain flow across the health and care system and ensure everyone has equal access to the right care and support at the right time in the right place. A review of the pilot will take place in July to explore opportunities for wider roll out across Bradford District and Craven. This includes plans for Bradford Teaching Hospitals NHS Foundation Trust.

AWARDS NEWS FROM VCSE PARTNERS - congratulations to all

myHappymind Bradford District and Craven shortlisted for the HSJ Digital Awards

Bradford District and Craven's myHappymind project has been shortlisted in two categories at the 2024 HSJ Digital Awards. The awards recognise innovative digital projects across the UK which are transforming care delivery, enhancing efficiency, and improving patient outcomes. The project has been shortlisted for the 'Reducing Health Inequalities' and 'Moving Towards Net Zero through Digital' award categories. Read more…

Safe Spaces wins Third Sector Care Award for collaboration

The Cellar Trust and Mind in Bradford are delighted Safe Spaces crisis service has been recognised at the Third Sector Care Awards today winning the Collaboration (Integration) Award for our partnership. This award recognises ways of working in partnership with other organisations or services, achieving outcomes that would otherwise not have been achieved.

Staying Put picks up Bronze at the Smiley Awards

Staying Put's 'Grow Your Wings' video has won Bronze at the Smiley Charity Awards. Staying Put would like to thank everyone who has voted for us and shared our story. The Smiley Charity Film Awards is one of the largest charity events of the year, promoting cause-based films. The awards share video campaigns with millions of viewers, highlighting charities tackling the most pressing issues of our time. The ceremony took place on Wednesday 20 March in London.

4. Partners

- **WYAAT Programme Executive, 2nd April 2024 and 7th May 2024**

I attended the WYAAT Programme Executive meeting on 2nd April where we received an update on NHSEs diagnostic governance, discussed the next steps for pharmacy aseptics, and heard about the remaining programme activities for the West Yorkshire Vascular Service (WYVaS). We also looked at future system architecture as part of the ICB Operating Model and received the Elective Recovery Funding (ERF) review. We also discussed the outputs from the recent WYAAT all executive session and received an update on secondary prevention.

I will also attend the next meeting on 7th May (post-dates this report) where we will receive an update from the latest Committee in Common (CiC) meeting, look at the WYAAT costing review and the efficiency workstream process, hear an update on the pharmacy aspetics action plan, receive an update on maternity and haematology services, and hear the latest on the LIMS deployment. *(LIMS is a healthcare Laboratory Information System.)*

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

I attended the WYAAT Committee in Common meeting on 30th April 2024, held at St James' Hospital. We received the usual updates from the Chairs and the recent programme executive meeting, and also reviewed the lessons learned exercise from pharmacy aseptics. Cathy Elliott and Rob Webster gave an update on the ICB and WYAAT, followed by a focused strategy session on productivity and efficiency. We also had an update on the Fit and Proper Person Test: WYAAT Benchmarked Application to Care Quality Commission (CQC) and Kark Recommendations.

5. National Reports

NHS Workforce Race Equality Standard (WRES) 2023 data analysis report for NHS trusts

The NHS Workforce Race Equality Standard (WRES) 2023 data analysis report for NHS Trusts was published in March 2024 and provides NHS Trusts with both national and regional WRES data for each of the 9 WRES Indicators (including some illustration of progression over the last 3 or more years). This report provides an opportunity to take stock of some of the progress that is being made around the workforce race equality agenda and provides opportunity for Trusts to compare their

performance with the aim of encouraging improvement by learning and sharing good practice. The report outlines a number of key findings which demonstrate progress but acknowledges the work that still lies ahead.

Some detailed analysis has taken place to compare the Trust position with both the national and regional data. As a Trust we compare favourably and have made improvement on a number of WRES indicators with a range of activity taking place over the last 12 months to raise the profile of race equality, empower our race equality staff inclusion network and strengthen our position on all the indicators.

Whilst we have met our target of having an overall workforce that is ethnically representative of our local population, we continue to experience challenges in the following areas, and where our position is currently less favourable than the national data:

- Career progression for both clinical and non-clinical staff at Bands 5 and under (towards Band 6/7 roles and towards 8a+ roles)
- Trust Board representation (overall and executive members)

We are currently collating and analysis our March 2024 WRES data which will be presented at May 2024 People Academy, this will be the most recent data along with our analysis and recommendations for action. Some initial analysis around our 2023 staff survey responses (which will feature in the March 2024 WRES submission) has shown improvements around experience of bullying & harassment, discrimination, and belief that the Trust provides equality in career progression/ promotion, and in 2024 we will be reporting results that are *better* than the national average on these indicators.

Although this analysis is not yet complete; we anticipate that our key areas of focus, where we need to improve compared to the national data, will continue to be:

- Talent management/succession planning with focus on the development of ethnically diverse staff into more senior roles.
- Addressing some of the barriers to development that exist for ethnically diverse staff at lower to middle level pay bands, ensuring they are encouraged to progress with focus on creating a level playing field.
- Addressing the under-representation at Executive Board level with focus on recruitment and selection, talent and succession planning and positive action approaches.

A more focussed action plan in 2024 will ensure more targeted actions at achieving improvements in these 3 key areas.

The report can be access here: https://www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/

Workforce Disability Equality Standard (WDES) 2023 data analysis report for NHS trusts

The NHS Workforce Disability Equality Standard (WDES) 2023 data analysis report for NHS Trusts was published in March 2024 and provides NHS Trusts with both national and some regional WDES data for each of the 10 WDES Metrics (including some illustration of progression over the last 5 years). This report provides an opportunity to take stock of some of the progress that is being made around the workforce disability equality agenda and provides opportunity for Trusts to compare their performance with the aim of encouraging improvement by learning and sharing good practice. The

report outlines a number of key findings which demonstrate progress but acknowledges the work that still lies ahead.

Some detailed analysis has taken place to compare the Trust position with national benchmark data. As a Trust our data compares very closely to the national data and we have made improvements on a number of WDES metrics with a range of activity taking place over the last 12 months to raise the profile of disability equality, empower our disability equality staff inclusion network and strengthen our position on all the WDES metrics.

There are a couple of area's where we have identified a need for further improvement (areas where our performance is slightly worse than the national average). The 2022 staff survey data on harassment and bullying levels (as used in the 2023 WDES) position the Trust slightly higher than the national average for disabled staff, although the 2023 staff survey data indicates this position has improved and we are now equal to or better than the national average. We continue to be above average for confidence to report incidents of harassment & bullying (but there is work to do, as this is still only 53%). Further work around civility in the workplace and raising managers awareness in terms of their role and responsibilities on the importance of creating a culture of dignity and respect within the workplace is required.

One area where we are currently performing better than the national average is the provision of reasonable adjustments (and with further improvement on this metric over the last 12 months). This is testament to the ongoing work to raise the profile of disability equality through our thriving Enable staff network, and to provide managers and staff with guidance and support around the provision of reasonable adjustments (including drop-in sessions and training for line managers).

We have made some progress around disability equality in recent years with the introduction of a Disability Equality & Disability Leave policy incorporating the NHS Employers disability passport (and included in the EDI training for line managers), Wellbeing conversations for all staff as part of their appraisal (as a minimum) were also introduced, along with a wealth of health promotion offers and support. We are also registered as a Disability Confident Employer with aspiration to progress to a Disability Confident Leader, but we still have work to do.

Continued focus is needed on creating inclusive cultures and practices that give people confidence in declaring a disability and eliminating the conditions in which bullying, discrimination, harassment and physical violence occur (in accordance with the NHS EDI Improvement plan). We will continue to focus on this over the coming 12 months.

Work is currently under way to gather and analyse our March 2024 WRES and WDES data.

The report can be access here: https://www.england.nhs.uk/long-read/workforce-disability-equality-standard-2023-data-analysis-report-for-nhs-trusts/

2024/25 Priorities and Operational Planning Guidance

Please see the update included in section 1 of this report.

The letter can be access here: https://www.england.nhs.uk/publication/priorities-and-operational-planning-guidance-2024-25/

Recommendation

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.17

The Board is asked to note this report.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.17

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	
☒	☒	☒	

INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.5.24.17 - Integrated Board Report Cover Sheet - March 2024.pdf

Bo.5.24.17 - BTHFT - MDC IBR -Board Dashboard March 2024 PR Edit Final.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.17

Integrated Dashboard – March 2024

Presented by	Mel Pickup, Chief Executive	
Author	Paul Rice, Chief Digital and Information Officer	
Lead Director	Paul Rice, Chief Digital and Information Officer	
Purpose of the paper	Integrated Board Report	
Key control		
Action required	For approval	
Previously discussed at/informed by		
Previously approved at:		**Date**

Key Options, Issues and Risks

The Integrated Board report is developed by combining the individual performance reports that are received and scrutinised by the academies –
(1) Finance and Performance
(2) People
(3) Quality and Patient Safety.

Historically the individual metrics have been agreed with the Executive Leads in these Academies, updated on a rolling basis as policy, planning and performance imperatives require.

The organisation has confirmed its intentions to adopt the principles of the NHS England Making Data Count Programme and is in a period of transition to confirm:
(a) which metrics should be included in a refreshed dashboard,
(b) what statistical tool is best suited to capture and illustrate absolute changes and trends in that data
(c) the rationale for any material changes in the data
(d) how the position (deteriorating) will be recovered or amplified (improving).

The attached dashboard represents a work in progress with further developments and improvements, including a comprehensive educational programme for Board members and colleagues on how to best apply the Making Data Count methodologies being timetabled as part of the refreshed Board development programme initiated by the Chair.

Recommendation

The Board is invited to receive and review the document attached.

The Board is asked to mark the progress to date and be assured of continued progress to create a comprehensive, detailed and informative performance dashboard going forward.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.17

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

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

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

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

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

Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard

Board of Directors

March 2024

Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of (H)igher or (L)ower values indicating areas of concern	Special cause of (H)igher or (L)ower values indicating improving performance	Common cause - no significant change	'Pass' variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	Fail' Variation indicates consistently - (F)ailing of the target	Data Current unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) specialty cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

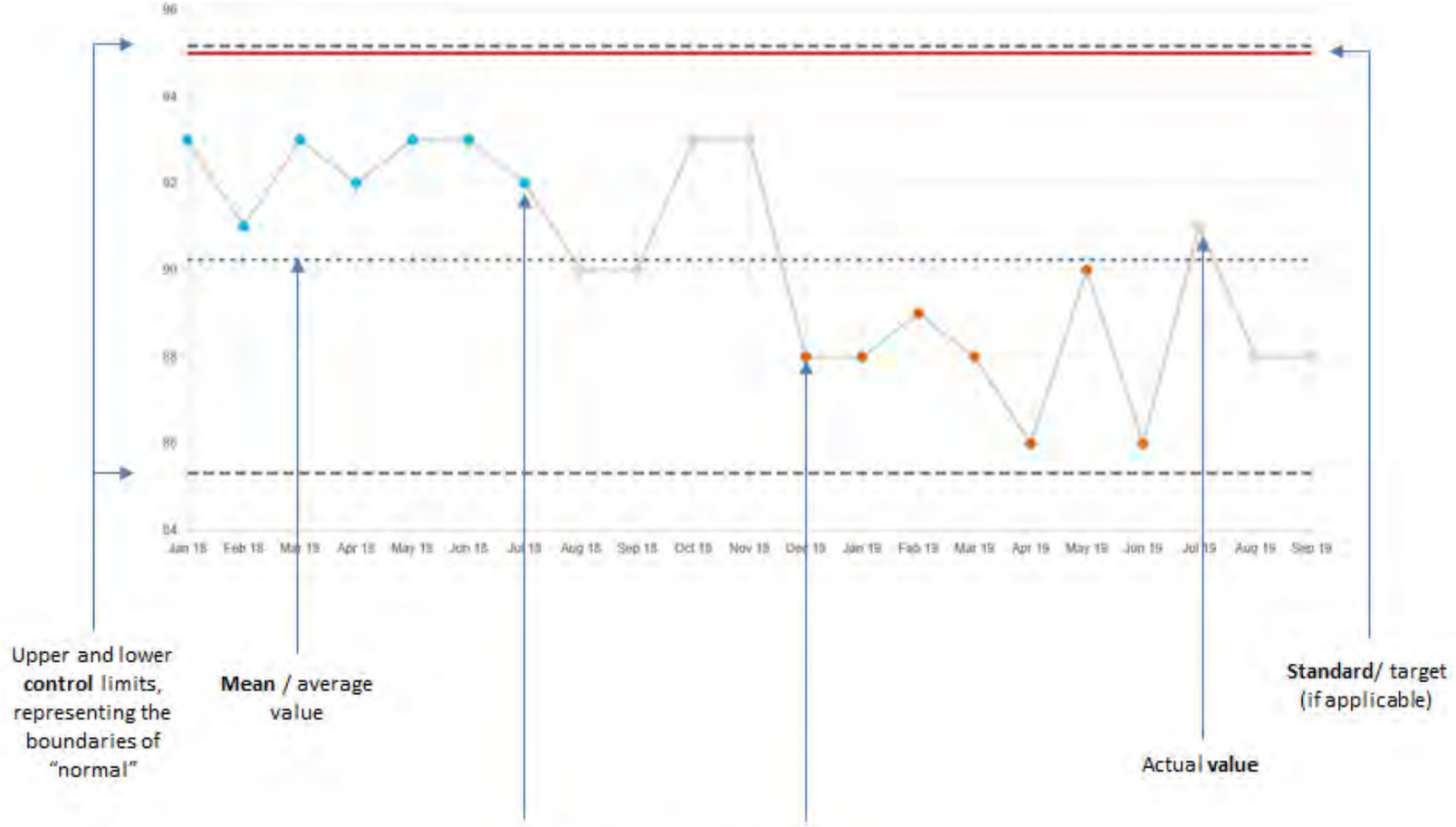
Special Cause Improvement - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls

Further Reading / other resources

The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

Interpreting Statistical Process Control Charts

Guidance notes: Reporting within this document uses a combination of chart types. Where appropriate, Statistical Process Control (SPC) charts have been used to aid analysis.



Points of **special cause variation:**

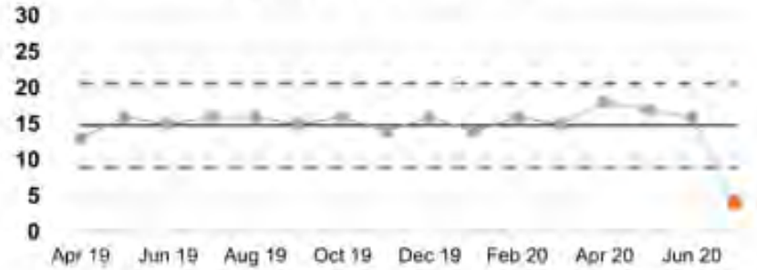
- Single point outside process limits
- Run of 7 points above/below the mean (**shift**)
- Run of 7 points all consecutively ascending/descending (**trend**)

Concern Improvement

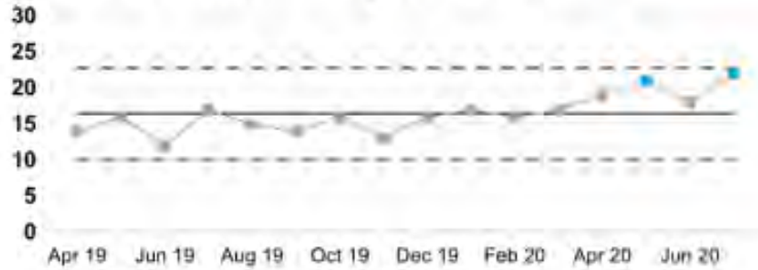
Interpreting Statistical Process Control Charts

SPC rules : special cause variation

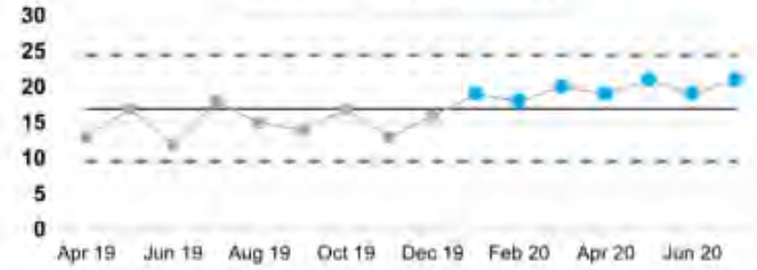
A single point outside the process limits



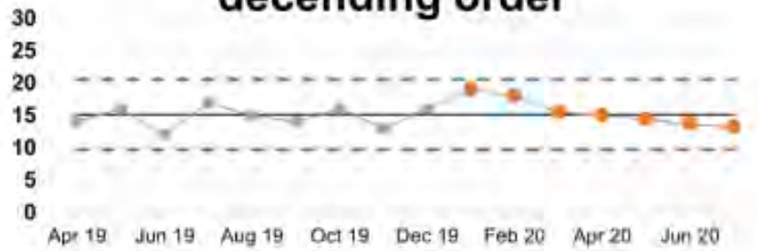
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or decending order



Operational Performance – Executive Director: Sajid Azeb

Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Lower Process Limit	Mean	Upper Process Limit
IBR - Operational Performance - % Ambulance Handover <15 Mins - * All	Mar-24	52.6%				52.82%	63.70%	74.59%
IBR - Operational Performance - % Ambulance Handover <30 Mins - * All	Mar-24	83.9%				80.36%	87.11%	93.86%
IBR - Operational Performance - % Ambulance Handover <60 Mins - * All	Mar-24	96.9%				92.45%	96.61%	100.77%
IBR - Operational Performance - % NMCtR - * All	Mar-24	11.76%	14.79%			9.65%	13.08%	16.51%
IBR - Operational Performance - Ambulance Arrivals - * All	Mar-24	3477				2783.28	3192.46	3601.64
IBR - Operational Performance - Ambulance Arrivals (Avg Daily) - * All	Mar-24	112.16				95.35	104.82	114.28
IBR - Operational Performance - Ambulance Arrivals with Handover - * All	Mar-24	3359				2329.59	2843.67	3357.74
IBR - Operational Performance - Average LOS - * All	Mar-24	3.34				2.9	3.33	3.75
IBR - Operational Performance - Bed Occupancy - * All	Mar-24	93.93%	93%			88.01%	90.70%	93.40%
IBR - Operational Performance - Cancer 2 Week Wait - * All	Feb-24	95.42%				86.02%	93.88%	101.74%
IBR - Operational Performance - Cancer 62 Day Urgent GP - * All	Feb-24	66.88	75%			61.81%	73.83	85.86
IBR - Operational Performance - Day Case Rate - * All	Mar-24	87.92%				87.57%	88.90%	90.23%
IBR - Operational Performance - Diagnostic Waiting List - * All	Feb-24	8234				8974.93	10406.7	11838.5
IBR - Operational Performance - Diagnostic Waiting List (% < 6 Weeks) - * All	Feb-24	77.47%	95%			62.15%	71.73%	81.31%

Operational Performance – Executive Director: Sajid Azeb

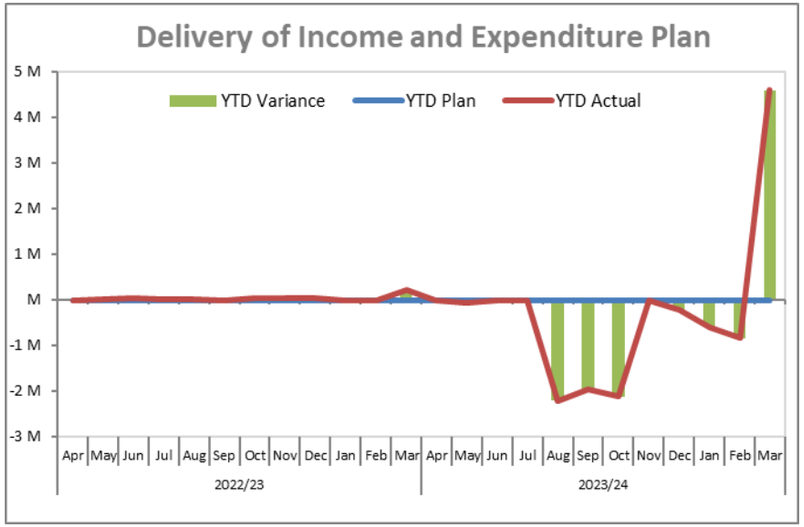
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Lower Process Limit	Mean	Upper Process Limit
IBR - Operational Performance - Discharges Before 1pm - * All	Mar-24	2876				2217.3	2746.88	3276.45
IBR - Operational Performance - DNA Rate - Follow Up	Mar-24	7.44%				6.68%	7.97%	9.27
IBR - Operational Performance - DNA Rate - New	Mar-24	10.09%				9.27%	10.56%	11.84
IBR - Operational Performance - ED - Time to Initial Assessment - * All	Mar-24	22.63				18.49	24.68	30.86
IBR - Operational Performance - ED Attendances - * All	Mar-24	12756		H		10141.7	11940.5	13739.4
IBR - Operational Performance - ED Attendances (% < 4hr) - * All	Mar-24	81.48%	77.30%	H	?	70.26%	75.03%	79.79%
IBR - Operational Performance - Elective Waiting List - * All	Feb-24	34450		L		33879.4	35633.6	37387.7
IBR - Operational Performance - LOS 21+ - * All	Mar-24	121		H		81.35	101.13	120.9
IBR - Operational Performance - LOS 7+ - * All	Mar-24	298		H		232.57	261.83	291.09
IBR - Operational Performance - New:Follow-Up Ratio - * All	Mar-24	2.5				2.38	2.57	2.76
IBR - Operational Performance - Pts in ED >12 Hrs - * All	Mar-24	682		H		197.26	674.58	1151.9
IBR - Operational Performance - RTT 18 Weeks (%) - * All	Feb-24	65.11%		L		67.26%	69.54%	71.83%
IBR - Operational Performance - RTT 18 Weeks (Total Pathways) - * All	Feb-24	34450	30571	L	F	33879.4	35633.6	37387.7
IBR - Operational Performance - RTT 52 Week Breaches - * All	Feb-24	475	426	L	F	519.24	635.91	752.59

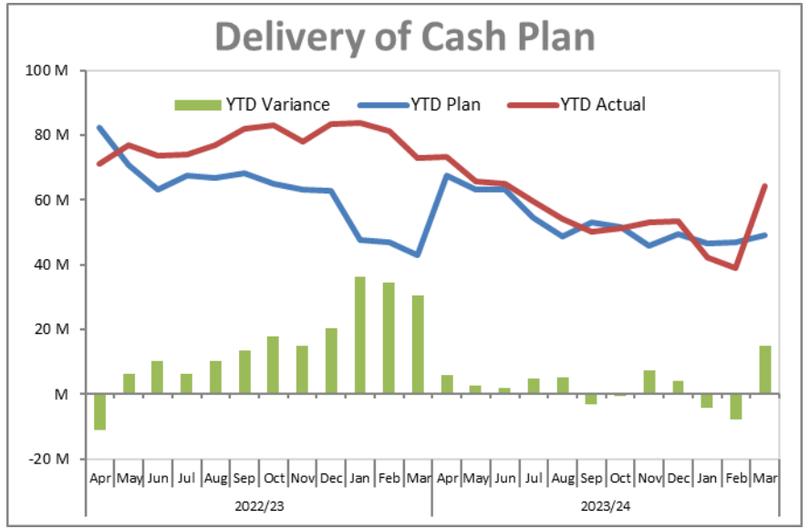
Finance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

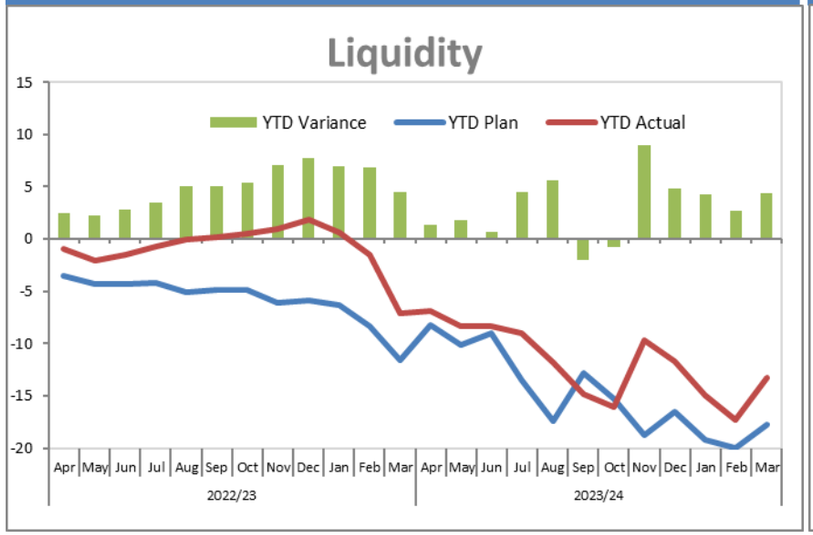
March 2024 – £4.6m



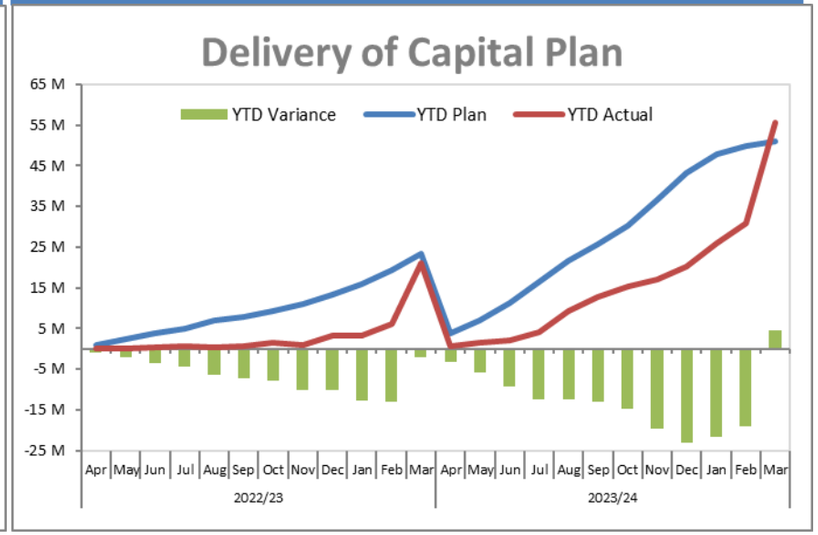
March 2024 – £64.2m



March 2024 – -£13.3m



March 2024 – £55.6m



Analysis

Income & Expenditure

The Trust's unaudited year-end Income & Expenditure position for 2023/24 is a surplus of £4.6m. This is £4.6m better than the breakeven plan for the year. The favourable position is due to £4.4m of additional non-recurrent funding distributed to the Trust from the West Yorkshire Integrated Care Board in Month 12.

Cash

The Trust currently has £64.2m cash at the end of the financial year. £12.9m is held on behalf of Research and Development leaving £51.3m for the Trust.

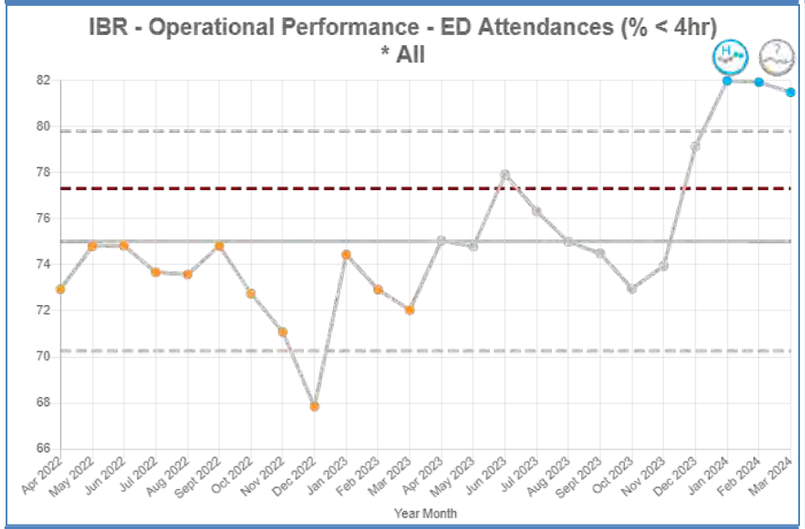
Capital

The Trust invested £55.3m on capital during 23/24 which is £0.1m more than planned.

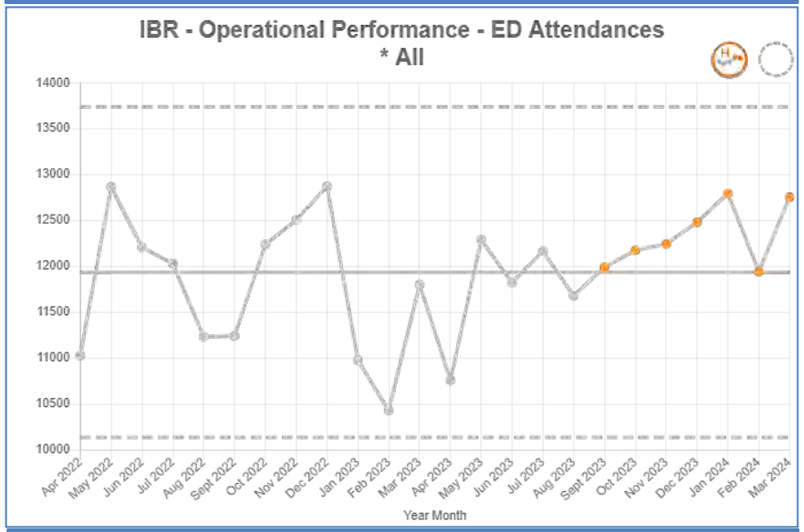
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

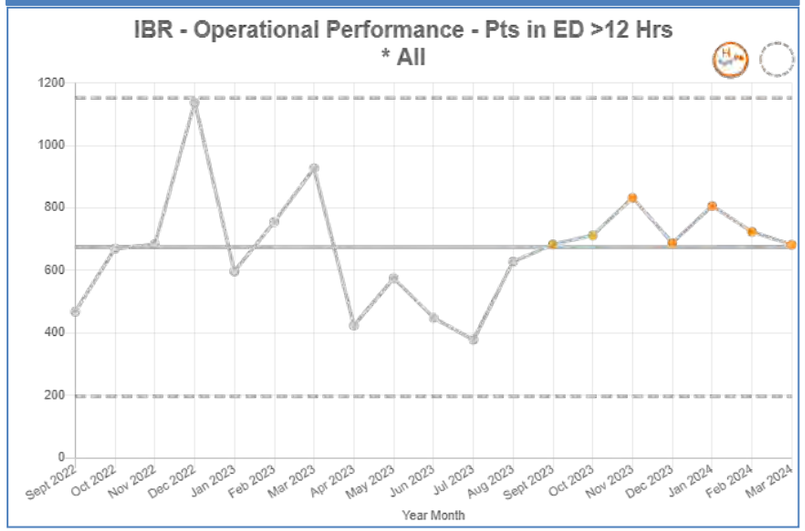
March 2024 – 81.97% - Year end target 77.3%
Special cause variation of an **improving** nature



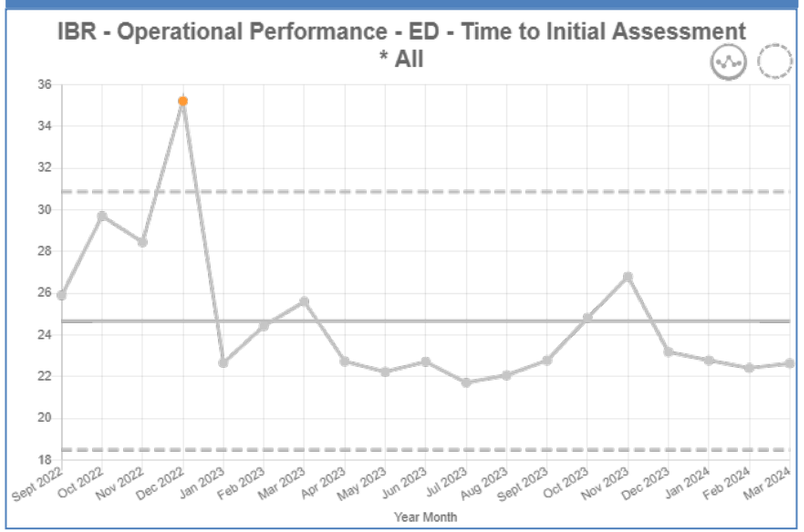
March 2024 – 12756 Attendances
Special cause variation of a **concerning** nature



March 2024 –682 patients
Special cause variation of a **concerning** nature



March 2024 – 22.6 minutes
Common cause variation



Analysis

ECS performance for Type 1, 2 & 3 attendances was 82.67% for March 2024 and is currently forecast at 85.03% for April 2024. The position is in the upper decile of Acute Trusts in England. In March 2024 Type 2 activity was included in the monthly submission following an agreement with the ICB and NHSE on a standardised approach to reporting.
Average daily attendances for March are in line with January and February and higher than the same period last year.

Risks, Mitigations and Assurance

Front door streaming is supporting improved time to initial assessment.
Streaming to the AECU service continues to have a positive impact on a range of UEC metrics. Utilising the capacity outside of the main ED and continued development of this through training and pathway review has supported significant performance improvement in recent months.
G&A adult bed occupancy remains high at 94.68% in March 2024 with high acuity and issues within the social care sector continuing to impact the timely discharge of patients. This impacts on the time in department for admitted patients, increasing time from DTA to admission and increasing the prevalence of 12 hour ED stays. Patient flow and discharge improvement are a prominent part of the overall UEC improvement plan.

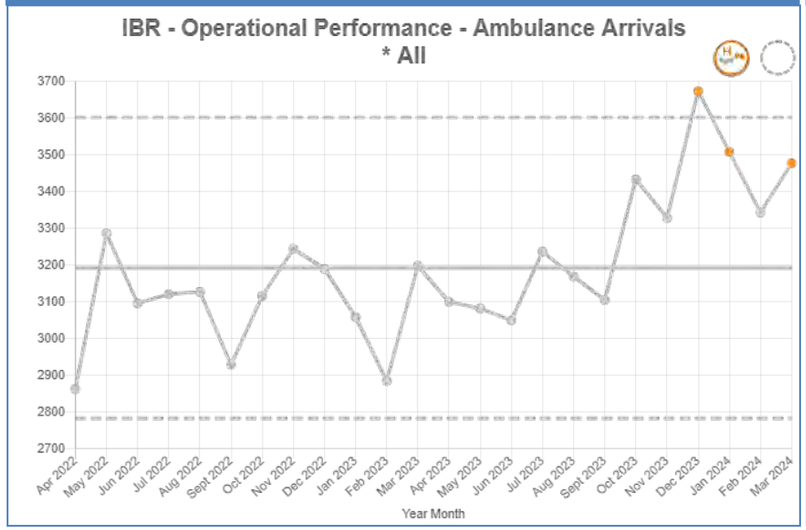
Benchmarking

Performance is above national, peer and WY averages. For ECS the Trust performs in the upper decile of Acute Trusts in England.

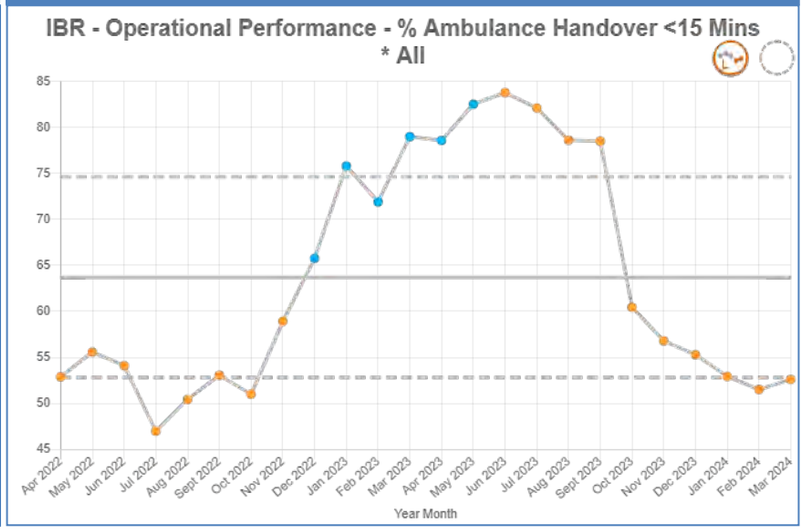
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

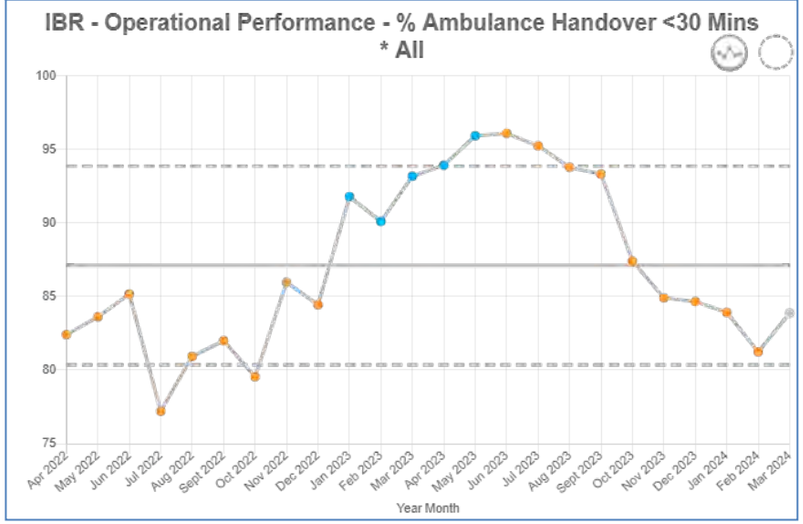
March 2024 – 3477 ambulance arrivals
Special cause variation of a **concerning** nature



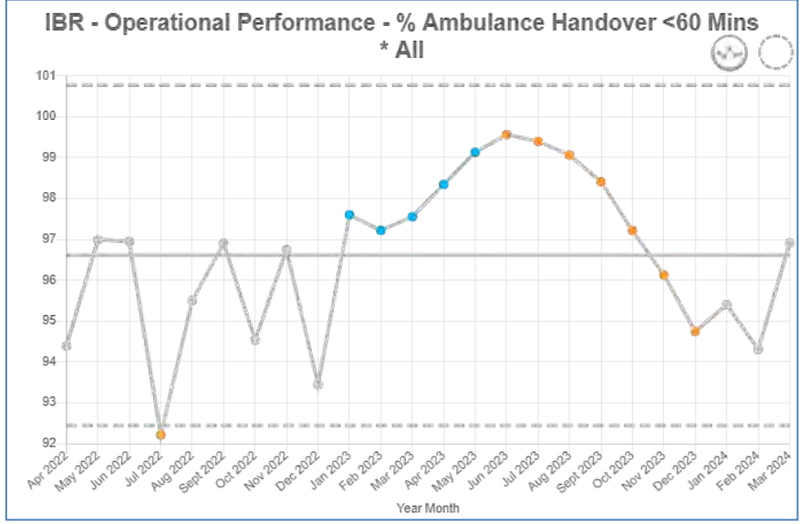
March 2024 – 52.6% ambulance arrivals
Special cause variation of a **concerning** nature



March 2024 –83.86% ambulance arrivals
Special cause variation of a **concerning** nature



March 2024 –96.9% ambulance arrivals
Common cause variation



Analysis

Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 52.92% in March compared to 51.51% in February. This remains above the regional average.
The number of ambulances arriving daily at BTHFT continues to remain high with a daily average of 112. These are up by 8% in March when compared to the same time last year.
Nationally mandated changes in clock reporting commenced in October 2023. This added 8-10 minutes to handover times and performance dropped accordingly.

Risks, Mitigations and Assurance

Recording of patient handover switched to the sole use of the YAS Ambulance Mobile Device Terminal (AMDT) during February. This has reduced duplication with recording on Trust systems which we had hoped would improve accuracy, but this is yet to be seen in the data.
Significant internal validation is still required with a c.45% discrepancy in handover clock stops. An increase in patients with no breach reason has prompted a further review of the differences between BTHFT and YAS handover reporting.
The YAS funded Hospital Ambulance Liaison Officer (HALO) position ceased at the end of March. Options continue to be explored to reinstate the role at BTHFT.
A direct access pathway to the Urgent Treatment Centre (UCC) or Ambulatory Emergency Care Unit (AECU) remains in place and agreed protocols and escalation are in place to support busy periods.

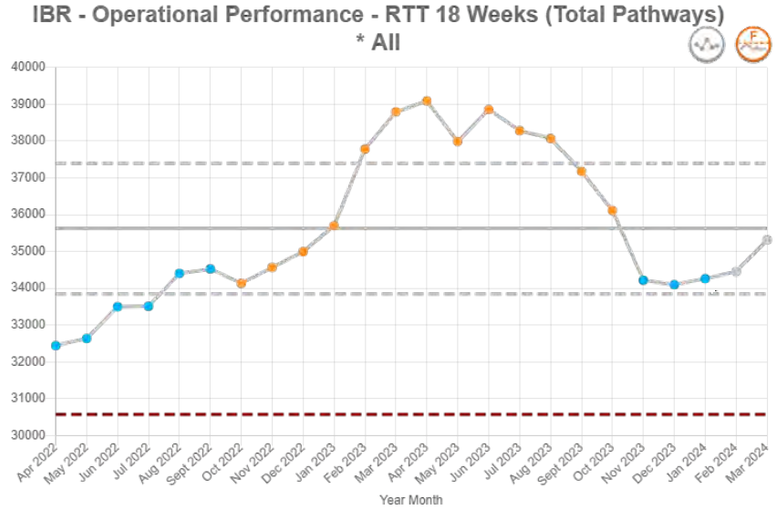
Benchmarking

All Trusts supported by YAS were impacted by the clock reporting changes. As a result we have remained better than peer average and in the upper quartile for the region.

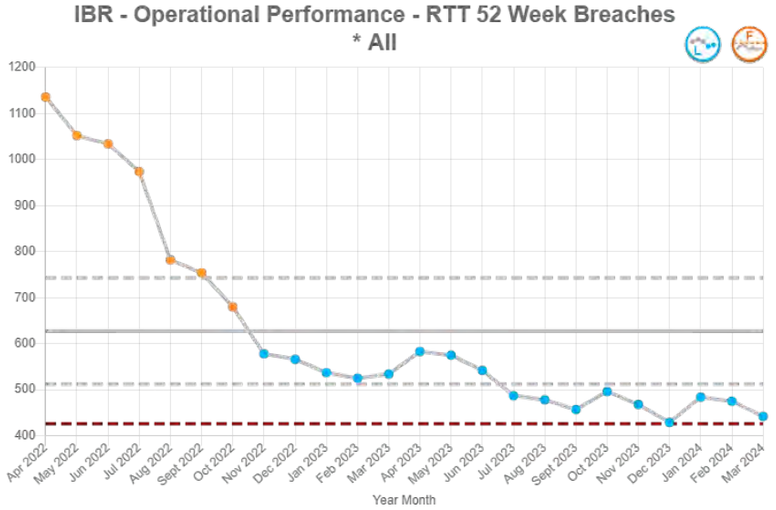
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

March 2024 – 35314 pathways – Year end target 30571
Special cause variation of an **improving** nature



March 2024 – 422 pathways – Year end target 426
Special cause variation of an **improving** nature



Analysis

Referral to Treatment (RTT) performance has reduced in March to 64.48% but remains within the upper quartile compared to other Acute Trusts. The waiting list and long wait metrics have remained stable in the last quarter. From February 2024, Community Paediatrics has been excluded from the national RTT submission. There was 1 patient reported over 78 weeks at the end of March, with 1 patient projected to breach 78 weeks at the end of April. 34 patients beyond 65 weeks breached at the end of April, predominantly in Trauma & Orthopaedics who are being supported to maximise available theatre capacity to reduce their long wait breaches going forward.

Risks, Mitigations and Assurance

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. Each CSU will be supported to interpret the available data and then implement and then track associated improvement actions. Aligned to Delivering Operational Excellence and existing work to recovery services and increase activity this work will support further waiting list improvements. Weekly access meetings and targeted patient-level long waiter reviews focus on increasing activity levels whilst ensuring the longest waiting and most clinically urgent patients are treated first. EPR optimisation focussed initially on outpatient clinics will help enable some of the outpatient productivity gains identified in the GIRFT work and resolve issues escalated by our clinical teams.

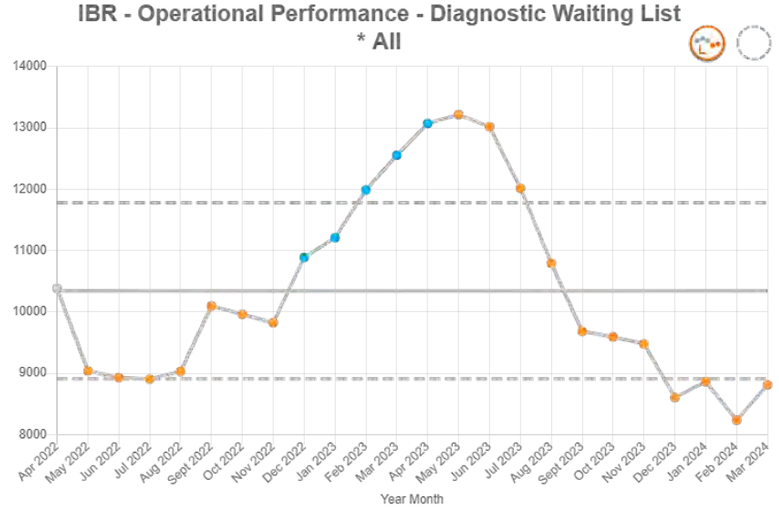
Benchmarking

Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, has increased from 96% to 99.5% during 2023/24. Validation is now better coordinated between teams and the themes from corrections are being fed into preventative work.

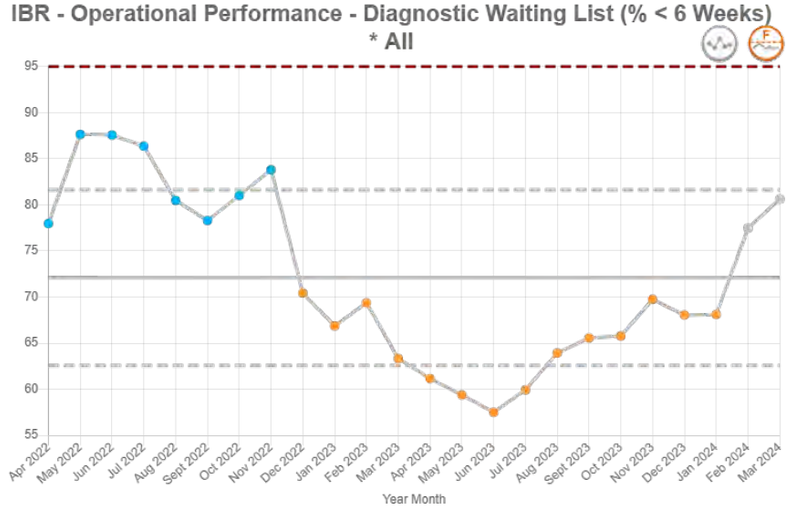
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

March 2024 – 8810 pathways
Special cause variation of a **concerning** nature



March 2024 – 80.6% <6 Wks – Year end target 95%
Common cause variation



Analysis

DM01 performance for March 2024 improved to 81.40% .
Non-obstetric ultrasound (NOUS) outsourcing has ended with the current position being significantly improved to almost 90%. A sustainability plan is now in place which includes insourcing to run alongside existing provision.
MRI scanner failures during February and March have impacted on Radiology but the overall position is still expected to improve in April as the Community Diagnostic Centre (CDC) capacity increases.
CDC capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography.
Recovery can also be seen in March for both echocardiology and respiratory sleep due to insourcing and process improvements.

Risks, Mitigations and Assurance

Delivery of the CDC program is now well underway. With increased provision available work is underway to develop a system-wide approach for access and the visibility of patient information.
The HISTO Programme is up and running. This is a structured improvement programme to bring clarity, governance, and accountability for the aim to improve Turnaround Time (TAT). There are three workstreams with agreed scope based on team & patient feedback. 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. Validation of full Endoscopy waiting list (diagnostic and surveillance) is ongoing with support to Endoscopy booking processes, implementation of SOPs and improved waiting list management.

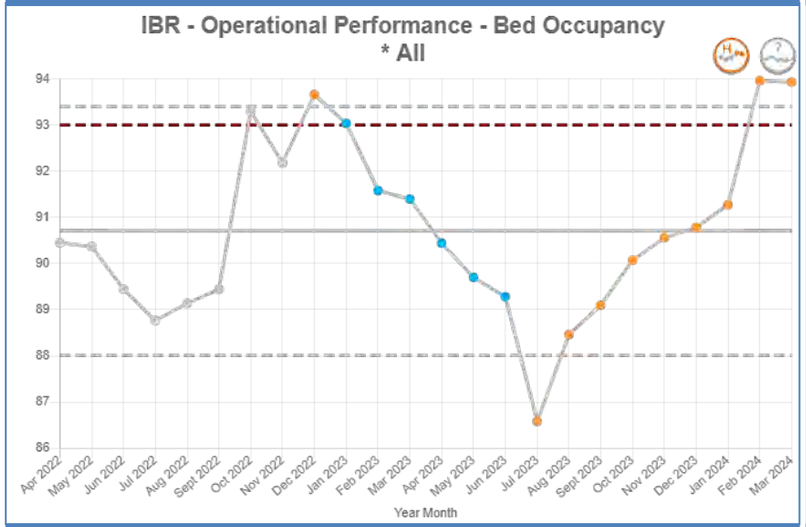
Benchmarking

It is expected that this additional capacity will mean the current improvement trend will continue into 2024/25 and bring performance back into the upper quartile nationally.

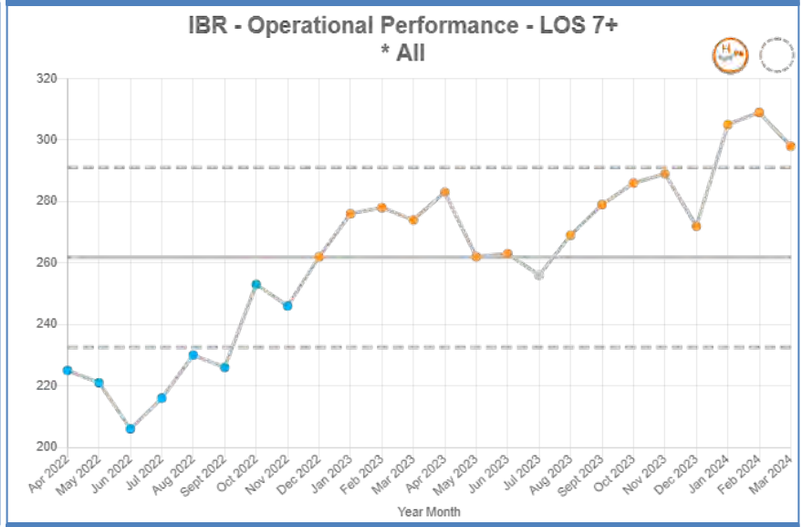
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

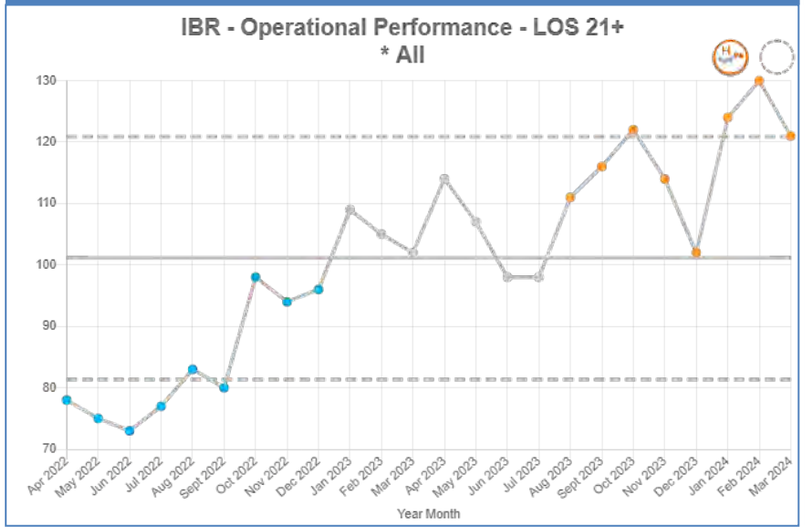
March 2024 – 93.9% occupancy – Year end target 93%
Special cause variation of a **concerning** nature



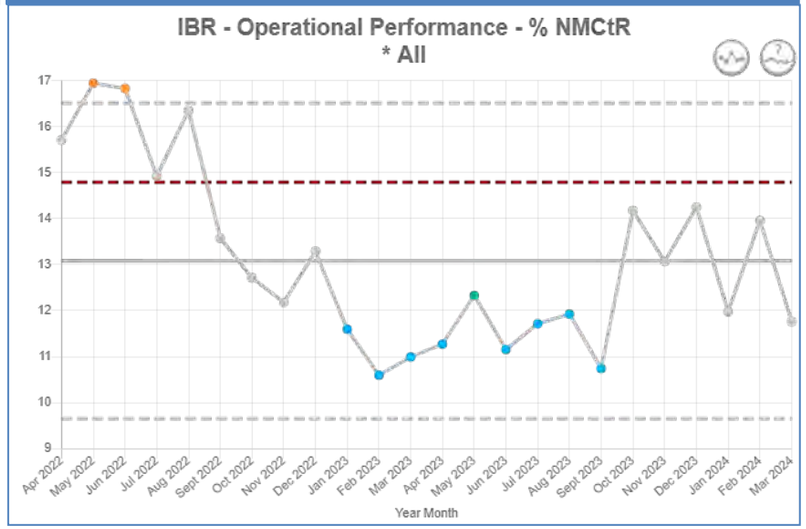
March 2024 – 298 patients
Special cause variation of a **concerning** nature



March 2024 – 121 patients
Special cause variation of a **concerning** nature



March 2024 –11.7% patients – Year end target 14.79%
Common cause variation



Analysis

The daily average number of patients with a length of stay (LOS) > 21 days reduced to 121 in March 2024, but increases are being seen during April 2024 with a projected daily average of 138.
These metrics remains high due to the number requiring therapy intervention in addition to external factors such as waiting for care home beds and social care assessment. A system approach to reducing the pressure on social care is being explored but the availability of care packages and Intermediate Care (IMC) capacity will present a challenge for discharge delays until resolved.

Risks, Mitigations and Assurance

A daily review of patients who no longer meet the 'Criteria to Reside' in a hospital bed for is in place and a review of IMC processes is being undertaken to identify efficiencies, and to escalate when required to system partners. Joint work with the Local Authority (LA) and the implementation of 'routes' in P1 and placing people directly into the independent sector and home care via the Bradford Enablement and Support Team (BEST) is improving the position. Discharge to Assess and improvements around intermediate care delivery are described within the Partnership IMC Blueprint document. The final version of this will be signed off by the Healthy Communities Board by the end of April. Delivery of the Blueprint is aligned to 8 key projects, a project timeline and milestones were presented at the Partnership Leadership Executive (PLE) in March. The IMC development work also aims to address pressure within providers around enhanced needs within pathway 2 and 3 by aligning patients to the correct pathway; a meeting with the commissioners is scheduled for April.

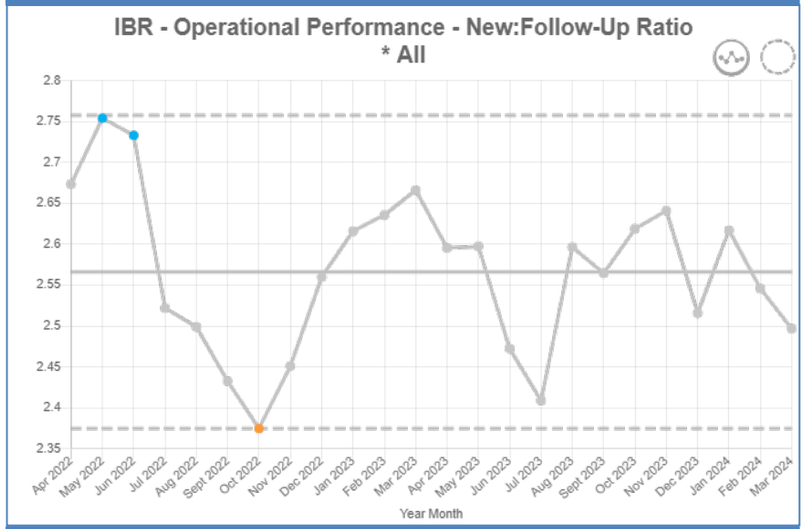
Benchmarking

As a % of emergency spells the number of 21-day LoS for BTHFT continues to benchmark better than the national and peer averages and close to the best quartile nationally despite the increases.

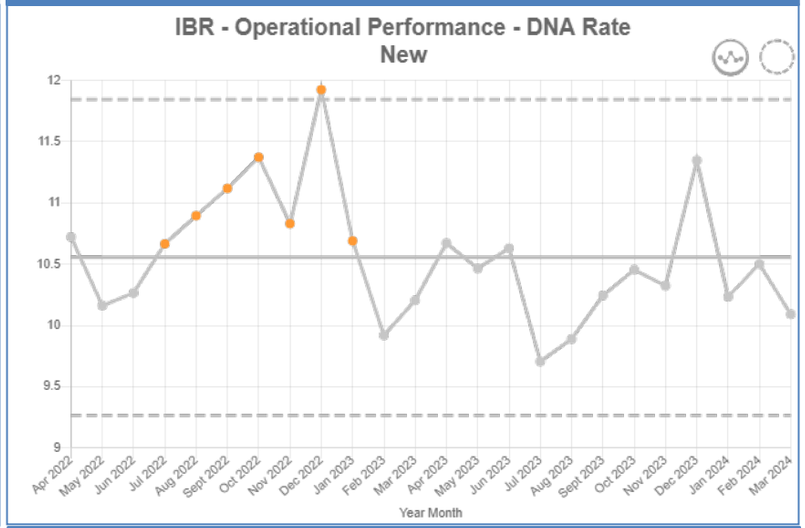
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

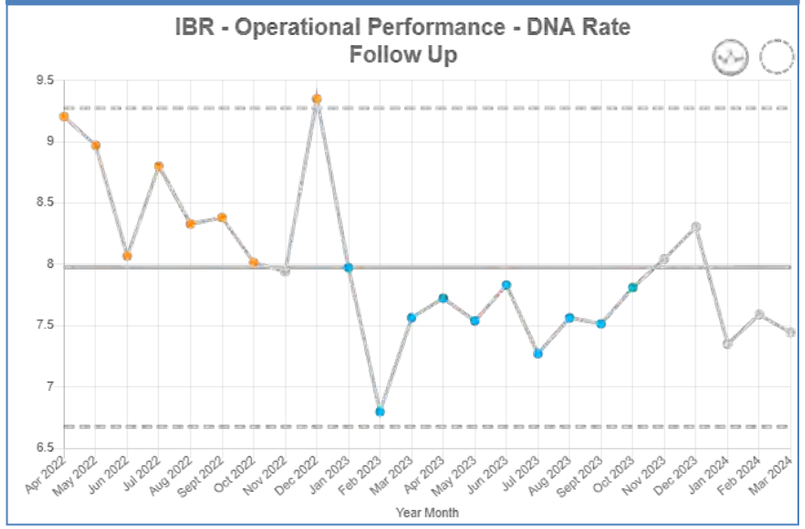
March 2024 – 93.9% occupancy – Year end target 93%
Special cause variation of a **concerning** nature



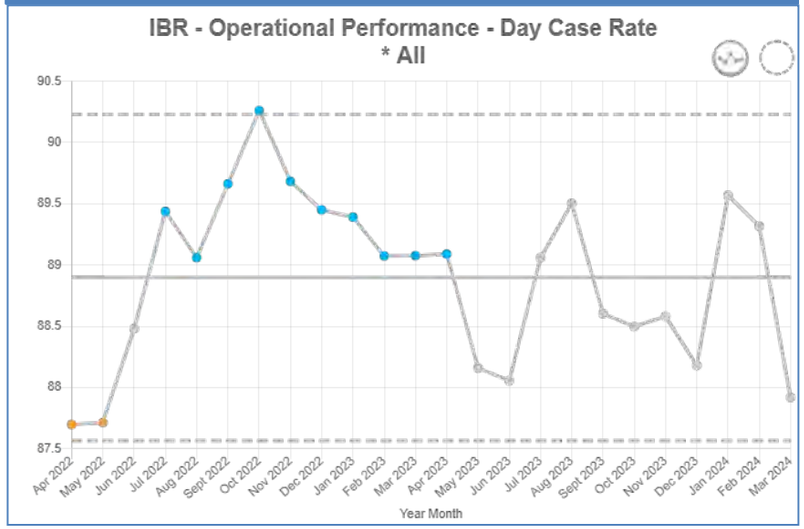
March 2024 – 298 patients
Special cause variation of an **concerning** nature



March 2024 – 121 patients
Special cause variation of a **concerning** nature



March 2024 –11.7% patients – Year end target 14.79%
Common cause variation



Analysis

New outpatient appointments increased to meet waiting list demand (at 110% of baseline). Follow ups also reduced slightly, with a number of schemes in place to reduce unnecessary attendances such as PIFU and digital outpatients.
Did not attend (DNA) rates have returned to pre-COVID levels. Analysis of our data shows a correlation between age, deprivation and DNA rates.

Risks, Mitigations and Assurance

The GIRFT Further Faster programme includes recommendations on outpatient and inpatient opportunities and is currently being launched with all CSUs.
This will align with existing improvement work being undertaken including theatre utilisation and scheduling changes. The opening of the DCU at SLH will also increase the day case rate.
The Trust is exploring what else can be done to improve attendance at appointments, particularly for communities with poorer health outcomes. The Trust is liaising with local care networks to review DNA rates and patterns in relation to GP practices and IMD. Options to improve attendances might include additional transport support or community-based clinics.

Benchmarking

GIRFT further faster packs are identifying DNA improvement opportunities at a service level which are being explored as part of this work.
The Trust is above the national average for day case rates.

Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Lower Process Limit	Mean	Upper Process Limit
IBR - Workforce - Agency - %	Dec-23	2.22%				1.56%	2.60%	3.65%
IBR - Workforce - Agency - WTE	Jan-24	114.23				91.38	152.97	214.56
IBR - Workforce - Appraisal Rate - Non-Medical	Mar-24	76.31				72.44%	75.19%	77.94%
IBR - Workforce - Apprentices - * All	Oct-22	315.00					302.33	
IBR - Workforce - BAME Split - Band 8+	Sep-23	18.67					17.45	
IBR - Workforce - BAME Split - Bands 1-5	Sep-23	45.59					43.91	
IBR - Workforce - BAME Split - Bands 6-7	Sep-23	26.39					25.57	
IBR - Workforce - BME - * All	Sep-23	40.24					38.47	
IBR - Workforce - BME - Senior Leader	Sep-23	18.67					17.45	
IBR - Workforce - Disability Declaration - * All	Sep-23	4.56					3.91	
IBR - Workforce - Freedom to Speak Up - * All	Oct-23	31.00				1.23%	13.81%	26.40%
IBR - Workforce - Harrassment and Bullying - Disciplinary Action	Sep-23	1.00					0.67	
IBR - Workforce - Harrassment and Bullying - Informal Action	Sep-23	3.00					3.00	
IBR - Workforce - Harrassment and Bullying - In-progress	Sep-23	6.00					7.00	
IBR - Workforce - Harrassment and Bullying - No Case To Answer	Sep-23	2.00					3.00	
IBR - Workforce - Harrassment and Bullying - Resigned	Sep-23	0.00					0.67	
IBR - Workforce - Harrassment and Bullying - Total Investigations	Sep-23	12.00					14.33	

People – Faeem Lal

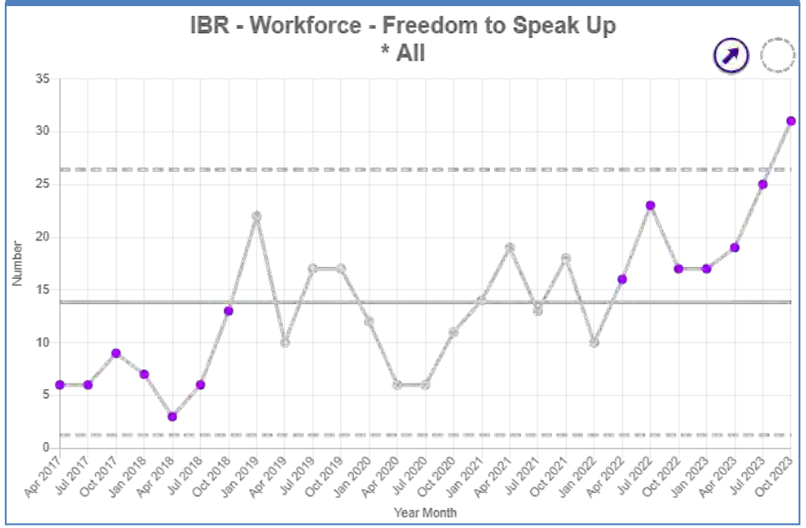
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Lower Process Limit	Mean	Upper Process Limit
IBR - Workforce - Job Planning - Allied Health Professional	Oct-22	68.87					57.96	
IBR - Workforce - Job Planning - Medics	Oct-22	10.30					8.05	
IBR - Workforce - Job Planning - Nurses	Oct-22	62.98					59.31	
IBR - Workforce - Nursing Agency Fill Rate - %	Mar-24	11.92%				11%	15.20%	20%
IBR - Workforce - Nursing Bank Fill Rate - %	Mar-24	60.23%				35%	42.61%	51%
IBR - Workforce - Refresher - * All	Feb-24	0.92				87%	89.81%	93%
IBR - Workforce - Staff Advocacy - Contacts	Sep-23	13.00					14.00	
IBR - Workforce - Staff Advocacy - Contacts Not Resolved	Sep-23	0.00					0.00	
IBR - Workforce - Staff Advocacy - Formal Complaints/Investigations	Sep-23	2.00					0.67	
IBR - Workforce - Staff Advocacy - In-progress	Sep-23	2.00					0.67	
IBR - Workforce - Staff Advocacy - Outcome Unknown	Sep-23	1.00					0.33	
IBR - Workforce - Staff Advocacy - Resolved Informally	Sep-23	8.00					9.00	
IBR - Workforce - Staff In Post - * All	Feb-24	6454.51				5885.65	5987.45	6089.25
IBR - Workforce - Staff Sickness - * All	Mar-24	5.77%				6.32%	6.53%	6.74%
IBR - Workforce - Staff Sustainability - * All	Mar-24	98.90%				96.64%	98.74%	100.84%
IBR - Workforce - Staff Turnover - * All	Mar-24	9.81%				10.97%	11.53%	12.09%

People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

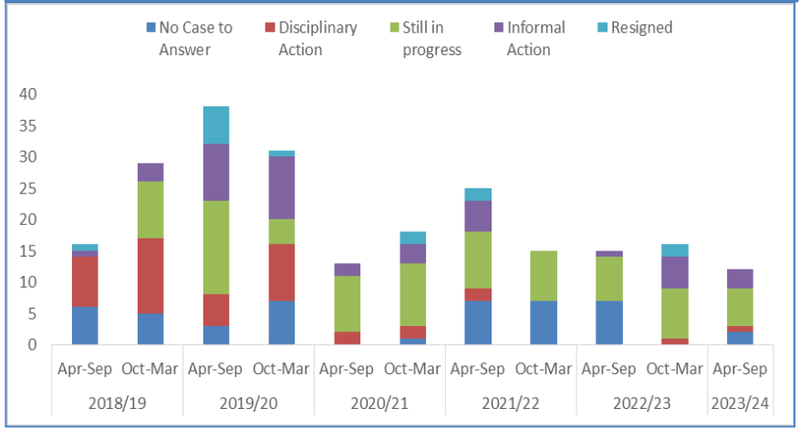
2023/24 Quarter 3 – 31
Special cause variation of an **increasing** nature



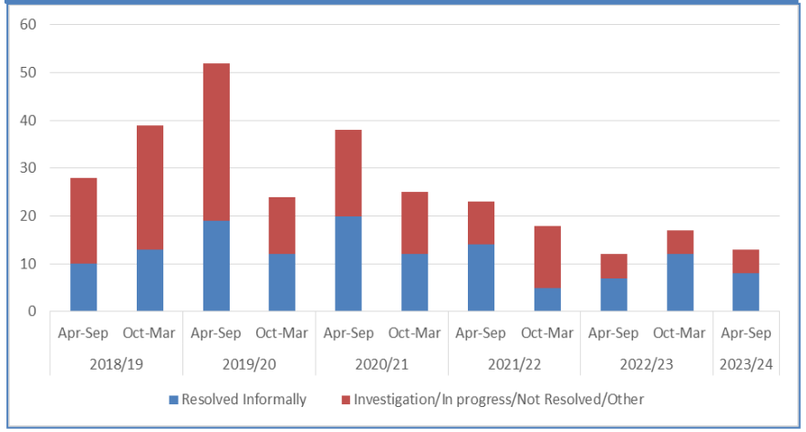
2023/24 Quarter 3 – Staff Advocacy

Month	Contacts	Formal complaint/ investigation	Resolved Informally	In Progress	Contacts not resolved	Outcome unknown	Staff Contacts
Apr 18 - Sep 18	28	5	10	6	3	4	0.53%
Oct 18 - Mar 19	39	18	13	5	3	6	0.72%
Apr 19 - Sep 19	52	11	19	6	4	12	0.95%
Oct 19 - Mar 20	24	3	12	2	1	8	0.43%
Apr 20 - Sep 20	38	4	20	5	1	8	0.67%
Oct 20 - Mar 21	25	1	12	2	1	9	0.44%
Apr 21 - Sep 21	23		14				0.40%
Oct 21 - Mar 22	18	5	5	4	0	4	0.32%
Apr 22 - Sep 22	12		7				0.21%
Oct 22 - Mar 23	17		12				0.30%
Apr 23 - Sep 23	13	2	8	2		1	0.23%

2023/24 April-September Harassment and Bullying



2023/24 Quarter 3 –Staff Advocacy



Analysis

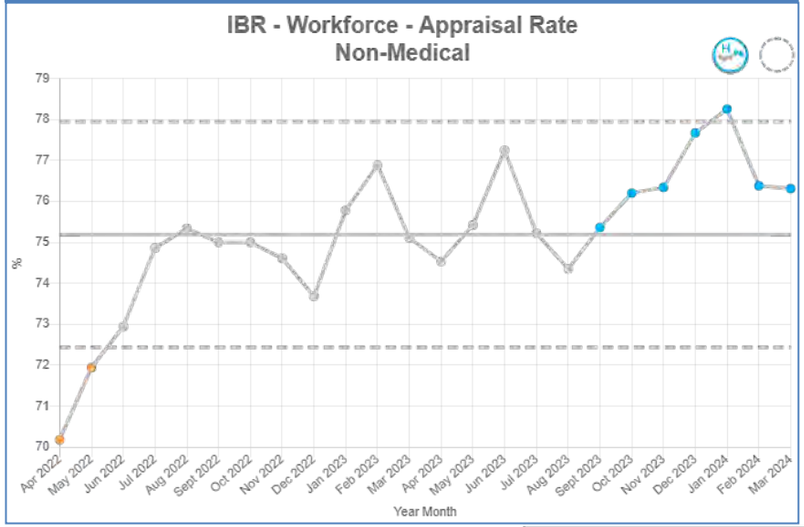
Staff Advocacy, Harassment and Bullying update will be provided in May 2024

Risks, Mitigations and Assurance

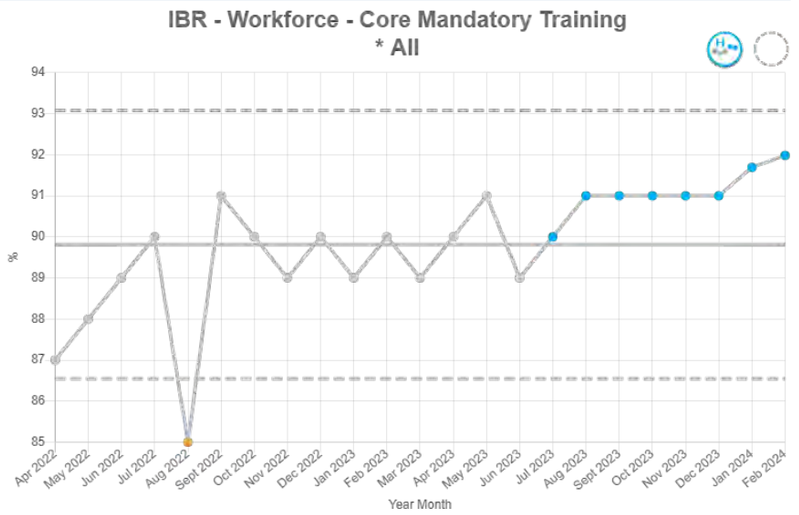
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

March 2024 -76.31%
Special cause variation of an **improving** nature



March 2024 -91.98%
Special cause variation of an **improving** nature



Analysis

Core Mandatory Training

- Overall Trust compliance continues to be above the Trust target of 85%, staying above 90% over the last several months.
- All CSU's continue to achieve above the 85% target, with several achieving an increase of 1% or more over the last quarter.

Appraisal

Appraisals are an important way of helping to ensure that all BTHFT colleagues are clear about Trust strategic objectives; how each person contributes to achieving the Trust's vision; and that each person is clear about what is expected of them. Since April 2024 the target for non-medical appraisal has been set at 85%. Although appraisal compliance has followed an upward trajectory since August 2023, there has been a decline since the beginning of the year and currently stands at 76.31% .

Risks, Mitigations and Assurance

Core Mandatory Training

- Overall and individual CSU compliance for Bloods training are regularly not meeting the 85% target.
- Work continues to improve the overall compliance for all blood competencies by way of regular reporting, increasing the number and pattern of training classes and regular meetings with the subject matter experts.
- Targeted actions continue to improve compliance across all areas due to the following actions:
- **Maintaining robust systems for reporting**
- **Analysis into low compliance areas**
- **Data quality checks**
- **Proactively targeting staff with low compliance**
- **Working with Individual CSU's to meet training capacity needs**

Appraisal

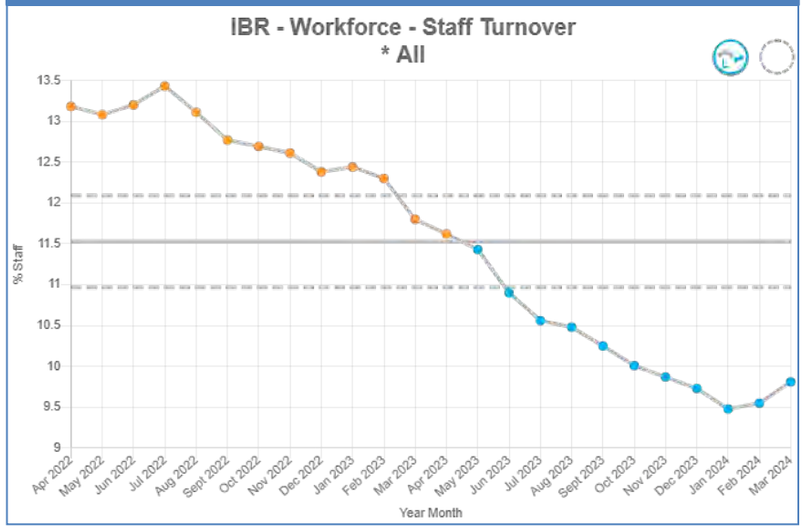
In order to increase compliance with the target, a range of actions are planned. These include :

- A review of the appraisal process to be undertaken with a view to streamlining and simplifying where appropriate
- A review of the current Trust intranet page 'Time 2 Thrive Appraisals Hub' to be conducted to ensure content is fit for purpose, and if improvements can be made to ensure better support for managers and appraisees
- A review of the content and scheduling of appraisal training
- Appraisal Roadshows for CSUs to be implemented, to include the benefits of appraisal, and what a good appraisal looks like
- Bite-size training sessions to be developed, including the offer of practice sessions for managers
- Regular meetings to be instigated (where these do not currently exist) with CSUs to track progress within departments/wards.

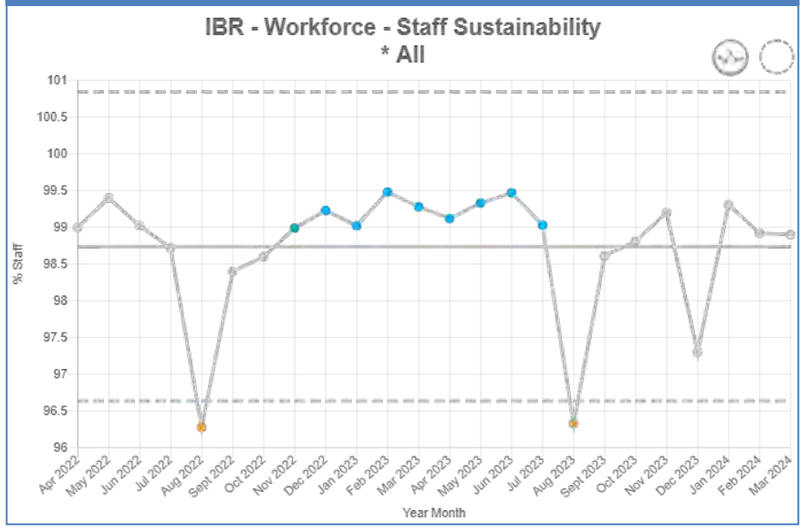
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

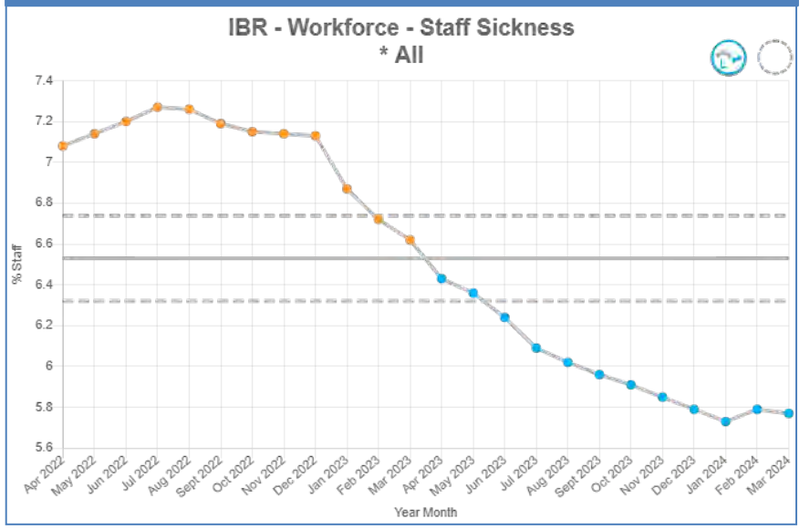
March 2024 -9.81%
Special cause variation of an **improving** nature



March 2024 – 98.9%
Common cause variation



March 2024 (rolling 12 months) -5.77%
Special cause variation of an **improving** nature



Analysis

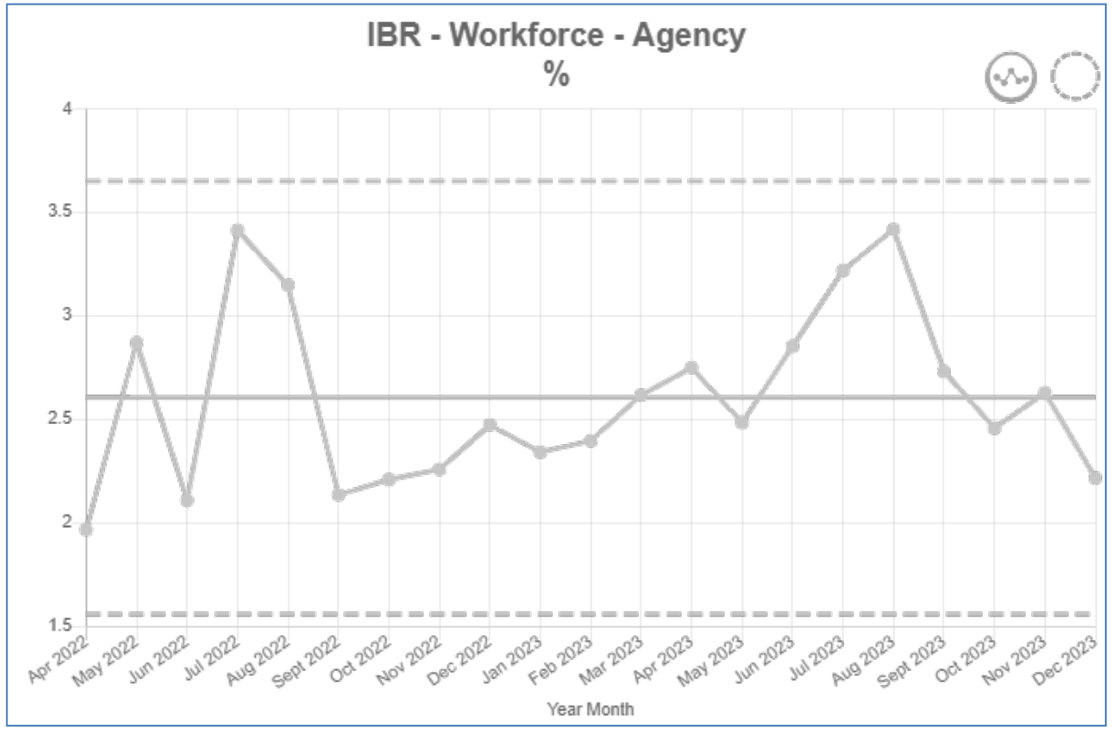
Sickness for the month of March is 5.88% and YTD is 5.77%, this has been a slight decrease from February which was 5.98% and YTD being 5.79%.
In Staff Groups the highest areas are in Additional Clinical Services at 8.46%, Estates and Ancillary staff at 8.06%, Nursing & Midwifery at 6.16% and Allied Health Professionals at 5.94% and the rest remain under 5.5%.
The overall sickness % has been under 6.5% for the past 12 months and has steadily decreased from April 2023 onwards.
The monthly **turnover** rate in March 2024 is 9.81%, an increase from 9.55% in February 2024. Over the last 12 months there is a gradual and consistent decrease in turnover from 11% in April 2023, reducing to 9% from November 2023 onwards.
The **sustainability** index shows the percentage of colleagues in post at the end of the period who were in post at the start of the period. The sustainability rate in March 2024 is 98.9%, which is a decrease from 98.92% in February 2024. The rate over the last 12 months has been consistently around 98% to 99% , with a dip in August to around 96%.

Risks, Mitigations and Assurance

The current Health, Wellbeing and Attendance Policy is being reviewed and is in line with current legislation supporting all the CSU's and Departments within the Trust. There is also a review of the Toolkit, in line with policy which will support Managers within the Trust.
In the last two years the sickness has been over 7% and there has been downward trajectory over this period of time towards the Trust target of 5.5%.
Regular Management of Attendance training is provided monthly as well as more specified training for all the CSU's and Departments.
The HRBPs attend monthly CSU Triumvirate and Performance meetings where sickness rates, and actions to improve these are discussed. Within certain areas, more specific regular monthly meetings have been established between management and a member of the HRBP team to go through sickness cases and to make sure that Trust policy is being followed and adhered to and that cases are progressed appropriately in a timely manner.
High **turnover** can affect patient outcomes if we do not have the right people in the right posts at the right time.
People wellbeing will suffer with increased pressures on colleagues leading to increased sick absence rates and higher turnover as well as reducing team effectiveness resulting in losing quality colleagues. This also leads to increased revenue as the cost of hire will increase as well as reliance on Bank and Agency staff.
To continue with the downward trajectory, our improvement plan will focus on people experience at recruitment and onboarding stages of the process.
We are working on an offboarding strategy to roll-out stay conversations across the Trust to improve attrition rates and identify why people consider leaving the Trust. Feedback and improvement plans from staff survey are also a critical element of the process. For **sustainability**, the dip in August is largely due to terminations of fixed term appointments and rotations, so it is necessarily that we have more staff leaving but that the average number of staff in post has increased that has had the effect of reducing turnover. This dip has been evident in previous years.

People – Engagement – To be in the top 20% Employers

December 2023 - 2.21%
Common cause variation



Bradford Teaching Hospitals
NHS Foundation Trust

Analysis

Workforce Agency %
There has been an increase in agency use in March for the following staff groups Professional Scientific & Technical, Admin and Clerical, AHP's, Estates and Facilities, and Medical and Dental. There has been a reduction in agency use between February and March for Healthcare scientists and Nursing and Midwifery.

Risks, Mitigations and Assurance

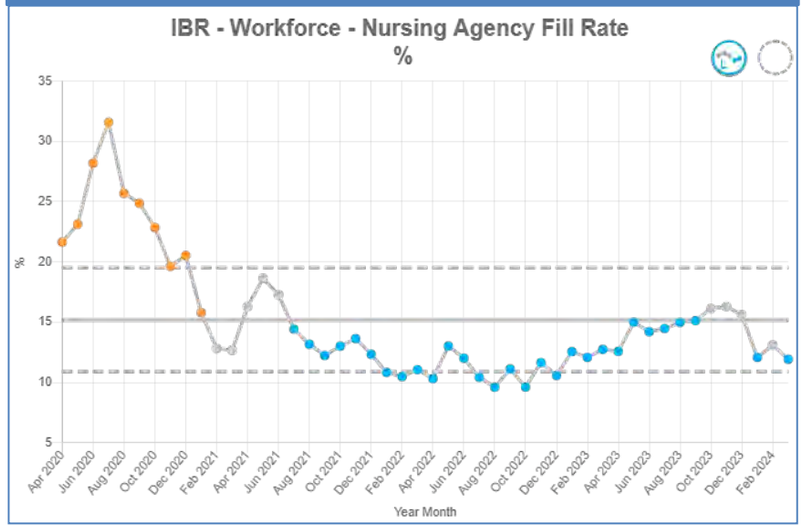
Workforce Agency %

Within the last 12 months a centralised admin bank has been created, we currently have 12 bank only staff and 253 substantive staff with bank contracts. The Flexible Workforce Team are going to put out a recurrent admin bank advert to grow our admin bank to remove the resilience on agency. The Flexible Workforce Team have also created an electronic bank for Estates and Facilities with 95 bank only staff and 415 substantive staff with a bank post. The Flexible Workforce Team are currently in the process of creating banks for AHP's and Professional Scientific & Technical staff. This will give the trust a bank for all staff groups therefore reducing the resilience on agency workers and achieving our agency reduction plan.

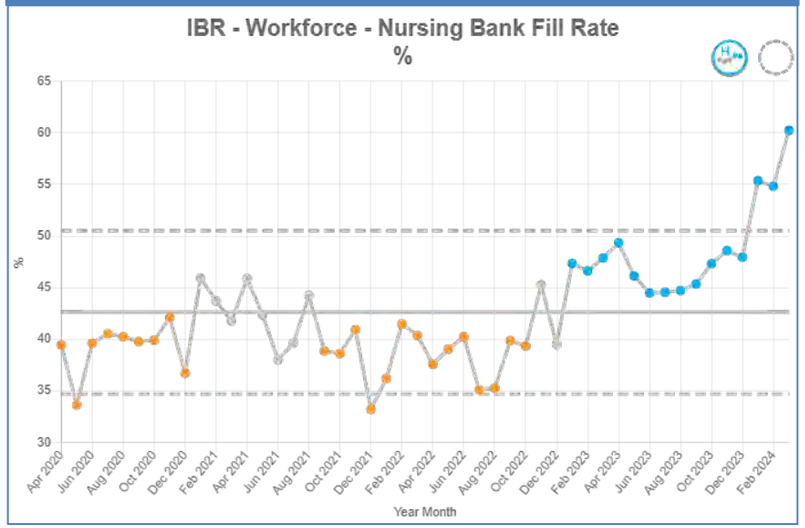
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

March 2024 -11.9%
Special cause variation of an **improving** nature



March 2024 – 60.2%
Special cause variation of an **improving** nature



Analysis

Nursing Agency

Agency staff filled 638 shifts in the month of March. This is split 638 registered and 0 unregistered staff. Out of the 638 filled registered shifts, 357 were filled with registered theatre staff. In March Agency fill rates decreased by 1.2% for registered staff. Agency fill rates for HCA's are 0 as these have not been in use since September 2023.

Nursing Bank

Instant pay was launched on the 29th February 2024, where staff are able to access 50% of their pay instantly for bank shifts approved. Since implementation of instant pay there has been an increase in bank fill rates of 5.4% from 54.8% in February 24 to 60.2% by the end of March 24.

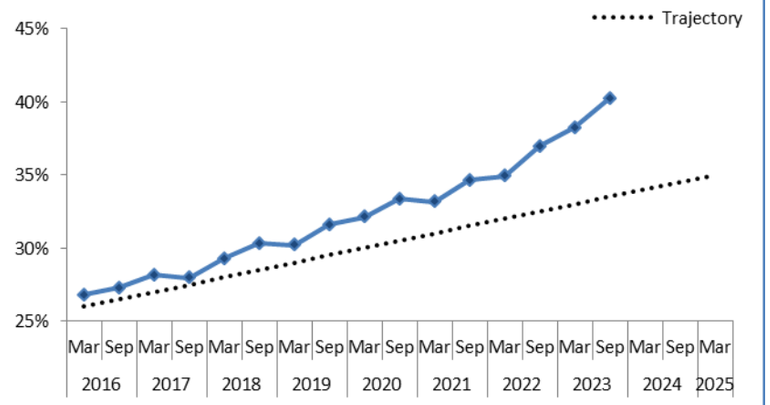
Risks, Mitigations and Assurance

From the 20th November 2023 a new nursing agency approval process was put in place to give assurance around agency use for nursing. Confirm and challenge meeting were added from January 2024 for all areas with an overspend. Once supernumerary periods of new starters have been completed from April 24 the trust should start seeing a reduction in bank as well as agency use.

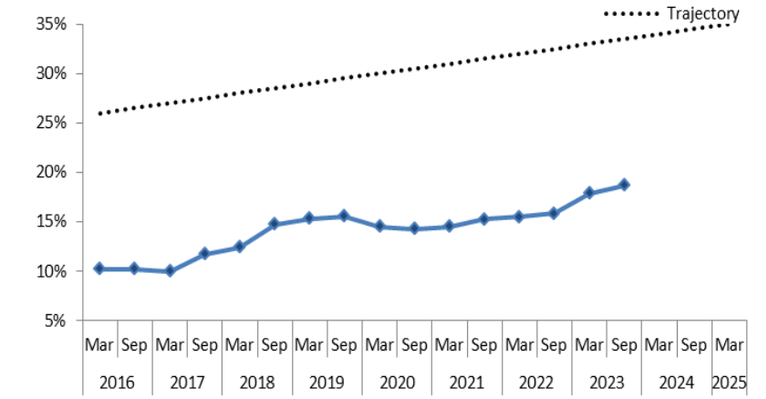
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

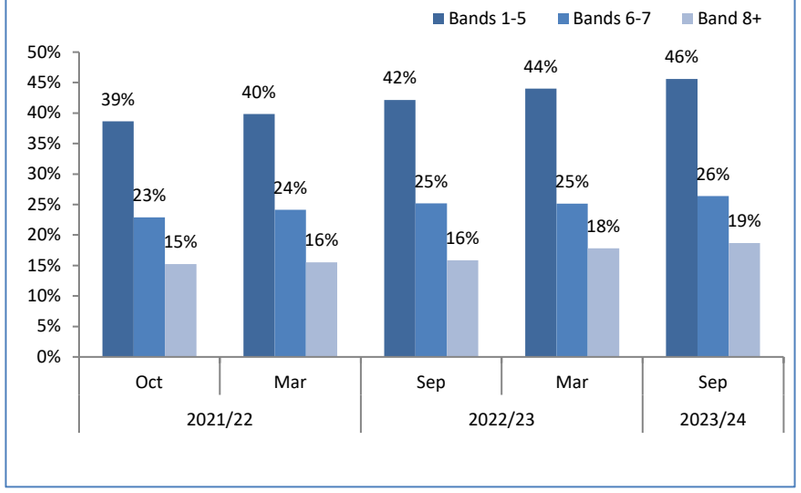
2023/24 Quarter 3 – BAME employee % and trajectory



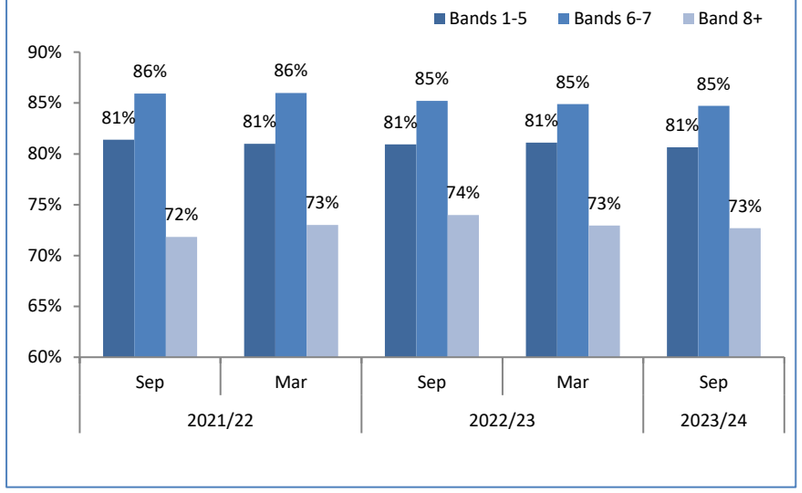
2023/24 Quarter 3 – BAME Senior Manager % and trajectory



2023/24 Quarter 3 – BAME employee % by band



2023/24 Quarter 32– Female workforce by band group



Analysis

BAME Employee, BAME Senior Manager, BAME Employee and Female workforce update will be provided in May 2024

Risks, Mitigations and Assurance

Quality – Executive Director: Dr Ray Smith & Karen Dawber

Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Lower Process Limit	Mean	Upper Process Limit
IBR - Quality - Breast Feeding Initiation Rates - * All	Sep-23	64.29%				55.94%	63.58%	71.21%
IBR - Quality - Cooling Babies - * All	Dec-23	1.00%				-1.99%	0.67%	3.33%
IBR - Quality - Falls - With Harm	Mar-24	47.00				18.06	46.63	75.19
IBR - Quality - Falls - With Harm per 10,000 bed days	Mar-24	18.52				6.39%	20.02%	33.66%
IBR - Quality - Falls - With Severe Harm	Mar-24	3				-1.97	0.92	3.81
IBR - Quality - HCAI - C. Difficile	Feb-24	2				-3.46	3.43	10.33
IBR - Quality - HCAI - E.coli	Feb-24	6				-1.36	7.35	16.05
IBR - Quality - HCAI - MRSA	Feb-24	1				-1.34	0.35	2.04
IBR - Quality - Medicine Reconcilliation - % Reconcilliation	Mar-24	73.30%				42.21%	61.57%	80.93%
IBR - Quality - Pressure Ulcers - All categories	Mar-24	31				21.29	43.38	65.46
IBR - Quality - Pressure Ulcers - All Categories per 10,000 bed days	Mar-24	12.21				7.28	18.61	29.93
IBR - Quality - Pressure Ulcers - Category 2	Mar-24	25				11.87	25.75	39.63

Quality – Executive Director: Dr Ray Smith & Karen Dawber

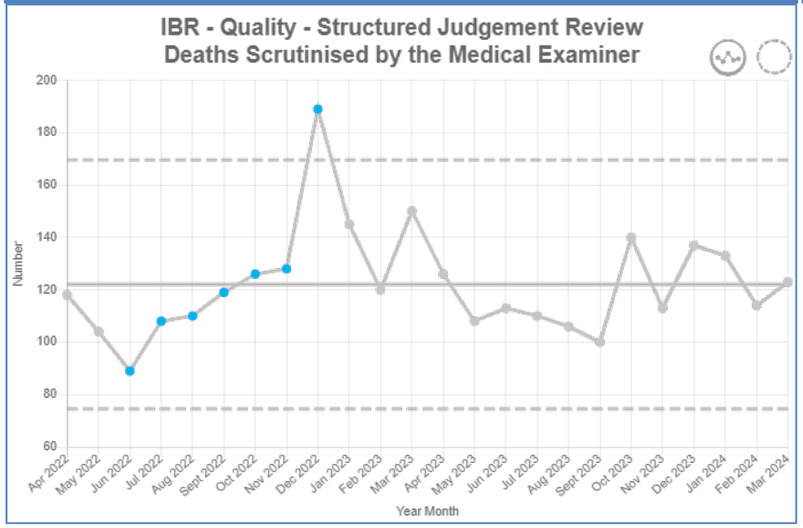
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Lower Process Limit	Mean	Upper Process Limit
IBR - Quality - Pressure Ulcers - Category 2 per 10,000 bed days	Mar-24	9.85				4.26	11.03	17.81
IBR - Quality - Pressure Ulcers - Category 3+	Mar-24	6				-1.19	5.75	12.69
IBR - Quality - Pressure Ulcers - Category 3+ per 10,000 bed days	Feb-24	2.11				-0.74	2.47	5.69
IBR - Quality - Readmissions - * All	Jan-24	8.00%				7.71%	8.92%	10.14%
IBR - Quality - Serious Incidents - Incidents	Jan-24	0				-1.78	2.4	6.58
IBR - Quality - Serious Incidents - Incidents per 10,000 bed days	Dec-23	0.42					1.11	
IBR - Quality - SHMI - * All	Oct-23	118.67				108.28	111.99	115.71
IBR - Quality - Still births - * All	Mar-24	0				-1.79	2.38	6.54
IBR - Quality - Structured Judgement Review - Deaths Scrutinised %	Mar-24	100%				100%	100%	100%
IBR - Quality - Structured Judgement Review - Deaths Scrutinised by the Medical Examir	Mar-24	123				74.51	122.04	169.57
IBR - Quality - Structured Judgement Review - Requests Raised	Mar-24	7				-1.18	8.42	18.02
IBR - Quality - Structured Judgement Review - Total number of In-patient Adult Deaths	Mar-24	123				74.51	122.04	169.57

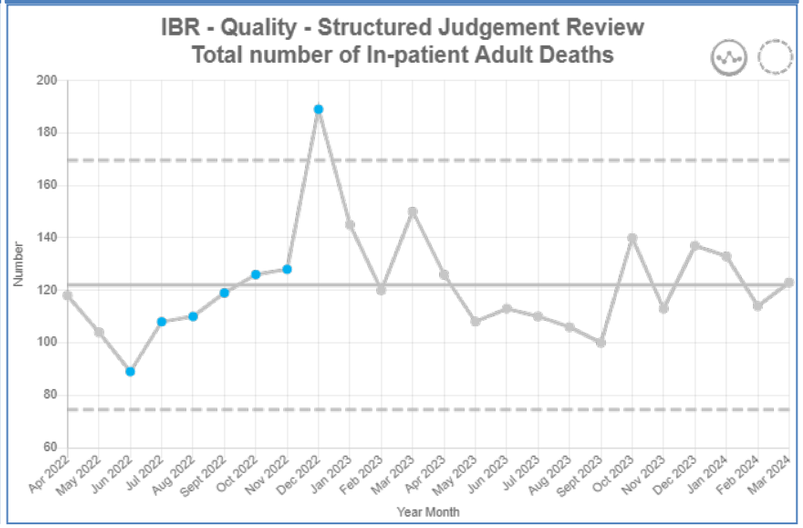
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

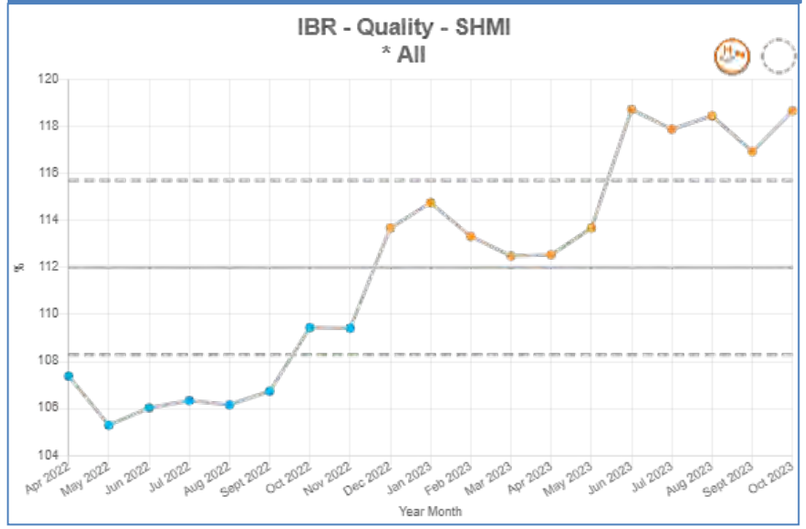
March 2024 - 123
Common cause variation



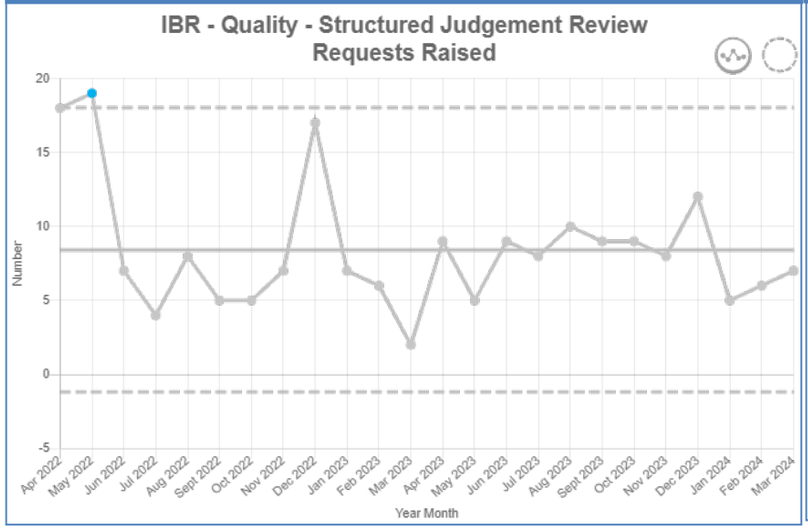
March 2024 - 123
Common cause variation



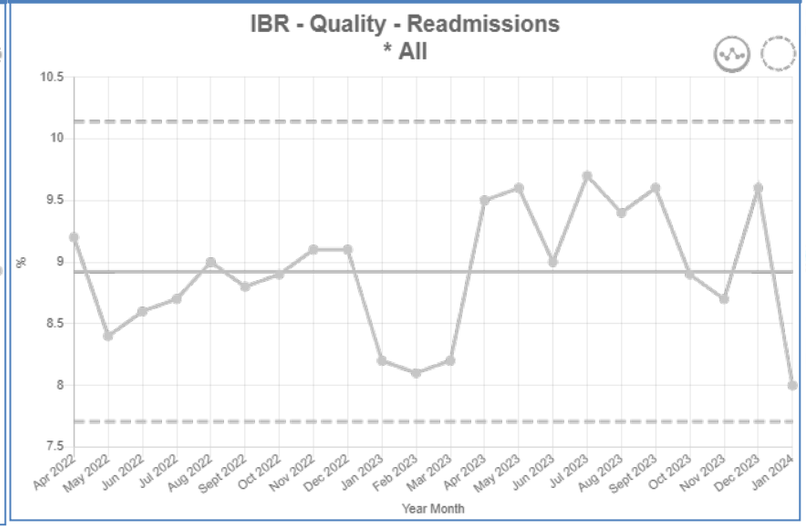
October 2023– 118.67
Special cause variation of a **concerning** nature



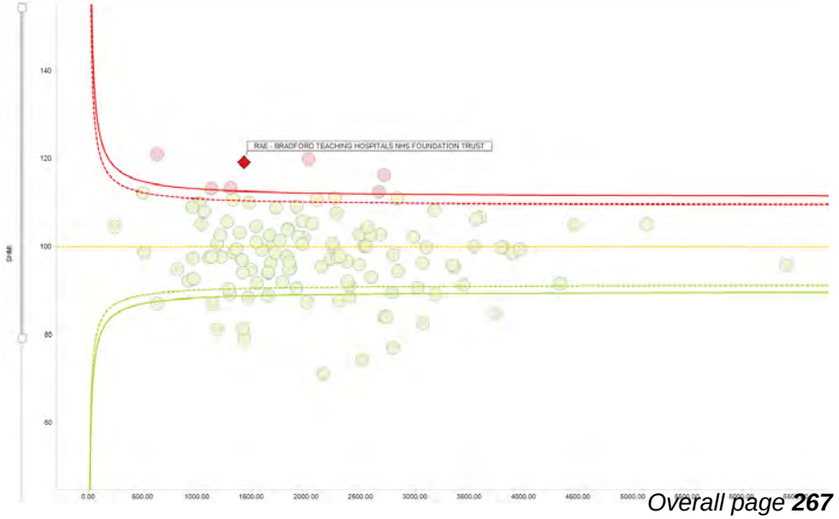
March 2024 - 7
Common cause variation



January 2024– 8.0%
Special cause variation of a **concerning** nature



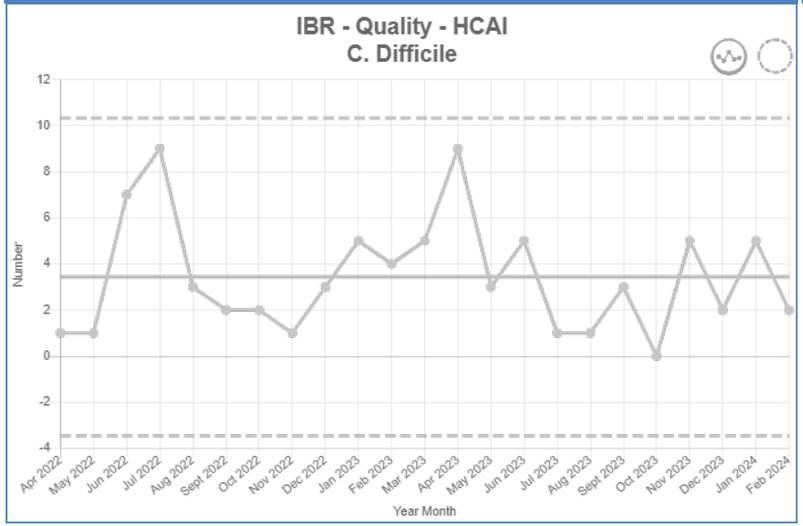
October 2023– 118.67
Special cause variation of a concerning nature



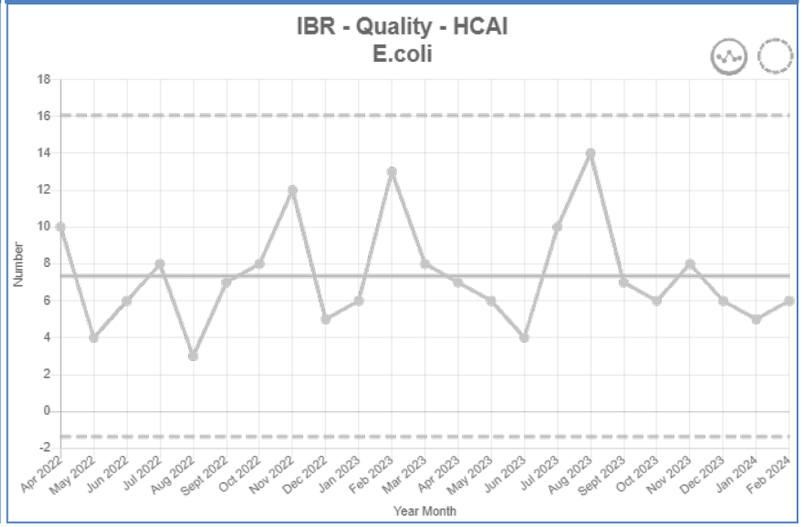
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

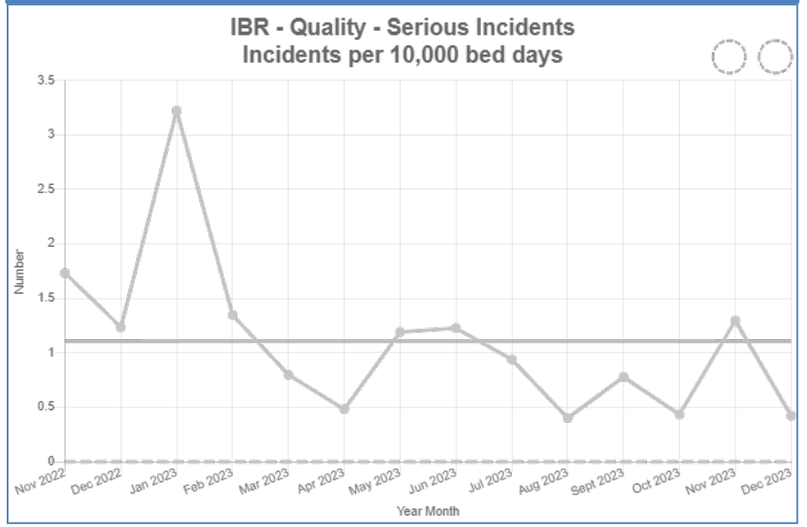
March 2024 - 2
Common cause variation



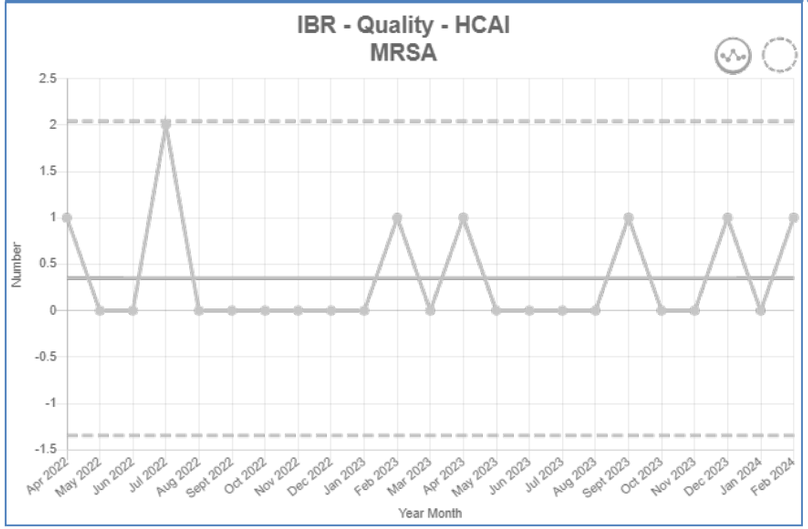
March 2024 - 6
Common cause variation



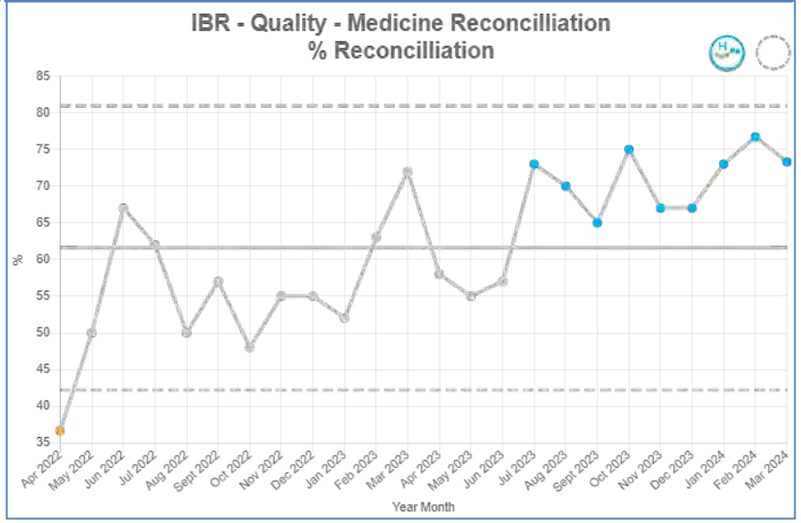
March 2024 - 3
Common cause variation



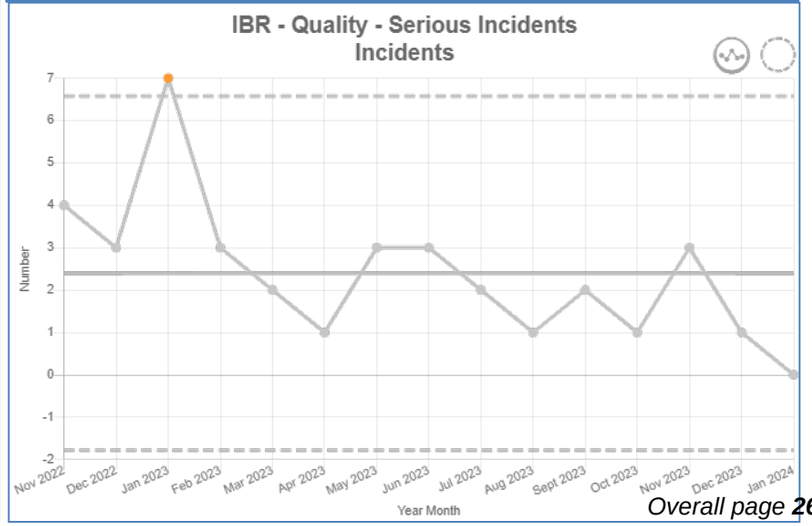
March 2024 - 7
Common cause variation



March 2024 – 73.3%
Special cause variation of an **improving** nature



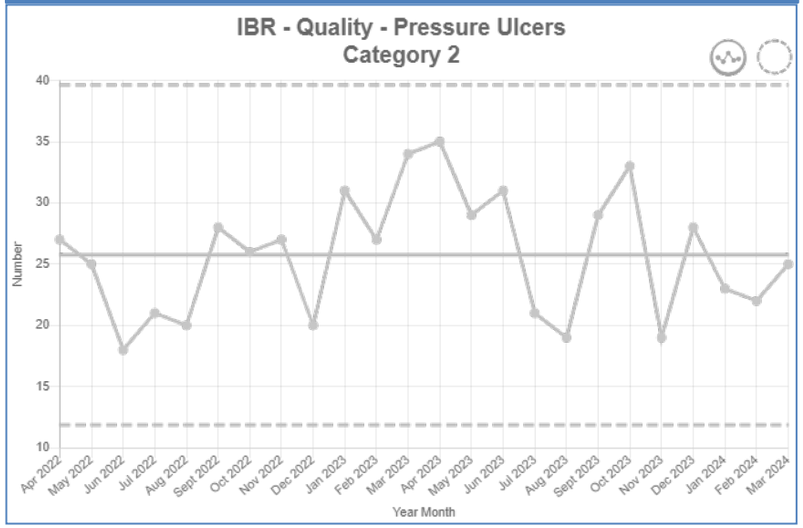
January 2024 - 0
Common cause variation



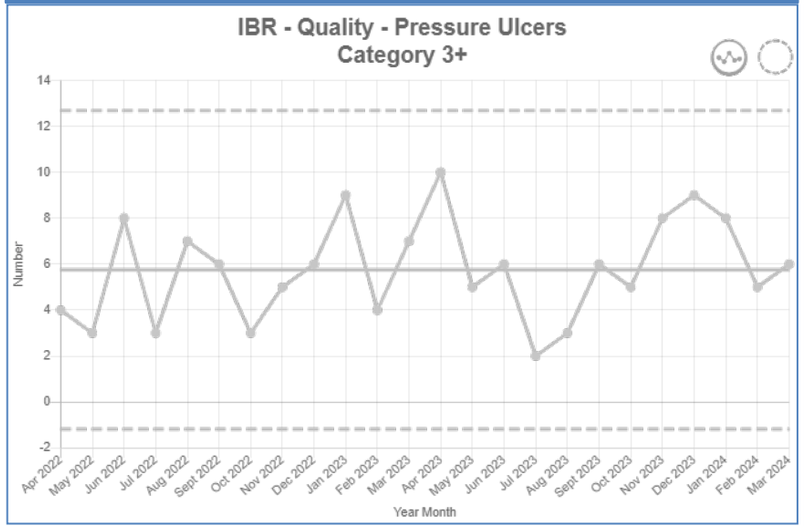
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals
NHS Foundation Trust

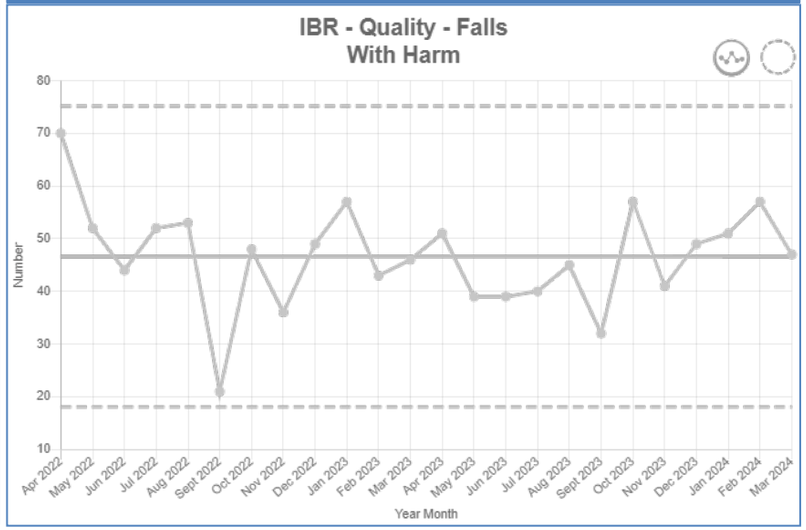
March 2024 - 25
Common cause variation



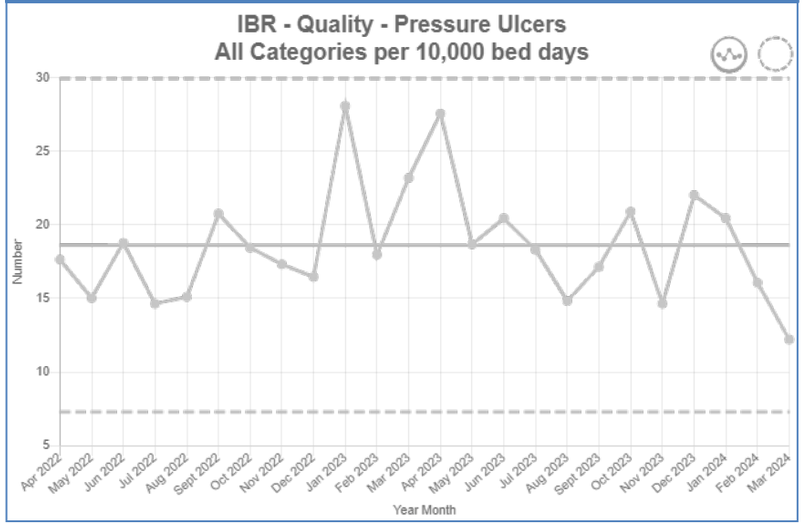
March 2024 - 6
Common cause variation



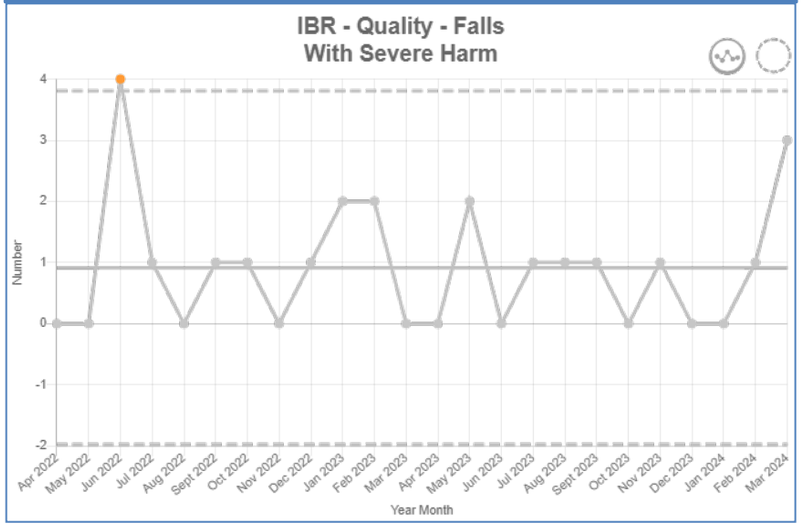
March 2024 - 47
Common cause variation



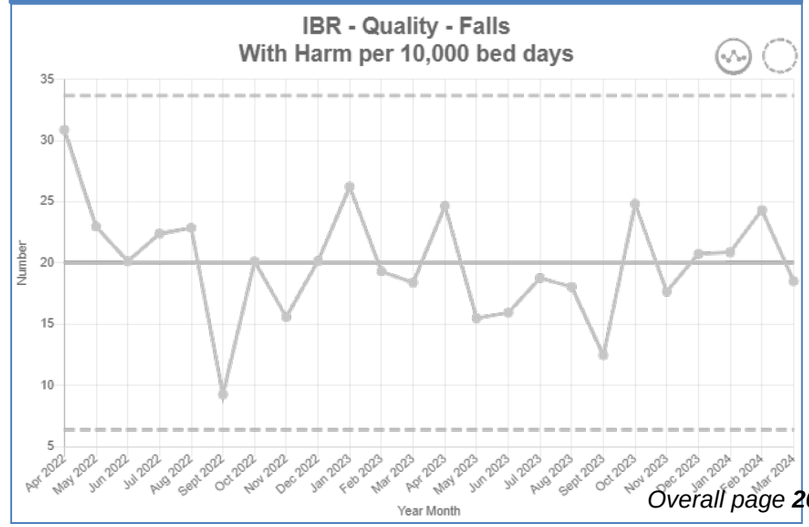
March 2024 – 12.21
Common cause variation



March 2024 - 3
Common cause variation



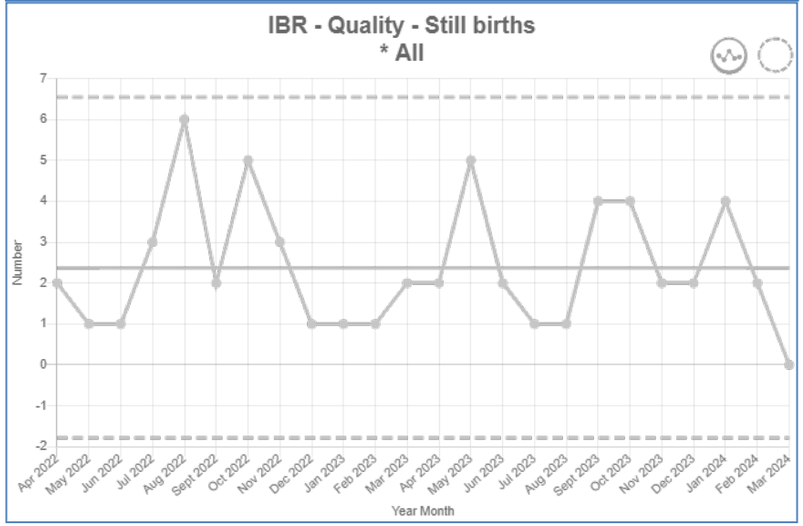
March 2024 –18.5
Common cause variation



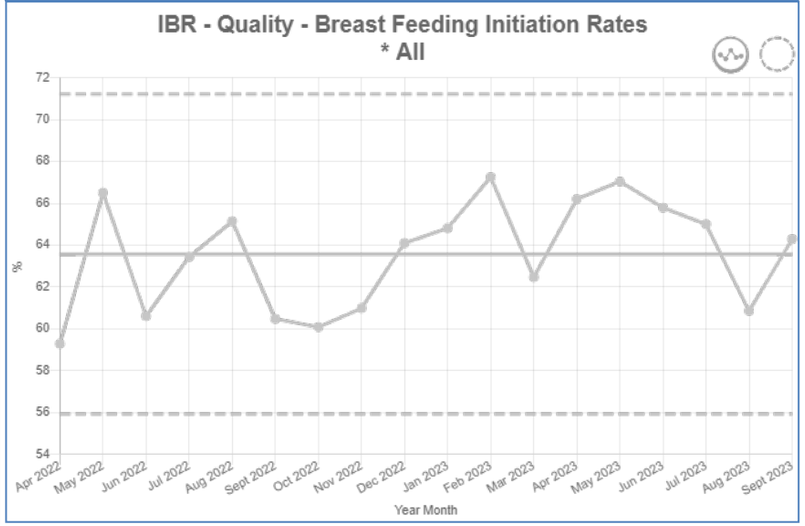
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

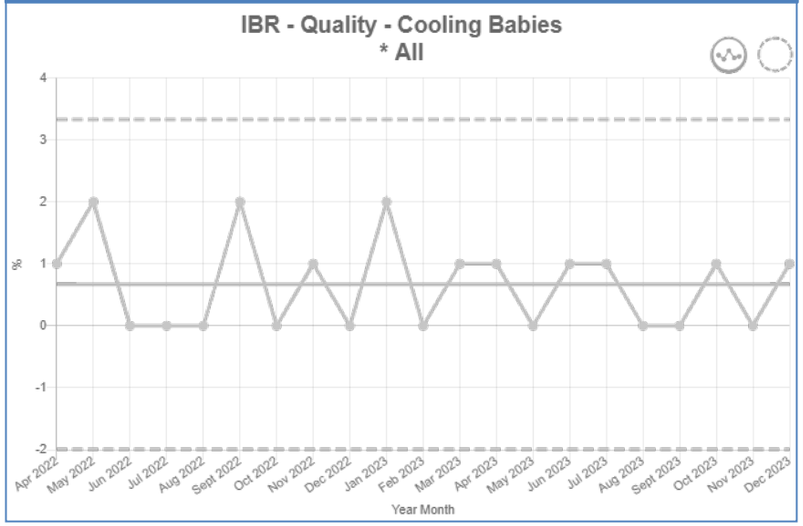
March 2024 - 0
Common cause variation



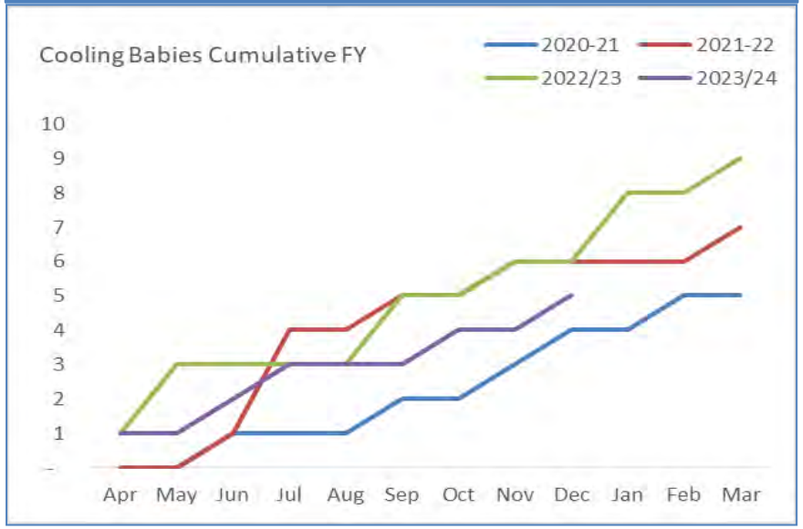
September 2023 – 64.29%
Common cause variation



December 2023 - 0
Common cause variation



December 2023 - 0
Common cause variation



FINANCE REPORT

REFERENCES

Only PDFs are attached

Bo.5.24.17 - BoD Finance Report - Month 12.pdf

BOARD OF DIRECTORS MEETING IN PUBLIC
Bo.5.24.17
FINANCE REPORT - MONTH 12

This report provides a brief interim update on the *unaudited* year end position for 2023/24.

1. Income & Expenditure Position (Unaudited)

Details	Annual Budget £m	Year End Outturn £m	Variance to Budget £m
Income			
NHS Contract Income	494.6	508.3	13.8
HEE Income	23.2	25.1	1.9
R&D Income	19.6	24.3	4.7
Other Income	21.0	28.4	7.5
Non-Operating Income	2.2	4.1	1.9
TOTAL INCOME	**560.5**	**590.2**	**29.7**
Pay Expenditure			
Substantive	(370.4)	(331.7)	38.7
Bank	(4.3)	(26.7)	(22.5)
Agency	(0.4)	(9.7)	(9.3)
Vacancy Factor	13.5	0.0	(13.5)
Total Pay Expenditure	**(361.5)**	**(368.1)**	**(6.6)**
Non-Pay Expenditure			
Drugs	(48.9)	(53.8)	(4.8)
Clinical Supplies	(46.3)	(47.3)	(1.0)
Pathology	(10.2)	(11.1)	(0.9)
Private Sector Capacity	(6.9)	(9.6)	(2.7)
Non-Clinical Supplies	(78.5)	(75.9)	2.6
Depreciation	(16.0)	(15.5)	0.6
PDC Dividend	(5.1)	(4.4)	0.8
CSU WRP target	13.0	0.1	(12.9)
Total Non-Pay Expenditure	**(199.0)**	**(217.5)**	**(18.5)**
TOTAL EXPENDITURE	**(560.5)**	**(585.6)**	**(25.1)**
NET I&E POSITION	**0.0**	**4.6**	**4.6**

Commentary
The Trust's **unaudited** year-end Income & Expenditure position for 2023/24 is a surplus of £4.6m. This is £4.6m better than the breakeven plan for the year. The favourable position is due to £4.4m of additional non-recurrent funding distributed to the Trust from the West Yorkshire Integrated Care Board in Month 12.

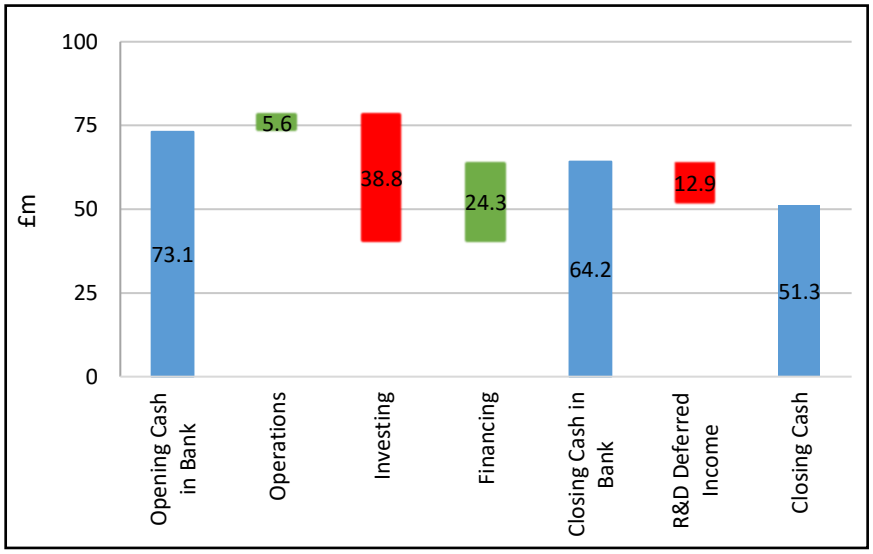
SECTION 2 - BALANCE SHEET, CASH & CAPITAL EXPENDITURE

2.1 Balance Sheet (actual movement)

		31-Mar-23 £m	31-Mar-24 £m	Movement £m	Commentary
Non-Current Assets to increase by £28.3m	Capital Assets	217.1	246.7	29.6	The Trust spent £55.3m this financial year on capital. This includes on £31.4m buildings, £14.7m on equipment and £9.0m on digital (including software).
	Leases	10.9	9.8	(1.1)	
	Other Non Current Assets	2.5	2.3	(0.2)	
	Total Non Current Assets	**230.5**	**258.8**	**28.3**	
Current Assets to decrease by £13.1m	Inventories	9.7	10.0	0.3	Please see Statement of Cash Flows for cash movements
	Receivables	27.1	22.6	(4.5)	
	Cash (see SoCF)	73.1	64.2	(8.9)	
	Total Current Assets	**109.9**	**96.8**	**(13.1)**	
Current Liabilities to decrease by £3.1m	Trade and other Payables	(84.3)	(64.0)	20.3	Reduction on trade and other payables (£20.3m) largely relates to the agenda for change non consolidated pay offer paid to staff and consultant study leave. £12.2m capital payables include valuations for work done on construction as at 31 March.
	Capital Payables	(9.3)	(21.5)	(12.2)	
	Loan	(4.5)	(4.5)	0.0	
	Provisions	(1.2)	(5.5)	(4.3)	
	Deferred Income	(11.7)	(12.4)	(0.7)	
	Total Current Liabilities	**(111.0)**	**(107.9)**	**3.1**	
Non-Current Liabilities to decrease by £8.3m	Loan	(23.1)	(18.9)	4.2	Loan repayments made for both the New Hospital Wing and Electronic Patient Records.
	Provisions	(7.2)	(4.6)	2.6	
	Deferred Income	(2.4)	(0.9)	1.5	
	Total Non Current Liabilities	**(32.7)**	**(24.4)**	**8.3**	
	Total Net Assets Employed	**196.7**	**223.3**	**26.6**	
Taxpayers Equity to increase by £26.6m	Public Dividend Capital	154.8	188.5	33.7	The Trust received £33.7m 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	40.0	(11.8)	
	Income and Expenditure	(9.9)	(5.2)	4.7	
	Total Taxpayers Equity	**196.7**	**223.3**	**26.6**	

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 metrics.

2.2 Full year forecast cash flow



Commentary
The SoCF reflects the Trusts cash inflows and outflows.

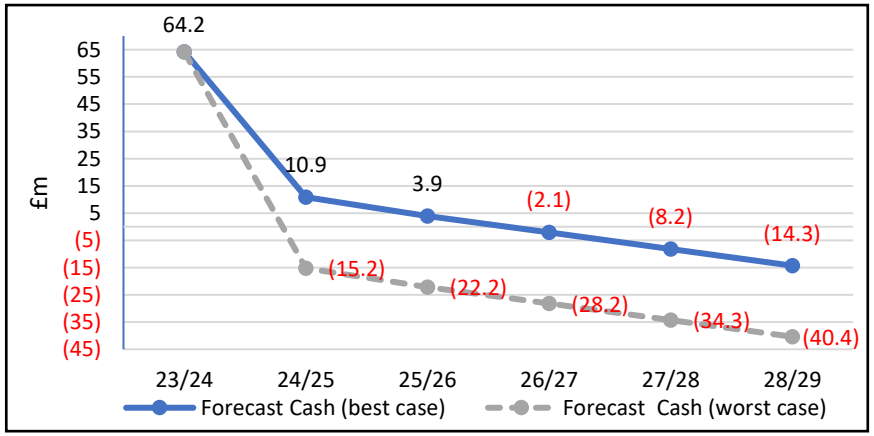
Operations - the Trust reporting £5.6m cash increase from its operations (I&E) this financial year. This includes £4.6m operating surplus and £15.7m depreciation less £15.3m movement in working capital.

Investing - the Trust reported a £38.8m cash decrease from investing activities which includes £55.3m for capital investments less increase in capital payables by £19.0m. The Trust is also received £3.9m interest from investments.

Financing - the Trust reported £24.3m cash increase from financing activities which includes £33.7m PDC and TIF less £3.1m loan repayments, £4.6m PDC dividend paid and £1.4m lease payments (IFRS 16).

The Trust currently has £64.2m cash at the end of the financial year. £12.9m is held on behalf of Research and Development leaving £51.3m for the Trust.

2.3 Five Year Cash Flow



Commentary

Cash is forecasted to fall to a negative £14.3m by the end of 2028/29 (including research and development funds of approx £12.9m). This assumes a break even I&E position from 25/26 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 each year. The main reason for the recurrent reduction in cash from 2024/25 onwards (approx. £5.4m per annum) is that the ICS has allocated approx. £6.1m more CDEL to the Trust than cash generated from its operations.

Should the Trust not deliver its waste reduction in 24/25 programme the worst case scenario highlights that cash could be negative by the end of March 2025.

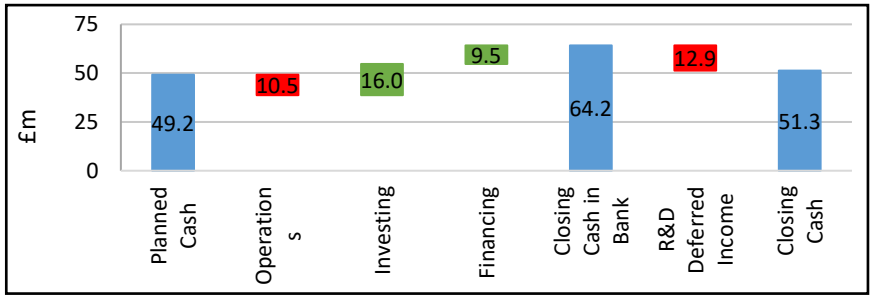
2.4 2023/24 Capital Programme

		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 £3.1m	Topslice	1.2	1.1	(0.1)	1.2	1.1	(0.1)	(0.1)
	Diagnostics	0.5	0.4	(0.1)	0.5	0.4	(0.1)	(0.1)
	Planned CSUs	0.6	0.7	0.1	0.6	0.7	0.1	
	Unplanned CSUs	0.5	0.2	(0.3)	0.5	0.2	(0.3)	(0.3)
	Breast Screening	1.2	1.9	0.7	1.2	1.9	0.7	
	Other	0.9	3.7	2.8	0.9	3.7	2.8	
Digital forecast to be overspent by £2.6m	General	1.0	3.9	2.9	1.0	3.9	2.9	
	Other	0.3	0.0	(0.3)	0.3	0.0	(0.3)	(0.3)
Estates forecast to be underspent by £0.7m	Rolling Backlog	4.0	3.7	(0.3)	4.0	3.7	(0.3)	
	Capitalised Salaries	0.4	0.0	(0.4)	0.4	0.0	(0.4)	
Capital Strategy forecast to be overspent by £2.7m	OMS Maternity	2.5	2.5	0.0	2.5	2.5	0.0	
	CT Scanner	1.8	1.8	0.0	1.8	1.8	0.0	
	TIF Theatres and Anaes	2.1	1.4	(0.7)	2.1	1.4	(0.7)	(0.7)
	Gamma Camera Turnkey	1.6	0.9	(0.7)	1.6	0.9	(0.7)	(0.7)
	Radiology Room 6	1.6	1.7	0.1	1.6	1.7	0.1	
	Wi-Fi Refresh and The Edge	1.5	1.8	0.3	1.5	1.8	0.3	
	R&D Entrance	1.3	0.6	(0.7)	1.3	0.6	(0.7)	(0.7)
	Hand Surgery Unit	1.1	0.9	(0.2)	1.1	0.9	(0.2)	(0.2)
	Single Isolation Rooms	1.1	1.4	0.3	1.1	1.4	0.3	
	Other	(3.7)	0.6	4.3	(3.7)	0.6	4.3	
PDC forecast to be underspent by £4.2m	Eccleshill CDC	5.6	6.0	0.4	5.6	6.0	0.4	
	Endoscopy Transformation	8.7	4.2	(4.5)	8.7	4.2	(4.5)	(4.5)
	Digital Diagnostics	1.1	1.1	0.0	1.1	1.1	0.0	
	Other	0.5	0.4	(0.1)	0.5	0.4	(0.1)	
TIF forecast to be underspent by £3.4m	SLH Day Case Unit	17.8	14.4	(3.4)	17.8	14.4	(3.4)	(3.4)
Total		**55.2**	**55.3**	**0.1**	**55.2**	**55.3**	**0.1**	(11.0)

The Trust invested £55.3m on capital during 23/24 which is £0.1m more than planned. £2.8m has been brokered across WY ICS. £11.0m slippage number is indicative as the accounts are finalised and audited.

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 £6.1m	Capital Assets	252.0	246.7	(5.3)	Capital spend is higher than plan by £5.8m due to the investment in external funded schemes during 23/24 (eg Endoscopy £4.2m). Impairment of assets following the valuation exercise (£11.8m) has reduced NBV.
	Leases	10.5	9.8	(0.7)	
	Other Non Current Assets	2.4	2.3	(0.1)	
	Total Non Current Assets	**264.9**	**258.8**	**(6.1)**	
Current Assets higher than plan by £23.4m	Inventories	9.7	10.0	0.3	YTD receivables is higher than plan by £8.1m. Research and Development debtors is £4.5m higher than plan and prepayments is £2.5m higher than plan.
	Receivables	14.5	22.6	8.1	
	Cash	49.2	64.2	15.0	
	Total Current Assets	**73.4**	**96.8**	**23.4**	
Current Liabilities higher than plan by £18.3m	Trade and other Payables	(69.1)	(64.0)	5.1	Capital Payables is higher than plan due to the significant amount of work that took place during Qtr 4 and the valuation of those works.
	Capital Payables	(2.5)	(21.5)	(19.0)	
	Loan	(5.1)	(4.5)	0.6	
	Provisions	(1.2)	(5.5)	(4.3)	
	Deferred Income	(11.7)	(12.4)	(0.7)	
	Total Current Liabilities	**(89.6)**	**(107.9)**	**(18.3)**	
Non-Current Liabilities lower than plan by £3.8m	Loan	(18.6)	(18.9)	(0.3)	Non Current Provisions has decreased as they are treated as current. Non Current research and development deferred income is lower than plan by £1.5m
	Provisions	(7.2)	(4.6)	2.6	
	Deferred Income	(2.4)	(0.9)	1.5	
	Total Non Current Liabilities	**(28.2)**	**(24.4)**	**3.8**	
	Total Net Assets Employed	**220.5**	**223.3**	**2.8**	
Taxpayers Equity higher than plan by £2.8m	Public Dividend Capital	179.0	188.5	9.5	The Trust was awarded £9.5m additional funding during 23/24 (£8.8m for Endoscopy).
	Revaluation Reserves	51.8	40.0	(11.8)	
	Income and Expenditure	(10.3)	(5.2)	5.1	
	Total Taxpayers Equity	**220.5**	**223.3**	**2.8**	



Commentary
Year to date cash is currently less than plan by £15.0m.
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 investment is £5.8m higher than planned and capital payables is ahead of plan by £19.0m. The Trust is also receiving more interest than planned £2.1m.
Financing - Trust has received £9.5m extra PDC funding.

Appendix 2 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%**	92.4%	92.5%	-0.1%	
- By Value	**95.0%**	94.3%	94.1%	0.2%	
BPPC % of Bills paid in target (NHS)					
- By number	**95.0%**	89.3%	88.9%	0.4%	
- By Value	**95.0%**	85.2%	84.9%	0.3%	
BPPC % of Bills paid in target (Non NHS)					
- By number	**95.0%**	92.5%	92.6%	-0.1%	
- By Value	**95.0%**	95.0%	94.8%	0.2%	
Creditor and Debtor Days (NHS and Non NHS)					
Creditor days	**171.0**	159.0	129.0	30.0	
Debtor days	**17.1**	16.0	22.0	-6.0	

PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

Bo.5.24.17 - Performance Report.pdf

Meeting Title	Board of Directors Meeting		
Date	9 May 2024	Agenda item	Bo.5.24.17

PERFORMANCE REPORT – FOR THE PERIOD MARCH 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 information	
Previously discussed at/ informed by	Finance & Performance Academy – 24 April 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 March 2024.

Analysis

Ambulance Handovers:

- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 52.92% in March compared to 51.51% in February. This remains above the regional average.
- The number of ambulances arriving daily at BTHFT continues to remain high with a daily average of 112. These are up by 8% in March when compared to the same time last year.
- Recording of patient handover switched to the sole use of the YAS Ambulance Mobile Device Terminal (AMDT) during February. This has reduced duplication with recording on Trust systems which we had hoped would improve accuracy, but this is yet to be seen in the data.
- Significant internal validation is still required with a c.45% discrepancy in handover clock stops. An increase in patients with no breach reason has prompted a further review of the differences between BTHFT and YAS handover reporting.
- The YAS funded Hospital Ambulance Liaison Officer (HALO) position ceased at the end of March. Options continue to be explored to reinstate the role at BTHFT.
- A direct access pathway to the Urgent Treatment Centre (UCC) or Ambulatory Emergency Care Unit (AECU) remains in place and agreed protocols and escalation are in place to support busy periods.

Emergency Care Standard (ECS):

- ECS performance for Type 1, 2 & 3 attendances was 82.67% for March 2024 and is currently forecast at 85.03% for April 2024. The position is in the upper decile of Acute Trusts in England.
- In March 2024 Type 2 activity was included in the monthly submission following an agreement with the ICB and NHSE on a standardised approach to recording Type 1, 2 and 3 activity.
- Streaming to the AECU service continues to have a positive impact on a range of UEC metrics.
- Average daily attendances for March are in line with January and February although improvements have been observed with LoS metrics for both admitted and non-admitted patients.
- G&A adult bed occupancy remains high at 94.68% in March 2024 with high acuity and issues within the social care sector continuing to impact the timely discharge of patients.

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- The UCC project group continues to look at further opportunities to improve ECS performance. Workstreams are in place to achieve improved utilisation, develop new pathways, review triage, and contractual arrangements with Bradford Care Alliance (BCA) who provide the GP input to the UCC.

Long Length of Stay and Discharge Pathways:

- The daily average number of patients with a length of stay (LOS) > 21 days reduce to 121 in March 2024, but increases are being seen during April 2024 with a projected daily average of 138.
- A 'Criteria to Reside' meeting occurs twice weekly with operational leads working closely to enable timely discharge of long length of stay (LLOS) patients. The Deputy Director of Nursing and Matrons conduct a weekly virtual review of 'Super Stranded Patients' with a LoS >21 days.
- Weekly system winter 'surge and escalation' meetings with system partners have now been stepped from the end of March. Escalation by exception when requested remains in place.
- The number of patients that are awaiting packages of care has reduced to 22 from 39 in February 2024 and of those 22, 13 now have agreed start dates.
- Joint work with the Local Authority (LA) and the implementation of 'routes' in P1 and placing people directly into the independent sector and home care via the Bradford Enablement and Support Team (BEST) is improving the position.
- Discharge to Assess and improvements around intermediate care delivery are described within the Partnership IMC Blueprint document. The final version of this will be signed off by the Healthy Communities Board by the end of April. Delivery of the Blueprint is aligned to 8 key projects, an overview of the project timeline and milestones were presented at the Partnership Leadership Executive (PLE) in March.
- The IMC development work also aims to address pressure within providers around enhanced needs within pathway 2 and 3 by aligning patients to the correct pathway; a meeting with the commissioners is scheduled for April.
- A soft launch of the Home-First Assessment Team (H-FAST) went ahead as planned in March with a go-live date for BTHFT still to be confirmed.
- The length of stay in community hospitals and wards 6 & 9 continues to remain a challenge due to social work vacancies with no mitigation currently identified due to LA budgetary constraints/ staffing pressures. A council-wide recruitment pause has resulted in posts remaining vacant.

Inpatient and Outpatient Activity:

- Outpatient, Elective and Day Case activity increased in March 2024 despite increased annual leave and bank holidays. Volumes are projected to decrease and remain below plan in April 2024.
- 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. Each CSU will be supported to interpret the available data and then implement and then track associated improvement actions.
- The use of PIFU is increasing and EPR optimisation focussed initially on outpatient clinics will help enable some of the outpatient productivity gains identified.
- Outpatient and Theatre sessions are also being reviewed against job plan capacity, activity run rates and waiting list profiles to support CSU teams with forward plans for 2024/25.
- 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.

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- Scheduling review meetings have supported start times improvements over the last four weeks.
- The Day Case Unit (DCU) at St. Lukes Hospital will support an increase in sessions and an uplift in session productivity with the ability to run high volume low complexity lists.
- A project group has been set up to improve activity levels of outpatients with procedures in line with the planning guidance. The initial focus is set on increasing and improving accuracy of procedure recording on EPR within Dermatology and Trauma & Orthopaedics, as well as identifying and addressing mapping issues within the data warehouse.

Referral to Treatment:

- Referral to Treatment (RTT) performance has reduced in March to 64.48% but remains within the upper quartile compared to other Acute Trusts.
- From February 2024, Community Paediatrics has been excluded from the national RTT submission. It is instead being submitted as part of the Community Health Services Sitrep alongside other community services delivered by BTHFT. Community Paediatrics performance against the 18 weeks standard will continue to be monitored through internal reports.
- Weekly access meetings and targeted patient-level long waiter reviews focus on increasing activity levels whilst ensuring the longest waiting and most clinically urgent patients are treated first.
- There was 1 patient reported over 78 weeks at the end of March, with 1 patient projected to breach 78 weeks at the end of April. These relate to complexity or patient choice during the treatment phase following previous delays due to service capacity.
- 34 patients beyond 65 weeks breached at the end of March , predominantly in Trauma & Orthopaedics who are being supported to maximise available theatre capacity to reduce their long wait breaches going forward.
- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, has increased from 96% to 99.5% during 2023/24. Validation is now better coordinated between teams and the themes from corrections are being fed into preventative work.

Diagnostic waiting times:

- DM01 performance for March 2024 was 81.40% which is an improvement on February.
- Non-obstetric ultrasound (NOUS) outsourcing has ended with the current position being significantly improved to almost 90%. A sustainability plan is now in place which includes insourcing to run alongside existing provision.
- MRI scanner failures during February and March have impacted on Radiology but the overall position is still expected to improve in April as the Community Diagnostic Centre (CDC) capacity increases.
- CDC capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. With greater community diagnostic provision available work is underway to develop a system-wide approach for access and the visibility of patient information.
- It is expected that this additional capacity will mean the current improvement trend will continue into 2024/25 and bring performance back into the upper quartile nationally. Recovery can be seen in March for both echocardiology and respiratory sleep due to insourcing and process improvements.
- Transformation work to support Digital Histopathology which will enable the ability to report from digital slides, anytime, anywhere is underway.

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Cancer Wait Times:

- 2WW performance recovered to above target at 95.42% in February. Demand remains high and has increased further for several tumour groups with national awareness campaigns underway.
- The 28-day faster diagnosis standard (FDS) performance was above target at 84.77% in February and is expected to improve further in March and April. Weekly oversight and targeted improvements have helped maintain delivery at such a high level.
- There has been significant focus on fast-track diagnostic turnaround times and a HISTO programme to improve histopathology processes launched. Endoscopy booking processes and routine capacity planning have also been reviewed. In addition, opportunities such as the one stop neck lump clinic will also help this phase.
- FDS also requires the data capture to be timely and accurate which has remained a priority for the central cancer team during Q4 with weekly improvements observed.
- The 31-day General Treatment Standard was reported for the first time in January. Performance continued marginally below the 96% target at 95.32% in February. Capacity and patient availability were impacted during the Easter and Eid leave period and performance will remain below target.
- The 62-day General Standard replaced the 62-day classic standard in January. Performance in February remained below the target of 85% at 66.88% but the backlog has reduced to meet the 2023/24 planning target with performance expected to improve into March and April as a result.
- 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.

Other KPI of note:

- 9 breaches of the re-booking target occurred in March 2024. Industrial action has reduced some of the capacity in which they would have been seen but services have also been asked to review prioritisation processes to ensure delays for these patients are minimised going forward.
- 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.

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

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

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

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

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

Meeting Title	Board of Directors Meeting		
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APPENDIX 1

LATEST REPORTED PERFORMANCE – MARCH 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	Mar-24	18 min	**21 min**	→
5	Emergency Care Standard	Mar-24	83.50%	**82.67%**	↑
7	Length of Stay ≥21days	Mar-24	95	**121**	↑
9.1	18 Week RTT Incomplete	Mar-24	73.52%	**64.48%**	↓
9.2	52 Week RTT Incomplete	Mar-24	1.08%	**1.25%**	↓
10	Diagnostics Waiting Times	Mar-24	83.00%	**81.40%**	↑
11.1	Cancer 2 Week Wait	Feb-24	93.00%	**95.42%**	↑
11.2	Cancer 28 Day FDS	Feb-24	75.00%	**84.77%**	→
11.3	31 Day General Treatment	Feb-24	96.00%	**95.32%**	↑
11.4	Cancer 62 Day General	Feb-24	85.00%	**66.88%**	↑

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan.

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement.

Meeting Title	Board of Directors Meeting		
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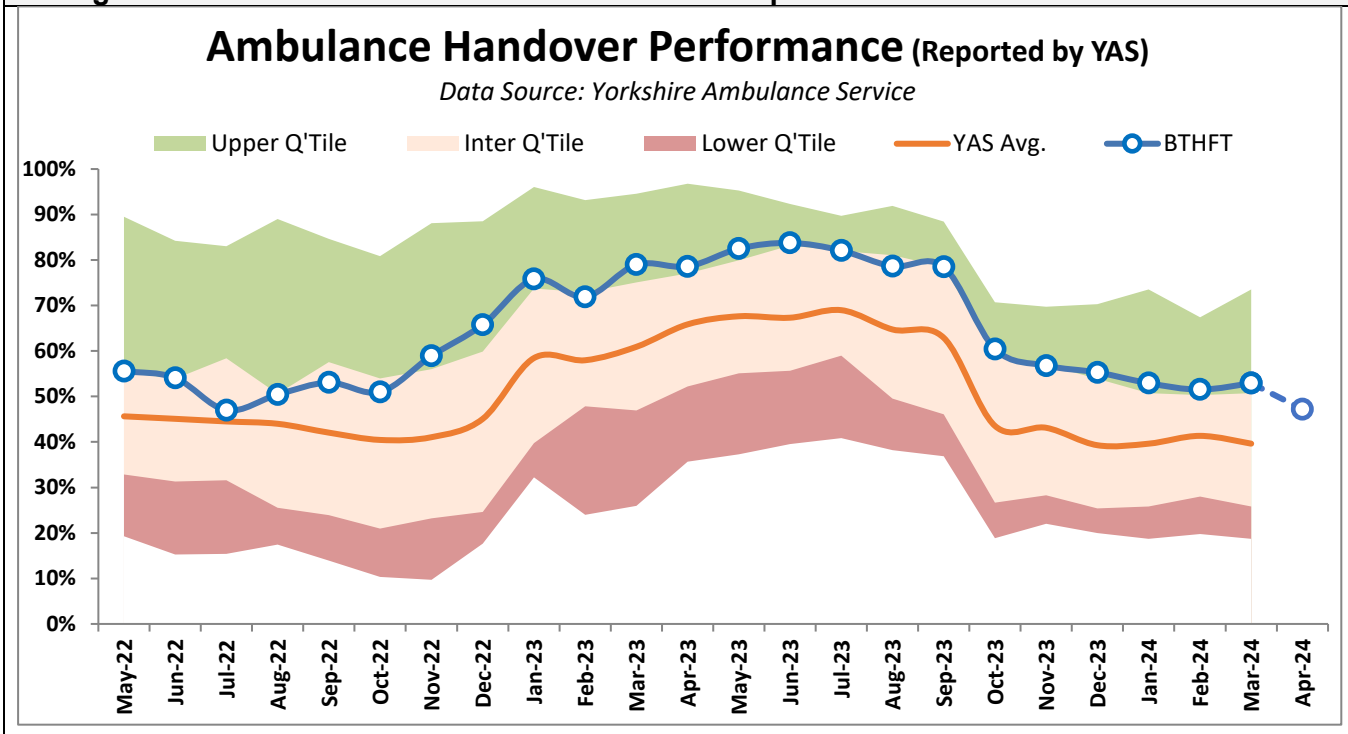
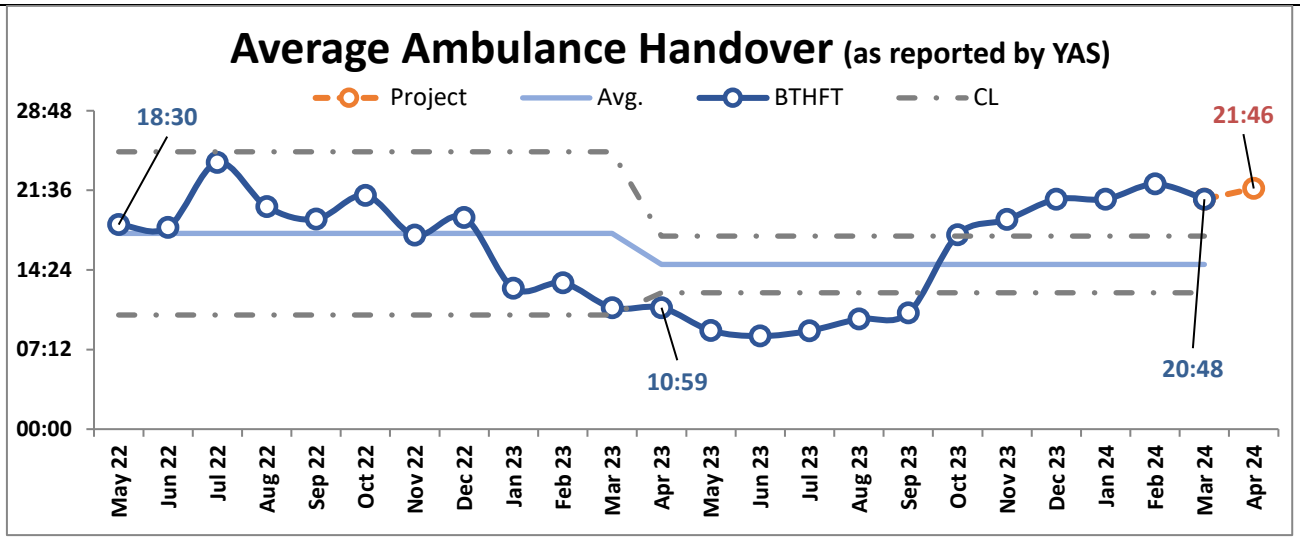
3. Emergency Ambulance Handover Performance

Figure 1 Ambulance Handovers – Yorkshire Comparison



Benchmarking data as supplied by the Yorkshire Ambulance Service (YAS) shows performance at BTHFT remains above the regional average for handover within 15 minutes (all reasons for delay included). ***Note:*** *Changes in YAS clock reporting commenced in October 2023.*



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Ambulance Handover Improvement:

- Live data sharing continues to support the deployment of YAS leads at site when required.
- An 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.
- A review of the ambulance assessment area (AAA) is set to commence 18th April to ensure it remains fit for purpose with sufficient nurse oversight to maximise patient safety and quality of care.
- Additional portering dedicated to the AAA to support efficient and timely transfers remains in place, however portering late shift coverage will come to an end in April. A business case is being proposed by ED to address this shortfall.
- Following the YAS internal audit in November, the ED clinical lead has agreed to be part of the 60-minute breach/ recovery response plan as outlined in the audit recommendation.
- To ensure the efficiency of self-handovers and minimise overcrowding within the AAA, the ambulance pre-alert, handover & preparedness supporting framework remains in circulation across medical and nursing staff.
- A daily validation exercise remains in place to support timely remedial action due to differences in YAS and BTHFT reported data. Recording of patient handover switched to the sole use of the YAS Ambulance Mobile Device Terminal (AMDT) from February. An increase in patients with no breach reason has prompted a further review of BTHFT and YAS handover reporting.
- Following a review of the Trusts' validated performance, a meeting was held with YAS to share findings. Subsequently YAS has endorsed a letter to NHS England recognising the impact human factors have had on handover data. This has been accepted regionally and is now awaiting national sign off which could unlock access to capital funding.

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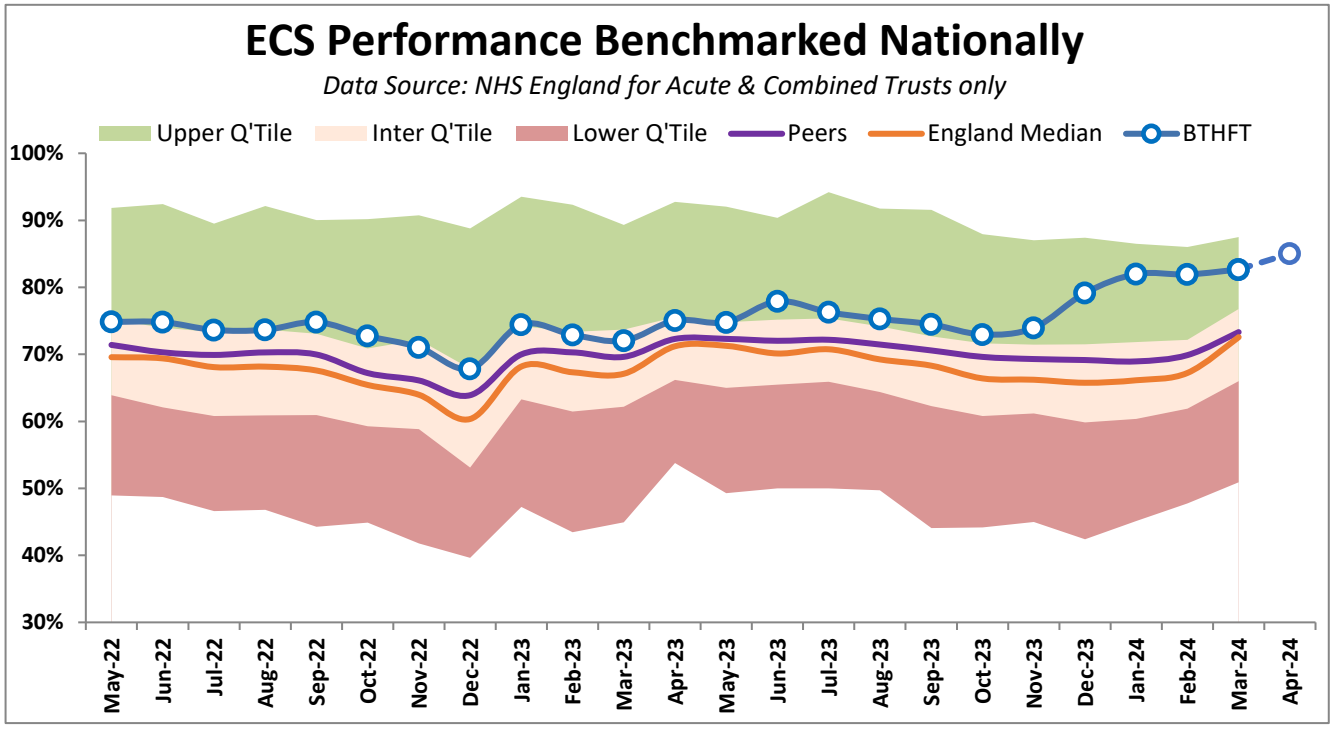
4. Emergency Care Standard (Type 1,2 &3)

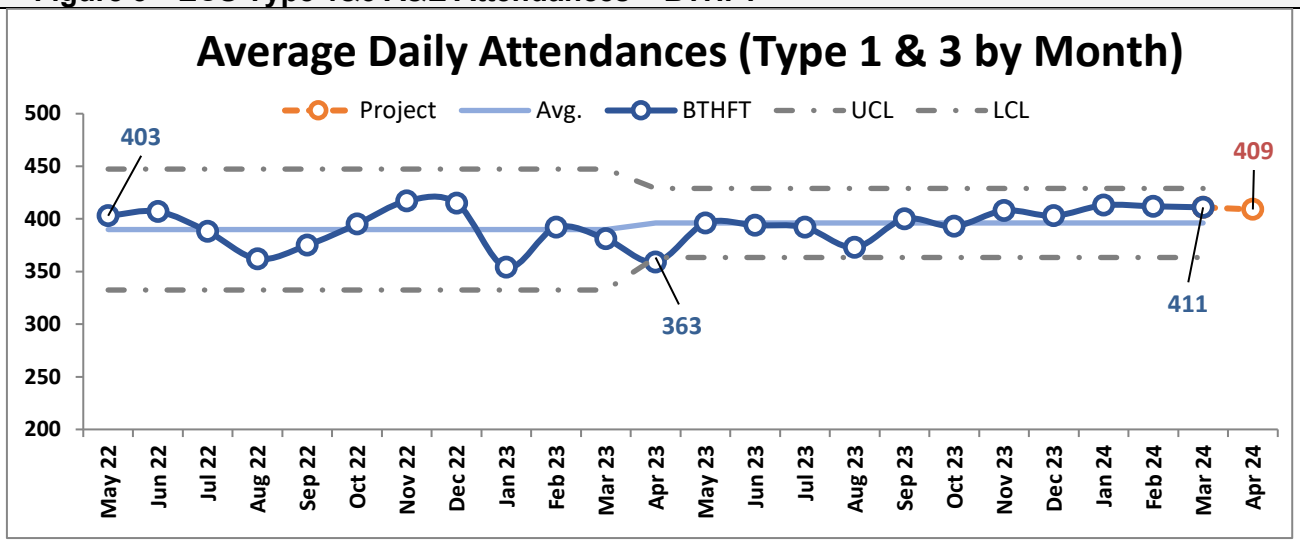
Figure 2 ECS Performance – National Comparison



Note: *In March 2024 Type 2 activity was included in the monthly submission following an agreement with the ICB and NHSE on a standardised approach.*

BTHFT reported a position of 82.67% for the month of March 2024. The April 2024 position is currently forecasted at 85.03%. BTHFT's performance remains above the England and peer averages.

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



The Trust continues to experience a high number of daily attendances with a daily average of 411 in March 2024. Attendances are projected to reduce to 396 in April.

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5. Emergency Department Measures

Table 2 ECS KPI Performance – BTHFT

ECS Performance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Average Daily Attendances	359	396	394	392	373	400	393	408	403	413	412	411	396
Average Daily Breaches	89	100	87	93	92	102	107	106	84	74	74	76	69
ECS Performance	75.08%	74.79%	77.91%	76.31%	75.30%	74.48%	72.84%	73.94%	79.14%	81.98%	81.92%	81.48%	82.47%
Arrival to Assess	00:22	00:22	00:22	00:21	00:22	00:22	00:24	00:26	00:23	00:22	00:22	00:22	00:20
Assess to Treat	01:41	01:47	01:42	01:44	01:40	01:47	01:47	01:58	02:10	02:15	02:12	02:08	01:41
Treatment Length	02:25	02:17	02:09	02:09	02:19	02:22	02:27	02:39	02:40	02:36	02:41	02:29	02:25
Total LOS - Discharged Patients	03:52	03:47	03:39	03:37	03:41	03:49	03:53	03:46	03:06	02:56	02:58	02:53	02:58
Total LOS	04:53	04:44	04:39	04:41	04:43	04:50	04:53	04:45	04:08	04:01	03:57	03:55	03:44

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 AECU model continues to contribute to an improved ECS performance.

Emergency Department Improvement:

- Expanded GP stream, supported by a primary care ANP, streamer and receptionist in place providing rapid assessments into the primary care services.
- Updated triage training for nurses commenced in March 2024 and focusses on a right first-time pathway selection, improving the patient experience and subsequently reducing conversion rates. Feedback to the training has been received positively, with 100% completion. The triage process is now being reviewed for streamers and will run concurrently to ensure the correct pathway continues to be utilised.
- Additional GP stream capacity was organised with the BCA to support the surge in the department. Minors/ MSK service is now seeing children from the age of 6 years (previously 8). Work continues to expand the age range and conditions covered by the GP Stream, with an aim to maximise the number of patients redirected from ED.
- Improvements to the AECU model are 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.
- 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 and a proactive approach from acute medics with care of the elderly being consistently available and providing support in senior decision making.
- A senior consultant led Rapid Assessment Triage (RAT) trial remains on hold until current consultant vacancies are fulfilled.
- The Family Support Workers (FSW) pilot will have a 3-tiered approach that will focus on the provision of signposting within the ED, telephone intervention and outreach support in the community/ home setting for families with complex health and social issues.

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6. Hospital Admission Measures

Table 3 ED Admissions KPI Performance – BTHFT

ED Admissions Performance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Conversion Rate*	23.71%	24.01%	22.63%	24.26%	24.69%	24.18%	24.98%	23.01%	21.56%	19.57%	19.38%	20.42%	16.76%
Average Daily Admissions*	85	95	89	95	92	97	98	94	87	81	80	84	66
DTA to Admit	04:42	04:17	03:38	03:20	04:03	04:02	04:21	05:06	05:22	06:37	05:57	05:17	04:42
Total LOS - Admitted Patients	08:11	07:44	07:03	06:42	07:15	07:31	07:38	08:01	07:33	08:23	07:55	07:27	06:53
% of Patients >12 Hours LoS	01:24	01:07	00:54	00:44	01:18	01:22	01:24	01:37	01:19	01:30	01:27	01:17	01:13

The AECU model continues to impact positively on these metrics.

ED Admission Improvement:

- 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 was relaunched in January 2024 and provides situational oversight to ensure a high-level understanding of how many patients are in the department and the associated risks and is a single access point for coordinating information and response to operational issues.
- Hub attendance has now been extended to include multi-disciplinary teams, supporting early interventions for patients with complex pathways. Bringing together teams provides a mechanism to identify complex requirements early and expediate safe and timely discharge.
- The ED team also continue to attend the operational huddle twice a day, improving communication between the department and those facilitating ward flow.
- Overnight senior decision-making gaps in ED rotas have impacted performance in March, with a notable increase in paediatric breaches, overnight admissions, time to be seen and treatment times. Learning from this the department is looking at options to minimise future impact.
- The Urgent Care Centre (UCC) project group continues to meet bi-weekly looking at further opportunities to improve ECS performance. Workstreams are in place to achieve improved utilisation, develop new pathways, review triage, and contractual arrangements with Bradford Care Alliance (BCA) who provide the GP input to the UCC.

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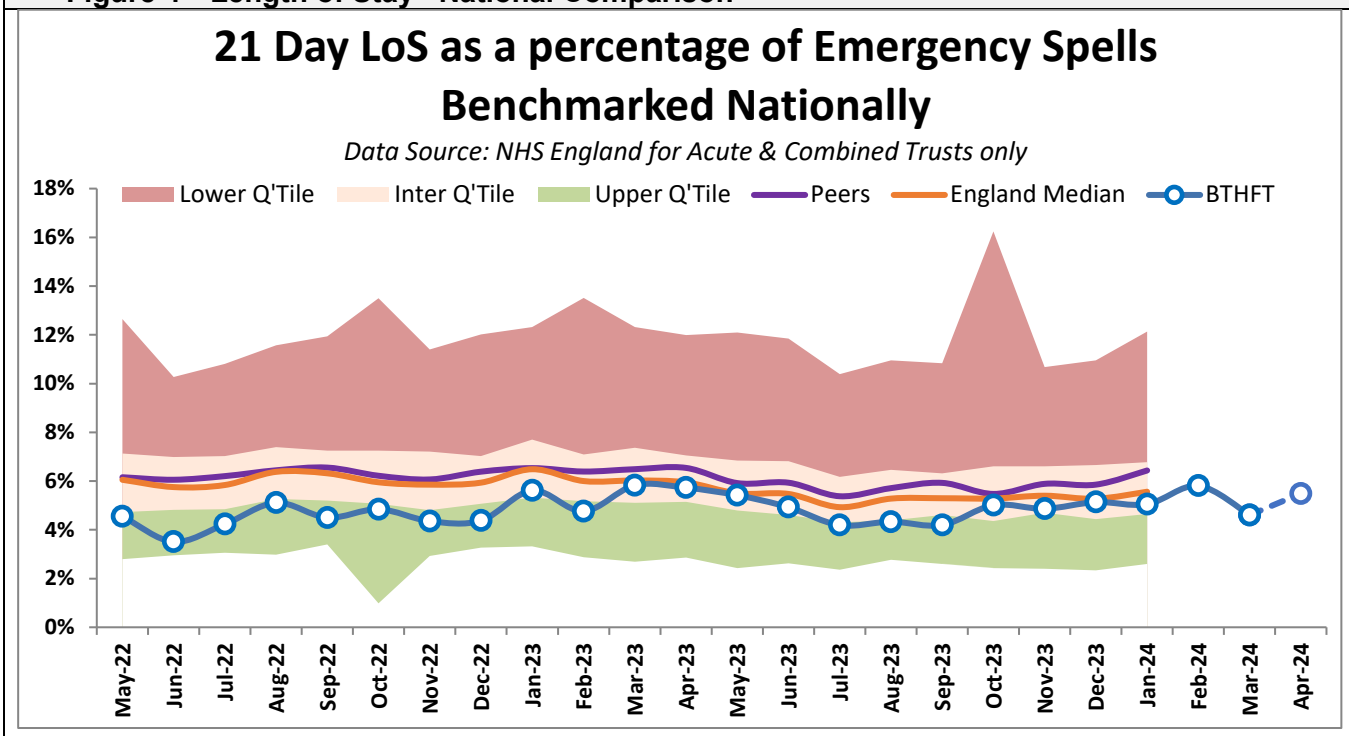
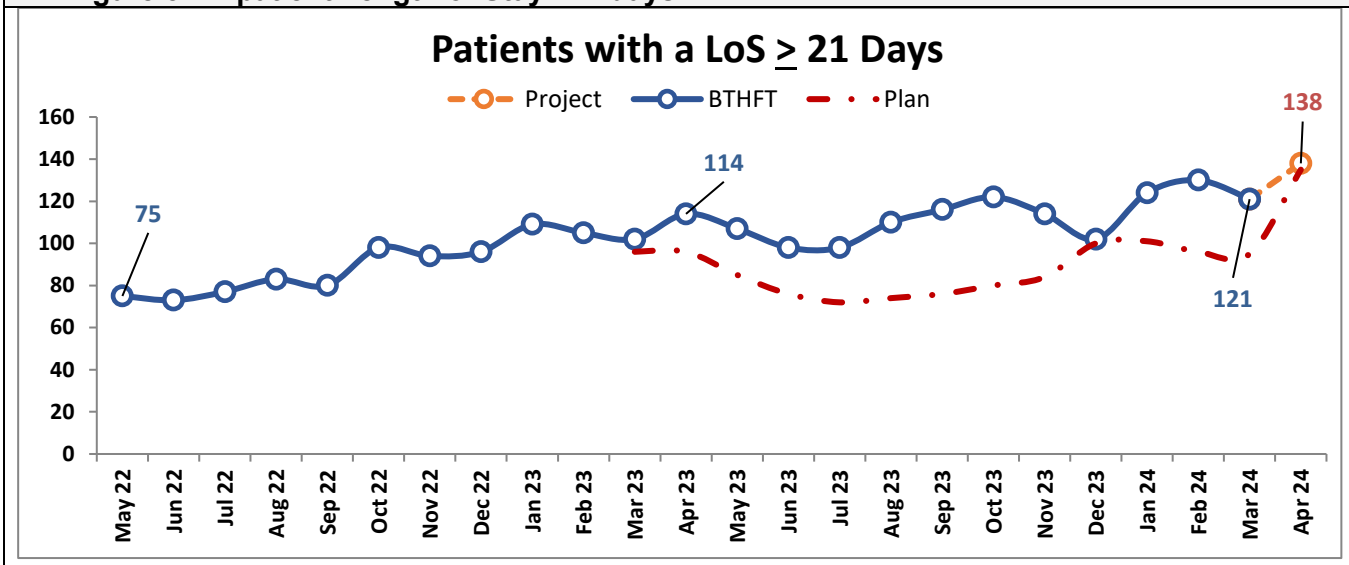
7. Inpatient Length of Stay (LOS) and Discharge KPI

Figure 4 Length of Stay– National Comparison



The percentage of patients with a LoS over 21 days was 4.60% in March.

Figure 5 Inpatient Length of Stay ≥21 days – BTHFT



The number of patients with a LOS over 21 days reduced to an average of 121 patients per day in March 2024. April 2024 is projected at 138 patients per day.

The number of patients with >21-day LoS remains high due to the number requiring therapy intervention in addition to external factors such as waiting for care home beds and social care assessment. A system approach to reducing the pressure on social care is being explored but the availability of care packages and Intermediate Care (IMC) capacity will present a challenge for discharge delays until resolved.

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Table 4 Discharges on Discharge Ready Date (MFFD)

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
# Total Adult G&A Discharges from Inpatient Wards	3680	3266	3226	3235	3009	3262	3107	3023	3196	2774
Of those Discharged, # with Discharge Ready Date	3521	3093	3039	3015	2821	3076	2944	2863	3025	2606
Of those Discharged, % with Discharge Ready Date	*96%*	*95%*	*94%*	*93%*	*94%*	*94%*	*95%*	*95%*	*95%*	*94%*
# discharged on or before MFFD date	2912	2525	2472	2476	2301	2473	2424	2339	2427	2094
% discharged on or before MFFD date	*83%*	*82%*	*81%*	*82%*	*82%*	*80%*	*82%*	*82%*	*80%*	*80%*
# discharged beyond MFFD date	609	568	567	539	520	603	520	524	598	512
% discharged beyond MFFD date	*17%*	*18%*	*19%*	*18%*	*18%*	*20%*	*18%*	*18%*	*20%*	*20%*
Avg stay beyond discharge ready (MFFD) date	3	4	3	4	5	4	4	5	4	4

In addition to delays, the Trust is monitoring several discharge KPI using the medically optimised for discharge date and criteria to reside process. MFFD data capture is at 94% for discharges from adult inpatient wards. Of those with an MFFD ~80% 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 which we are working through with system partners.

Length of Stay and Discharge Improvement:

- Our lead for in-patient therapy continues to review all those patients with a LLOS >21 days attributed to being medically but not therapy-optimised and attends the weekly ECS meeting where trends and themes will be identified and shared for learning and continuous improvement.
- The Multi Agency Integrated Discharge Team (MAIDT) and Therapy colleagues are reviewing any roles or tasks that could potentially be undertaken by the discharge co-ordinator.
- 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, continue to be held with Deputy Directors of Nursing, & Therapies to focus on this cohort of patients.
- 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.

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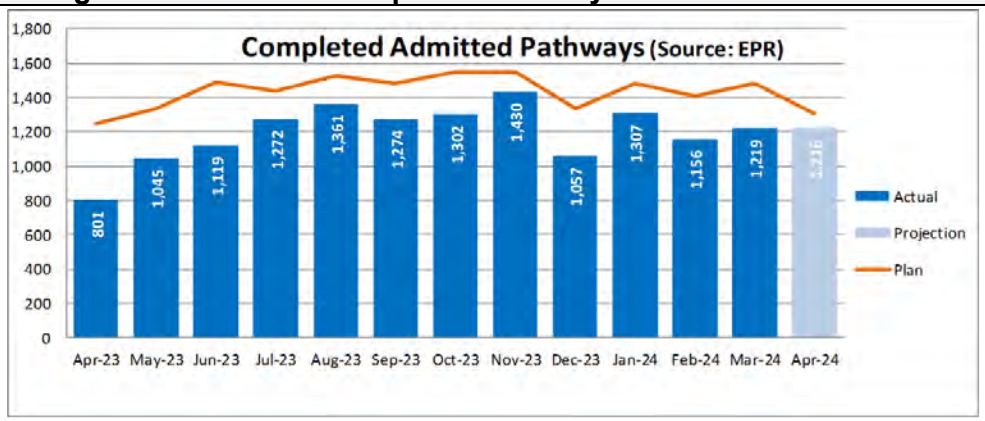
8. Activity Compared to Plan

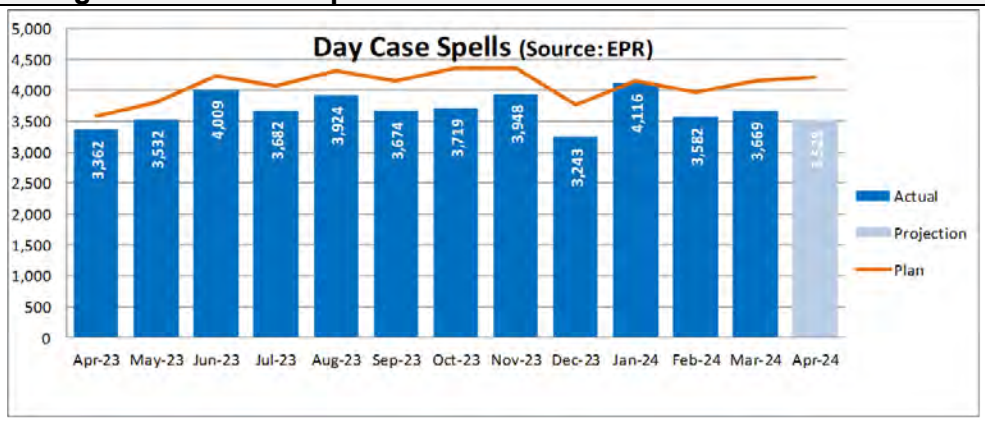
8.1. Inpatient Activity

Figure 6 Admitted Completed Pathways

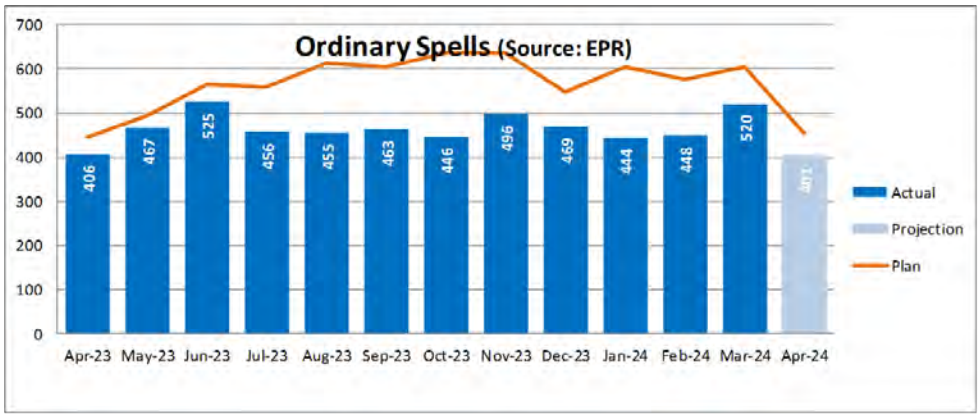


	Plan	Actual
Apr-23	89%	57%
May-23	97%	76%
Jun-23	117%	88%
Jul-23	108%	96%
Aug-23	123%	109%
Sep-23	113%	97%
Oct-23	115%	97%
Nov-23	114%	105%
Dec-23	112%	88%
Jan-24	99%	87%
Feb-24	104%	86%
Mar-24	109%	90%

Figure 7 Elective Spells



	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%	106%
Feb-24	110%	113%	102%
Mar-24	110%	107%	94%

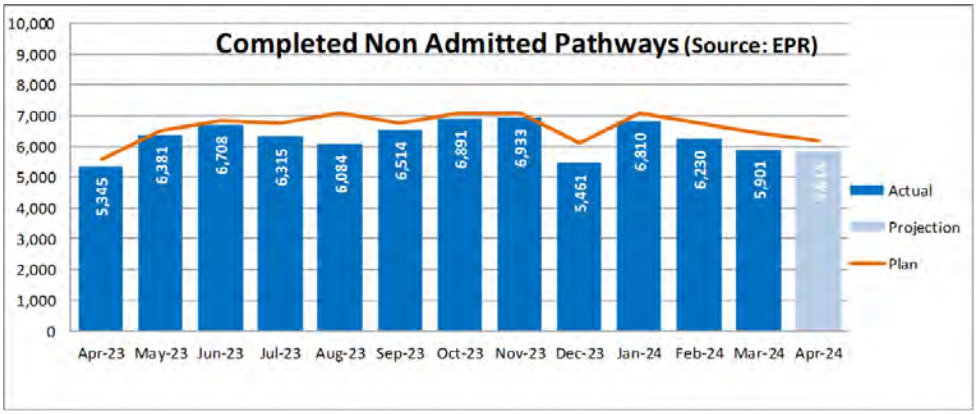


	Target	Plan	Actual
Apr-23	110%	82%	75%
May-23	110%	85%	81%
Jun-23	110%	94%	88%
Jul-23	110%	96%	78%
Aug-23	110%	102%	76%
Sep-23	110%	105%	81%
Oct-23	110%	111%	78%
Nov-23	110%	108%	84%
Dec-23	110%	100%	86%
Jan-24	110%	102%	75%
Feb-24	110%	95%	74%
Mar-24	110%	99%	85%

Day case and ordinary activity increased in March 2024. Total elective activity recorded an average of 1,064 spells per week exceeding the baseline of 934 spells per week. Both day case and ordinary activity is projected to reduce in April.

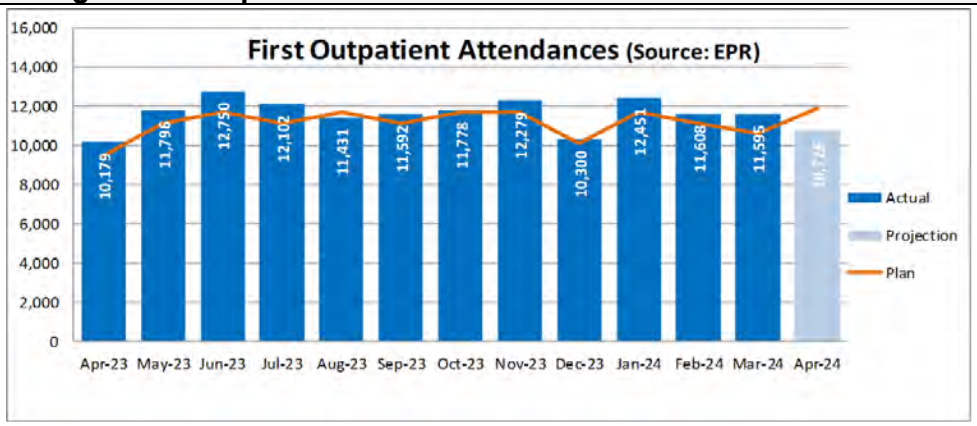
8.2. Outpatient Activity

Figure 8 Non-Admitted Completed Pathways

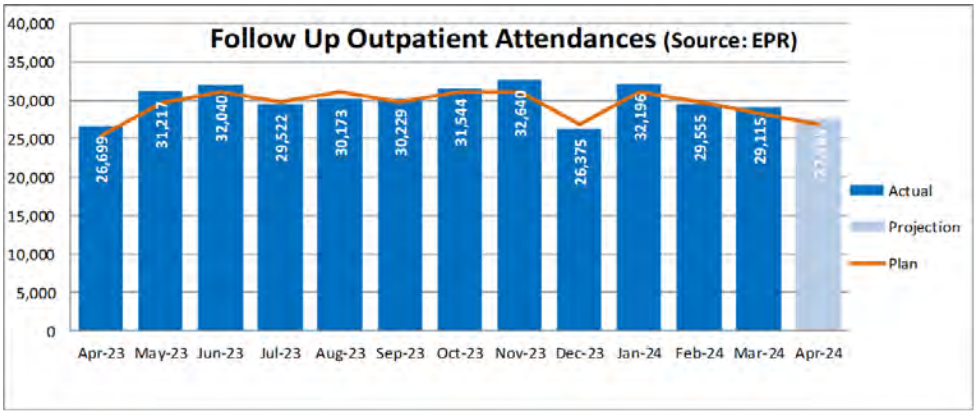


	Plan	Actual
Apr-23	96%	92%
May-23	109%	106%
Jun-23	126%	123%
Jul-23	103%	96%
Aug-23	132%	113%
Sep-23	115%	111%
Oct-23	106%	104%
Nov-23	112%	110%
Dec-23	108%	96%
Jan-24	105%	101%
Feb-24	110%	102%
Mar-24	99%	91%

Figure 9 Outpatient Attendances



	Target	Plan	Actual
Apr-23	110%	99%	107%
May-23	110%	112%	119%
Jun-23	110%	126%	138%
Jul-23	110%	105%	114%
Aug-23	110%	127%	124%
Sep-23	110%	115%	120%
Oct-23	110%	113%	113%
Nov-23	110%	118%	124%
Dec-23	110%	115%	118%
Jan-24	110%	112%	119%
Feb-24	110%	122%	127%
Mar-24	110%	121%	133%



	Target	Plan	Actual
Apr-23	85%	92%	96%
May-23	85%	104%	109%
Jun-23	85%	115%	118%
Jul-23	85%	97%	96%
Aug-23	85%	121%	118%
Sep-23	85%	104%	106%
Oct-23	85%	102%	103%
Nov-23	85%	111%	116%
Dec-23	85%	108%	106%
Jan-24	85%	103%	106%
Feb-24	85%	113%	113%
Mar-24	85%	108%	111%

First and follow up attendance activity remained stable in March despite increased annual leave and bank holidays. 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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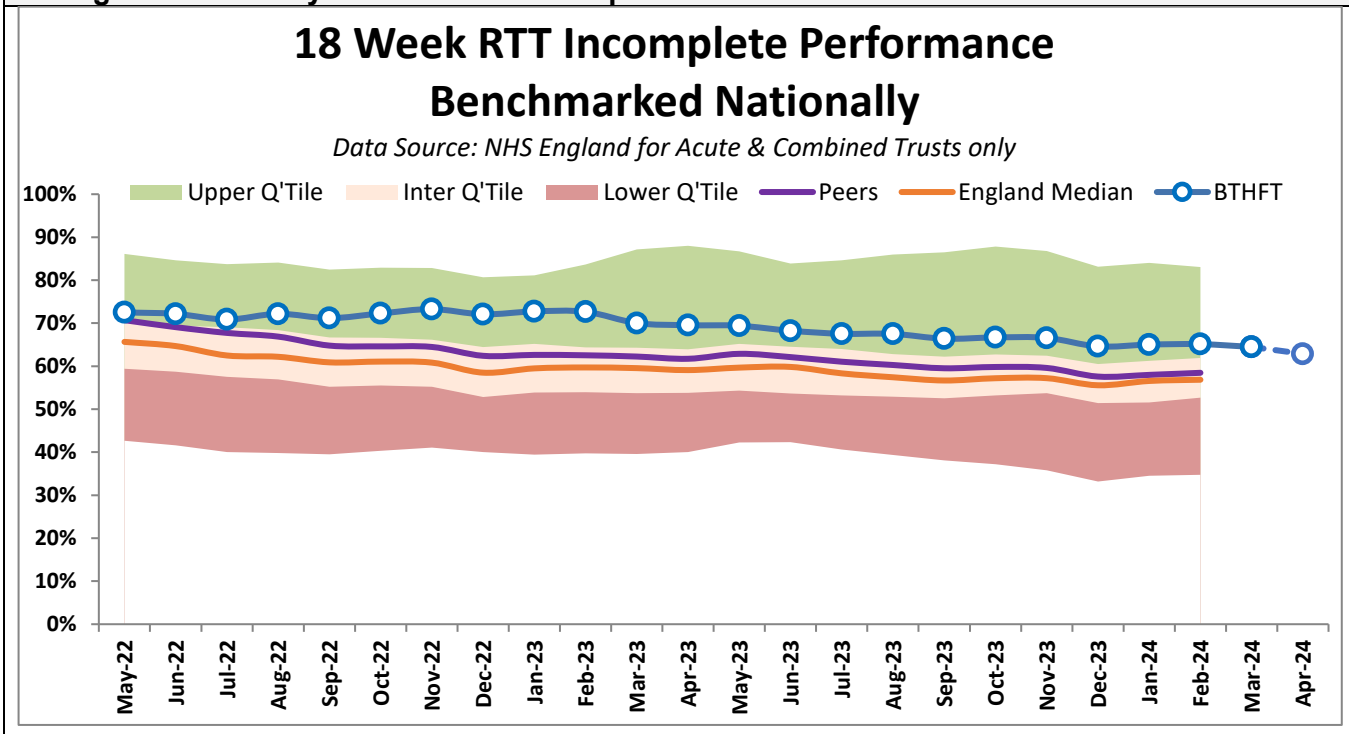
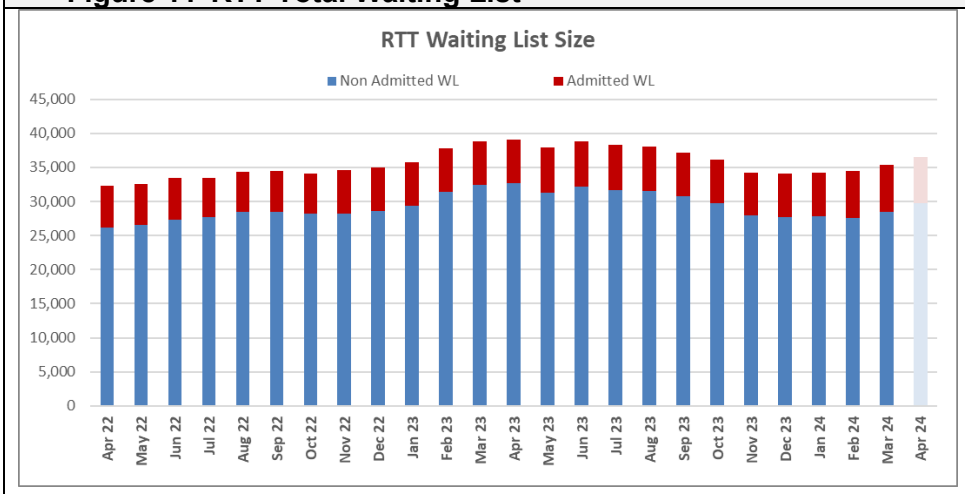
9. Referral to Treatment (RTT)

Figure 10 Monthly 18 Week RTT Incomplete Performance



The Trust's 18 Week RTT position for March 2024 was 64.48%. Performance is currently projected to decrease in April to 62.88%. BTHFT is significantly above the England and Peer average and remaining in the upper quartile.

Figure 11 RTT Total Waiting List



The overall waiting list increased in March and is projected to continue to increase in April.

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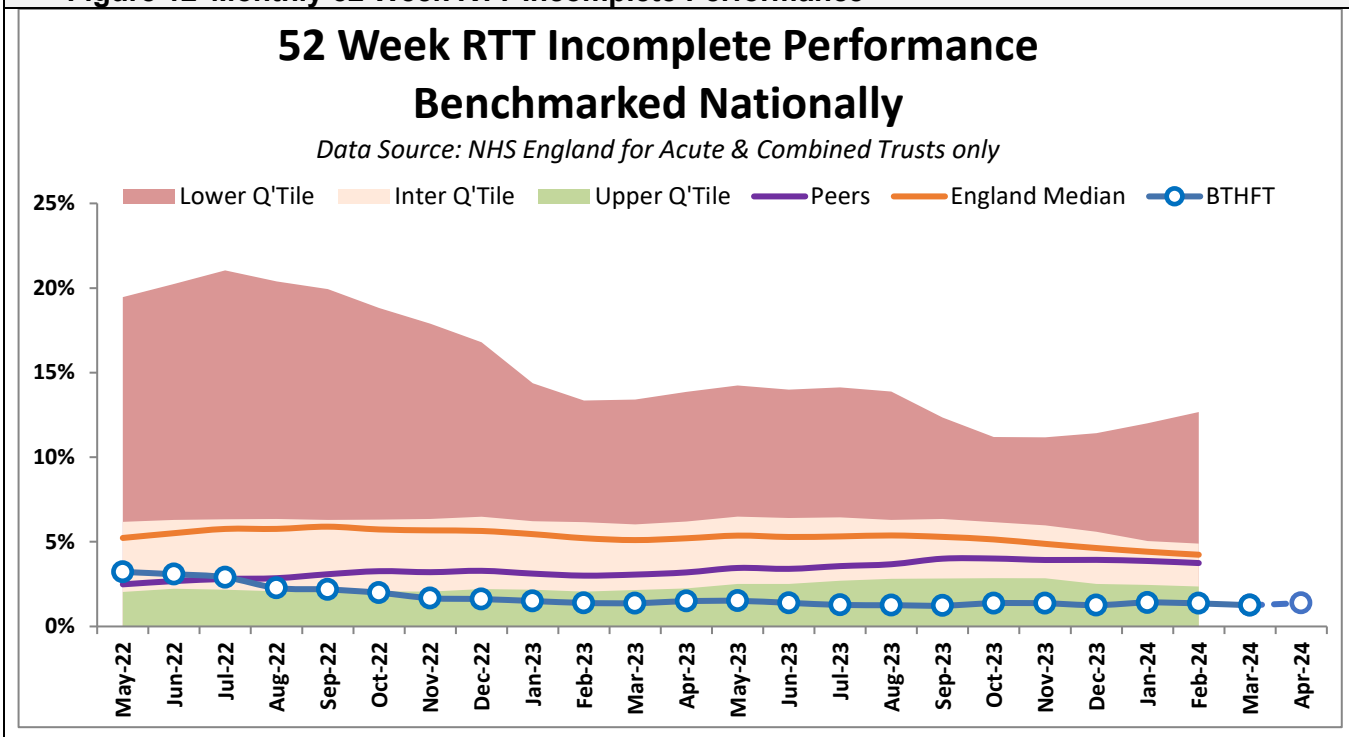
Figure 12 Monthly 52 Week RTT Incomplete Performance



52 Week RTT performance was 1.25% in March. 1 patient had a wait time of 78+ weeks at month end. Projections indicate there will be 1 patient that will breach the 78+ week position at the end of April.

Activity and RTT Improvement:

- Trust-wide theatre improvement initiatives focused on schedule efficiency by confirming theatre timings, updating the group and save process, and monitoring phone call confirmations for patients attending for procedures have been added alongside surgical team efficiency plans.
- Sending of the first patient across all theatres prior to the morning brief to support efficient start times and improved patient experience has been implemented. Early indicators demonstrate an improvement in theatre start times over the last four weeks as a result.
- The number of patients per theatre list remains at 1.8 and capped utilisation is below the 2019/20 average, but it is hoped the wider improvements will give the confidence to book additional cases.
- The GIRFT Further Faster programme includes recommendations on outpatient and inpatient opportunities and is currently being launched with all CSUs.
- A project group has been set up to improve activity levels of outpatients with procedures in line with the planning guidance. The initial focus is set on increasing and improving accuracy of procedure recording on EPR within Dermatology and Trauma & Orthopaedics, as well as identifying and addressing mapping issues within the data warehouse.
- Patients are being routinely contacted via SMS as part of the waiting list management initiative aligned to the national validation toolkit recommendations. 64,392 patients have been contacted to date who meet the required criteria with 2,303 requesting discharge (3.6%).
- PIFU use increased to 2.5% in March (+0.6% to February). The Trust has worked with Calderdale to update PIFU options on Cerner to support a consistent and streamlined process.
- EPR optimisation focussed initially on outpatient clinics will help enable some of the outpatient productivity gains identified in the GIRFT work and resolve issues escalated by our clinical teams.

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- Outpatient and Theatre sessions are also being reviewed against job plan capacity, activity run rates and waiting list profiles to support CSU teams with forward plans for 2024/25.
- The Trust is exploring what else can be done to improve attendance at appointments, particularly for communities with poorer health outcomes. The Trust is liaising with local care networks to review DNA rates and patterns in relation to GP practices and IMD. Options to improve attendances might include additional transport support or community-based clinics.
- Weekly access meetings are utilising forward-view reports which enable services to take action to ensure theatre lists and clinics are fully utilised.
- The Access cycle incorporates a rotational focus on CSUs, allowing a monthly update in more detail from each service to highlight areas of concern as well as celebrating successes.
- Web-based waiting list management tools are being launched which will improve functionality and support better oversight of patient pathways. The Central Access Team are currently trialling the application with focus on RTT validation with the aim to roll out for other waiting lists next month. The application will shortly be implemented in CPBS to support chronological booking and to services to manage next steps within patient pathways.
- Services are clinically validating non-RTT patients in line with the validation toolkit and the prevent-correct-clear model. Text based validation and PIFU will be extended to this process as appropriate.
- A review of RTT sequencing on Cerner is underway. This is 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.
- Auto-text options are also being added to EPR which will improve the clinician's system experience and support post clinic validation and pathway management processes.

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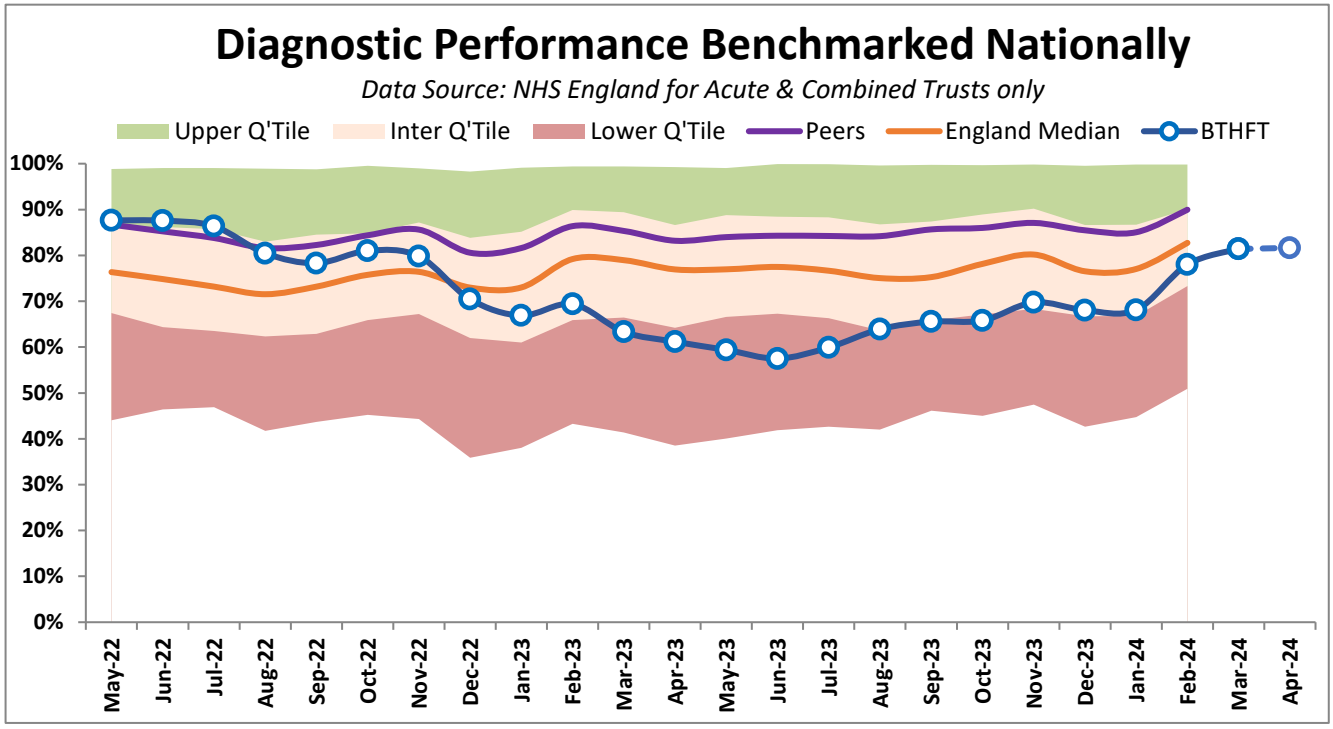
10. Diagnostic Waiting Times

Figure 13 Diagnostics 6-week DM01 performance – National Comparison



March 2024 performance is at 81.40% which is an improvement from February. April performance is also forecast as a further slight improvement at 81.63%. As a result, performance is expected to be in line with national average and moving towards peer and upper quartile.

Table 5 DM01 6-week diagnostic standard by modality

Site	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
TRUST	61.2%	59.4%	57.5%	59.9%	63.9%	65.6%	65.8%	69.7%	68.0%	68.1%	77.5%	81.4%	81.6%
Audiology Assessments	88.1%	95.1%	85.1%	80.4%	79.3%	79.0%	75.5%	68.8%	67.1%	67.4%	67.4%	67.7%	64.6%
Cardiology - echocardiography	71.8%	86.4%	86.2%	90.2%	91.7%	83.8%	65.5%	57.4%	47.5%	35.6%	53.1%	74.3%	74.4%
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	72.4%	76.0%	72.5%	71.6%	72.1%	66.3%	75.9%	73.6%	90.0%	81.8%	85.2%	97.3%	97.6%
Cystoscopy	97.2%	94.6%	72.5%	82.0%	100.0%	100.0%	100.0%	100.0%	97.5%	98.4%	100.0%	100.0%	100.0%
Flexi sigmoidoscopy	80.2%	70.4%	75.3%	84.2%	70.7%	74.6%	84.5%	80.0%	91.4%	85.3%	86.0%	82.9%	84.0%
Gastroscopy	73.4%	67.6%	77.3%	75.7%	71.5%	69.3%	77.0%	74.2%	84.9%	81.1%	79.3%	83.0%	83.3%
Computed Tomography	90.1%	95.9%	94.7%	97.4%	94.3%	94.3%	92.3%	99.7%	97.1%	98.5%	99.1%	99.4%	97.7%
DEXA Scan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%
Magnetic Resonance Imaging	73.6%	75.3%	76.0%	80.1%	71.3%	68.7%	67.8%	74.2%	64.6%	57.5%	67.0%	64.2%	62.6%
Non-obstetric ultrasound	38.8%	33.2%	33.1%	32.3%	38.9%	38.6%	42.4%	49.1%	58.7%	70.0%	91.8%	89.7%	92.5%
Neurophysiology - periph neuro	100.0%	100.0%	98.5%	100.0%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%
Respiratory phys - sleep studies	92.6%	95.8%	97.1%	93.1%	88.2%	79.8%	67.8%	70.7%	61.2%	53.8%	63.1%	74.9%	79.5%
Urodynamics - pressures & flows	89.0%	80.7%	81.8%	91.1%	86.3%	76.0%	71.4%	64.3%	70.0%	59.3%	63.5%	84.1%	90.7%

Non-obstetric ultrasound (NOUS) outsourcing has ended with the current position being significantly improved to almost 90%. MRI scanner failures during February and March have impacted performance. Community Diagnostic Centre (CDC) capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography.

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Diagnostic Improvement:

- Digital Histopathology (the ability to report digital slides anywhere, anytime) goes live in April 2024. This will lead to improved information sharing and collaboration with streamlined double-reporting and rapid access to second opinion and expert review. Fast case transfer times between the laboratory and assigned pathologists will improve resulting in streamlined turnaround times.
- Delivery of the CDC program is now well underway. With increased provision available work is underway to develop a system-wide approach for access and the visibility of patient information.
- Ultrasound & Echo activity went live in January along with CT & Primary Imaging (x-ray) activity. MRI came online in February and Sleep will go live in April and will be joined by Radiology modalities. Cardio-respiratory will be the last to come online later this month.
- Sustainability of the NOUS DM01 performance and plan for further obstetric growth in underway with CDC additional NOUS capacity up and running through two scanners, providing an average of an additional 196 scans per week over a 7-day model.
- Recruitment to the ultrasound workforce has been a challenge and therefore insourcing is in place and will remain in place until all vacancies are filled.
- Obstetric admin has moved to the Gynae booking team which is having a positive impact, and work is ongoing to prepare for the new 24 hour and 72-hour scanning targets. There has been a significant improvement in the delivery of 72-hour obstetric ultrasound scanning.
- The HISTO Programme is up and running. This is a structured improvement programme to bring clarity, governance, and accountability for the aim to improve Turnaround Time (TAT). There are three workstreams with agreed scope based on team & patient feedback.
- Insourcing to support recovery in Echocardiography is also in place and impacting positively on the back log. Longer term plans are being explored to ensure sustained service resilience.
- Partial booking has been introduced for Sleep Studies which has been very successful from both a waiting list management and patient experience perspective.
- 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.

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11. Cancer Standards

Table 6 Cancer Standards – Overview by Indicator – BTHFT

Measure	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
14 day GP referral for all suspected cancers	93%	91.5%	93.5%	94.4%	96.8%	95.0%	94.0%	95.8%	96.4%	93.4%	82.5%	95.4%	*95.4%*	*95.4%*
14 day breast symptomatic referral	93%	97.3%	98.7%	93.5%	97.4%	94.5%	96.9%	93.5%	96.6%	90.7%	77.4%	87.8%	*87.8%*	*69.8%*
28 Day FDS	75%	73.4%	75.2%	78.7%	83.8%	84.3%	81.5%	82.0%	78.8%	91.8%	85.7%	84.8%	*85.7%*	*84.8%*
31 Day Decision to treat to treatment	96%	91.4%	94.8%	93.6%	95.1%	95.7%	93.9%	91.7%	87.2%	91.8%	87.5%	95.3%	*95.6%*	*96.7%*
62 day combined	85%	80.4%	69.6%	79.1%	74.2%	72.9%	65.3%	70.8%	64.3%	65.6%	60.9%	33.1%	*66.6%*	*71.7%*

Cancer Wait Time Improvement:

- Version 12 (V12) of the Cancer Wait Time (CWT) standards is now embedded with reporting transitioning fully over to V12 from April onwards.
- A new cancer IT system to replace PPM1 is being implemented (Civica formerly Infoflex) and will be in the test environment by end of March 2024. This will bring many benefits, including supporting Personalised Stratified Follow Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups.
- This will also support implementation and monitoring of Best Practice Timed Pathways, as it will inform service-level performance against patient pathway milestones, highlighting challenges and shaping plans for improved patient experience and outcomes.
- Work to support the expansion of the Pathway Navigator and Cancer Nurse role is underway. Review being undertaken by Lead Cancer Nurse with a view to development of a business case to address the capacity gap. MacMillan internship opportunity to be explored to develop future CNS workforce and attract nurses to these roles.
- Implementation of One Stop Clinic for palpable neck lumps is planned to be in place in May 2024 to support the diagnostic phase for this tumour group. Revised referrals forms to ensure correct patients are referred to weekly clinic with access to ENT, Consultant Radiologist & US – currently with Primary Care for approval prior to go-live.
- The Cancer Board has been re-established with appropriate clinical engagement. The Board will meet monthly with additional benefit of a complementary rolling programme of Site-Specific Cancer MDT Forums for focussed discussion with individual teams, at least twice a year.
- A Cancer 'Time-Out' is taking place 21st June 2024 to develop a shared clinical vision for the Trust's Cancer Strategy.
- Joint working with primary care is underway to better understand high referral patterns whilst also 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 DNAs 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.
- The Histopathology Improving Services & Transforming Outcomes programme has commenced with three workstreams (People, Place & Processes) in place, with the intention of improving turnaround times which will significantly impact cancer pathways.

11.1. Cancer 2 Week Wait

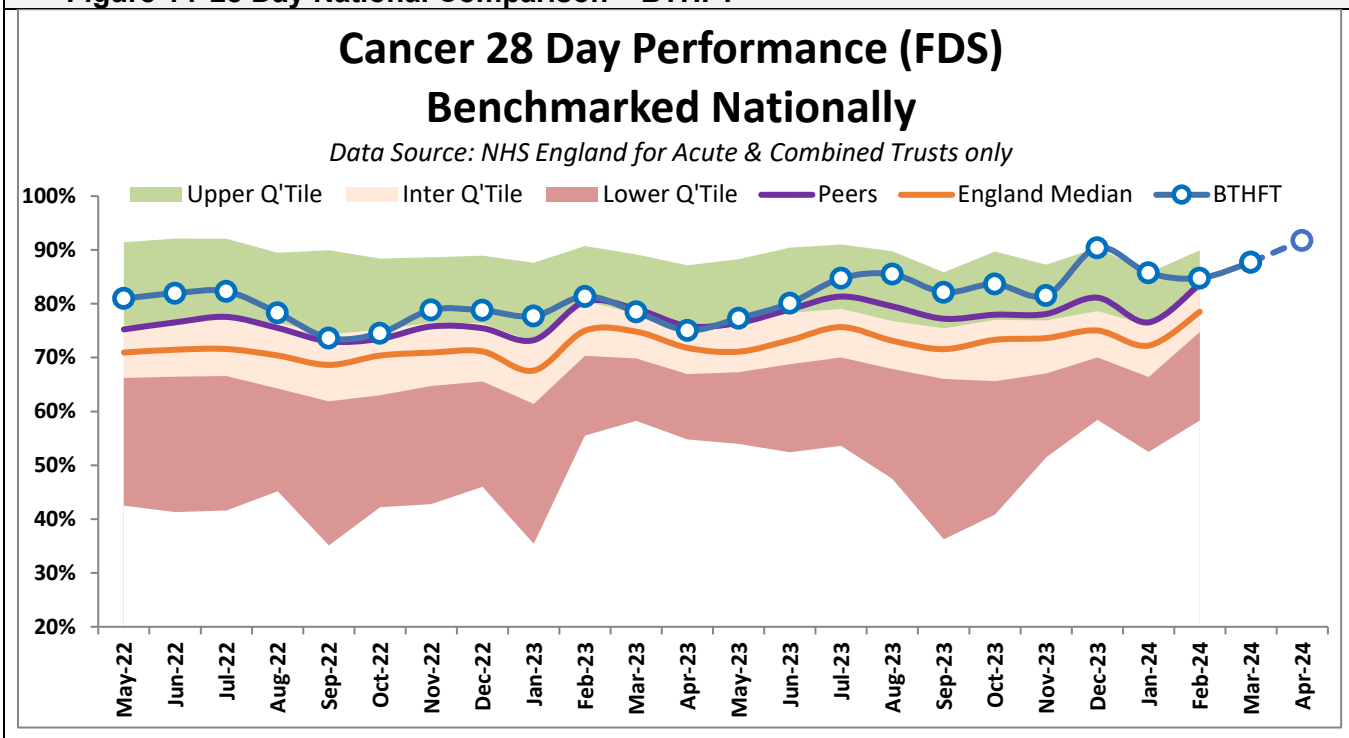
Table 7 2WW Performance by Tumour Group

Site	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*	*Apr-24*
TRUST	94.1%	91.5%	93.4%	95.8%	96.8%	94.9%	94.0%	95.8%	96.4%	93.4%	82.0%	95.4%	94.0%	93.0%
Breast	96.3%	96.6%	99.5%	95.8%	96.8%	97.5%	97.8%	93.4%	97.0%	92.9%	76.2%	89.3%	81.9%	88.1%
Gynae	96.6%	92.6%	93.5%	92.2%	94.5%	93.3%	78.2%	93.1%	94.9%	93.9%	86.7%	96.6%	96.1%	99.3%
Haematology	75.0%	84.6%	88.2%	66.7%	100.0%	40.0%	90.5%	76.5%	84.6%	66.7%	48.0%	100.0%	100.0%	92.6%
Head & Neck	94.5%	96.2%	93.7%	94.9%	98.3%	96.6%	91.3%	95.1%	96.3%	95.3%	86.8%	91.2%	95.3%	95.3%
Lower GI	83.6%	69.3%	80.7%	93.6%	93.8%	86.9%	86.5%	92.1%	94.7%	93.3%	80.3%	96.6%	90.0%	83.6%
Lung	100.0%	98.2%	100.0%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	98.5%	100.0%	98.2%
NSS					100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	90.0%	100.0%	100.0%
Other	96.8%	100.0%	85.7%	97.7%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Upper GI	92.5%	92.4%	96.4%	99.2%	97.2%	95.7%	89.6%	93.2%	94.8%	95.7%	88.8%	97.4%	93.4%	89.6%
Skin	98.3%	100.0%	97.3%	96.4%	97.0%	98.9%	99.5%	99.3%	97.9%	89.9%	80.0%	97.4%	98.6%	97.1%
Urology	97.4%	98.4%	100.0%	99.2%	99.2%	96.6%	98.5%	99.3%	97.7%	99.2%	89.6%	99.2%	96.9%	90.9%

2WW performance in February recovered to above target at 95.42% following a difficult period of Christmas, New Year and Industrial Action. Breast continue to see higher than expected referrals and will not recover as quickly.

11.2. Cancer 28 Day Faster Diagnosis Standard (FDS)

Figure 14 28 Day National Comparison – BTHFT



Performance in February 2024 places the Trust in the upper quartile, remaining above peer group and England average.

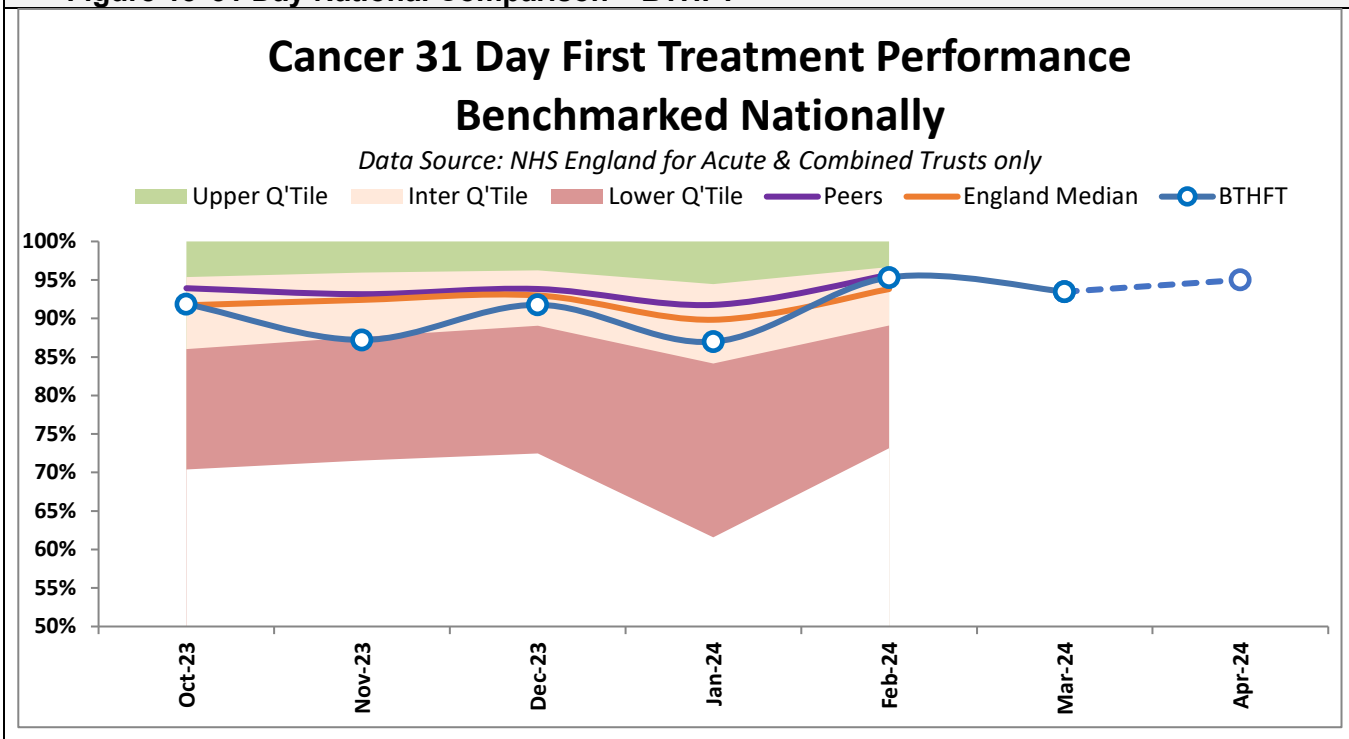
Table 8 28 Day Faster Diagnosis Standard (FDS)

Site	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	Apr-24
TRUST	76.8%	73.3%	75.1%	79.3%	84.2%	85.3%	81.5%	83.5%	81.8%	92.1%	85.7%	84.8%	87.7%	91.8%
Breast	98.7%	96.1%	97.5%	98.4%	97.4%	97.6%	97.7%	96.6%	98.7%	97.9%	95.6%	96.3%	94.1%	98.6%
Gynae	55.2%	61.5%	63.3%	65.7%	59.3%	67.5%	49.6%	64.7%	77.1%	86.9%	70.7%	43.9%	61.8%	85.7%
Haematology	36.8%	50.0%	23.1%	27.3%	30.0%	20.0%	70.0%	33.3%	43.8%	50.0%	13.3%	52.9%	50.0%	80.0%
Head & Neck	66.8%	77.6%	77.4%	74.3%	81.6%	91.3%	80.4%	86.5%	86.7%	93.5%	82.2%	83.7%	88.4%	84.7%
Lower GI	74.2%	64.5%	63.0%	68.8%	80.2%	77.6%	71.9%	73.6%	71.6%	88.0%	73.6%	76.2%	78.0%	82.2%
Lung	81.7%	86.5%	87.9%	87.2%	96.7%	76.7%	90.0%	83.3%	78.4%	84.2%	78.6%	82.2%	91.8%	94.0%
NSS					20.0%	57.1%	66.7%	50.0%	77.8%	90.0%	84.6%	75.0%	66.7%	64.3%
Other	71.4%	65.0%	79.4%	61.1%	97.6%	33.3%	100.0%	100.0%	0.0%	66.7%		100.0%	0.0%	0.0%
Skin	81.7%	74.6%	79.5%	88.5%	87.6%	89.0%	88.5%	86.7%	80.7%	93.9%	96.9%	95.0%	95.9%	97.2%
Upper GI	80.0%	72.5%	62.2%	73.5%	79.1%	89.6%	76.7%	84.7%	90.8%	90.0%	78.5%	80.4%	84.4%	92.2%
Urology	65.4%	65.1%	71.7%	71.8%	67.5%	80.5%	65.7%	81.3%	72.0%	80.0%	70.9%	76.9%	76.0%	80.0%

FDS performance has continued above target in February. Histology delays continue to impact on this phase for certain tumour sites, this is being address via the HISTO programme.

11.3. 31 Day General Treatment

Figure 15 31 Day National Comparison – BTHFT



Performance against the 31 Day standard placed the Trust in the Inter-quartile and in line with national average although this is forecast to remain above 90% in March and April this will still remain below target.

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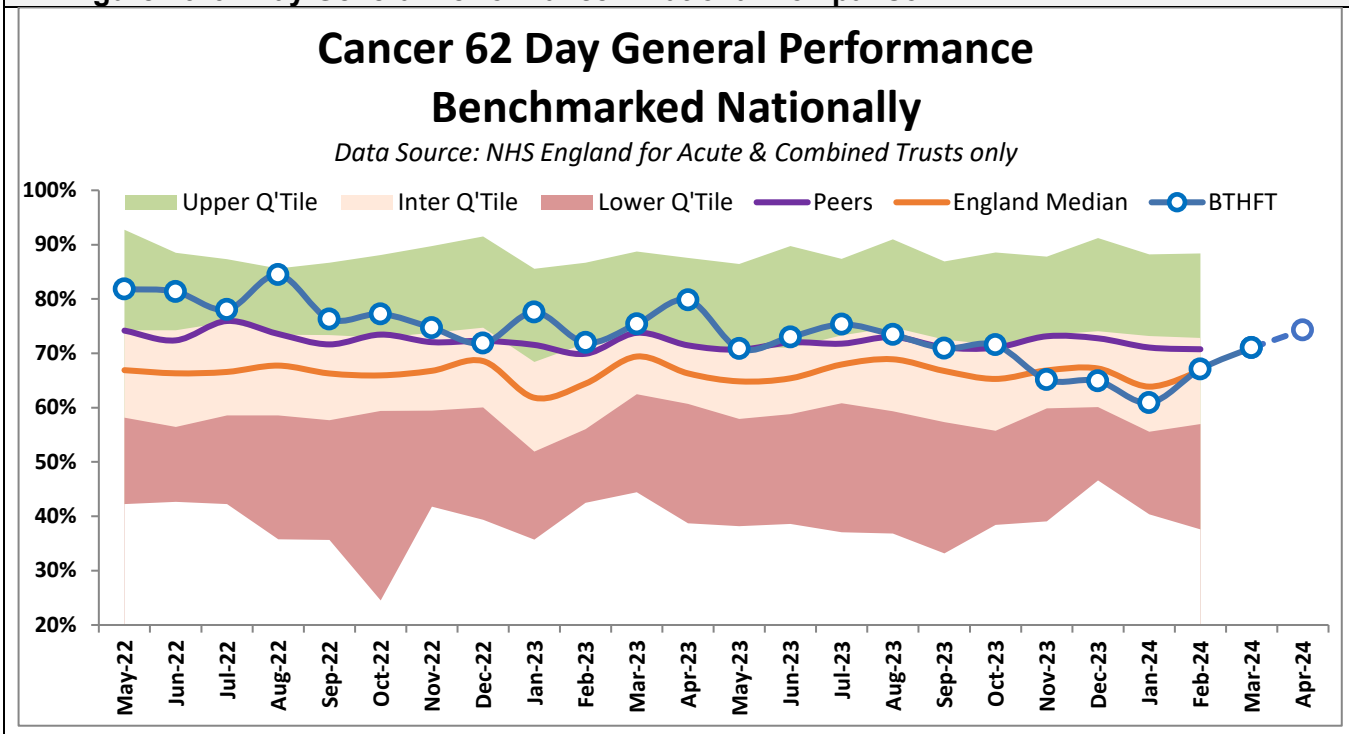
Table 9 31 Day General Treatment Standard by Tumour Group

Site	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	Apr-24
TRUST	93.6%	88.7%	93.3%	93.3%	95.4%	94.8%	94.0%	90.9%	86.0%	92.4%	87.5%	95.3%	93.5%	95.0%
Breast	94.3%	89.8%	97.4%	95.5%	95.0%	96.8%	92.2%	90.8%	87.7%	88.2%	78.6%	96.3%	92.5%	91.4%
Gynae	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	84.6%	100.0%	60.0%	100.0%	87.5%	85.7%	100.0%	100.0%
Haematology	100.0%	100.0%	94.4%	100.0%	100.0%	93.8%	100.0%	92.3%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%
Head & Neck	90.9%	86.7%	87.5%	100.0%	100.0%	86.7%	85.7%	85.7%	100.0%	92.9%	100.0%	100.0%	88.2%	93.3%
Lower GI	96.8%	100.0%	96.2%	97.1%	92.3%	96.4%	92.6%	100.0%	85.7%	96.3%	88.9%	100.0%	100.0%	100.0%
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	92.9%	95.0%	93.3%
Skin	96.2%	97.3%	98.0%	92.2%	98.1%	98.2%	98.4%	92.0%	87.3%	97.4%	92.0%	95.3%	100.0%	100.0%
Upper GI	100.0%	78.6%	84.6%	87.5%	80.0%	85.7%	90.9%	100.0%	81.8%	72.7%	100.0%	90.9%	100.0%	100.0%
Urology	92.0%	87.9%	90.6%	88.3%	89.1%	95.9%	95.6%	84.6%	87.5%	93.8%	86.9%	93.9%	87.0%	93.3%

Performance in February improved, particularly for high volume tumour groups like Breast, Skin and Urology however performance is forecast to remain below target through March and April due the impacts of a prolonged Easter and Eid period with patient availability and attendance affecting the number of first treatments completed.

11.4. Cancer 62 General Performance

Figure 16 62 Day General Performance – National Comparison



The 62-day combined performance replaced the 62 classic standard in January 2024. February performance was 66.88% but is forecast to improve further into March and April.

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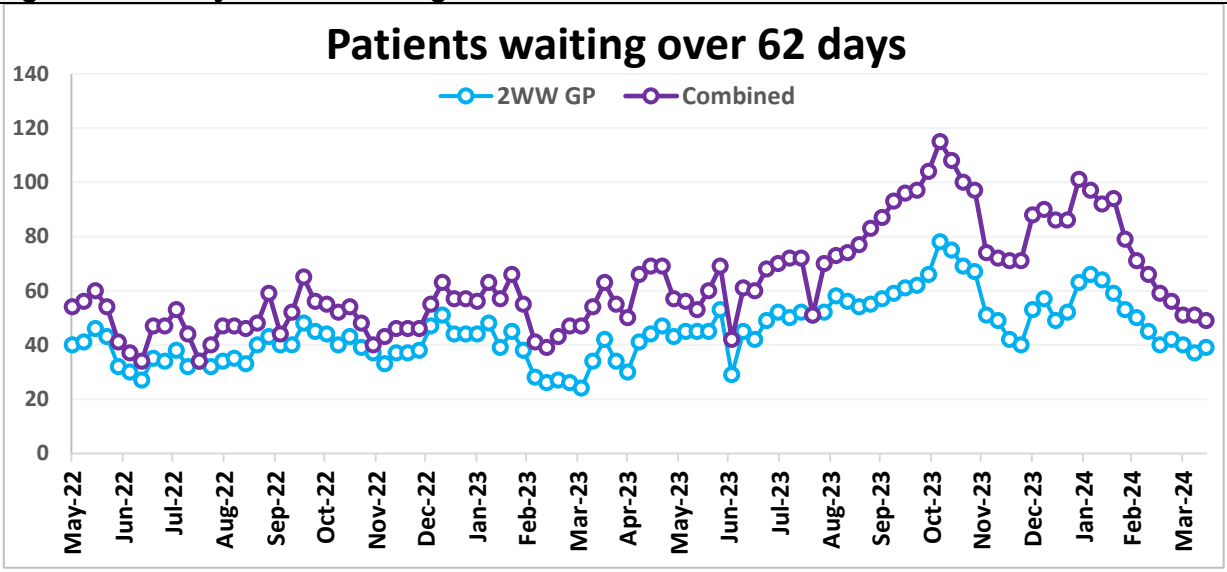
Figure 17 62 day or over waiting list size



The number of patients waiting over 62 days has reduced during the last 3 months and this will support improved performance into 2024/25.

Table 10 62 Day General Standard Performance by Tumour Group

Site	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	Apr-24
TRUST	78.7%	81.9%	68.1%	77.3%	74.6%	72.2%	70.3%	69.5%	62.5%	67.4%	60.9%	66.9%	*66.6%*	*71.7%*
Breast	100.0%	92.3%	64.7%	100.0%	81.8%	83.3%	72.7%	73.3%	100.0%	91.7%	72.1%	75.0%	*82.7%*	*86.2%*
Gynae	33.3%	40.0%	22.2%	100.0%	66.7%	63.6%	28.6%	57.1%	33.3%	40.0%	41.7%	25.0%	*66.7%*	*75.0%*
Haematology	33.3%	100.0%	33.3%	60.0%	60.0%	50.0%	75.0%	100.0%	57.1%	40.0%	20.0%	33.3%	*46.7%*	*50.0%*
Head & Neck	73.3%	85.7%	38.5%	60.0%	75.0%	50.0%	50.0%	33.3%	53.3%	36.4%	51.6%	33.3%	*57.1%*	*41.2%*
Lower GI	66.7%	36.4%	45.0%	72.7%	70.6%	52.0%	57.1%	54.5%	54.5%	28.6%	81.5%	64.3%	*63.2%*	*62.5%*
Lung	20.0%	50.0%	18.2%	16.7%	0.0%	0.0%	15.4%	0.0%	33.3%	61.5%	33.3%	44.4%	*50.0%*	*42.9%*
Other	0.0%	0.0%	66.7%	0.0%	33.3%	0.0%	0.0%		66.7%				*0.0%*	*0.0%*
Upper GI	66.7%	100.0%	0.0%	60.0%	0.0%	66.7%	0.0%	50.0%	50.0%	55.6%	47.6%	81.8%	*100.0%*	*100.0%*
Skin	97.0%	100.0%	96.8%	93.8%	100.0%	91.4%	77.1%	81.3%	66.7%	75.0%	69.6%	84.6%	*62.5%*	*60.0%*
Urology	85.1%	81.4%	83.0%	73.4%	68.8%	69.7%	84.9%	81.4%	69.2%	86.4%	68.2%	78.5%	*89.7%*	*93.8%*

Performance from January includes consultant upgrades, urgent suspected cancer and urgent screening as per V12 reporting. 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 sustained pressure during Q4 to date however work to reduce the backlog is having a positive impact and performance is improving towards the 70% target for 2024/25.

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12. Other Contractual KPI – by exception

12.1. Cancelled Operations

Table 11 28 Day Rebook Breaches

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Cancellations to rebook	30	55	40	26	39	40	33	54	25	62	37	43
28 day rebook breaches	6	7	11	4	3	4	3	1	0	3	7	9

9 breaches of the re-booking target occurred in March 2024. Re-booking breaches continue to increase over the past 3 months. Services have been asked to review prioritisation processes to ensure delays for these patients are minimised going forward.

12.2. Sentinel Stroke National Audit Programme (SSNAP)

Table 12 SSNAP Level: Bradford and Airedale Stroke Unit

Team	Bradford and Airedale SU	Bradford and Airedale SU	Bradford and Airedale SU
Time period	Oct-Dec 2023	Jan-24	Feb-24
SSNAP level	D	C	C
1) Scanning	B	B	B
2) Stroke unit	E	E	E
3) Thrombolysis	E	D	D
4) Specialist Assessments	D	C	C
5) Occupational therapy	C	A	C
6) Physiotherapy	C	B	B
7) Speech and Language therapy	C	B	C
8) MDT working	C	C	C
9) Standards by discharge	A	A	A
10) Discharge processes	B	B	B

Recruitment work continues into the stroke response team, the intention is to extend daily coverage from 8am to midnight, enabling the service to commence a straight-to-scan pathway with YAS.

Interviews for the substantive stroke consultant vacancy have been arranged while a locum SHO continues to support the stroke response team.

A specific piece of work is now underway looking at the impact reduced therapy provision is having on length of stay and patient experience. A new risk assessment has been added to the Corporate Risk Register describing the current issues in stroke, specifically around therapy, a rapid response is now in place.

Collaborative work between MSK and UEC CSUs have identified a 'quick win' opportunity to utilise three therapists (via secondment) to deliver training to the ward staff in rehabilitation and re-ablement techniques to prevent de-conditioning and provide physiotherapy (PT) and occupational therapy (OT). The long-term plan is to engage therapy clinical educators to deliver this training for Healthcare Assistants (HCA) on inpatient wards, starting with Stroke and expanding to Elderly care, discussions have taken place with the education department to start the process and improve links between the services.

Insourced support has also been secured from the private sector for both PT and OT. Links with a suitable private neuro-rehabilitation company have been established and availability/costs have been confirmed – the CSU and procurement are working together to progress this.

The success of each of the measures being implemented will be tracked and reported on to ensure progress is being made and that this is visible through improvement in the SSNAP report.

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Date	9 May 2024	Agenda item	Bo.5.24.17

APPENDIX 2

SUMMARY OF CONTRACTUAL KPI

Operational Planning	Month	Threshold	Trajectory Target	Performance
Elective Day Case Spells	Mar-24	110%	107%	94%
Elective Ordinary Spells	Mar-24	110%	99%	85%
First Outpatient Attendances	Mar-24	110%	121%	133%
Admitted Clock Stops	Mar-24	n/a	109%	90%
Non-Admitted Clock Stops	Mar-24	n/a	99%	91%
RTT - Patients waiting >52 weeks on incomplete pathways	Mar-24	476	428	442
RTT - Patients waiting >78 weeks on incomplete pathways	Mar-24	0	0	1
RTT - Total Waiting List size	Mar-24	39,122	35,920	35,314
Cancer - Patients waiting over 62 days	Feb-24	42	42	50
Operational Standards	**Month**	**Threshold**	**Trajectory Target**	**Performance**
A&E Emergency Care Standard *(Type 1,2 & 3)*	Mar-24	95.00%	83.50%	82.67%
Ambulance handovers taking between 30-60 minutes	Mar-24	0	30	402
Ambulance handovers taking longer than 60 minutes	Mar-24	0	10	101
Trolley waits in A&E longer than 12 hours	Mar-24	0	0	76
Emergency Inpatient Length Of Stay >=21days	Mar-24	100	95	121
Cancer 2-week wait	Feb-24	93.00%	93.00%	95.42%
Cancer 2-week wait - breast symptomatic	Feb-24	93.00%	93.00%	87.80%
Cancer 28-day Faster Diagnosis	Feb-24	75.00%	75.00%	84.77%
Cancer 31-day General Treatment Standard	Feb-24	96.00%	96.00%	95.32%
Cancer 62-day General Standard	Feb-24	85.00%	85.00%	66.88%
Diagnostics - patients waiting under 6 weeks for test	Mar- 24	99.00%	83.00%	81.40%
RTT - Patients waiting <18 weeks on incomplete pathways	Mar-24	92.00%	73.52%	64.48%
Cancelled Operations 28--day breach	Mar-24	0	0	9

**Latest prediction at the time of writing*

BO.5.24.18 - HIGH LEVEL RISKS

REFERENCES

Only PDFs are attached

- Bo.5.24.18 - HLRR - Board cover paper.pdf
- Bo.5.24.18 - Appendix 1 - HLRR.pdf
- Bo.5.24.18 - Appendix 2 - Risk on a Page Report.pdf
- Bo.5.24.18 - Appendix 3 - Target Mitigation Date.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.xx

High Level Operational Risks Report

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	Karen Dawber, Chief Nurse	
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	
Previously discussed at/ informed by	High Level Risk Register: ETM – 18 March 2024 and 15 April 2024 Academies – Quality and Patient Safety Academy, People Academy, and Finance and Performance Academy – 27 March 2024 and 24 April 2024	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

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 18 March 2024 and 15 April 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 27 March and 24 April 2024.

The HLRR, showing all high level risks rated 15+ for April 2024, is attached at Appendix 1.

High Level Risks Report on a Page

The document at Appendix 2 provides a visual overview of all high level risks at BTHFT for March and April 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 there were no risks that had passed the target date for completion of the mitigating actions during March and April 2024.

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Changes to target mitigation dates

The document at Appendix 3 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 March 2024, there were no new risks.

In April 2024, three new risks were accepted onto the HLRR:

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:
April 2024:						
2549	**16**	**4**	There is a risk that the current Non Surgical Oncology (NSO) workforce within BTHFT and also WYAAT can't continue to support the current NSO model of care within the region, which will delay cancer treatment causing harm to patients.	Ray Smith, Chief Medical Officer	31/03/2025	People Quality & Patient Safety Academy
2566	**16**	**12**	Delayed discharges to Adult Social Care	Sajid Azeb, Chief Operating Officer	30/11/2024	Finance and Performance Academy and Quality and Patient Safety Academy

One further risk was increased in score from 12 to 16 and accepted onto the high level risk register. This is a 'closed board risk' and will be reported as such.

Risks which have been removed/closed

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

Risk ID:	Score before closure:	Target score:	Risk Description:	Lead Director:	Reason for closure:	Academy
April 2024						
448	**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.	Saj Azeb, Chief Operating Officer	Closed as the risk no longer reflects the current context, new risk assessment to be completed.	Finance & Performance Quality & Patient Safety Academy

Risks which have changed in score

ETM agreed three changes in risk score:

Risk ID:	Current Score:	Previous Score:	Target Score:	Risk Description:	Lead Director:	Reason for change in score:	Academy:

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April 2024:							
607	**20**	**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	Ray Smith, Chief Medical Officer	Histopathology improvement plan commenced. 3 work streams - people, place (environment) and processes. Decreased staff levels across AGH & BRI (BRI minus 7 - 3 x mat, 2 x sick, 2 x a/l). Significant backlog & delays with increasing level of reported incidents.	Quality & Patient Safety Academy
111	**8**	**20**	**8**	Industrial action	Renee Bullock, Chief People & Purpose Officer	Updated 12/4/24 - Consultants have confirmed that they have accepted the pay offer, therefore no more risk of industrial action in the immediate future. Junior Doctors have still not accepted any pay deal, we have as of 12/4/24 not received any notice of strike dates, they still have a mandate to strike. A review of incidents during IA periods have not shown any adverse impact on quality of care, this is due to the strong mitigation in place. There does though continue to be a risk on staff health and wellbeing.	All
35	**9**	**15**	**6**	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,	Sajid Azeb, Chief Operating Officer	13/4/24 - likelihood lowered to 3 based on recruitment, risk score now 9	People Academy

				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.			

During March 2024 it was proposed that risk 3810, which related to haematology, be reduced from a score of 16 to a 12, however the Executive Team did not accept the reduction pending further improvements in outcomes. The improvement work and action plans were noted.

Risks beyond their review date

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

Risk ID:	Score:	Risk Description:	Lead Director:	Review Date:
3660	**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	08/03/2024
3850	**15**	There is a risk to the patient care, staff wellbeing and trust finances arising from inadequate pharmacy accommodation.	Saj Azeb, Chief Operating Officer	31/01/2024

In April, there were no risks beyond their review date.

Recommendation

The Board is asked to:

- confirm whether it is assured that all risks on the High Level Risk Register are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

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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

All Open Risks with a current scoring of >=15 sorted by risk score - highest to lowest (as at 12/04/2024)

IRIS ID	Legacy ID	Date of entry	Risk Lead	Lead Director	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)
2566		14 Apr 2024	Farah Naz	Sajid Azeb	Risk Assessment	Finance and Performance Academy, Quality and Patient Safety Academy	If we are unable to facilitate timely discharge of patients due to changes in the provision of social care, then we will struggle to meet our commitment to close our additional winter beds, incur financial costs, and experience an increased in 12-hour breaches, Accident & Emergency Department (AED) overcrowding, bed waits, and ambulance delays. This will result in an increased risk to patients, increase in patient safety alerts, decrease in quality of care, an increased financial risk to the Trust, and a reputational risk.	31-May-24	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	12	(4) Major	(4) Will probably recur, but is not a persistent issue	-Ward staffs to ensure that patients risk assessments are in updated. -Development of IMC blueprint to improve discharge planning and timely discharges within 24 hours of no longer meeting criteria to reside -Patients are only transferred to ward 27 when they no longer meet the criteria to reside and there is no known discharge date, when this has been approved by a senior reviewer considering the impacts of the transfer to an alternative ward on psychological and physical health and well-being. -Mixture of patients on ward 27 creating increasing difficulties for staff on the wards to provide appropriate care. -Additional audits completed provided by matron to ensure that all care plans are in place, monitored and reviewed -Winter pressure wards opened to create excess capacity to meet demand. -Requirement for a medically optimised for discharge ward (27). - Request a speciality review in the department, consideration of elderly virtual ward pathway (where appropriate). Patients are provided with an hospital bed (non-pressure relieving) and oral or intravenous nutrition (where appropriate). - Patient's carers and family members are offered to stay with the patients for reassurance and familiarity to prevent increasing confusion and agitation	•Implementation of the IMC Blueprint and the subsequent project activity is designed to improve flow, quality and outcomes for people. •The IMC blueprint project areas 3(10), 4 (1-8), 5, will result in effective 24/7 recovery, rehabilitation and reablement with discharge planning commencing on admission with a target length of stay of 28 days or less. The IMC blueprint project areas 5, to focus on the development of timely discharges into a nursing or residential 24hr bedded setting for an initial 4-week assessment period to determine long-term care requirements. Commissioners' development of a service specification for Care Homes (CHs) in the Independent Sector (Nursing & Residential) to enable these homes to take people for assessment prior to determination of long-term needs.	30-Nov-24	16	(4) Major	(5) Will undoubtedly recur, possibly frequently
290	3627	10 Feb 2021	Chris Davies	Matthew Horner	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.	26 May 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.	•The formal submission on 30th April 2021 of SOC to NHSE/I to seek capital funding for new development this is now being reviewed for progression to a formal business case . The Bradford and Craven Estates strategy has been updated to include the SOC as part of the regional estates strategy plans. The SOC has been provided to the West Yorkshire and Harrogate ICS for support and approval. •Enhanced investment into Backlog Maintenance Programmes of Work to reduce Critical Infrastructure Risk (CIR). Approval at ETM for £4m to support backlog maintenance program in 22/23. •Seek additional NHSE/I capital funding resources. May 2022 Update:- Back-log programme now developed, phased and prioritised. June 2022 Update:- Work continues to procure a project delivery team. This team will commence the back-log scheme and take it through a 2-5 year cycle. July 2022 Update:- Confirmation of the back-log budget, planning / designing projects for the next 5 years continues with focus on high risk items. October 2022 Update:- The new works / minor works team are progressing the back-log plan for this year which includes a focus on fire alarm upgrades in Maternity, generator replacement, roof replacement to name a few. January 2023 Update:- 2022/23 back-log works progressing including the replacement of the generator is now complete. Fire Alarm upgrade commencing in Maternity. The 5 year back-log / capital plan now complete and agreed addressing all back-log infrastructure risks and issues across the estate. March 2023 Update:- Closing down on 22/23 works, a prioritised back-log program now agreed commencing in FY 23/24	31 Mar 2025	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue
607	3109	26 Nov 2018	Nima Maleki	Ray Smith	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	31 Aug 2024	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	12/3/24 - Histopathology improvement plan commenced. 3 work streams - people, place (environment) and processes. Decreased staff levels across AGH & BRI (BRI minus 7 - 3 x mat, 2 x sick, 2 x a/l). Significant backlog & delays with increasing level of reported incidents. 25.1.24 ETM have advised that consequence score should be 4x4=16 as could potentially impact greater number of patients. 15/09/23 - 1 Colleague LT Sick , Sickness management in process. 1 colleague on Mat leave return date 17.10.23, 2 Vacancies , recruited to with Over seas candidates . 1 colleague submitted request for Unpaid leave 4 months. Service continue to outsource to SBS, in reach support from Leeds when possible. The service is looking at BC for additional BMS's to support cut up long term. 29/04/23 Recent resignation of substantive colleague as created a service gap. Recruitment process in place and awaiting closing date for the advertised post . Consultant colleague as planned maternity leave , advertisement for back fill is advertised. Further resignation receive April 23 with planned termination of July 23 , will leave a further gap in the service. Recruitment plans to be created. The service is struggling to deliver to the demand , outsourcing service is used regularly and support to the neighbouring organisation as been requested with plans in situ to support 8/2/23 Recruitment successful, accommodation being developed. Remains a service under pressure due to workload. 08/12/22 - Team are fully established , existing pressures in the service due to adhoc sickness. Reviewed establishment and identified no further funds to appoint additional consultants , to work on BC. identified further reporting to be sent to SBS during the Christmas period to support turn around times 31/10/22 - Two new doctors joined the team. 1 Existing consultant considering Retirement. Culture amongst team still very fragile and need to review working processes. Still out sourcing to SBS but limited slides are outsourced. Regular meetings still taking place to finalise a tender process for outsourcing companies 13/09/22 - -1 New doctor planned to start 17th October 2022, still awaiting a date for the second doctor to start. Our doctor who was on Sabbatical as now returned from leave , and high holiday season for the other consultants as now ended. there is a number of administration planned to leave in the next couple of months , recruitment approval and advertisement is in processes but the business manager is working through processes and already implemented interim plans to minimise disruption. out sourcing to SBS as reduced and still plans in place to review outsourcing supplies through the procurement team.	31 Aug 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently
171	3748	15 Feb 2022	Jen Green	Ray Smith	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.	31 Aug 2024	16	(3) Moderate	(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. 15/09/23 3 business cases to increase Renal dialysis were approved at Planning Committee this week . Recruitment approval process to begin for the expansion at St luke's . Skipton expansion will start the process of change management with the support of HR 14/06/23 Task and Finish Group is being established to clarify the in house capacity and risks and develop a plan for the service with clear timescales. 5/5/23 Exploration of central funding possibilities underway 8/2/23 Funding agreed for work to commence on ward 15 for additional outpatient area. BRI acute dialysis unit ventilation work awaiting commencement. Central funding sought for replacement of Skipton Dialysis unit. 26/08/2022 A business case for HD staffing expansion. If a business case is accepted to increase our HD staffing capacity, we could open an addition dialysis room that we created as part of an expansion and reconfiguration initiative during the Covid-19 pandemic. This would allow us to provide HD at St Luke's for all 47 of our 47 stations (for 282 patients), OR if we were to follow IPC guidance and close 4 stations (as above) we would only be able to provide HD at St Luke's for 43 of our 43 stations (for 258 patients). High level Task and Finish group (Renal Programme Board) set up to take the proposed Airedale Managed Service Haemodialysis Unit, BRI and St Luke's projects 2019 Service review to identify funding requirements and capacity limitation Business cases for St Luke's and BRI ADU/ Ward 15 developments including additional water facilities.	30 Sep 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently

2549		05 Apr 2024	Jen Green	Ray Smith	Escalated from Division	People Quality & Patient Safety Academy	There is a risk that the current NSO workforce within BTHFT and also WYAAT can't continue to support the current NSO model of care within the region, which will delay cancer treatment causing harm to patients. The delivery of NSO services has become significantly challenging in recent years due to: •Growth in the prevalence of cancer •Increase in treatments and complexity of treatment regimens meaning we are treating more patients and for longer •Significant national vacancy levels in the Consultant medical oncologist workforce where numbers of trained specialists have been outstripped by demand •Workforce pressures across all NSO professional groups including specialist nursing, SACT nursing, Advanced Clinical Practitioners and pharmacist groups The above factors not only within BTHFT have led to significant pressures across WYAAT which have been particularly acute in Mid Yorkshire. As a result, mutual aid support has been required from Trusts within the region. The support offered has been dependent on tumour site in order to protect the current service. The NSO Programme has been tasked by WYAAT to develop a robust and sustainable model for delivering NSO services across North and South sectors in West Yorkshire and Harrogate and developing a sustainable acute oncology service is a key part of this work. The Trusts in West Yorkshire and Harrogate Cancer Alliance have been divided into 2 "sectors". North – Airedale, Bradford, Harrogate and Leeds South – Calderdale and Huddersfield and Mid Yorkshire Each sector has developed their own Target Operating Model and will work to implement this model over the duration of the NSO Programme. Both sectors will work together on cross cutting themes. Having the right mix of staff and skills is essential for the delivery of high-quality care. By working together across organisational and professional boundaries, the workforce will meet the needs of our population and deliver new models of care whilst reflecting the core principles of national guidance and individual Trust strategies.	13 May 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue	4	(4) Major	(1) Cannot believe that this will ever happen again	•Local monitoring of waiting times with adhoc additional sessions where possible •BTM approved locum consultant •Exec sponsored involvement in NSO Programme	1.Local review and response to gaps in service - Jen Green 2.Overview and support of NSO Programme - Ellie MacIver	31/03/2025	16	(4) Major	(4) Will probably recur, but is not a persistent issue
257	3660	25 May 2021	Helen Jkpps	Karen Dawber	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)	02 Jun 2024	12	(4) Major	(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	May 2021 - Additional control measures required to reduce the risk to the lowest possible level: Escalation policy to be reviewed to look at other mitigation which can be introduced. See also Nurse staffing risk assessment already in place. And Airedale Collaboration. Paed/Ed interface risk assessments. Recruitment of nursing staff Ensure double Paediatric Registrar cover sustained at night time Work/Collaborate with WYAAT - principle of 'Mutual Aid' Backfill maternity cover for General Paediatric Consultant Update 04/08/2021 No change however as surge progresses additional risks and mitigation required Review again in Sept 2021 Update 29.09.2021 RA update in progress Update Oct 21 No change to situation. High levels of activity and acuity (Sept busy month for stabilisation). Some extra measures required but in control. PICU bed shortages persist. Agreed scores to stay the same at present time" Update 08.04 2022 RA update in progress review date extended to end of April 22 Update April 2022 HJ Risk score remains at 12 due to impact of staff vacancies bed base at capacity and transfers out of BTHFT Risk expected to reduce later in the year due to planned over recruitment in September Review in 6 months Review of RA req 07/11/2022 Update 16/11/2022 - RA updated see attached V5 • Significant challenges due to a combination of patient acuity, bed base and nursing skill mix • Consultant workforce challenges due to a combination of intensity and external factors and level 1 and level 2 patients • Escalated through CSU to Exec meeting due to the level of concerns • These issues tie in with the Paediatric Nurse Staffing risk assessment and the High dependency risk assessment	31-May-24	16	(4) Major	(4) Will probably recur, but is not a persistent issue
109	3810	14/10/2022	Jen Green	Ray Smith	Risk Assessment	People Academy Quality & Patient Safety Academy	Highlighting the service risk for Haematology, oRisk to Acute consultant Rota and timely inpatient reviews oRisk to Outpatient delivery and the increase to wait times for Urgent / routine / cancer and the specialised Haemophilia patients oService delivery for the whole Haemophilia service , surgical and outpatient work oService delivery for complexity of haematology patients oIn reach to transfusion service There is no clinical haematology representation at cross site senior management meetings Pathology . Neither site BTHFT / AFT can provide time to attend this and lack of clinical haematology support has been identified - Lack of clinical direction for the lab, Delay in reporting of blood films for complex technical cases Lack of regular review of clinical documentation eg reference range review and validation Inability to obtain clinical advice in a timely manner and including out of hours when needed Lack of morphology case training and competency for BMS staff to ensure additional essential underpinning knowledge and experience.	31/08/2024	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	Leeds Comprehensive Care Centre Support oCover for out of hours on call for the regional haemophilia network oLeeds are the agreed point of contact and can support with severe, surgery, high risk and acquired haemophilia patients oHigh risk patients to be transfer to Leeds. oAcquired haemophilia , to be transferred to Leeds oSharing of protocols , triaging protocols of what patients they can support and not oMild issues, Leeds can give guidance – consultant to consultant (Meadows – CNS can communicate to Leeds) oContact can be made to duty haemophilia consultant oSevere patients to have 6 monthly review at Leeds oPregnant patients transferred to Leeds if Dr Pollard unavailable oLeeds to get back about elective patients – in first instance, call from consultant to consultant to find out urgency and sensible triage oLeeds want consultant to consultant communication/discussion, not comfortable with CNS queries oIn reach to the paediatric service oSarah Garside to work with CNS – offer support and suggestions. Sarah and Cecilia to sort a list of patients who are classed as high risk bleeders oLeeds to write clear rules on what they can and cannot do oTransfer of new outpatient complex patients They cannot support: oOn-site support oMilder Haemophilia Inpatient care oOutpatient review of the routine and new patients currently in our system oVery elective patients, these would have to be delayed oAny thrombosis patients Submitted ETM paper to executives to be discussed Monday 12th September 2022 Recruitment approval for locum doctor Advert for substantive consultant Request to recruit through agencies	12/3/24 - Improved position due to the recovery plan work that has been undertaken. Job planning completed. Business case for an additional consultant to be submitted. Risk to remain at 16 until results of improvement work evident.	30/09/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
447	3469	11 Oct 2019	Karen Dawber	Karen Dawber	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 Apr 2024	6	(4) Major	(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, increased to Monthly, 1 hour during EPR go live planning and launch phase •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	09.02.24 Education - 3 new ReSPECT packages built in to ESR for staff to access. These include basic overview for non-clinical staff, ReSPECT fundamentals for clinical staff and a specialist authorship module for staff who complete the documentation. In addition to this we offer a competence assessment that has been agreed across place for non-medical authors of ReSPECT documents. Electronic ReSPECT - The project build is progressing well, the anticipated go live date is end of March 2024. This build will allow all the areas of improvement highlighted on the Audit Yorkshire report to be resolved. Audit - The most recent Genome Audit (December 2023) have shown a compliance rating of 95% 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.	30 Apr 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
221	3696	18 Aug 2021	David Smith	Sajid Azeb	Business Continuity	Finance and Performance Quality & Patient Safety Academy	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.	30 Apr 2024	20	(3) Moderate	(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.	01/03/2024 Temporary unit ready for handover but issues with insitue isolator. Isolator need repairing before sterility testing and handover can begin. 24/11/2023 Temporary unit has been repaired. Awaiting sign off by contractor before passing over to the trust to validate. 21/08/2023 Temporary unit is on site at St Luke's Hospital however awaiting formal handover from company following which the unit will undergo commissioning and validation prior to first use. Handover date delayed due to water damage to unit as a result of heave rainfall repairs currently being undertaken by the comany who own the unit. Additional steps as per last update remain in place. Additional steps have been taken to increase cleaning regimens and environmental monitoring. Workload has been reduced to ensure these regimens can be maintained. Contingency plans are being worked up with neighbouring trusts should the unit fail. Clinical teams are being asked to improve / review their workflows in order to support the unit to meet their patients needs. A Review has been commenced to quantify the nature and consequences, in terms of patient care, of a unit failure / shut down. Plans are being developed to identify potential future options for the unit. Update 9th February 2022 Interim plans and costings for a temporary unit are being worked up. A location has been identified by the main entrance to St Luke's Hospital Horton Wing. Costing for connection of the unit is almost complete March 2022 Approval from ETM received on installation of a temporary unit. Installation of new temporary unit to begin in the next month with unit being on site from June 2022 and running from late June / July 2022 Update September 2022. The proposed temporary unit is still in situ in its exsiting location in the channel islands. All works are lined up to transfer the unit to St Luke's and install it as soon as it is available for the trust use.	31-May-24	16	(4) Major	(4) Will probably recur, but is not a persistent issue

187	3732	20 Jan 2022	Joanne Hilton	Karen Dawber	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.	30 Apr 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. 15/08/2023 (JH) - Risk reviewed, surge rates of pay in place for August-10th September. Trajectory for recruitment of international nurses and newly qualified nurses on track currently. Support roles in place (legacy mentors, preceptorship and pastoral support). Daily staffing processes remain in place and work ongoing with NHS England for team based rostering. Focus continues on HCSW recruitment. 27/06/23 (JH) - Risk reviewed as past target date for implementation. Timeline produced regarding nurse staffing vacancy at band 5 level indicates better staffing position by end of calendar year. Target date amended to October 2023. 26/05/23 (JH) - Risk reviewed with further work taking place around the use of the safecare acuity and dependency tool, live staffing decisions with patient information and accuracy of data entry. There are no changes to current risk level. Recruitment event held on 25th May with 54 newly qualified nurse jobs offered and 64 HCAs. Risk level will continue to be assessed and reviewed as part of the ongoing safe staffing work. 14/4/23 (JH) - Risk reviewed and remains in place - whilst there is a slight reduction in the sickness absence / vacancy rate with the ongoing impacts of industrial action and additional capacity in place the risk score remains the same. The risk assessment has been updated and attached. 03/01/23- Risk reviewed and increased back to 5 x 4 (from 5 x 3). Increase in risk changed due to increase in sickness absence, increase in numbers of patients with higher acuity requiring greater care (including NIV), increases in number of COVID, FLu and RSV cases leading to additional capacity requirements Mitigation remains in place and is effective but severely restricted by the availability of staff.	31 Oct 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
39	3881	27 Jul 2023	David Smith	Sajid Areb	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	31 May 2024	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 .	09/04/24 Medicines Reconciliation rates above 70%. Risk score unchanged as there are still service gaps. Ongoing recruitment. 23/10/23 More pharmacists now in place to undertake med rec. Risk score reduced to 12. Further review once the department is fully staffed Update 08/09/23 A number of new starters have commenced with the service and are currently being trained up. In addition a number of colleagues have returned from leave. To retain current risk rating and then review when impact of new staff on meds rec figure is known. - Active recruitment campaign in place. Phil Moore - Assistant Director of Pharmacy - Clinical Services (ongoing) - Skill mix to attract and recruit a greater number of foundation level pharmacists. Amna Khan-Patel Clinical Pharmacy Team Leader Education and Training (completed) - Skill mix to recruit two teacher practitioner posts at the local schools of pharmacy to further attract staff. Amna Khan-Patel Clinical Pharmacy Team Leader Education and Training (Recruited UoB Post - awaiting start date, UoH Post at recruitment stage) - Recruitment of a Pharmacist in the Emergency Department to facilitate medication reconciliation. David Smith - Director of Pharmacy, Farah Naz - Senior General Manager - Urgent, Elderly and Intermediate care - To explore the feasibility of creating SytmOne access for junior doctors in Urgent and Emergency care to ensure medication reconciliation, Farah Naz - Senior General Manager - Urgent,	30 Aug 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
512	3404	31 May 2019	Sara Hollins	Karen Dawber	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 May 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	31 May 2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
30	3890	30 Aug 2023	Carly Stott	Karen Dawber	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	31 May 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 6. Radiology to complete a risk assessment regards to ultrasound staffing and a business case to Increase headcount of sonographers Simon kirk/Alison burns/K Lomas Complete 7. USS task and finish group to be held monthly with actions to enable achievement of best practice guidance of scanning within the required timeframes Carly Stott/Nada Sabir 30 August 2024 8. Monitor the number of scans performed within the required timeframe to ascertain compliance with best practice guidance and inform the risk E Quinlan/A Kundi/N O'Grady Ongoing	31 May 2024	15	(5) Catastrophic	(3) May recur occasionally
95	3824	14 Sep 2023	Farah Naz	Ray Smith	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 Oct 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	12/3/24 - Staffing paper not approved by ETM on the basis of affordability. Work underway with job plans and rotas to explore alternate means of providing safe and resilient cover. 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	31 Aug 2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently

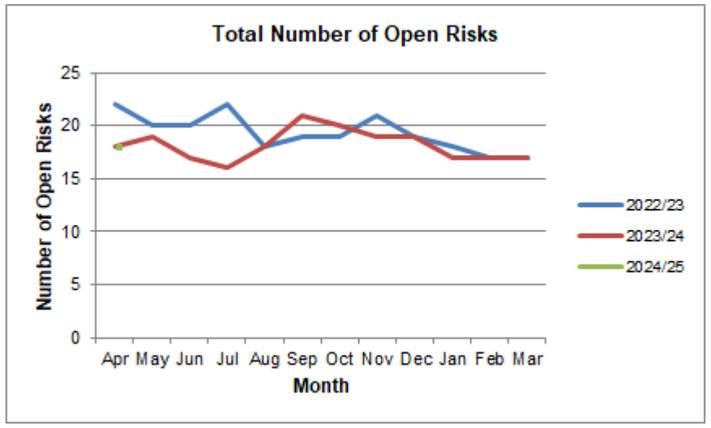
70	3650	29 Mar 2023	David Smith	Sajid Azeb	Risk Assessment	Finance and Performance People	There is a risk to the patient care, staff wellbeing and trust finances arising from inadequate pharmacy accommodation. The key risk are: Aseptic Unit The pharmacy aseptic unit is listed as a separate risk - risk 3696. Pharmacy Dispensary The Pharmacy dispensary is cramped and can be overcrowded at busy times which increases the risk of dispensing errors. In addition to this, the cramped accommodation means the trust is unable to further automate the dispensary with the latest dispensing robots. Current dispensing robots are significantly more efficient meaning dispensing times can be further reduced and include technology such as automatic labelling which further reduces the chances of dispensing errors. The current accommodation means waiting times are longer and dispensing errors more likely than a modern automated dispensary. Pharmacy Quality Assurance / Control The quality assurance area has recently been face lifted but like other areas accommodates more colleagues than there are spaces for. In addition to this there is inadequate storage areas to store expensive equipment which may become damaged leading to a financial risk to the organisation. There is also a lack of space for the incubators which are key to the functions of the department. Incubators are currently located in a long corridor without windows meaning the working environment is poor. The current accommodation means there is a financial risk to the organisation arising from potential damage to equipment and through staff absence resulting from the poor environment. Pharmacy Stores The pharmacy store is currently spread across two floor levels and two separate unheated store rooms. In addition to this the layout of the building means that automation, common in other trusts, cannot be installed. The lack of automation increases the risk of stock outages and picking issues leading to an increased risk of patients missing doses of medication and potential patient harm. Equality Diversity and Inclusion The department has numerous different floor levels, some of which are connected by ramps whilst others are connected by stairs. This means that any staff or visitors who are mobility impaired will be unable to access all areas of the department Staff rest facilities are inadequate in that there are only two toilets for over 130 people. Office accommodation is limited meaning colleagues often need to hot desk which limits the scope for work station related adjustments. The accommodation also means that staff are less able to mix and form a coherent team leading to issues with morale impacting staff wellbeing. The current accommodation means there is a risk to staff wellbeing and trust finances through absences as a result of the poor accommodation.	30 Jun 2024	20	(2) Minor	(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 Apr 2025	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently

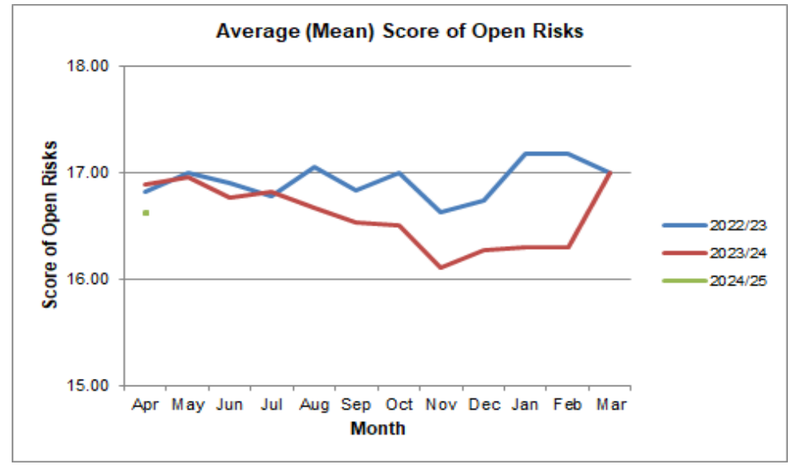
High Level Risks Report on a Page – April 2024

Total High Level Risks	17*
Aligned to F&PA	3
Aligned to QPSA	14
Aligned to PA	8
Aligned to Board	2

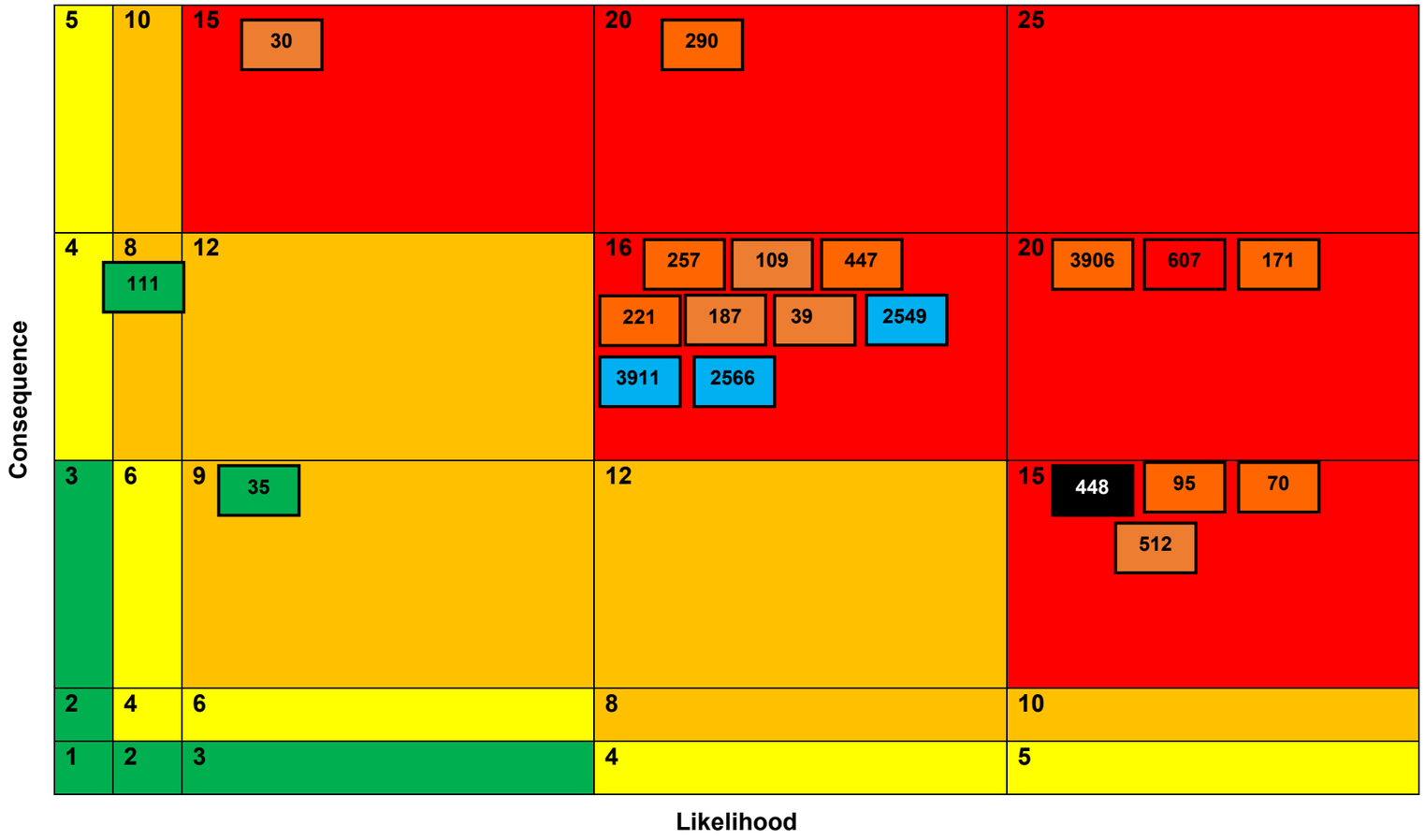
*Note some risks are aligned to more than one Academy

Movement of Risks	
New	3
Marked for closure	1
Risk score increased	1
Risk score static	13
Risk score decreased	2

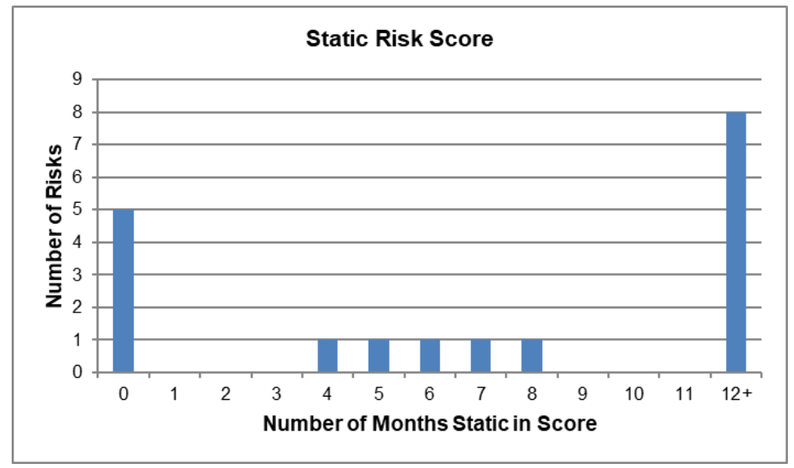




Risk Overview



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



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

IRIS ID	Legacy ID	Date of entry	Academy	Current Score - April 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
512	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		
257	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	31/05/2024		
221	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	31/05/2024					
187	3732	20/01/2022	PA & QPSA	16	10	02/01/2023	31/03/2023	31/05/2023	31/10/2023	31/03/2024	31/10/2024									
447	3469	11/10/2019	QPSA	16	8	31/12/2019	30/09/2021	29/07/2022	29/07/2023	30/04/2024										
607	3309	26/11/2018	QPSA	20	4	30/04/2019	31/12/2019	30/04/2020	30/12/2022	31/08/2024										
109	3810	14/10/2022	PA & QPSA	16	6	30/10/2022	08/12/2022	01/04/2023	30/09/2023	30/09/2024										
290	3627	10/02/2021	QPSA	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025											
171	3748	15/02/2022	QPSA	20	3	31/01/2023	31/01/2024	30/09/2024												
14	3906	17/10/2023	Board	15	10	30/11/2023	31/03/2024	30/09/2024												
30	3890	30/08/2023	QPSA	15	5	31/08/2024	31/05/2024													
95	3824	14/12/2022	PA & QPSA	15	6	28/02/2024	31/08/2024													
70	3850	29/03/2023	F&P & PA	15	6	01/04/2025														
39	3881	27/07/2023	PA & QPSA	16	8	30/08/2024														
2549	N/A	05/04/2024	PA & QPSA	16	4	31/03/2025														
9	3911	10/11/2023	Board	16	8	30/09/2024														
2566	N/A	12/04/2024	F&P & QPSA	16	12	30/11/2024														

Key:

Target mitigation date changed since last report

Past the target mitigation date

BO.5.24.19 - NED ACADEMY/COMMITTEE MEMBERSHIP AND CHAMPION ROLES

REFERENCES

Only PDFs are attached

Bo.5.24.19 - NED Champion Roles.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.19

NED Committee/Academy membership and champion roles

Presented by	Sarah Jones, Chair	
Author	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Lead Director	Sarah Jones, Chair	
Purpose of the paper	To seek approval of proposed changes to the NED Committee/Academy membership and 'champion' roles.	
Action required	For approval	
Previously discussed at/informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

Committee/Academy membership

The code of governance for NHS provider trusts states that 'the value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees'.

The current Academy and Committee memberships have been reviewed and it is proposed that three NEDs are appointed to each forum (instead of four), to ensure that the NEDs' workload is more manageable. The exception to this is the Quality & Patient Safety Academy which it is proposed retains four NEDs due to the broad remit covered by this Academy.

The proposed memberships from May onwards are as follows:

	Audit Committee	**Quality & Patient Safety Academy**	**People Academy**	**Finance & Performance Academy**	**Charitable Funds Committee**
Chair	Bryan Machin	Louise Bryant	Karen Walker	Julie Lawreniuk	Altaf Sadique
Members	Zafir Ali Mohammed Hussain	Sughra Nazir Karen Walker Julie Lawreniuk	Louise Bryant Altaf Sadique	Zafir Ali Sughra Nazir	Mohammed Hussain Bryan Machin

All NEDs will also continue to be members of the Board Nomination & Remuneration Committee, and are expected to attend Council of Governor meetings.

The Terms of Reference and work plans for the Academies and Committees are currently being reviewed as well as the number and scheduling of meetings, to ensure that our arrangements are both efficient and effective. Any proposed changes will be developed in consultation with Board members and the aim is to seek approval of the revised arrangements at the next Board meeting in July.

NED 'champion' roles

In November 2022, the Board was advised of guidance published by NHS England which reduced the number of NED 'champion' roles from 18 to five. NEDs were appointed to the roles and it was agreed that the appointments would be reviewed on an annual basis as part of the NED appraisal process. Due to the changes in Chair, it has not been possible to do this as part of appraisals, therefore the changes have been communicated to NEDs at their meetings with the Chair and via e-mail.

In addition to the five roles included in the guidance, NED leads have been assigned to additional areas as outlined below. This ensures that each NED has a lead/champion role.

Area	Lead
Roles included in NHSE guidance	
Wellbeing Guardian	Sarah Jones
Fredom to Speak Up	Julie Lawreniuk
Maternity	Sughra Nazir
Security Management / Emergency Planning	Altaf Sadique
Doctors Disciplinary	All (appointed by the Chair on a case by case basis)
Additional roles	
Waste Reduction Programme	Bryan Machin
Equality, Diversity & Inclusion	Karen Walker
Green Plan	Mohammed Hussain
Research	Louise Bryant
Safeguarding	Zafir Ali

Role descriptions were developed for the five roles included in the NHSE guidance and are available in the NED reading room on Team Engine.

Recommendation

The Board is asked to:

- **Approve** the proposed changes to Committee/Academy memberships as outlined above; and
- **Note** the assignment of NEDs as champions/leads for specific areas.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.19

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

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

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

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

BO.5.24.20 - BRADFORD HOSPITALS CHARITY ? SUPPLEMENTAL DEED

REFERENCES

Only PDFs are attached

Bo.5.24.20 - Supplemental deed (cover paper).pdf

Bo.5.24.20 - Appendix 1 - BHC Supplemental Trust Deed - adding power to incorporate.PDF

Bo.5.24.20 - Appendix 2 - Governing document.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.20

Bradford Hospitals Charity – supplemental deed

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Lead Director	Reneé Bullock, Chief People and Purpose Officer	
Purpose of the paper	To seek approval to amend the charity's governing document to add an express power to incorporate the charity	
Key control	N/A	
Action required	For approval	
Previously discussed at/ informed by	Charitable Funds Committee (CFC)	
Previously approved at:	**Committee/Group**	**Date**
	Charitable Funds Committee	30 April 2024

Key Options, Issues and Risks

At the Charitable Funds Committee meeting held on 7 March 2024 and the subsequent Board meeting on 14 March 2024, approval was granted to incorporate Bradford Hospitals Charity.

As part of the due diligence in preparing the case for independence, our legal advisors recommended that the charity's governing document is amended, to include an express power to incorporate the charity.

This is required prior to the formal application to incorporate the charity. The change does not commit the charity to conversion, but it confirms the ability to do so as and when required.

This requires the approval of a supplemental deed (appendix 1) which will have the effect of amending the charity's governing document (the original version is attached at appendix 2, the Board is asked to note that two supplemental deeds have been approved previously, to change the name of the charity).

The Charitable Funds Committee approved the supplemental deed which is now presented to the Board for final approval.

The Board is asked to note that if approved, the supplemental deed will be required to be signed by one director and a witness whereafter it will then be filed with the Charity Commission.

Recommendation

The Board of Directors is asked to **approve** the supplemental deed attached at appendix 1.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.20

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

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

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

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: 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)
☐	☐	☐	☐

THIS DECLARATION OF TRUST IS MADE

The 25th day of March 1997 by

(a) Bradford Hospitals NHS Trust

("the first trustees" who together with the future trustees of this deed are referred to as "the trustees").

WHEREAS the trustees hold

(b) £1,513,217

on the trusts declared in this deed and it is contemplated that further property or assets may be paid or transferred to the trustees upon the same trusts.

NOW THIS DEED WITNESSED FOLLOWS:

A. Administration

The charitable trust constituted by this deed ("the Charity") and its trust property ("the trust fund") shall be administered and managed by the trustees under the name of the Bradford Hospitals NHS Trust Charitable Fund Charity or by such other name as the trustees from time to time decide with the approval of the Charity Commission for England and Wales ("the Commissioners").

B. Trustees

The trustees of the Charity and the trust fund shall be the Bradford Hospitals NHS Trust or such other trustees as may be appointed by virtue of any legislation from time to time in force.

C. Objects

The trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Bradford Hospitals NHS Trust.

(hereinafter referred to as "the objects").

D. Powers

In furtherance of the objects but not otherwise the trustees may exercise any of the following powers:

(1) to raise funds and invite and receive contributions: Provided that in raising funds the trustees shall not undertake any substantial permanent trading activity and shall conform to any relevant statutory regulations;

(2) to buy, take on lease or in exchange, hire or otherwise acquire any property necessary for the achievement of the objects and to maintain and equip it for use;

(3) subject to any consents required by law to sell, lease or otherwise dispose of all or any part of the property comprised in the trust fund;

(4) subject to any consents required by law, to borrow money and to charge the whole or any part of the trust fund with repayment of the money so borrowed;

(5) to co-operate with other charities, voluntary and statutory authorities operating in furtherance of the objects or of similar charitable purposes and to exchange information and advice with them;

(6) to establish or support any charitable trusts, associations or institutions formed for the objects or any of them;

(7) to employ such staff as are necessary for the proper pursuit of the objects and to make all reasonable and necessary provision for the payment of pensions and superannuation to staff and their dependants;

(8) to charge against the trust fund the proportion of the cost of administrative overheads incurred by the trustees both in the administration of the Charity and in the discharge of other functions which is attributable to the administration of the Charity;

(9) to permit any investments comprised in the trust fund to be held in the name of any clearing bank, any trust corporation or any stockbroking company which is a member of the Stock Exchange (or any subsidiary of such a stockbroking company) as nominee for the trustee and to pay such nominee reasonable and proper remuneration for acting as such;

(10) to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, shares, securities or other investments of whatsoever nature and whatsoever situate as the trustees in their discretion think fit but so that the trustees:

(a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom they felt morally obliged to provide;

(b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisitions of futures or traded options).

(c) shall not have power under this clause to engage in trading ventures; and

(d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.

(11) to designate, at their discretion, particular funds out of the trust fund in order to give effect to the wishes of any donor to the Charity or for administrative or other purposes and power to vary and cancel such designation: Provided that any such designation or variation does not permit the use of any part of the trust fund other than for the objects of the Charity;

(12) to accept and or create and administer, restricted fund for any purposes within the objects of the Charity but so that any restricted funds shall be administered in accordance with the trusts attaching to them;

(13) to transfer the trust fund or any part of the trust fund to itself as a body responsible for the maintenance of a health service hospital or to any other such body for or in connection with the acquisition, improvement or maintenance of any property: Provided that in making any such transfer the trustees shall have regard:

(a) to any directions of expressed wishes of the donors as to the terms and conditions on which such a transfer may be made; and

(b) generally to the desirability of making the transfer subject to terms and conditions which will ensure that the property so acquired, improved or maintained will continue to be used for the purposes for which the funds were transferred;

(14) to spend money on the insurance of any property comprised in the trust fund to its full value against such perils and upon such terms as the trustees think fit;

(15) to make regulations from time to time, within the limits of this deed, for the management of the Charity and for the conduct of its business including the deposit of money at a bank and the custody of documents.

(16) to do all such other lawful things as are necessary for the achievement of the objects.

E. Accounts

The trustees shall comply with their obligations to account to the Secretary of State for Health and with their obligations under the Charities Act 1960 or, when Part VI comes into force, the Charities Act 1993 (or any statutory re-enactment or modification of that Act) with regard to:

(1) the keeping of accounting records for the Charity;

(2) the preparation of annual statements of account for the Charity;

(3) the auditing or independent examination of the statements of account of the Charity; and

(4) the transmission of the statements of account of the Charity to the Commissioners.

F. Annual Report

The trustees shall comply with their legal obligations under the Charities Act 1993 (or any statutory re-enactment of modification of that Act) with regard to the preparation of an annual report and its transmission to the Commissioners.

G. Annual Return

The trustees shall comply with their obligations under the Charities Act 1993 (or any statutory re-enactment of modification of that Act) with regard to the preparation of an annual return and its transmission on the Commissioners.

H. Amendments of Trust Deed

(1) The trustees may amend the provisions of this deed provided that:

(a) no amendment may be made to clause C (the objects clause), unless it appears to the trustees that the objects can no longer provide a suitable and effective method of using the trust fund;

(b) no amendment can be made to clause C (the objects clause), or this clause without the prior consent in writing of the Commissioners; and

(c) no amendments may be made which has the effect of the Charity ceasing to be a charity at law.

(2) Any amendments shall be made by deed.

(3) The trustees should promptly send to the Commissioners a copy of any amendment made under this clause.

I Dissolution

It appears to the trustees that the objects no longer provide a suitable and effective method of using the trust fund, the trustees shall in these circumstances, but only so far as the trust attaching to any particular gift to the Charity may permit, hold the trust fund upon trust to apply the income and at their discretion, so far as may be permissible, the capital for any charitable purpose relating to the National Health Service.

IN WITNESS whereof the parties hereto have hereunto set their respective hands the day and year first before written.

Signed as a deed by the said

..... CHAIRMAN. .....

in the presence of:

..... D. Smith .....

Witness's name:

..... Dorothy Smith .....

Witness's address:

... 11 ... Hirst ... Road .....

... Newsburg ... Road .....

... Wakefield ... WF2 ... 9.D.H .....

Signed as a deed by the said:

David ..... CHIEF EXECUTIVE.

in the presence of:

D. Smith

Witness's name:

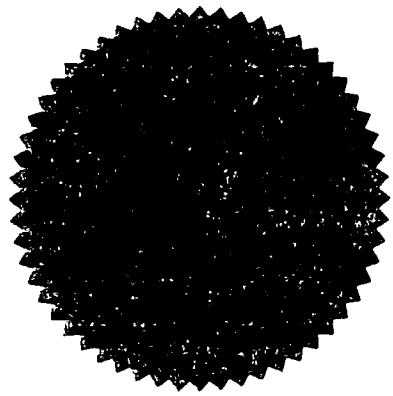
Dorothy Smith

Witness's address:

11 Hill Road

Dewsbury Road

Wakefield WF2 9DH



BO.5.24.21 - DATA SECURITY & PROTECTION TOOLKIT

REFERENCES

Only PDFs are attached

Bo.5.24.21 - Data Security and Protection Toolkit Assessment Report 2023-24 (cover).pdf

Bo.5.24.21 - Appendix A -Summary Position DSPT draft v0.1.pdf

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.21

Data Security and Protection Toolkit (DSPT) Assessment 2023/24

Presented by	Paul Rice, Chief Digital and Information Officer and SIRO	
Author	Jenny Pope, Head of Information Governance Graeme Holmes, Information Governance Manager	
Lead Director	Paul Rice, Chief Digital and Information Officer and SIRO	
Purpose of the paper	This paper sets out the recommended Data Security and Protection Toolkit (DSPT) 2023/24 annual assessment 'rating'	
Key control		
Action required	For approval	
Previously discussed at/informed by		
Previously approved at:		**Date**

Key Options, Issues and Risks

The Data Security and Protection Toolkit (DSPT) is a Department of Health and Social Care (DHSC) policy delivery vehicle that NHS Digital (now NHSE) is commissioned to develop and maintain. It is an online self-assessment tool that allows organisations to measure their performance and provide an assurance of Standards Met against all mandatory assertions in line with the National Data Guardian's data security standards. The 2023/24 DSPT assessment final submission will take place on the 30th of June 2024.

This paper updates the Board on the expected final position and sets out the recommended Data Security and Protection Toolkit (DSPT) annual assessment 'rating'.

There are 34 assertions (2 are non-mandatory) in total and 108 mandatory evidence items.

91 of 108 mandatory assertion evidence items have been provided. 25 of the assertions are complete and 21 confirmed at the time of this report to Board. The accompanying appendix summarises the items remaining to evidence. These will be confirmed as complete prior to submission.

Analysis

During the year the Information Governance service has sought evidence from the business against the mandatory standards set out in the DSPT, receiving assurance from assertion owners that the evidence complies with the DSPT.

A review of all available evidence had been completed at the time of this report and a review of the remaining evidence is ongoing. The Board is asked to note the ''Standards Met' forecast rating.

Audit Yorkshire has undertaken its review of the assertion items this assessment year and a draft report of the outcome of this review was outstanding at the time of this report. A final version is expected to be available in early May.

Recommendation

The Board is asked to note the position and delegate approval of the DSPT submission to the Digital and Data Transformation Committee (DDTC)/SIRO on behalf of the Board of Directors prior to submission on the 30th of June 2024.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.21

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: 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	9 May 2024	Agenda item	Bo.5.24.21

1 PURPOSE/ AIM

The purpose of this report is to update the Board on the current position of the 2023/24 Data Security and Protection Toolkit (DSPT) assessment.

It confirms that the recommended DSPT annual assessment 'rating' is forecast to be 'Standards Met' against all mandatory items, subject to final evidence.

2 BACKGROUND/CONTEXT

The Information Governance service has received updates from the assertion owners and their assurances on the evidence they have provided to comply with the DSPT. A review of the available evidence has been completed and is ongoing.

Progress against individual assertion items is monitored via a separate 'master' DSPT plan, which is a working document. The graph below summarises the position at the time of this report to the Board.

Audit Yorkshire has reviewed a sample of assertion items this assessment year. Its draft report of the outcome of the review is anticipated in early May. Any recommendations fundamental to or supplementing existing evidence will be completed by the 30th of June 2024 if they are necessary for the final submission.

It is to be noted that Audit Yorkshire's review was conducted in accordance with the new national DSPT audit framework, Strengthening Assurance, developed for NHS Digital (now NHSE), with a mandated audit approach introduced in 2020/21. This means that the format and assurance the report provides is different to previous years and the testing extends beyond what is prescriptive in the DSPT.

3 PROPOSAL

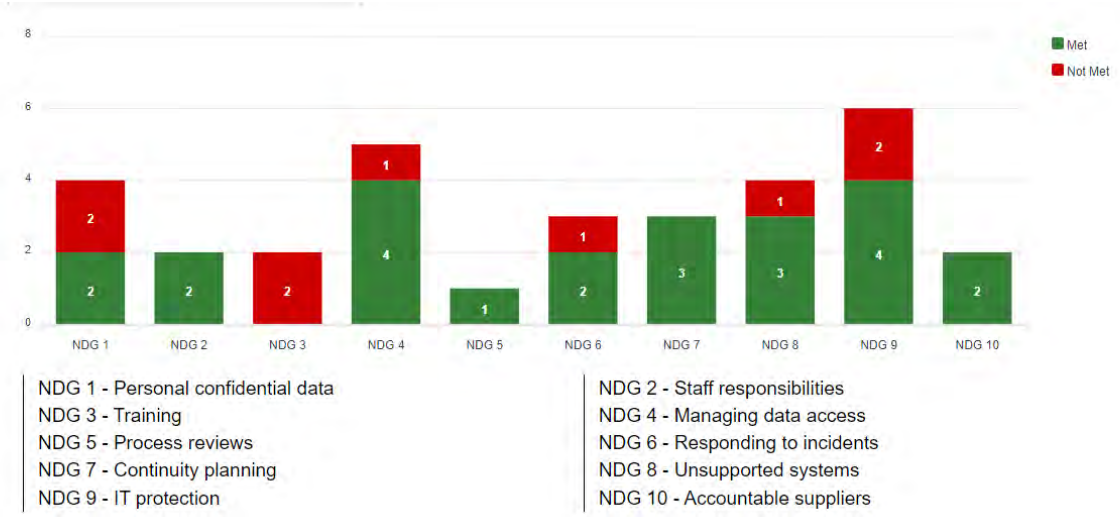
Once all mandatory items for a particular assertion are complete and have been reviewed they are considered 'met'.

The final submission date is the 30th of June 2024. The annual submission deadline was changed in 2020/21 due to the pandemic.

A separate master 'DSPT plan' tracks progress against each assertion item, mandatory and non-mandatory. Items marked amber in the DSPT plan require minor or final adjustments prior to submission, but are considered evidenced.

The SIRO/DDTC reviews the final assessment prior to the 30th of June 2024 and will be invited to confirm that the DSPT overall self-assessed rating of 'Standards Met' has been achieved.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.21



Above shows that 9 of the assertion items are incomplete at the time of this report to Board. These are related to standards NDG 1, 3, 4, 6, 8 and 9. They will be complete prior to the final submission.

NDG 1 - Outstanding actions re IAO refresh to be completed for the end of May 2024.

NDG 3 – At the time of this report the Trust was 88% compliant, with all staff IG training against a target of 95% (compliance is taken to be the highest percentage for the period between the 1st of July 2023 and the 30th of June 2024). There is a high level of IG awareness in the Foundation Trust, but further efforts will continue throughout May and June 2024 to raise the compliance level. A reminder will be issued to all staff in May and IG have confirmed that Education Services are reminding staff too. A verbal update of the latest position will be provided if requested at the Board meeting. Nb; This assessment has introduced changes to the training requirement. A draft training proposal is to be finalised prior to submission regarding a training needs analysis and future training provision.

NDG 4 – audit of user accounts outstanding.

NDG 6 - Multi-factor authentication is enforced on all remote access and privileged user accounts on all systems. To be confirmed and signed off by the cyber group by June 2024.

NDG 8 - IT to review and update as statements are present but not in-year or confirmed.

NDG 9 - Outstanding evidence is related to the IT pen test results and report.

Colleagues are requested to note that this reflects the current position and tracking of the completion of outstanding items is positive with no cause for concern.

4 BENCHMARKING IMPLICATIONS

N/a

5 RISK ASSESSMENT

Non-compliance with the DSPT could lead to reputational damage to the Foundation Trust and scrutiny from external stakeholders.

Meeting Title	Board of Directors		
Date	9 May 2024	Agenda item	Bo.5.24.21

In the event of an externally reportable serious IG breach, non-compliance with the DSPT may contribute to an Information Commissioner's Office (ICO) decision to take action, including potential monetary penalties.

Risks to quality of DSPT assessments are monitored via the DSPT plan and via the SIRO.

6 RECOMMENDATIONS

It is recommended that the Board notes the current position and supports the proposal to delegate approval of the 2023/24 DSPT assessment prior to the 30th of June 2024 to the DDTC/SIRO based on a Standards Met conclusion, which equates to a position of compliance with all mandatory assertion items by the 30th of June 2024.

This is subject to final evidence, as outlined above.

7 Appendices

Appendix A: summary position (separate attachment).
Appendix B: The National Data Guardian 10 data security standards of the DSPT (below).

10 Data Security Standards

Home > Data Protection and Cyber Security > 10 Data Security Standards

In 2017, the Department of Health and Social Care put in policy that all health and social care providers must follow the 10 Data Security Standards. These were developed by the National Data Guardian https://www.gov.uk/government/organisations/national-data-guardian

The standards are organised under 3 leadership obligations.

The 10 Data Security Standards

People	Process	Technology
Ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles.	**Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.**	**Ensure technology is secure and up to date.**
1. All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.	4. Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access data to personal confidential data on IT systems can be attributed to individuals.	8. No unsupported operating systems, software or internet browsers are used within the IT estate.
2. All staff understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to to handle information responsibly and their personal accountability for deliberate or avoidable breaches.	5. Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.	9. A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.
3. All staff complete appropriate annual data security training and pass a mandatory test, provided through the revised Information Governance Toolkit	6. Cyber attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.	10. IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.
	7. A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.	

See further - National Data Guardian - GOV.UK (www.gov.uk)

Appendix A

Data Security and Protection Toolkit (DSPT) - BTHFT 26/04/2024 Summary Position

34 assertions (2 are non-mandatory) in total. 91 of 108 mandatory assertion evidence items have been provided.

The table below summarises the position of all mandatory assertions. It is split into:

- assertions where some or all its items are 'incomplete', which means full or partial evidence is still required.
- assertions (entire assertion or assertion items) that the assertion owner has provided evidence/a statement against and which are ready for IG review. Some may have been reviewed but required further clarity and
- assertions (entire assertion or assertion items) that the assertion owner has provided evidence/a statement against which have been reviewed by IG.

Once all items beneath an assertion are complete and have been reviewed they are considered 'met'. Final submission is the 30th of June 2024.

The table also highlights mandatory assertion items which have been subject to this year's internal audit review by Audit Yorkshire. The audit commenced on the 18th of March 2024. Significant work has been completed to this point; however, some evidence is still outstanding and final reviews cannot take place until it is received. Assertion owners have been asked to provide evidence as a matter of priority. Assertions that are subject to an audit should ideally be complete at this stage. Where they are not, the audit opinion is based on status, taking account of 'plans' for evidencing an assertion prior to the final submission.

Yellow: Subject to Audit

Standard	Assertion	Ref	Assertion Owner	Complete
Personal confidential data	The organisation has a framework in place to support lawfulness, fairness and transparency.	1.1.	Jenny Pope	1.1.2 reviewed but to revisit, 1.1.3 reviewed but to revisit,1.1.4 reviewed but to revisit, 1.1.5 reviewed but to revisit.
	Individuals' rights are respected and supported.	1.2.	Graeme Holmes	1.2.3 to include stats, 1.2.4 pending AO clarity.
	Accountability and governance are in place for data protection and data security.	1.3.	Graeme Holmes	1.3.2 incomplete,1.3.3 reviewed but to add to, 1.3.6 incomplete and subject to review.

	Records are maintained appropriately.	1.4.	Graeme Holmes	Reviewed, final checks to make.
Staff responsibilities	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards.	2.1	Graeme Holmes	Reviewed, final checks to make.
	Staff contracts set out responsibilities for data security.	2.2.	Graeme Holmes	Reviewed 12/03, to revisit before submission.
Training	Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness.	3.1.	Graeme Holmes	All reviewed, to revisit before submission.
	Your organisation engages proactively and widely to improve information governance and cyber security and has an open and just culture for information incidents.	3.2.	Graeme Holmes	All reviewed, to revisit before submission.
Managing data access	The organisation maintains a current record of staff and their roles	4.1.	Ian Scott	Reviewed 4.1.2 incomplete.
	The organisation assures good management and maintenance of identity and access control for its networks and information systems.	4.2.	James Townend	Reviewed 4.2.1 incomplete.
	All staff understand that their activities on IT systems will be monitored and recorded for security purposes.	4.3.	James Townend	All reviewed, to revisit before submission.
	You closely manage privileged user access to networks and information systems supporting the essential service.	4.4.	Ian Scott	All reviewed, to revisit before submission.

	You ensure your passwords are suitable for the information you are protecting	4.5.	James Townend	All reviewed, to revisit before submission.
Process reviews	Process reviews are held at least once per year where data security is put at risk following data security incidents.	5.1.	Ian Scott	
Process reviews	Action is taken to address problem processes as a result of feedback at meetings or in-year.	5.2	Ian Scott	
Responding to incidents	A confidential system for reporting data security and protection breaches and near misses is in place and actively used.	6.1.	Graeme Holmes	6.1.1, 6.1.2 subject to review.
	All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway	6.2.	James Townend	Allsubj ect to review.
	Known vulnerabilities are acted on based on advice from NHSE and lessons are learned from previous incidents and near misses.	6.3.	Ian Scott	Reviewed 6.3.5 incomplete.
Continuity planning	Organisations have a defined, planned and communicated response to data security incidents that impact sensitive information or key operational services.	7.1.	Ian Scott	
	There is an effective test of the continuity plan and disaster recovery plan for data security incidents.	7.2.	Carl Hanson	Reviewed – incomplete.
	You have the capability to enact your incident response plan, including the effective limitation of the impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.	7.3.	Ian Scott	Reviewed 7.3.5 incomplete.
Unsupported systems	All software and hardware has been surveyed to understand if it is supported and up to date.	8.1.	Ian Scott	All reviewed, to revisit before submission.
	Unsupported software and hardware is categorised and documented and data security risks are identified and managed.	8.2.	Ian Scott	Reviewed 8.2.1 incomplete.

	Supported systems are kept up-to-date with the latest security patches	8.3.	Carl Hanson	Reviewed – incomplete.
	You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service.	8.4.	Ian Scott	All - subject to review.
IT protection	All networking components have had their default passwords changed.	9.1.	Ian Scott	All reviewed, to revisit before submission.
	A penetration test has been scoped and undertaken	9.2.	Paul Dyson	9.2.3 subject to review.
	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities.	9.3.	Ian Scott	All reviewed, to revisit before submission.
	You have demonstrable confidence in the effectiveness of the security of your technology, people, and processes relevant to essential services.	9.4.	Ian Scott	Reviewed 9.4.1,9.4.4 incomplete.
	You securely configure the network and information systems that support the delivery of essential services.	9.5.	Ian Scott	All - subject to review.
	The organisation is protected by a well-managed firewall	9.6.	Ian Scott	All- subject to review.
Accountable suppliers	The organisation can name its suppliers, the products and services they deliver and the contract durations.	10.1.	Frances May	
	Basic due diligence has been undertaken against each supplier that handles personal information.	10.2.	Ian Scott	
	All disputes between the organisation and its suppliers have been recorded and any risks posed to data security have been documented.	10.3	Ian Scott	All - subject to review.

BO.5.24.22 - ANY OTHER BUSINESS

BO.5.24.23 - ISSUES TO REFER TO BOARD COMMITTEES OR ELSEWHERE

BO.5.24.24 - REVIEW OF MEETING

BO.5.24.25 - DATE AND TIME OF NEXT MEETING

BO.5.24.26 - BOARD WORK PLAN

REFERENCES

Only PDFs are attached

Bo.5.24.26 - 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 & Transformation	x							x		Jan 2024 - for information only
Communications - Annual Update	Chief People & Purpose Officer							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	
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	Chief People & Purpose Officer	x	x	x		x	x	x	x	x	
High Level Risk Register	Chief People & Purpose Officer	x	x	x		x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief People & Purpose Officer							x			SFIs/SOD - Nov 2024 SOs - Sept 2025
Constitution - annual review	Chief People & Purpose Officer			x		x					
Self Certification of Provider Licence	Chief People & Purpose Officer			x							
NED Independence Test	Chief People & Purpose Officer			x							
Compliance with NHS Code of Governance	Chief People & Purpose Officer			x							
Well Led Review & Board Self Assessment	Chief People & Purpose Officer										Date TBC
Annual Report from Academies	Academy Chairs			x							
Annual Report from Audit Committee	Chair of Audit Committee			x							
Risk Appetite Review	Chief People & Purpose Officer			x		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)
Annual Fire Safety Report	Director of Estates & Facilities			x		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	Chief People & Purpose Officer			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	Chief People & Purpose Officer						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	Chief People & Purpose Officer		x	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.5.24.27 - CONFIRMED ACADEMY MINUTES

REFERENCES

Only PDFs are attached

- Bo.5.24.27 - Confirmed Finance & Performance Academy minutes - 28 February 2024.pdf
- Bo.5.24.27 - Confirmed Finance & Performance Academy minutes - 27 March 2024.pdf
- Bo.5.24.27 - Confirmed People Academy minutes 28 February 2024.pdf
- Bo.5.24.27 - Confirmed People Academy minutes - 27 March 2024.pdf
- Bo.5.24.27 - Confirmed QPS Academy Minutes - 28 February 2024.pdf
- Bo.5.24.27 - Confirmed QPS Academy Minutes - 27 March 2024.pdf

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	28 February 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) - Chris Danson, Director of Transformation (CD) - Sarah Freeman, Deputy Chief Nurse (SF) - Adele Hartley-Spencer, Director of Nursing – Operations (AHS) - Joanne Hilton, Director of Nursing and Deputy Chief Nurse (JHil) - Matthew Horner, Director of Finance (MH) - Ellie MacIver, Deputy Director of Operations for Cancer and Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations – Unplanned Care (SM) (item FA.2.24.10 only) - Michael Quinlan, Deputy Director of Finance (MQ) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - James Taylor, Deputy Chief Operating Officer (JT) up to 9am - 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)		
Observing	- Sindy Jones and Andrew Hughes (ANHH Consulting)		

No.		**Action**
FA.2.24.1	**Apologies for Absence**	
	The following apologies were noted: - Louise Bryant, Non-Executive Director - Mohammed Hussain, Non-Executive Director - Terri Saunderson, Director of Operations - Neil Scott, Head of Business Intelligence	
FA.2.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.2.24.3	**Unconfirmed Minutes of the Meeting held 31 January 2024**	
	The minutes of the meeting held on the 31 January 2024 were approved as an accurate record.	
FA.2.24.4	**Matters Arising**	
	JL welcomed everyone to the meeting and introduced Sindy Jones and Andrew Hughes of ANHH Consulting who are observing all the Academy meetings taking place today in relation to a piece of work that they are undertaking on Academy structures at the Trust. The Academy reviewed the actions. Updates are noted within the action log	

No.		Action
	and the following actions were closed: - FA24001: **Matters arising:** Revised governance chart for the Waste Reduction Group is currently being finalised and will be provided at a future meeting. Action covered at item FA.2.24.13. Action closed. - FA24002: **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. Workplan updated. Action closed. - FA24003: **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. Added to work plan. Dates to be confirmed depending on core standards submission deadline. Action closed. - FA24004: **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 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. Covered within the report provided at agenda item FA.2.24.10. Action closed. - FA230042: **Service Development – Post Implementation Reviews:** costs and timelines projected to be included in the next report which is due at the May meeting. Action closed.	
	Assurance	
FA.2.24.5	**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. CSm highlighted that at the time the dashboard information was submitted the Trust was forecasting a deficit position at year end. That has now been revised to a break-even position. The subsequent information is included within the Finance Report which will be discussed later in the meeting. SA and MH confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting.	
FA.2.24.6	**Finance & Performance Academy Work Plan**	
	LP confirmed that no further changes had been made to the workplan other than the two noted within matters arising as part of the updates to actions from the previous meeting.	

No.		Action
FA.2.24.7	**High Level Risks Relevant to the Academy**	
	JL reminded colleagues of the Academies responsibility to review, challenge 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. The Academy noted the matters raised by the Executive Team at its meeting on 19 February 2024 in relation to high level risks. JL noted that no new risks have been added to the register and no risks have been closed in relation to performance and finance. However, there are two risks which have changed in score since the last meeting. JL referred to risk 3877 which is in relation to managing ongoing operational pressures due to high demand, Covid backlogs and industrial action and asked whether this can now be closed as it has now reached the target score of 12. SA agreed and said that the target score is actually now lower than 12 and although there is still the potential for industrial action related cancellations the Covid impact is now much less. In addition to this a lot of good work has been undertaken in reducing the backlogs of the long wait patients against the 104 weeks and 78 week expectations. There are some 65+ week patients all of whom are subject to the recommended reviews of the waiting list at the appropriate timescales. It was agreed that the target score would be reduced. The Academy was assured by the update.	Chief Operating Officer & Deputy Chief Executive FA24005
FA.2.24.8	**Board Assurance Framework – Strategic Risks Relevant to the Academy**	
	LP presented the item and explained that the Board Assurance Framework (BAF) records the strategic risks aligned to the Trust's strategic objectives, i.e. the risks which could prevent us from achieving our corporate strategy. LP explained the distinction between the BAF and high level risk register as described in the report. LP advised there have been no key changes since the last report and therefore all of the risk scores remain the same. MH reported that a break-even position is forecast for the current year but it should be noted that this remains very tight. In terms of the next financial year the risk is likely to be at a score of 25 for the financial plan and highly likely to rate red in terms of deliverability and is therefore a huge challenge. MH confirmed that this risk runs on an annual cycle therefore the current risk will be closed at year end and a new one will be opened for 2024/25. The Academy was assured by the update.	
	Learning & Improvement	
FA.2.24.9	**Finance Improvement Plan**	
	This item was covered as part of the Finance section of the agenda later in the meeting.	

No.		Action
FA.2.24.10	**Operational Improvement Plan – Urgent & Emergency Care**	
	SA introduced the item and explained that the presentation provides an update on progress to date, the current performance and the learn and improve element in terms of building resilience and supporting performance to improve going forward. It also builds on the outputs from the delivering operational excellence workshop that was held with the Clinical Service Units (CSUs) in September 2023. The presentation incorporates what is planned for the next 18 months to help the Trust to get into the top decile performance. SA was pleased to report that as a Trust we are already achieving quite a lot of the desired ambitions. SA invited SM to provide an overview of the presentation. - SM talked through the five principles that were set by NHS England (NHSE) in September 2023 to help make improvements in the Emergency Care Standard (ECS). These principles were already in place at the Trust a few months in advance. - The baseline of the ECS standard has demonstrated an improvement for both ECS Type 1 & 3 and ECS All Types from March 2022 to March 2023 and this is largely due to implementation of the co-located Urgent Care Centre (UCC) as well as clinical streaming of primary care minor illness and minor injury patients. - The Ambulatory Emergency Care Unit which runs 24/7 was opened in November 2023 and jointly run by Acute Physicians, ED clinicians, ACPs and a dedicated nursing team. This has resulted on a positive impact on the ECS performance and a sustained improvement. - SM provided an update on the impact that the challenges in the local authority are having on the Trust's admitted pathway. The Trust is working closely with health and social care partners to reduce delays and mitigate the impact of the financial pressures. Traditionally delays in discharges related to social care have been minimal and there has been an efficient social care system with strong admitted patient flow metrics. However, due to financial challenges faced by Bradford Council there has been an impact on adult social care which has resulted in the closure of 71 out of 154 Local Authority beds resulting in a 46% bed reduction. In addition to this, home care provider contracts were also re-tendered in September 2023 which led to delayed discharges for patients on a P1 pathway and this resulted in an increase in the numbers of patients waiting to be discharged on a complex discharge pathway. The average delay from when a patient in an acute bed has no criteria to reside (NCTR) to discharge to either home care package (Pathway 1), a short term rehab bed (Pathway 2) or long term nursing home (Pathway 3) is now 12.8 days compared to 9.8 days before September 2023. Delays at IMC sites are even longer and have increased by 9 days on average. The impact of length of stay has increased by 1.2 days for all medical and care of elderly admissions and this increase is the first one seen in a number of years. SM summarised the impact as detailed within the presentation and reported that not only will the Trust struggle to close the additional winter beds but there will also be a financial cost due to the increased length of stay as well as an impact on urgent and emergency care metrics. - There is a plan to reduce delays and mitigate the financial impact but	

No.		Action
	this is an ambitious plan which requires significant change processes, flexibility of workforce and the risk of further financial pressures. SM talked through the three proposed pathways to support this plan as detailed within the presentation. - SM shared his concern in relation to the financial position of health and social care and its impact on the Trusts performance this year. SA hoped that colleagues now had a good overview of the progress in terms of how improvements have been made and their impact on performance as well as the next steps that need to be taken to manage the challenges and mitigate the risks highlighted by SM. To put the performance of the Trust into context SA reported that the Trust is currently ranked 3rd best in the region and 7th best nationally against delivery of the four-hour Urgent Care Target. This is excellent performance, the Trust has seen this sustained improvement over the last two to three years, it was also important however to note that there are still patients who experience 12-hour breaches whilst awaiting a bed. It is important to continue to review the data closely to help understand what else can be done to improve bed occupancy to ensure good flow of patients through the ED. It is good to celebrate the success of this performance but it should be recognised that there is a lot of work to do going forward to manage the risks in relation to financial pressures and the potential negative impact that may occur on the Trusts performance as well as on the patient experience. KW was pleased to note how well data is being utilised to help understand where the issues are or may occur and how other factors may impact performance. Although it may not be possible to control some of the factors, external ones in particular, it does provide the opportunity to help others learn and improve alongside us for the benefit of patients. KW acknowledged the excellent performance against a very tough landscape and was assured by the level of data / intelligence available to help manage performance as effectively as possible. JL felt proud to listen to the strong urgent care performance and recognised that this was the result of difficult but steady progress over the last two to three years. JL thanked colleagues and the wider team for their ongoing efforts to keep performance strong. The Academy was assured by the update.	
	Finance	
FA.2.24.11	**Monthly Finance Report**	
	MH presented the report and said there was nothing to report by exception other than noting that 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. The Academy was assured by the update.	

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FA.2.24.12	**Capital Programme**	
	MQ presented the item and made the following key points: - The year to date spend at Month 10 is £26m against an annual forecast spend of £57m. Although there is a risk given the amount still to be spent, the teams are confident that the plan will be delivered. However, this is subject to deliverability by contractors and suppliers of medical equipment who have confirmed they will deliver on time but it was important to note that there will be risk to deliverability throughout March. - Steps have been taken to mitigate the risk of slippages and this has included bringing forward scheme from the next financial year into the current financial year. A reserve list for investment has been maintained throughout the year and items have been drawn down and committed to minimise any underspend in 23/24. Steps have been taken to vest for equipment this financial year for items that may not be delivered on time but can be accounted for in the current financial year - The Trust is faced with a big challenge over the next few months and colleagues from procurement, estates and digital teams are working hard to get the capital position over the line. - A three year indicative capital plan has also been included within the slide pack. The indicative allocation from the ICS for 24/25 is £23.5m for operational capital and £17.2m for the external funding scheme which is largely for the completion of the Endoscopy programme. - The main risk to highlight for the next financial year is the slippage of £3.1m. If this increases it will reduce the flexibility in 2024/25. Discussions are currently taking place in relation to the Outstanding Maternity Services scheme and whether that should be deferred into the new financial year. MH added that this is due to the impact of slippage from other schemes and therefore there is a chance that it may need to be deferred. If this needs to happen then further discussions will take place at Board level as consideration needs to be given to what this would mean from the perspective of the CQC. The Academy was assured by the update.	
FA.2.24.13	**Budget Setting Process – Final Budget Plans**	
	MH presented the report and provided some context of the current position. MH highlighted that the new financial year provides one of the biggest challenges he has seen in the last decade. There will be no non-recurrent resources to deploy like there has been in previous years which have helped manage the position. There are a number of changes to the national guidance and although there are a range of overarching assumptions there is yet no definitive guidance. MH believed that the ERF model is going to change at a system level and revert back to a PBR model. If this happened it would provide an opportunity in relation to the day case unit which is due to open at SLH and stretch targets would need to be built into the plan to get the Trust over the threshold and enable us to generate more money.	

No.		Action
	At this stage in the planning process there is £54.6m of financial risk in 2024/25. MH referred to the Headline Plans for 2024/25 which were recently presented to the System Oversight & Assurance Finance Group. The West Yorkshire System is £159m in deficit after efficiency plans of £321m. The Trust has submitted a headline plan to the ICS of a deficit of £29.4m which is after saving £25.3m making the Trust's opening plan £54.6m deficit based on a range of assumptions and the underlying run rate. The Trust has set an efficiency target of 4.4% which is average for acute providers. However, MH was concerned that there may be some pressure to level up to a 5.5% waste reduction target which is £6m to £7m more than the current prediction. Acute providers account for £126m of the overall challenge which is about 80%. At Place level, Bradford is currently an outlier therefore it is expected that there will be a lot of external scrutiny to demonstrate that we are doing all that we can to recover the position. There will need to be a balance in decision making between finance and performance in addressing this challenge. CSm talked through the slides and made the following key points: - There is yet no confirmed date for publication of national guidance. A draft outline plan was submitted through the ICB to NHSE on 20 February which was based on a deficit prior to any waste reduction of £54.6m with a waste reduction target of £25.3m giving a net deficit of £29.3m. - A realistic assessment of inflation has been made to utilities, drugs and non-pay which has had an impact as detailed within slide two. The pay inflation assumption has reduced from 2.7% to 2.1% as per national guidance. - NHS contract income growth has been confirmed at 0.6% which is equivalent to £3m – this was previously planned at 1% which would have been £5m, therefore this is a £2m difference to what was planned. - There is a risk in relation to the depreciation on the Community Diagnostic Centre (CDC) of £1.25m as well as a risk in relation to depreciation on TIF capital schemes of £0.82m. Values are yet to be confirmed in relation to both of these. - There is the possibility of reverting to the PBR arrangement for elective and outpatient work which could be an opportunity for the Trust. - CSm talked through the summary of the draft plan for 2024/25 which details the cost pressures and the benefits and cost reductions compared to 2023/24. In summary the Trust is forecasting a deficit figure of £54m for 2024/25 before a waste reduction target of £25.3m which if achieved leaves a residual deficit plan of £29.3m. - CSm described the table on slide four which identifies £41m of premium variable expenditure. CSm emphasised that the table is not a comprehensive list and does not demonstrate a worked up waste reduction programme but rather it illustrates the art of the possible to help start the process in relation to items that may deliver savings. - Indicative waste reduction plan targets: CSm explained that the internal allocation of formal targets is yet to be finalised and the figures illustrated on slide five are an example. CSUs have been asked to develop plans against a 5% waste reduction plan – 5.6% would equate to £25.3m of all departmental budgets. - CSm explained the revised approach for delivery of the waste reduction	

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	plan for 2024/25. A corporate project management structure will be implemented based on the successful "Outstanding Services" model to oversee the delivery of the waste reduction and financial recovery plan. CSUs will be accountable to the Executive Team for delivery against all of their financial targets. - CSm talked through the next steps from an internal and external perspective as detailed within the slide pack. The formal submission of the draft financial and waste reduction plan to NHSE is expected to be made in March. EM referred to high cost drugs and asked if there was any scope to look at waste reduction within that area. CSm advised that this was something that was undertaken in the past and he was aware that the Director of Pharmacy was reviewing some options in relation to renal prescribing. There is a medicines management workstream within the waste reduction programme which should explore this as part of their area. KW was pleased to note the model that is being proposed for implementation of the plan and emphasised the importance of getting people to think differently about this. The plan needs to be communicated creatively to gain interest and engagement from all levels of the organisation. KW suggested a buddying system between CSUs to provide scrutiny and the opportunity to challenge each other which will provide an independent view from outside of the CSU. Another suggestion KW made was to consider a NED champion aligned to the programme to act as a critical friend with an independent view given the size of the challenge. MH welcomed the suggestions and said these would be built into the proposal to ETM. MH recognised the importance of the wider communication to ensure the whole organisation is involved in the delivery of the plan which would be captured as part of the launch event. JL asked whether it has been determined that the deficit can be managed over two years. MH responded that this has not yet been approved but it was important to be realistic and submit a plausible plan as the delivery of a £55m reduction in one year is not possible. JL asked whether a Board level session needs to take place due to the size of the challenge faced. MH expected that like previous years a session will need to be arranged in due course to ensure the full Board is sighted on the challenge. An informal discussion is taking place this afternoon with NED colleagues to provide an update on the current situation. The Academy noted the update.	
FA.2.24.14	**Operational and Financial Plan Update**	
	The item was discussed at agenda item FA.2.24.13.	
FA.2.24.15	**Internal Audit – Audit Plan**	
	MH provided a verbal update and explained that the process for collating the internal audit plan was underway. Colleagues were asked to flag anything that they felt needed including within the plan to MH.	

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	The Academy noted the update.	
	Performance	
FA.2.24.16	**Operational Highlight Report**	
	SA introduced the item and invited CSt to present the report. CSt highlighted the following key points: - Inpatient Pathway Activity: The outturn for day case activity is in line with the original forecast, which was challenging in terms of plans for the current year. The forecast is that the Trust will deliver behind plan but at the forecast run rate. Medinet activity continues to reduce, with 16% of theatre and surgical activity being insourced compared to 36% in January 2023 which is a positive step. - Outpatient Pathway Activity: Delivery of first outpatient appointment is very good at 108.3%. However follow ups with procedure has not delivered as hoped. A big piece of work is underway for 2024/25 in relation to the recording of outpatient procedures. A reduction in follow-ups in line with the 25% reduction target has not yet been seen but an increase in PIFU is evident. - 18 Week Referral to Treatment: The waiting list remains broadly stable and this has been generally driven by validation work. A series of recovery meetings are taking place to get services back into using the broader metrics in terms of the capacity and demand assessment. - 52 Week Referral to Treatment: Longest waiting patients beyond 65 weeks is forecast at approximately 30 patients at the end of the current financial year. This is due to a pressure principally within trauma and orthopaedics where external support was not utilised as expected. Although this is disappointing it is a positive position in comparison to other Trusts in West Yorkshire. As detailed within the planning guidance the focus is now to clear all greater than 65 week waits by September 2024 rather than at financial year end. The Trust is in a good position to achieve this. It is also expected that the 52 week wait will reduce significantly in comparison to the industrial action adjusted targets. - Waiting List Data Quality: Focus has been given to the Prevent and Correct Model in relation to the RTT pathway. This process has involved errors being corrected and then feedback provided to the different service areas to prevent similar errors occurring in the future. Confidence levels of 99.5% in the waiting list data on the Luna dashboard has been achieved. This model will now be extended to other waiting lists starting with the non-RTT pathway. SA also highlighted this point and emphasised the significance that this improvement has had on the waiting list. - Diagnostics: Although this metric has been a challenge this year, the output of the recovery plans has shown improvements in various areas. There are still areas which are yet to show change and improvement from the recovery plans before year end. It is unlikely that the 85% ambition that was set will be achieved, it is likely to be closer to 80%, however, we there is the ability to go into the new financial year to achieve 85% or higher. The impact of the opening of the new CDC also	

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	provides the opportunity to stretch the ambition further. - Cancer 2 Week Wait: The impact of the Christmas bank holidays as well as the industrial action was seen on the two week wait metric but it should be noted that this was a bigger drop than is usually seen in January. Services have worked hard to support capacity plans and with the exception of a couple of modalities most will recover the position during February which is a big success for this metric. The breast tumour group has seen a significant increase in demand which the team currently responding to with plans to flex capacity to accommodate the surge in demand which is most likely due to a combination of awareness campaigns and national publicity. - Cancer 28 Day Faster Diagnosis: This standard is set at an ambition of 77% for the new financial year. CSt reported that the Trust is currently achieving 81.5%. Regardless of this there are challenges i.e. histopathology which have been discussed previously and improvement and transformation work is underway for this service. CSt had previously reported a slight dip in the data capture for December which has now been resolved and weekly monitoring is in place to ensure the metric is captured accurately. - Cancer 62 Day First Treatment: CSt described that the 62 day standard is underpinned by the 31 day treatment target where there are some pressures within skin and urology cancers. These areas are being reviewed in terms of resilience into next year as referral numbers have returned back to the expected trends. JB referred to the support being offered to another Trust in relation to urology cancer and asked if this is contributing to the pressure. SA explained that support has been offered to another Trust due to the pressures they are under and despite our own challenges we are in a better position than most other Trusts. The request came from NHSE to offer mutual aid support to provide operating capacity on a weekend which has been completed. A further approach has come from NHSE requesting further support during March and SA has responded to advise that the Trust already has cancer patients listed during the March weekends therefore was concerned that we may lose goodwill from surgeons if we remove access to theatres for our own patients. The mutual aid offer will be reviewed again in April. - Sentinel Stroke National Audit Programme (SSNAP): Workforce and bed plans are progressing well and the underpinning improvement work to support further change is moving in the right direction. Challenges are being responded to efficiently to maintain the service and further improvements are expected going forward. KW was pleased to note the improvements made to diagnostics but asked what is being done to raise awareness and to reach people to present earlier. SA explained that a detailed piece of work has been undertaken to get a real understanding of the makeup and profile of patients on the waiting list using the Core20 +5 tool. This can be broken down into three clear areas of access, patient experience and outcomes. This work helped identify that patients from areas of high deprivation also have a predominantly high population of people from ethnic minorities. It does appear that these individuals are waiting longer therefore a process was undertaken to identify why this is the case. The data analysis demonstrates that patients are waiting longer from the earlier step of getting onto the	

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	waiting list rather than once they are on the waiting list. This may be due to the fact that these patients have more DNAs. There are a number of different hypothesis as to why this might be the case. To address this issue initiatives such as DrDr, phone calls to some groups of patients and other technological options have been explored and implemented to make access easier. Another factor is that patients from the more affluent areas seem to be able to access a fast track pathway quicker than patients from lesser affluent areas and it is thought that this can be due to the proportion of GP to patient population or due to the number of underlying conditions people have and their ability to express their symptoms clearly as to how quickly they get referred to hospital. However, it has been identified that once the patient is on the fast track waiting list they progress at the same rate regardless of any factor relating to health inequalities. One of the other key pieces of work that has been undertaken which was approved at Board level is in relation to patients with learning difficulties who can be moved up the waiting list within their priority status which is another initiative that is tackling health inequalities. SA highlighted that these examples are just the start and there is a lot of further work to be done to continue to address this important piece of work. SA provided a brief update in relation to the Day Case Unit which is currently being built at the SLH site. This is an £18.9m development which is expected to be in use from the first quarter of the new financial year. The site will provide resilience in the form of two additional theatres which will be used for high volume, low complexity day cases which is expected to have a positive impact on RTT. The Academy was assured by the update.	
FA.2.24.17	**Performance Report**	
	The performance report was noted.	
FA.2.24.18	**Health Inequalities & Waiting List Analysis**	
	This item was discussed at FA.2.24.16 and SA advised that a presentation will be provided at a future meeting which will articulate the current position and next steps. CSt added that following a statement from NHSE in November in relation to the information requirements with regards to health inequalities there is quite a significant piece of work to be undertaken to understand the ask and this will be included within the report to provide a complete picture which is why the report has been deferred. The Academy was assured by the update.	
FA.2.24.19	**Any Other Business**	
	There were no further items of business to discuss.	
FA.2.24.20	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	

No.		Action
FA.2.24.21	**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 challenge going into the new financial year. - The financial position in relation to intermediate care and the impact on the Trust.	
FA.1.24.22	**Date and Time of the Next Meeting**	
	27 March 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 28 February 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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.
FA24005	28/02/23	**FA.2.24.7**	**High Level Risks Relevant to the Academy:** Target score for risk 3877 to be reduced (in relation to managing ongoing operational pressures due to high demand, Covid backlogs and industrial action).	Chief Operating Officer & Deputy Chief Executive	27/03/24	
FA24006						

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	27 March 2024	**Time:**	08:30-10.45
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director (JL)
Present:	- Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - Louise Bryant, Non-Executive Director (LB) - Chris Danson, Director of Transformation (CD) - Adele Hartley-Spencer, Director of Nursing – Operations (AHS) - Matthew Horner, Director of Finance (MH) - Shaun Milburn, Deputy Director of Operations – Unplanned Care (SM) - 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:	- Katie Shepherd, Corporate Governance Manager (KS) - Jacqui Maurice, Head of Corporate Governance (JM) - Nagina Javaid, Priority Director, Act as One (NJ) for agenda item FA.3.24.9 - Steven Amos, Emergency Planning Manager (SAm) for agenda item FA.3.24.18		
Observing	- David Wilmshurst, Governor		

No.		**Action**
FA.3.24.1	**Apologies for Absence**	
	The following apologies were noted: - John Bolton, Deputy Chief Medical Officer - Sarah Freeman, Deputy Chief Nurse - Mohammed Hussain, Non-Executive Director - Ellie MacIver, Deputy Director of Operations for Cancer and Diagnostics - Laura Parsons, Board Secretary/Associate Director of Corporate Governance - Michael Quinlan, Deputy Director of Finance - James Taylor, Deputy Chief Operating Officer	
FA.3.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.3.24.3	**Unconfirmed Minutes of the Meeting held 28 February 2024**	
	The minutes of the meeting held on the 28 February 2024 were approved as an accurate record.	
FA.3.24.4	**Matters Arising**	
	The Academy reviewed the actions. Updates are noted within the action log and the following actions were closed: - FA24005: **High Level Risks Relevant to the Academy:** Target score for risk 3877 to be reduced (in relation to managing ongoing operational pressures due to high demand, Covid backlogs and industrial action).	

No.		Action
	This has been completed. Action closed. JL referred to the slide pack which has been included in the meeting papers in relation to the CSU to Academy Engagement Event which took place on 8 March 2024. KW provided feedback on the event which she felt was very well delivered. Assurance was taken from the presentations provided and the Academy also noted that the teams presenting were very passionate about their areas.	
	Assurance	
FA.3.24.5	**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 MH confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting. CSt highlighted that a refresh of the dashboard is underway to ensure metrics are reflective of the ask from the annual planning. SA added that Paul Rice, Chief Digital Information Officer has committed to looking at the overall dashboard and there will likely be a revised dashboard going forward. The revised version will be subject to sign off by Academies and the Board.	
FA.3.24.6	**Finance & Performance Academy Work Plan**	
	JM confirmed that no changes had been made to the workplan since it was previously presented to the Academy.	
FA.3.24.7	**High Level Risks Relevant to the Academy**	
	JL reminded colleagues of the Academies responsibility to review, challenge 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. The Academy noted the matters raised by the Executive Team at its meeting on 18 March 2024 in relation to high level risks. JL noted that no new risks have been added to the register, no risks have been closed in relation to performance and finance and there are no risks that have changed in score since the last report. The Academy was assured by the update.	
FA.3.24.8	**Draft Internal Audit Plan 2024/24**	

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	MH presented the item and explained that the plan incorporates comments following a discussion at the Executive Team Meeting on the overall plan. The Academy noted that the only potential change was the inclusion of an audit on Equality, Diversity and Inclusion (EDI). This is the final plan for 2024-25 subject to sign off at Academy meetings today and approval by the Audit Committee in April. The Academy noted the plan.	
	Learning & Improvement	
FA.3.24.9	**Act as One Programme Update – Deep Dive on Children's Services**	
	JL welcomed Nagina Javaid (NJ), Priority Director (Act as One Programme) to provide an update on the Healthy Children and Families Programme. NJ talked through the presentation and made the following key points: - Under 18s make up 26.3% of the population in Bradford compared to an England average of 21.3%. - In 2021/22 32.4% of children had visible dental decay in Bradford compared to 23.7% nationally. - Over 18,000 children and young people are classified as SEND in Bradford and boys account for 65% of this group. - In 2021/22 40% of children in Bradford were classed as overweight or obese at Year 6. - 35.6% of children and young people in Bradford live in relative low-income families compared to only 19.9% across England. - There were 106 in 10,000 hospital admissions caused by unintentional /deliberate injury compared to the England average of 84. - Issues of self-harm are becoming more common in primary school children aged 12 and 13 years. - A recent survey of 10,000 children and young people in the Bradford district shows that mental health, cost of living and discrimination (mainly racism) are their biggest concerns. - Statistics from within Bradford demonstrate different outcomes depending on which part of Bradford someone lives. - NJ provided an overview in terms of the highlights of the Healthy Children and Families programme which has made significant progress since 2023. Some of the achievements have included: o £1m funding secured for early language support for every child. o Ten sites identified and now working across partners to deliver intensive support around speech, language and communication. o Set up of the dynamic support register which identifies children that are at risk and/or have got a learning disability or autism. o £30k secured for a pilot for some work that was recognised as good practice by West Yorkshire ICB and links to complex support needs for high-cost children and what can be done to support them. o 20 volunteers recruited to the volunteer to career pathway. - NJ emphasised that collectively it was important to find better solutions to support children and young people in order to create better outcomes	

No.		Action
	as well as cost savings. - NJ summarised the current position and advised that the Programme Board met recently to think about what the areas to focus on going forward as detailed within the slide pack. KW asked about staff resource and whether there were any recruitment challenges and if so, what can be done to address them. NJ reported that recruitment and workforce is a huge issue particularly as the number of children in care has increased from 700 during 2017 to 1500 currently in 2024. This is a phenomenal increase in demand, yet the workforce has not reflected this. Workforce and retention is a challenge across education and social care and there is a huge turnover of staff. Work is underway to try and address the challenge and one example is that of the volunteer to career route which has been successful in securing volunteers who have the potential to make a career within the sector. Out of the 20 volunteers that were selected from 76 applications 16 of them were from an ethnic minority background with some from areas of high deprivation therefore reflective of the demographics of the community they will support. LB asked if an analysis has been undertaken in terms of ethnicity and poverty as it was important to understand that poverty is the bigger factor in health inequalities. NJ explained that this is work in progress and as there are certain factors that affect some ethnicities more than others such as diabetes it is important to have data to analysis this. It has therefore been agreed that the Centre for Education and Applied Research will allocate a scientific advisor to work with the various areas of the programme to gather data for analysis. LB recognised that there are many compounding factors that lead to health inequalities that are outside the control of the Trust but asked whether there are any interventions within the Trust that can make a difference in relation to health and inequality and improving outcomes. NJ felt that it was important to start with the basics such as offering staff the opportunity to undertake training packages that are on offer e.g. understanding of genetics and how it affects babies. Trusts are under real pressure due to limited capacity and being able to release staff to go on training sessions but educating staff giving them will make a difference to staff understanding. SA agreed that poverty plays a larger role in health inequalities and what is evident is that there is a higher concentration of ethnic minorities within the most deprived areas, and it is the deprivation that drives the health inequalities. In terms of young people accessing services there is a big focus on DNAs (did not attend) and work is underway to review why there is a disproportionately higher level of DNAs from the more deprived communities as this may also be a factor contributing to health inequalities which needs to be addressed. NJ referred to health hubs in school which are being developed to address some of the main issues faced by the community and suggested that she will help create a link between the hub and the Trust to explore options that will support access for children and young people. NJ agreed to share the details with SA and CSt.	FA24006 NJ

No.		Action
	CSt reported that although there is assurance that once a patient is on a waiting list, they are treated in priority order and therefore are no systemic issues however it is important to understand what is contributing to the delay in accessing care in the first place and understand what else may be contributing to the inequity of outcomes for people in Bradford. This is therefore also an aspect that is being explored. The Academy was assured by the update.	
FA.3.24.10	**Finance Improvement Plan**	
	This item was covered as part of the Finance section of the agenda later in the meeting.	
FA.3.24.11	**Operational Improvement Plan – RTT**	
	SA introduced the item and explained that the presentation provides an update on the operational improvement plan in relation to Referral to Treatment (RTT). SA invited RW to provide an overview of the presentation. RW talked through the presentation circulated to colleagues and noted that the internal target for RTT was to remain in the top quartile nationally across each KPI by the end of March 2024. Following the launch of 'Delivering Operational Excellence', there were several aspirational areas of focus detailed in the presentation. The Further, Faster project would oversee improvements to outpatients with a full programme board structure, including the SLH day case unit which would focus on high volume, low complexity procedures. It's hoped that the project will reduce short notice cancellations, improve further theatre efficiencies and access to care and more generally reduce patient wait times. The presentation also included some of the transformational projects in further detail such as the implementation of Digital PIFU and SeeMeSooner which allowed patient more control over their appointments. The Ops team had also worked closely with services over the last 12 months to prioritise patients with the LD flag, with the number of patients waiting over 18 weeks down to 11 from 73. In terms of proactive performance, RW highlighted that there was a lot of areas covered by the Further Faster project. In addition, Cerner would shortly go live this year replacing Galaxy to further improve theatre session management. The Prevent, Correct, Clear model to ensure improvement in data quality and error prevention is also now live and data quality specialists were now located in high volume CSUs to work directly with service staff to improve data quality. There was now 72 hour calling across all services to confirm attendance for operations and the aim now was to get to a position where backfill opportunities could be introduced to theatre if necessary. RW also highlighted a number of digital improvements for proactive	

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	performance including the roll out of patient-driven functionality tools and the upcoming move to Bookwise which would improve efficiency of outpatient clinics and identify opportunities for delivery of extra clinics in unused space. In relation to business as usual, the focus remained on reduction of long waits and weekly huddles continue with services to ensure patients are treated in chronological order. The structure of Access meetings has evolved to more service-led and allows for them to identify where improvements are potentially possible. RW also noted that chronological booking has now been handed over to CPBS who regularly review booked outpatient appointments to make sure the longest waits are seen soonest. Non-RTT monitoring at all levels has also been reinstated, and work is ongoing within clinical prioritisation to ensure all patients are clinically safe. RW ended the presentation by updating on the Trust's performance against long waits: - There was 0 104+ wait patients - There was 1 78+ wait patient - There was 72 65+ wait patients It was expected that in a worst-case scenario there would be 32 65+ week wait patients at the end of March 2024, and these were within the trauma and orthopaedic service. The team continued to explore options for treating patients sooner. She highlighted that the target by the end of March 2025 would to be to reduce the overall number of 52 week waits. SA recognised that the Trust was performing well in comparison with other organisations in the region, particularly given the size and scale of BTHFT in relation to other Trusts. He advised that the internal target would be to reach zero 65 week waits by the end of August 2024, which would be a challenge particularly in trauma and orthopaedics as already highlighted. LB welcomed the improved performance but queried the drivers for this and whether this would confidently be maintained. SA recognised the good performance was due to a collection of actions, but a large impact was a result of targeting those specialities who have known long wait and capacity issues. There would be a need to maintain focus on this to continually improve performance including understanding the GIRFT opportunities that may help to increase efficiencies. JL reflected on the industrial action which would impede on staff morale and RW advised that the ops team have a good relationship with colleagues within CSUs and so regular communication and working with them helped to maintain morale even during times of increased pressure. KW noted that it would be helpful to measure the impact of prevention work on outcomes, recognising that this may be challenging to quantify. SA would work with Helen Farmer and Ray Smith to connect UEC, diagnostic, cancer and RTT and devise a way to demonstrate measurable performance against outcomes.	FA24007 Chief Operating Officer

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	The Academy was assured by the update.	
	Finance	
FA.3.24.12	**Monthly Finance Report**	
	MH presented the report and highlighted the following: - The Trust has formally forecast a year end breakeven position for the financial year to NHSE, which is in line with the plan. - However, this position is delivered entirely using non-recurrent measures and the impact this would have on the 2024/25 plan have already been noted by the Academy. - Subsequent to external reporting, the Trust has been notified by the ICB that two substantial tranches of non-recurrent surplus funding are to be distributed across all West Yorkshire ICS providers. These sums relate to: - Additional funding provided by NHSE to offset the adverse impacts of the Industrial Action on providers' ability to deliver waste reduction plans and Elective Recovery. BTHFT's share of this funding stream is £2.3m. - Distribution of surplus funds held by the ICB non-recurrently in 2023/24. The ICB's plan for 2023/24 was a surplus of £25m, which was necessary to offset deficit plans in some providers to ensure the ICS in aggregate submitted a balanced plan. The ICB has pragmatically decided to distribute this cash to providers to support their cash positions in the next financial year. BTHFT's share of this funding is £2.1m. - Both allocations have been made non-recurrently on the basis that year end forecasts improve by a commensurate amount. BTHFT's revised forecast position for 2023/24 is therefore a surplus of £4.4m. This does not improve the outlook for 2024/25. JL noted that the revised forecast surplus position did not support the reality of the challenging financial situation the Trust is in. MH echoed this and advised of requests made by other local Trusts to reallocate the surplus to them to offset their deficit, but this had not been supported given the real risks of cash shortage in 2024/25, and the resultant scrutiny this may bring. LB also queried internal communication about the financial challenges and MH recognised the perception that staff hold that failing organisations are bailed out despite this not being the case. The messaging would continue to be open and transparent to try to manage this and the reality that the Trust would inevitably forecast a deficit position by the end of month one 2024/25. The Academy was assured by the update.	
FA.3.24.13	**Procurement Update**	
	MH presented the item and made the following key points: - The market has been very challenging particularly in terms of	

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	increasing prices but despite this a number of savings and cost avoidance opportunities have been achieved. - A WYAAT Central Catalogue Management Team has been established which will allow the WYAAT Trusts to operate in a more aligned and collaborative manner on the purchase of a wide range of consumables. - We have now completed the roll out of the new Inventory Management System in Radiology, Central Stores and Nuclear Theatres; we are currently working on the roll out for Modular Theatres. - The national landscape continues to change, and it is expected that the Procurement Act will be published this year. There is lots of work nationally around how the procurement environment should evolve. - Work remains ongoing across the ICS around the collaboration model and that is now coming to a point of decision on the procurement model for West Yorkshire and how this should look. - The contract management team continues to work on developing relationships with suppliers, extracting benefit and protecting the Trust. - The investment in the team has meant that we are on course to deliver record breaking savings this year – we have gone from a historical average of less than £1m pa to well over £2m. - There were two risks on the risk register for the procurement department relating to warehousing and lack of storage space., both rated at a 12. The chances of securing capital to rectify this over the next two years is limited so other risk mitigations will need to be maintained and explored. The Academy was assured by the update.	
FA.3.24.14	**Operational and Financial Plan Update**	
	CSm presented the item and made the following key points in relation to the financial plan: - Previous iterations of the draft plan detailed a £54.6m deficit before WRP, this has since increased to £58.6m. Therefore, the waste reduction target has increased to £32.3m which is in line with the ICB stretch target for providers. This is however a cosmetic change as previously £4m of the full year effective savings delivered in 2023/24 were excluded. It results in a net deficit of £26.m - The WRPs currently in place are not sufficiently developed, CSUs had been asked for updated plans. There are very few new ideas being developed which places greater reliance on the new governance structure and workstreams proposed to deliver the WRP targets. - In relation to impact on cash position, if the plan is delivered there will be £5m cash in the bank at the end of the financial year which is below what is felt to be a comfortable level. - The Trust has received significant challenge from the ICB finance director on the draft plan and the indication is a £26m deficit plan is unlikely to be accepted by NHS England and the organisation will likely be asked to improve on that. - Following discussion with operational and performance teams it was not felt that the Trust could increase activity volumes beyond the existing stretch plans but there could be opportunity regarding the depth of coding of activity which is a WRP workstream.	

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	- The plan suggests a larger deficit in months one to four with the expectation that waste reduction programmes will begin to deliver from month five and steadily increase. - NHS England has suggested that the inflation expenditure plan could be reduced by nearly £1m and the ICB is not being defunded for this. The debate is ongoing with providers and the ICB as to whether to reduce expenditure plans accordingly. - The plan needs to be submitted to NHS England on 2nd May, but Board approval was needed prior to this. There was an agreement for a dedicated board planning session to be scheduled in April which will seek approval from the Board for submission of the plan. - The local place continued to look for solutions to close the gap through shared joint actions. - The internal budget setting process needed to be finalised and this was due to go to ETM on 15th April and then shared with the Academy at the 24th April meeting. - The WRP governance structure has now been developed with executive sponsors identified for each CSU and leads for each workstream. This would be led by the Director of Strategy who was due to start in post from 15th April. JL requested that consideration be made as to how best to keep the Academy updated on the work of the WRP programme Board and bring a proposal back to the next Academy meeting. JL also would welcome insight into a proposed draft plan for 2025/26 and what this would potentially look like. MH advised colleagues were working up a longer-term plan which would address the new pressures that we are likely to see in 2025/26 given that 2024/25 is primarily focused on rectifying the underlying existing issues. CSm also noted that CSUs were working on two-year waste reduction programmes as were the workstreams. JL also reflected that the Board would need to be clearly sighted on the significant challenges faced by the organisation and understand the mitigations and actions that might need to be taken to address these. KW queried if there was a way to quantify the cost impact of efficiency savings to encourage the CSU to understand the value of simple improvements. MH advised that the finance team are already considering how best this can be communicated to CSUs. SM referred to other organisations within the Place and how best to assure ourselves that they were also seriously working on their financial challenges. MH advised that consistency checking is being undertaken at ICS level by way of the peer-to-peer reviews, and that local providers were putting in place stricter measures than BTHFT, e.g. vacancy freezes, so there are processes in place at place and ICS level to ensure a consistent approach. The Academy noted the update.	FA24008 Director of Finance
	Performance	
FA.3.24.15	**Operational Highlight Report**	

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	SA introduced the item and invited CSt to present the report. CSt highlighted the following key points: - The waiting list improvement work was now being extended to include a focus on EPR optimisation as part of the data quality work. - Diagnostic performance had greatly improved which demonstrated the impact of improvement plans and the impact of additional capacity through the Community Diagnostic Centre. - There have been improvements across all cancer metrics but recognised that there is still work to be done to reach target performance. Beginning to identify more clinical lead improvements. - There has been significant growth in demand (around 15-20%) and the benchmarking position remains strong. 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. - In relation to UEC, the Trust still benchmarks well across the region. A review of the ambulance assessment area (AAA) is underway to ensure it remains fit for purpose with sufficient nurse oversight to maximise patient safety and quality of care and work remains ongoing with HALO. - ECS standard remains strong with a notable improved year on year performance despite the 14% increase in attendance and higher acuity. However, IMC capacity and out of hospital placements remains a challenge for discharge and flow. - A significant amount of work in relation to stroke remains ongoing and there has been some slight improvement already as a result of measures in place. The Academy was assured by the update.	
FA.3.24.16	**Performance Report**	
	The performance report was noted.	
FA.3.24.17	**Health Inequalities & Waiting List Analysis**	
	SA introduced the item and invited CSt to present the report which updated on the work being undertaken to address health inequalities from an Access lens. CSt highlighted the following key points: - For context, national guidance for 2022/23 focused on improving the use of data to help us better understand health inequalities. The guidance from 2023/24 shifts focus to coordinated access to improve access, outcomes and experience. In November 2023, NHSE released a statement on Health Inequalities setting out the data gathering and reporting requirements for NHS Bodies. The Trust will be compliant regarding this. - The master patient index now includes indices of multiple deprivation (IMD), ethnicity, age, sex and LD data. The CORE20 cohort has been identified from national data. Outputs from analysis has been shared with internal groups and partners across the place footprint but needs streamlining. - In terms of ongoing learning, approaches to analysis are discussed with	

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	partner organisations including the BIHR and the Trust ensures regular attendance at national sessions on reducing health inequalities and inclusive recovery. - In relation to the waiting list, approximately 50% of patients are from CORE20, and they are more likely to be routine priority (55%) and less likely be fast track (40%). They now wait slightly less time than non-CORE20 for first outpatient appointment having previously waiting longer. Routine activity has increased with growth exclusively in CORE20 and the routine waiting list for CORE20 has reduced as a result. These changes may relate to post-Covid recovery of routine services taking longer than urgent and cancer service. - Patients remain twice as likely to DNA if they are from a CORE20 background despite improvement in some specific areas. There is a strong correlation between DNA rate and age (younger population more likely to DNA), and this is repeated for all specialities looked at. Therefore, focused action to reduce DNA rates for younger patients in lower IMD areas would have the best impact. The findings have been shared with Act as One access programme and operational colleagues within BTHFT to inform actions to improve attendance. This also demonstrates the need to do a lessons learned exercise on initiatives that did not result in anticipated improvement. - Analysis by treatment priority shows no evidence of variance in clinical prioritisation of surgical waiting lists for CORE20 patients and treatment dates are given fairly within priority grouping. The performance team replicated a report by Nuffield completed in November 2022 which observed lower drop-off rates for BAME patients compared to white patients which is opposite to national trends. - Skin cancer referrals are significantly less likely to be CORE20 (only 20%) with similar diagnosis and treatment per referral rates. During summer 2023 referrals increased for skin cancer which resulted in a 13% increase in diagnosed cancer and a 26% increase in diagnosed cancer for the CORE20 cohort. With skin cancer excluded, fast track demand is 47% CORE20 (much closer to the 50% overall waiting list distribution). Breast cancer referrals are increasing following national awareness campaigns. - There are a number of areas for further improvement including: o working with Act as One and BIHR colleagues to discuss next steps in analysis and how to use the findings o linking findings to patient experience data and feedback to services to identify any variance in actual experience of service users o Elective recovery, operational improvement plans, and implementation of policy are being considered with the positive impact they should aim to have on this agenda in mind o Increasing referrals and improving OPA attendance (reducing DNA) require targeted work to support priority cohorts, this is being built into our operational excellence plans SA reflected that there is such an increased level of understanding of health inequalities and the waiting list, so there would now be a need to include an update in the action plan, outcomes impact and results in the next update to the Academy.	FA24009 Associate Director of Performance

No.		Action
	KW noted that it would be compelling to view the data and trends visually. In relation to the increased rates of DNA in younger population she suggested that this could be due to not wanting to take time off work or being fearful of any possible clinical findings. CSt agreed there is more work to be done externally around this and discussions remained ongoing across the Place as to how best to encourage people to come forward for their appointments. JL recognised the hard work being put into the waiting list analysis, but she queried the level of assurance that we are doing all we can in this space. SA reflected that this is somewhat of a 'we don't know what we don't know' process and so we can demonstrate improvement on the analysis outcome, but we will always be able to go further as/when more analysis is available. The Academy was assured by the update.	
FA.3.24.18	**Emergency Preparedness Resilience and Response (EPRR) Update**	
	SA introduced the item and invited Steven Amos to present the paper which had been developed in response to the new way to evidence the compliance against core standards. SA reminded colleagues that BTHFT performance was in line with other regional trusts, and it was hoped that following the Academy's approval of the enclosed documents, the compliance performance rating could increase to 50%. SAm highlighted the following key points: - The 2023/24 work plan has largely been completed although there are some elements that will roll forward to 2024/25 due to the impact of industrial action slowing progress. - The largest stalling block is with the ICS and NHSE. The idea was to have a repository for the whole region, but this has never really happened and so the sharing of best practice has impended progress. - The Trusts evacuation plan has been updated following a comprehensive review and it is asked that the Academy approve the plan following approval at ETM on 11/03/24. To note this will allow 1 core standard to go to fully compliant. The Academy confirmed approval of the evacuation plan. - The Trusts EPRR policy has been updated to reflect NHSE guidance from the core standards and from the annual policy on policies review which reviewed this policy, and it is asked that the Academy approve the plan following approval at ETM on 18/03/24. - to note this will allow 4 core standards to go to fully compliant. The Academy confirmed approval of the plan. The Academy approved the requested documents and confirmed assurance of the EPRR work that is ongoing.	
FA.3.24.19	**Any Other Business**	
	There were no further items of business to discuss.	

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FA.3.24.20	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.3.24.21	**Matters to Escalate to Board**	
	JL advised that any relevant matters would be escalated to Board via the formal Finance & Performance Academy Chair report:	
FA.1.24.22	**Date and Time of the Next Meeting**	
	24 April 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 27 March 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	24/04/24	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 April 2024. Verbal update to be provided at the meeting.
FA24006	27/03/24	**FA.3.24.9**	**Act as One Programme Update – Deep Dive on Children's Services:** NJ referred to health hubs in schools suggested that she will help create a link between the hub and the Trust to explore options that will support access for children and young people. NJ agreed to share the details with SA and CS.	NJ (Chief Operating Officer / Associate Director of Performance)	24/04/24	Action complete: NJ has shared details via email on 3/4/24.
FA24007	27/03/24	**FA.3.24.11**	**Operational Improvement Plan – RTT:** KW noted that it would be helpful	Chief Operating Officer	24/04/24	

			to measure the impact of prevention work on outcomes, recognising that this may be challenging to quantify. SA would work with Helen Farmer and Ray Smith to connect UEC, diagnostic, cancer and RTT and devise a way to demonstrate measurable performance against outcomes.			
FA24008	27/03/24	**FA.3.24.11**	**Operational and Financial Plan Update:** JL requested that consideration be made as to how best to keep the Academy updated on the work of the WRP programme Board and bring a proposal back to the next Academy meeting. JL also would welcome insight into a proposed draft plan for 2025/26 and what this would potentially look like. JL also reflected that the Board would need to be clearly sighted on the significant challenges faced by the organisation and understand the mitigations and actions that might need to be taken to address these.	Director of Finance	24/04/24	Agenda item on April F&P Meeting & Dedicated Board Development Session on 18.4.24 Action Closed.
FA24009	27/03/24	**FA.3.24.17**	**Health Inequalities & Waiting List Analysis:** SA reflected that there is an increased level of understanding of health inequalities and the waiting list, so there would now be a need to include an update in the action plan, outcomes impact and results in the next update to the Academy.	Associate Director of Performance	24/07/24	

FA24010						

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 28 February 2024	**Time:**	11:00-13:00
Venue:	MS Teams meeting	**Chair:**	Karen Walker, Non-Executive Director
Present:	- Karen Walker, Non-Executive Director (KW) - Louise Bryant, Non-Executive Director (LB) - Faeem Lal, Interim Director of HR (FL) - Ray Smith, Chief Medical Officer (RS) - John Bolton, Deputy Chief Medical Officer (JB) - Karen Dawber, Chief Nurse (KD) - Joanne Hilton, Deputy Chief Nurse - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) - 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 (Operations) (AHS) - Amanda Grice, Manager Workplace Health and Well-being Centre (AG) - Amandeep Singh, Partnership Lead (AS) - Georgi Dyson, Assistant Director of HR (GD) - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) - Laura Gornall, Education Manager, Professional Education (LG) - Rachel Pyrah, General Manager to CDIO Office (RP) - Sonia Sarah, Co-chair of the Enable Staff Equality Network (SS)		
In Attendance:	- Sean Willis, Associate Chief Nurse (SW) - Katie Shepherd, Corporate Governance Manager (KS) - LeeAnne Elliott, -Consultant Paediatric Radiologist/Patient Safety Specialist\Deputy FTSU guardian, for agenda item PA.2.24.10 only - Ruth Haigh, Equality, Diversity and Inclusion Manager for agenda item PA.2.24.13 only -		
Observers	- Andrew Hughes, - Sindy Jones, ANHH Consulting (SJ) - Michelle Mahoney, HR Business Partner (MM)		

Agenda Ref	Agenda Item	Actions
PA.2.24.1	**Apologies for Absence**	
	- Altaf Sadique, Non-Executive Director - Sughra Nazir, Non-Executive Director - Catherine Shutt, Head of Organisational Development Absent: - James Taylor, Deputy Chief Operating Officer - Amy Ilsley, Clinical Lead for Medical Workforce - Susan Parker, Co-chair of the Enable Staff Equality Network - David Smith, Director of Pharmacy - Samia Hussain, Associate Director of HR	

	- Abbie Wild, Chair of Staff LGBT Network (AW) - David Robinson, Consultant in emergency Medicine/Director of Education	
PA.2.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.2.24.3	**Draft minutes of the meeting held on 31 January 2024**	
	The minutes of the meeting held on 31 January 2024 were approved as an accurate record. The actions marked as closed were confirmed as such by the Academy. The following action was discussed. • P24001 Staff Story – Outstanding Theatre Services - AHS would take responsibility for obtaining a copy of the review.	
PA.2.24.4	**Matters arising**	
	There were no matters arising from the minutes that were not already on the agenda.	
	Assurance	
PA.2.24.5	**People Academy Dashboard**	
	FL referred to the Dashboard and highlighted the following key points: • Non-medical appraisal rate for January 2024 has decreased from 79.07% in December to 78.25 and so concerted effort was needed to push for an increase in this. • Mandatory training has seen an increase in 1% from the previous month. • Turnover has seen a decrease by 0.25% to 9.48% in January 2024 from 9.73% in December 2023 and it is believed that the Trust is the top performer across the place on this metric. • The number of staff who are under an apprenticeship programme has increased to 374. • Staff sickness absence has reduced to 5.77% compared to 5.78% in December. The Academy was alerted to the fact that it was unlikely to reach the 5.5% target by end-March, and there would need to be a discussion around what an achievable and realistic target would be for 2024/25. KW commented on the achievement in turnover reduction, which was to be celebrated. She recognised that the sickness absence rate was not surprising given winter illnesses. It was agreed that the Board should be alerted to the decrease in the non-medical appraisal rate and KW would include this in her Academy Chairs report to the Board. She would also include the positive progress made on turnover rates. **Action**: KW to include the decrease in the non-medical appraisal rate and the positive progress made on turnover rates, in her Academy Chairs report to the Board.	(PA24009) Chair

	KD queried whether the current approach to managing sickness absence was fit for purpose or whether a new one was needed given that sickness absence remains one of the biggest issues for nursing staffing. FL confirmed that work was ongoing to review the sickness absence policy and the Bradford factor score to see if it is still appropriate. RH suggested that the staff networks should also be contributors to this policy review, and FL would discuss this with Samia Hussain to ensure that they are included. SS confirmed she would be keen to engage in this as Co-Chair of the Enable network. **Action:** FL to discuss with Samia Hussain the need for staff networks to be involved in the updated sickness policy review. AHS would welcome the opportunity for more focus on specific areas with a higher rate of sickness absence, particularly in some individual cases, to see how managers and staff can be supported to encourage a return to work. FL recognised there is an educational piece required to equip managers with the means to support staff during sickness absence, and the knowledge of how to implement the sickness policy. AS referred to a management skills audit being undertaken by Bradford District Care Trust which would be beneficial if replicated by the Trust, and this would be brought for discussion at the next JNCC. The academy noted the update.	(PA240010) Interim Director of HR
PA.2.24.6	**High level operational risk**	
	FL introduced the high-level operational risk paper. He highlighted that there was one new risk added which is also past its target mitigation date (risk 3309 – in relation to delays in receiving histopathology results). This was a new addition due to escalating in risk score, with a current target mitigation date of December 2022. This was being closely monitored by the Quality and Patient Safety Academy as the lead Academy for the risk. There were two risks which have decreased in score from 16 to 12 (risk 3877 relating to management of operational pressures, and risk 3896 in relation to gynaecology histopathology being delayed). JHi referred to risk 3732 in relation to staffing, which had reduced in score from 20 to 16. This was not included in the report due to having recently being amended and this update was noted by the Academy. The Academy confirmed their assurance that all relevant key risks have been identified, reported to the Academy and are being managed appropriately.	
PA.2.24.7	**Board Assurance Framework – strategic risks relevant to the Academy**	
	LP introduced the Board Assurance Framework update noting that in relation to the People Academy there was one relevant strategic objective, which is to be one of the best NHS Employers. There are	

	currently three risks within that objective relating to recruiting to vacancies, maintaining a healthy and engaged workforce, and recruiting a workforce that's representative of the population that we serve, which are scored as 12, 9, and 9, respectively. There have been no material changes since the last report and the overall assurance level is amber. The Academy was assured by the update.	
PA.2.24.8	**Nursing and Midwifery staffing data publication report**	
	SW introduced the paper which sought to report on the nursing and midwifery staffing data for January 2024, identifying planned vs actual staffing levels and any mitigation taken to maintain patient safety. He made the following key highlights: • There has been an improved position on fill rate across the wards and departments over the last three months all of which are above 80%. • On the 17th January 2024, the organisation moved from the Datix system to IRIS, therefore the safety data for falls needs to be validated. This would be included within the next report to the Academy. • The number of patients identified with pressure ulcers was 46, which remains within the control limits. • Bank rates for all wards and departments are now at Standard Rates. The vacancy position continues to improve and we are on target to reach under 10% by end March 2024 with a further target of under 4% for healthcare assistant vacancy by July 2024. • To support retention and recruitment, work is ongoing to promote recognition events for staff and engagement events with 2nd and 3rd year student nurses including a focus upon the onboarding process for the newly qualified nurses for 2024. The Academy was assured by the report.	
PA.2.24.9	**Nursing and Midwifery recruitment and retention plan**	
	SW gave an overview of the paper which provided an update on the recruitment and retention plans within nursing and midwifery and summarised the work of the Recruitment, Retention and Recognition (RRR) shared governance council. He made reference to the following key points: • The vacancy position has improved due to the arrival of 150 internationally educated nurses, and a reduction in the staff turnover rate which is now below 10%. • Agency usage has also reduced and the ambition is to reduce both agency and bank use further. • The number of leavers has reduced in all areas (nurses, midwives, healthcare assistants), but there is ongoing recruitment drives to fill these posts. • Data shows that midwife retention is high, and this year, there is the opportunity for 5 registered nurses to receive a salary whilst undertaking the shortened Midwifery Programme with the	

	University of Bradford. • There is a risk in that there is no further funding allocated to overseas recruitment from NHS England beyond March 2024 and there has been no indication if future funding will be available. • Since the launch of the Daisy Award in June 2023, several hundred staff have been nominated and an award has been given each month. • Work is underway to assess the requirements for the NHS Long-term workforce plan and the impact this has on training places. • In 2024 we will be launching the Safe Learner Environment Charter, an initiative supported by NHS England, which sets out what a good clinical placement looks like and how it can be achieved. • Work started in November 2023 with BDCT, University of Bradford and BTHFT to support the appointment of Dual Registered nurses (Mental Health and Childrens/Adult) from the Universities 4-year Programme. The aim is to develop pathways and roles to allow new registrants to undertake their preceptorship programme in both areas and work in dual roles across the two organisations. JHi referred to the financial pressures experienced by the organisation and the ongoing discussions taking place about which areas are the most beneficial to invest in. RS queried what work was ongoing to support specifically challenged areas, such as ICU. SW recognised that turnaround times for recruitment in speciality areas was longer than average, and the challenge in attracting experienced candidates into these such departments. He offered to make contact with the ICU team post-meeting to discuss whether there were any specific support requirements they had. It was agreed that AHS would undertake a deep dive exercise into the workforce profile of ICU and what different approaches could be made to recruiting into this area, and bring this back to the Academy in two month's time. SW also suggested that a recruitment target be set for this area which would be a measurement tool for progress. **Action**: AHS would undertake a deep dive exercise into the workforce profile of ICU and what different approaches could be made to recruiting into this area and bring this back to the Academy in two months' time. AS queried whether the pay was appropriate for ICU nurses, and FL confirmed that they work to a national pay scale and so were in line with other organisations. This would suggest a failing in retaining and supporting staff which would need to be addressed. There was also the question of whether the staffing model and skill mix was still appropriate. AS suggested it would be helpful to see appraisal comments to identify if there was the perception of a higher responsibility of nursing in the ICU. AHS advised that there has been recruitment into positions within	(PA24011) Director of Nursing (Operations)

	the ICU, but there was a lack of experience due to leavers post-covid and this was proving a challenge. The Academy was assured by the update.	
PA.2.24.10	**FTSU Quarterly Report**	
	LEA joined the Academy to provide an overview of the Quarter 3 FTSU Report and made the following key highlights: • 31 concerns had been raised in this quarter which is the highest number since the implementation of FTSU. October is FTSU month and a lot of promotion is given to this through means such as various stands on the concourse, and linking in with other initiatives including Black History Month and the patient safety work. In October 2023, the Lucy Letby investigation findings made national press which may also be a factor. • The most common theme of concerns was in relation to inappropriate attitude and behaviours, followed by worker safety or wellbeing. • 12 anonymous complaints had been received, and this has been benchmarked across other Trusts. 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. • The FTSU Policy had been reviewed and updated in January 2024, and this was now published and available through the intranet. • The team continues to promote the Health Education England e-learning module and the three modules in relation to FTSU (Speak Up, Listen Up, Follow Up). • Promotion of the FTSU process had ramped up over the last six months including speaking to new starters during the induction period. • 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. • 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. The two student midwives who were ambassadors have now moved posts and so discussion was ongoing as to how we continue to involve and engage students in the FTSU process. • The number of concerns raised in quarter 4 has already exceeded those in quarter 3, and there is recognition that more ambassadors and champions are likely needed, and more protected time for a single Guardian to work on individual cases.	

	FL queried whether the increased number of concerns raised had also been seen at other Trust's, and LEA confirmed that quarter 3 data for other organisations has not been published so there is no way to benchmark. Anecdotal evidence from discussion with other guardians was that they were also seeing an increase, but there is no clarity on the level of increase in comparison to that of BTHFT. KD recognised that whilst the benchmarking data would be useful, it was also important to consider what the data may imply, for example, are concerns anonymous due to a lack of confidence in staff speaking up openly, and then aim to improve where necessary. KW reflected the importance of the anonymous route, as whilst this isn't the preferred approach, it is important for all staff to feel they can speak up and not stay silent on concerns. KW also confirmed that other channels were available for raising concerns, and data is triangulated across bullying, harassment cases, disciplinary cases, exit questionnaires, etc. Whilst there had been an increase in concerns raised, this had been a steady increase rather than a sudden influx. KW queried if there were any themes from the concerns that the Academy should be sighted on. LEA commented that there was nothing very specific, but something more general about how junior staff that raise concerns are handled, and attitudes and behaviour. She and Sue Franklin had discussed this and how this links in with the Civility workstream of Thrive. AS reflected that from an ambassador perspective, there was still some fear from staff about speaking up and this may result in the rise of anonymous complaints. Consideration would be needed on how to address this, perhaps by way of case studies to demonstrate how concerns are positively acted upon with tangible difference as a result. LEA advised that this could also be included as part of the next rendition of the FTSU feature in Let's Talk. The Academy was assured by the update and thanked LEA for joining the meeting.	
PA.2.24.11	**Guardian of safe working hours quarterly report**	
	RS gave an overview of the paper which sought to provide assurance that doctors and dentists in training are working safe hours. He highlighted that: • During Q3, 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. • Both of the immediate safety concerns 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. • Both junior doctors were spoken to by the Guardian of safe	

	working hours separately, and following discussion were not thought to be immediate patient safety concerns. • In total, 17.75 additional hours were reported. • The number of locum cover requests speaks to the challenges faced by not having enough junior doctors to meet requirements. The Academy were assured by the report.	
PA.2.24.12	**Cases with practitioner performance advice**	
	RS introduced the presentation detailed cases with practitioner performance advice, which is under the auspices of NHS resolution and discusses any cases under a formal disciplinary process. The data was benchmarked against Trust's of a similar size (medium), and the following observations made: • BTHFT had nine cases (all closed) against an average of 17. • The data also shows that BTHFT resolves cases quicker than the comparators (three months compared to an average of five months) • All nine concerns have behaviour and misconduct as the principal complaint. • In terms of ethnicity group, 44% of cases were Asian or Asian British, 11% was in the Chinese or other ethnic group and 44% of the cases were white. • Eight of the cases were men, and one was a woman. • The majority of cases were from the surgical speciality, and at consultant level. The data suggested that the Trust does well at managing concerns in an informal way, and those that are escalated to a formal disciplinary process are resolved in a timely manner which is important for staff wellbeing. RS also highlighted that of the nine cases, three were temporarily excluded which was a last resort. KW queried how the Trust could set expectations around civility from the moment an employee starts in the Trust. With reference to Doctors specifically, RS referred to the General Medical Council 'Good Medical Practice' guide which has recently been revised and modernised to include aspects such as social media conduct. He was confident that all doctors are aware of the rules governed by the regulatory body and have a professional responsibility to follow these. JB also highlighted that these nine cases are not employees that have just breached the Trust's conduct policies but have breached those set by the regulatory body. However, their values are not misaligned and therefore to breach the regulatory body code of conduct is to also breach the Trust's conduct. FL echoed the desire to resolve cases informally where possible, and these nine cases are beyond informal resolution and there is little other option but to subject them to a formal disciplinary process. With regards to the need to set expectations on civility, FL noted that all new employees are subject to an induction process where expectations are set, and there is further information on the intranet through Thrive.	

	The Academy was assured by the update.	
PA.2.24.13	**Equality Delivery System 2 – workforce elements / EDS2022 Final report**	
	RH introduced the report which summarise the process undertaken and the approach to implement the Equality Delivery System (EDS2022) for Domains 2 (workforce health and wellbeing) and 3 (inclusive leadership), and updates on the EDS ratings that have been achieved for each of the 2 Domains and consider next steps as part of contractual requirements. RH made the following key highlights: • Task & Finish groups were established with relevant colleagues to gather data (evidence and insights) which could be used to provide an evaluation of the Trusts performance under the outcome measures for each Domain. • A Staff Engagement event involving wider staff, trade union reps and staff network members was held on 29th January 2024 to showcase the evidence/ insights through presentations, discussion, and café style networking. Participants were also invited to complete a survey providing their scores for each outcome measure (in accordance with the EDS2022 rating & scoring guidance), along with any feedback or recommendations for improvement they wanted to share. • BTHFT was rated as Achieving for both Domain 2 and 3 and an overall rating of Achieving for the organisation as a whole. • Following feedback, it is proposed to focus on inclusion and belonging for all staff groups, ensuring there's a good diversity representation at all levels of the trust and ensuring policy and practices are applied consistently and effectively across the trust. However, rather than develop another action plan the intent is to align with existing areas of work. KW queried if there was a demographic breakdown of the people that attended and filled in the surveys and contributed to the feedback, and RH confirmed that there was, but this had not yet been analysed. LB asked whether the plans and recommendations would help meet the criteria to get all areas to ‘excelling’. RH advised that there would be a targeted approach to areas that could improve further, including a rollout of training, empowering managers, focusing on compassionate leadership approaches, and ensuring consistency. The Academy noted the contents of the report and approve the EDS2022 rating submissions for 2023 with a future update to be brought to the People Academy in relation to EDS2022 progress and an update on the next round of EDS2022 implementation with an improved implementation plan.	
PA.2.24.14	**Draft Workforce Planning submission**	
	FL provided an update on the workforce planning submission for 2024/25, highlighting that there was as yet no confirmed guidance	

	so there was a reliance on assumptions. The Trust has made a first draft submission showing that there is a reduction in temporary staffing and no significant growth in workforce other than that expected (due to the new day case unit, the community diagnostic centre etc). However, a piece of validation work was required to confirm the net growth. In terms of priorities, there was a need to reduce the reliance on temporary staffing usage for substantive vacancies, and investing in the recruitment service to ensure there are no delays to processing new starters and that there is a focus on front-end recruitment. FL also highlighted that the draft submission is on the basis that there is no further industrial action and so does not account for additional temporary staff usage if required for this purpose. RS reflected that this would possibly lead to unrealistic guidance. AHS recognised that employee preferences have changed, and staff now often want more flexibility in their working hours so they generally take up part-time substantive posts and pick up any additional shifts from the bank to suit them. FL confirmed it was important to ensure the staffing model is appropriate, but recognised the existing financial challenges and constraints that may lead to difficult conversations. KW questioned how the plan was received at ICB level, and FL advised that there was some pushback on the workforce growth, which was higher than other local Trusts, but there were also some areas recognised for high performance such as staff turnover rate being better than others. He also noted that there was learning from other organisations, such as the high appraisal rates at BDCT and AFT. The Academy was assured by the update.	
PA.2.24.15	**Bradford District and Craven People Committee update**	
	FL advised that the recent Committee meeting was largely taken up by a discussion on risks and whether they sit appropriately with the People Academy or need to be taken to a forum with more oversight. Workforce plans were also presented, and FL highlighted that VCSE were struggling from a planning perspective due to not having the stable budgets to be able to forecast and not having the resources to undertake this. FL also made reference to the Inclusive Language Guide being developed by Act as One. FL noted that the Committee was going to undertake a review to identify the role of the Committee and the frequency of meetings required. The Academy noted the update.	
PA.2.24.16	**Industrial Action update**	
	FL advised that there was nothing to note.	

PA.2.24.17	**People Academy work plan**	
	KW advised that there was nothing to note.	
Learning and Improvement		
PA.2.24.18	**Looking after our People**	
	The paper was taken as read and noted by the Academy.	
PA.2.24.19	**Recruitment Improvements**	
	GD introduced the presentation detailing recruitment improvements and highlighted the following: • The recruitment improvement programme board was set up 6 months ago to identify issues within recruitment processes and propose solutions. • Key issues included slow time to recruit, lack of quality communication with candidates, an overly complex process, and low confidence in the recruitment systems. • Some improvements have already been made including training provided on how to use trac systems, improved communications with candidates, and reorganisation of the recruitment team to create a more robust service. • Data shows success in a number of areas in HRs control and highlighted potential areas for further improvements. • Next steps included further system improvements, ongoing onboarding communications, improving the talent pool and improved advertising for recruitment. The Academy thanked GD and noted the update.	
PA.2.24.20	**Any other business**	
	There was no other items for business.	
PA.2.24.21	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.2.24.22	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.2.24.23	**Date and time of next meeting**	
	27 March 2024 – 11.00 - 13.00	
PA.2.24.24	**Internal Audit Reports relevant to the Academy**	
	There was nothing to report on this agenda item.	

ACTIONS FROM PEOPLE ACADEMY – 28 February 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	27.03.2024	
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	27.03.2024	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	27.03.2024	
PA24009	28.02.24	PA.2.24.5	**People Academy Dashboard:** KW to include the decrease in the non-medical appraisal rate and the positive progress made on turnover rates, in her Academy Chairs report to the Board.	Chair	27.03.2024	KW included the update in her Chairs report. Action Closed
PA24010	28.02.24	PA.2.24.5	**People Academy Dashboard:** FL to discuss with Samia Hussain the need for staff networks to be involved in the updated sickness policy review.	Interim Director of HR	27.03.2024	
PA24001	31.01.2024	PA.1.24.5	**Staff Story – Outstanding Theatre Services -** AHS to share a copy of the review undertaken in theatres for the leadership protected time.	Matron – Theatres, Critical care and day case.	24.04.2024	A presentation will be shared by Jade Stephenson at April's meeting.

PA24011	28.02.24	PA.2.24.9	**Nursing and Midwifery recruitment and retention data:** AHS to undertake a deep dive exercise into the workforce profile of ICU and what different approaches could be made to recruiting into this area, and bring this back to the Academy in two months time.	Director of Nursing (Operations)	24.04.2024	
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	29.05.2024	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	27.11.2024	

Bradford Teaching Hospitals NHS Foundation Trust

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 27 March 2024	**Time:**	11:00-13:00
Venue:	MS Teams meeting	**Chair:**	Karen Walker, Non-Executive Director
Present:	- Karen Walker, Non-Executive Director, Chair (KW) - Zafir Ali, Non-Executive Director (ZA) - Faeem Lal, Interim Director of HR (FL) - Karen Dawber, Chief Nurse (KD) - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) - Jane Kingsley, Lead Allied Health Professional (JK) - Raquel Licas, Interim Chair of RESIN (RL) - Adele Hartley Spencer, Director of Nursing (Operations) (AHS) - Amandeep Singh, Partnership Lead (AS) - Laura Gornall, Education Manager, Professional Education (LG) - Samia Hussain, Associate Director of HR (SH) - Rachel Pyrah, General Manager to CDIO Office (RP) - David Smith, Director of Pharmacy (DS)		
In Attendance:	- Sean Willis, Associate Chief Nurse (SW) - Carly Wilson, People Promise Manager (CW) - Debbie Jackson, OD Manager (DJ) for item PA.3.24.6 only - Julie Snellgrove, OD Practitioner (JS) for item PA.3.24.6 only - Hannah Nutting, Service Improvement Practitioner (HN) for item PA.3.24.6 only - Sophie Detraux, Pharmacy Lead for OPS (SD), for item PA.3.24.6 only - Zoe Ridewood, Parkinson's Disease Nurse Specialist (ZR) for item PA.3.24.6 only. - Ruth Haigh, EDI Manager (RH) for item PA.3.24.13 only - Chris Boyne, Deputy Director – Internal Audit (CB) for item PA.3.24.17 only - Justine Carroll, HR Business Partner (JC) - Jacqui Maurice, Head of Governance Manager (JM) - Katie Shepherd, Corporate Governance Manager (KS) - Tabitha Lawreniuk, Personal Business Manager (TL) as secretariat		
Observers			

Agenda Ref	Agenda Item	Actions
PA.3.24.1	**Apologies for Absence**	
	- Altaf Sadique, Non-Executive Director - Sughra Nazir, Non-Executive Director - Catherine Shutt, Head of Organisational Development - Ray Smith, Chief Medical Officer - Laura Parsons, Associate Director of Corporate Governance / Board Secretary Absent: - James Taylor, Deputy Chief Operating Officer - Amy Ilsley, Clinical Lead for Medical Workforce - Susan Parker, Co-chair of the Enable Staff Equality Network - Abbie Wild, Chair of Staff LGBT Network (AW)	

	- Joanne Hilton, Deputy Chief Nurse (JH) - Georgi Dyson, Assistant Director of HR (GD)	
PA.3.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.3.24.3	**Draft minutes of the meeting held on 28 February 2024**	
	The minutes of the meeting held on 28 February 2024 were approved as an accurate record. The Academy noted that the following actions had been concluded: PA24002 – PA.1.24.7 – Workforce Civility Update: update would be presented at the next meeting in April on the triangulation of data, for FTSU and staff surveys. PA24006 – PA1.24.13 – Report/Minutes from the Health and Safety Committee: An update on the assignment of a NED to the Committee would be provided at the next meeting. PA24007 - PA.1.24.13 Report/Minutes from the Health and Safety Committee: *LP discussed with Steve Amos and he did not feel there was a risk relating to this at present. Action* Closed PA24010 – PA.2.24.5 – People Academy Dashboard*: FL confirmed that staff networks will now be involved in the policy review*. Action Closed	
PA.3.24.4	**Matters arising**	
	• CSU to Academy Engagement Event – 8 March 2024 KW attended this event and thanked colleagues who helped to support the event on the day.	
	Learning and Improvement	
PA.3.24.5	**Staff story – Experience of new mums returning to work**	
	FL shared details of a new mother at the Trust returning to work who faced issues regarding the lack of facilities to support breastfeeding. FL advised that whilst this individuals line manager was supportive of her in providing a space for her to express milk or to bring her baby in to be breastfed, other employees were not mindful of this nor were respectful of the privacy she required. An incident report was submitted in relation to this and the individual felt that the response to that incident report was in general, quite poor. The employee in question had discussed this with other colleagues who had recently returned to work from maternity leave who also reflected the difficulties they experienced in continuing to breastfeed or express milk at work - so these challenges were not unique to the individual. FL further advised that there is a legal requirement for the Trust to provide facilities for breastfeeding mothers and that there was a lack of understanding from the organisation in respect of this. FL	

	has therefore set up a working group to look at the experience of employees returning to work from maternity leave, particularly women who are breastfeeding, and what the organisation can do to better support them. In response to KHs request that a representative from EDI be added to the group membership; FL confirmed that this was in place. ZA expressed his disappointment that the facilities are not available given the promotion of breastfeeding within the Trust and queried what routes are available for staff to voice their concerns. FL advised that there are various routes for raising concerns but that it would be important for staff to have the confidence to do so, which often is lacking. AS suggested the new and expectant parents policy be amended to include information on support offered to employees returning to work who wish to continue to breastfeed / express milk on site, and also include this on the KIT day guidance. FL stated this was an education piece as our policies reflect best practice but we need to ensure managers understand their responsibilities. KD asked if a central breastfeeding facility could be made available within the Trust, with a pack similar to the Ramadan prop packs being given to employees on their return to work including items such as a water bottle that includes details of the policy relating to them and where they can go to express milk in private. Such a facility should however include a lockable fridge for expressed milk to be stored. The Academy also reflected that there is an education piece for managers to be supported to provide appropriate guidance for staff and help them with these matters on their return to work. The Academy thanked FL for the staff story and recognised there were a number of improvements to be made in relation to this area.	
PA.3.24.6	**NHS Staff Surey results**	
	DJ and JS joined the meeting to present an update on the NHS Staff survey results. DJ advised that the survey ran from September to November 2023 amongst a backdrop of industrial action and continued cost of living pressures. Despite this, the overall response rate increased by 6% and most services across the Trust made improvements compared to the previous year. DJ and JS highlighted the following: • The Trust was above national average on all people promise factors which demonstrates the success of the ongoing work in the Trust. • The Trust scored above average in most of the 'compassionate and inclusive' elements. • The number of staff experiencing discrimination at work from manager/team leader or other colleagues has dropped by 0.5%. • Recommending the organisation as a place to work has improved from 57% to 62%. • In relation to 'having a voice that counts', the Trust scored	

	above average on most elements. • There has been a slight dip in the percentage of staff confident that the organisation would address concerns (dropped by 0.03%). • The Trust scored above the national average in all elements relating to recognition and rewards. • 36% of staff are happy with their level of pay which is above the national average of 30% and a big improvement on last year. • There has been a slight drop in the number of staff feeling that the organisation takes positive action on health and wellbeing. • The number of staff that have been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleague is 92 (3.26%) and this would be an area of focus. • The Trust scored above the national average in all elements relating to 'always learning'. • The Trust scored above average in most elements relating to 'we work flexibly'. • The Trust scored above average in most elements relating to 'we are a team'. • There was a large increase in the percentage of staff who believe their immediate manager takes a positive interest in their health and wellbeing. • The Trust scored above average in most elements relating to 'staff engagement'. • The Trust scored above average in most elements relating to staff morale. • The number of colleagues thinking about leaving the Trust has reduced by 5%. • The free text comments had been grouped into themes and were predominantly negative. The main themes were civility / incivility, managers, pay, and staff levels. • The team were looking to focus in on any areas with high levels of comments on a similar theme. KW recognised the great engagement levels, particularly in the context of what was happening at the Trust during the time of the survey. However, as ever, there would be a need for continued improvement. ZA queried if the action plan from the previous year had been realised. DJ confirmed this was the case but some elements would carry forward as there is a need for further improvement, such as in relation to civility. He also recognised that whilst the number of staff completing the survey had increased, there was still more than half of staff not completing it and so it would be helpful to plan for next year to maximise uptake. DJ referred to the efforts in the latest staff survey to have designated leads for some areas and the aim to increase this further for the next survey. She also reflected that the survey is not primarily owned by the OD team and the importance of everyone in encouraging uptake where possible. FL noted the need for further improvement year on year. He recognised that with a continued focus on looking after staff, initiatives to improve wellbeing, and a drive to improve staff	

	experience at work, this should naturally drive an improvement in staff survey results. He confirmed that an action plan was scheduled to come to the People Academy for approval and that CSUs would also be asked to complete individual action plans which are driven by staff. The Academy thanked DJ and JS for the update.	
PA.3.24.7	**Workforce Growth and Transformation**	
	SW introduced the paper which sought to provide the Academy with an update and assurance of the actions of the Workforce Growth and Transformation sub-group. He highlighted the following points: • There was no confirmation of CPD funding for 2024/25 for nursing and midwifery and AHP's however there was a wider discussion regarding how other staff access funding to support progressional development including Estates and Facilities, Digital and Physicians Associate roles. • The group agreed to look at the Study leave policy and how we can unlock the potential of apprenticeship programmes and promote access to Organisational Development and BTHFT and Place courses. • The key message was how we encourage staff to access the help and support available to them, especially the international nurses who may not be aware of the application process and opportunities. Further work in this area will be ongoing. • The University of Bradford confirmed they have finalised their Introduction to Translation short course which will be available from April 2024, initial work with Maternity has been positive with more information to follow. • The Lead Physicians Associate gave an update regarding her role and the negative media stories as they move towards regulation. There was assurance the WGT group would offer advice as needed and to reach out to any member of the team for support. KD thanked SW for his help and support in the finalising of the Introduction to Translation course which had been in train for a couple of years. She recognised that risk assessments were still needed as best practice is that clinicians should not translate. However, she reflected that some clinicians in Bradford will have other languages as their 'first' language and so they should be able to provide clinical information to patients. At present, the policy is that they can only give non-clinical guidance (such as directions) to members of the public. The update was noted by the Academy.	
PA.3.24.8	**Organisational Culture**	
	CW provided an update on the Thriving Together programme. She advised that retention is starting to improve, with Thrive initiatives making an impact. The Thriving Together programme provides a practical evidenced based approach to understand how colleagues, partners and patients perceive our culture.	

	CW advised that at the beginning of the programme, staff were asked for three words which describe the current culture of our organisation. The top three words used were 'hierachical', 'challenging' and 'quick to blame.' When asked what three words describe the culture they want at BTHFT, the top three words used were 'learning', 'work-life balance' and 'compassionate'. Similarly, when receiving responses for the development of a new People Strategy, 'kindness and compassionate leadership', and 'how we do things' (i.e., respect and civility) were also in the top 3 priority areas. CW advised that the programme gained executive approval in May 2023 and was launched at the Leadership Conference in June 2023.Since launch date, a change team has been developed and the team are now in a position to launch the culture element, which consists of: • A culture and outcomes dashboard to look at key metrics including FTSU, staff survey data, sickness etc. • Culture focus groups will hear directly from staff about their experiences. • Leadership behaviour surveys • Patient experience feedback • A leadership workforce analysis to understand the needs of the organisation in terms of further roles. CW emphasised that this is a significant piece of work and encouraged colleagues to participate where possible. KD recognised that there is more that can be done to encourage staff to partake in this culture work, and suggested that managers be invited to learn about the background of the Thrive programme through mini roadshows. KD reflected that as part of preparing for the well-led review, she was struggling to find a publicly available document that describes the work being done within the OD team around Leadership and Wellbeing. She suggested that the information available on the intranet in relation to Thrive be replicated on the public internet site which would also demonstrate the Trust as a good place to work and encourage recruitment. KD queried if a specific People Strategy would be developed. FL confirmed that this was included as part of the Trust's overarching corporate strategy, but the new Chief People and Purpose Officer may have a view on whether a specific people strategy should be developed.	
PA.3.24.9	**Outstanding Pharmacy Services**	
	HN, SD and ZR joined the meeting to provide an update on the Outstanding Pharmacy Services programme and highlighted the following: • A new programme manager started in January 2024, and there	

	remained 6 active workstreams across the programme (education and training; medication supply; digital; estates and facilities; wellbeing and culture; and patient journey) • Since the last report shared with People Academy, there has been increased engagement from staff, and input from the SPaRC team to help understand how to support staff through Ramadan. • Every three months, a wellbeing measure check is completed and this shows that staff wellbeing is continually increasing. • The programme is aware of the need to engage with the patient voice so a survey is being drafted to seek feedback. • Nex steps included a mid-point celebration and review which will provide an opportunity for staff to re-engage, and the underpinning of the wellbeing and culture work with mental health training and support. The presentation also detailed the 'Get it on Time' project which was developed to improve the delivery of time critical Parkinsons medication for patients. The project was working towards the implementation of the Parkinson's UK 'Time critical medication, on time, every time' recommendations for hospitals. Next steps included a collection of quantitative data to see impact of work on missed doses and delays to medication administration, and a continued collaboration with Parkinson's UK groups and patient networks. KD recognised that April is Parkinson's awareness month and suggested that ZR work with SW to share the four-minute training video at all nursing handovers throughout the month so that all staff can view it. ZA queried the connections of the programme with other areas in the Trust, and more widely within pharmacy networks. SD reflected that the programme is very pharmacy specific as it is driven by the staffing group, in line with other outstanding programmes. However, there was a good network with other pharmacy colleagues in other organisations which helped share best practices and help collective problem solving. KH congratulated SD on her leadership capabilities and her efforts in helping the department deal with some complex issues. AS queried the process on gathering information around workplace related incidents. SD advised this would likely sit with senior leadership team rather than the OPS which has more a quality improvement and transformation focus. DS would look into this and provide a report to a future Academy. **Action**: DS to provide a report on gathering information around workplace related incidents in Pharmacy. The Academy noted the update.	(PA24012) Director of Pharmacy
Assurance		
PA.3.24.10	**Board Assurance Framework for Nurse Staffing**	

	SW referred to the BAF for nurse staffing which had been brought in during Covid. This had not been updated since November 2022, and it is recommended to continue to provide assurance via the monthly Nursing and Midwifery Workforce reports and twice-yearly Establishment reviews and step down this report to the People Academy. This would be reviewed in line with any National Quality Board recommendations or updates to the framework. This proposal was accepted by the Academy.	
PA.3.24.11	**Nursing and Midwifery Staffing Data Publication Report**	
	SW introduced the paper which sought to report on the nursing and midwifery staffing data for February 2024, identifying planned vs actual staffing levels and any mitigation taken to maintain patient safety. He highlighted the following: • SW had discussed with the ICU team how to best support newly qualified nurses into ICU and work remains ongoing with this. • The aim remains to reduce the nursing and midwifery vacancy position from 20% to 10% by March 2024 and to reduce HCA vacancy position to less than 4% by July 2024 and we are on track with both of these. • The team are beginning to prioritise recruitment to those areas with the biggest vacancies. • The harms data remains unchanged and is in line with previous months. • IRIS reports highlight the number of staff deployments and SW reflected that it would be good to see the number of staff moves reduce over time. The Academy was assured by the update.	
PA.3.24.12	**Staff Progression**	
	KD introduced the paper which provided an analysis of workforce data and sought to update the People Academy on how this will inform the work of the Workforce Growth and Transformation Group. KD highlighted that an analysis of nursing and midwifery and clinical (non-medical) workforce data, over time, has shown that while we still have work to do, the Trust has become one of the most diverse organisations within the Northern and Yorkshire region. This change has been seen in all bands of staff except for Band 8b. The largest percentage change over time has been seen in senior roles (bands 8-9) and specifically nursing and midwifery roles Bands 7 and 8a. KD noted that this trend also continues when reviewing the Workforce Race Equality Standard 9, which refers to the diversity of senior leadership within BTFHT. When the BTHFT position is compared to peer organisations within the Northern and Yorkshire Region via Model Hospital (Health), against the Workforce Race Equality Standard 9, the Trust continues to be in the highest	

	quartile for the diversity of the senior leadership team. ZA asked if work was ongoing to proactively promote minority ethnic staff within the nursing workforce. KD advised that this was a priority not only for the Trust, but also more widely for NHS England. She noted there was support by way of external courses, and access to networks and coaching sessions, and that staff mindset had changed to a new confidence in progression opportunities for BAME staff. AS commented that he still receives anecdotal reports from minority ethnic staff that they are being held back and band 5 is a bit of a glass ceiling for them in nursing. He welcomed the improvements and reflected that it would be helpful to continue to receive assurances around ongoing work to target progression of the minority ethnic workforce. KD offered the support from her or members of the Chief Nurse team to any member of staff who feels that they have reached a glass ceiling to help them progress further.	
PA.3.24.13	**Gender Pay Gap**	
	KH and RH introduced the paper which sought to inform the People Academy of the Trust's Statutory Gender Pay Gap Report that will be published for 30th March 2024 deadline in line with our contractual and legal obligations. KH noted that it is a legal requirement for all relevant employers to publish their gender pay data and report within one year of the 'snapshot' date. The 'snapshot' date is 31 March 2023. RH highlighted that: • There has been a 0.5% increase in men across the Trust and a 5.8% increase in men in AHP roles. • Men continue to be under-represented in nursing and midwifery professions. • Women continue to be under-represented at more senior levels by 12.2% and over-represented at supervisory and middle management levels. • There has been a 1% reduction in the proportion of women in the upper quartile since March 2022. • When it comes to pay, although there are more women employed in the organisation, women earn less than men. However, we have seen the following improvements over the last 12 months: A 1.7% decrease in the mean gender pay gap (from 26.1% in 2022 to 24.4% in 2023). • A 2.5% decrease in the median gender pay gap (from 7.7% in 2022 to 5.2% in 2023). • A 20.5% decrease in the median average bonus pay gap (from 42.4% in 2022 to 21.9% in 2023). This is a significant difference from previous years and is caused by a slight reduction in the number of people receiving the 'old style' (higher value) CEA and a slight increase in the number of people getting the new style (equal shares) CEA - which means the central (median) point has shifted.	

	• Next steps included publishing report by 30th March 2024, recruitment of a new gender equality champion, and development of the action plan focusing on women in leadership, further development of flexible working culture and addressing under-representation of men in nursing and midwifery. Will also look at ethnicity and disability pay gap too. FL advised that as part of the BMA pay deal there is a proposal that local clinical excellence awards will cease to exist which will possibly impact bonus pay in the long term. AS queried if work has been undertaken on job redesign for women in senior roles to make them more conducive towards caring responsibilities. It was recognised that this should be included in future plans as it was an important aspect.	
PA.3.24.14	**People Academy dashboard**	
	The People Academy dashboard was noted.	
PA.3.24.15	**High level operational risks**	
	The high-level operational risks report was noted.	
PA.3.24.16	**Report/Minutes from Health and Safety Committee**	
	The minutes from the Health and Safety Committee were noted.	
PA.3.24.17	**Draft Internal Audit Plan 2024/25**	
	CB joined the meeting to provide an update on the draft internal audit plan for 2024/25. He advised that this had been to ETM for approval, and the normal processes were in place to link the plan to the Trust's strategic objectives. He advised that this was designed to be flexible and so would likely change before it is submitted to the Audit Committee on 22 April. He welcomed any further comments from the Academy offline. The Academy noted the audit plan.	
PA.3.24.18	**Industrial action update**	
	FL advised that further dates for industrial action were likely but there was no confirmation as yet.	
PA.3.24.19	**People Academy work plan**	
	The work plan was noted.	
PA.3.24.20	**Any other business**	
	Staff Progression Report – Supplementary Information This was discussed under item PA.3.24.12. **People Strategy** In the interests of time and recognising that this was a late submission with minimal opportunity for colleagues to review, FL sought comments from Academy members outside the meeting. **AHS Retirement:** Colleagues thanked AHS for her service and	

	contributions to the People Academy, and KW reflected that she would be greatly missed across the organisation. **Administration of Academy papers:** ZA requested that papers be provided in a more timely manner and be made more succinct to allow for sufficient review prior to the meeting. He also requested that where possible these be shared at the same time to allow for easier review. **Action.** Report authors and Executives to be reminded of the deadline dates for papers to enable sufficient time for meeting members to review.	(PA24013)Associate Director of Corporate Governance / Board Secretary
PA.3.24.21	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.3.24.22	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.3.24.23	**Date and time of next meeting**	
	24 April 2024– 11.00 - 13.00	
PA.3.24.24	**Internal Audit Reports relevant to the Academy**	
	There was nothing to report on this agenda item.	

ACTIONS FROM PEOPLE ACADEMY – 28 March 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	24.04.2024	This was on the agenda for the next civility programme board agenda and FL will bring summary of discussion back to People Academy following this.
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	24.04.2024	Sarah Jones, Chair, is reviewing NED roles and responsibilities so LP should be able to report back next meeting.
PA24011	28.02.2024	PA.2.24.9	**Nursing and Midwifery recruitment and retention data:** AHS to undertake a deep dive exercise into the workforce profile of ICU and what different approaches could be made to recruiting into this area, and bring this back to the Academy in two months time.	Director of Nursing (Operations)	24.04.2024	
PA24012	28.03.2024	PA.3.24.9	**Outstanding Pharmacy Services:** DS to provide a report on gathering information around workplace related incidents in Pharmacy.	Director of Pharmacy	24.04.2024	
PA24013	28.03.2024	PA.3.24.20	**Any other business:** Report authors and Executives to be reminded of the deadline dates for papers to enable sufficient time for meeting members to review.	Associate Director of Corporate Governance / Board Secretary	24.04.2024	Email communication sent out by Executive Leads reminding of the deadline along with the need to inform if any papers will be late as a consequence of CQC inspection. Action closed.

PA24001	31.01.2024	PA.1.24.5	**Staff Story – Outstanding Theatre Services -** AHS to share a copy of the review undertaken in theatres for the leadership protected time.	Matron – Theatres, Critical care and day case.	29.05.2024	Jade Stephenson, Matron will provide an update at the May Academy meeting
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	29.05.2024	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	27.11.2024	

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) - ASSURANCE MEETING MINUTES

Date:	Wednesday, 28 February 2024	**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 - Ms Julie Lawreniuk (JL), Non-Executive Director **Executive Directors:** - Professor Karen Dawber (KD), Chief Nurse (CN) - 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 - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Dr Debbie Horner (DH), Deputy Chief Medical Officer - Ms Judith Connor (JC), Associate Director of Quality - Ms Louise Horsley (LH), Senior Quality Governance Lead - Mrs Sarah Freeman (SF), Director of Operations (Nursing) - Ms Adele Hartley-Spencer (AHS), Director of Operations (Nursing) - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary - Ms Kay Pagan (KP), Assistant Chief Nurse for Informatics		
In Attendance	- Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District Care Health and Care Partnership - Ms Carly Stott (CS), Associate Deputy Director of Midwifery representing Sara Hollins (SH) - Ms Karen Bentley (KB), Assistant Chief Nurse, Patient Experience - Ms Sarah Buckley (SB), Clinical Lead for Patient Flow, Command Centre and Mortuary Services, and Ms Julie Wilson (JW), Mortuary Manager, in attendance for agenda item QA.2.24.11 - Ms Ruth Haigh (RH), Equality, Diversity and Inclusion Manager, in attendance for agenda item QA.2.24.12 - Mr Nazzar Butt (NB), Moving to Outstanding Lead, in attendance for agenda item QA.2.24.13 - Ms Katie Shepherd (KS), Corporate Governance Manager - J Kitching, Minute-taker		
Observers	- Professor Alastair Goldman, Partner Governor, University of Bradford - Mr Andrew Hughes, ANHH Consulting - Ms Sindy Jones, ANHH Consulting		

Agenda Ref	Agenda Item	Actions
QA.2.24.1	**Apologies for Absence**	
	- Mr Altaf Sadique (AS), Non-Executive Director - Mr Zafir Ali (ZA), Non-Executive Director - Mr Mohammed Hussain (MH), Non-Executive Director/Co-Chair - Ms Sughra Nazir (SN), Non-Executive Director - Mrs Sara Hollins (SH), Director of Midwifery **Absent** - Dr Yaseen Muhammad (YM), Nurse Consultant/Director of Infection, Prevention and Control - Mr David Smith (DS), Director of Pharmacy - Ms Denise Stewart (DS), Quality and Patient Safety Facilitator	
QA.2.24.2	**Declarations of Interest**	
	There were no declarations of interest.	
QA.2.24.3	**Minutes of the meeting held on 31 January 2024**	
	The minutes of the meeting held on 31 January 2024 were approved as a correct record. Verbal updates were given at the meeting on the outstanding and closed actions and these were reflected in the action log. The following actions were closed: QA23033 – OA.12.23.9 (13.12.23) – Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 reports. QA23034 – QA.12.23.9 (13.12.23) – Complaints, Litigation, Incidents and Patient Experience (CLIP) Report – Quarters 1 and 2 reports. QA23037 – QA.12.23.13 (13.12.23) – Safeguarding Children – Six monthly update. QA23038 - QA.12.23.14 (13.12.23) – Electronic Patient Record (EPR) Programme Update.	
QA.2.24.4	**Matters Arising**	
	The following escalations were noted by the Chief Nurse and Chief Medical Officer. • The two recent on-going Serious Incidents (SI), a dialysis incident and an insulin pen incident will be discussed later in the meeting in agenda item QA.2.24.8. • The five day period of Junior Doctor industrial action will cease at 23:59 hours on 28 February 2024. Strike rate numbers were reported to have varied between 52% and 72% across the five days. Consultants have been on-site covering and future modelling with an overnight increase in consultant presence, particularly in the Accident and Emergency Department, to assist with patient flow will be considered. To date no adverse incidents or evidence of direct harm have been reported. Patient waiting time was highlighted noting over 500 patients had attended the Accident and Emergency Department on 26 February 2024. No evidence had been noted of any publicity	

	around the junior doctor strikes. • The organisational response to the United Kingdom Covid Inquiry has been submitted with the Trust being one of a handful of organisations selected in the North of England to take part. The inquiry has emphasised that there is no concern over how patients were managed in Bradford, this is about learning, with particular interest in the way national decisions impacted the Trust's ability to care for patients with specific questions asked for example around vaccinations, conditions, Personal Protective Equipment procurement and distribution and Oxygen requirements. The questionnaire did not allow the Trust to tell the 'story'. This inquiry is lawyer run and not clinical. Clarifications for the Trust are likely to be around the impact of national decisions and how these helped/hindered the Trust during the Covid pandemic. The Trust can speculate as to why it was selected to participate, for example good practices and outcomes and due to the Bradford population make-up being a contributing factor. Any additional information required will be requested. No timeline for publication has been provided, however, is expected to be in the next few years. RS expressed his thanks to all those who had contributed to this mammoth task of information gathering. LB noted the significant ask from the questionnaire and again reiterated RS's thanks to all contributors. There were no additional matters arising or further issues to escalate.	
QA.2.24.5	**High Level Risks**	
	The paper was presented by RS concerning all high-level risks scoring 15 and above, aligned to the Academy, noting the changes since the last report and the summary of the Executive team's discussion regarding the risks. The paper also provided a summary of the strategic risks which are reported on the Board Assurance Framework for reference. The following were highlighted: • One new risk has been added Risk 3309 relating to delays in processing histopathology samples. The Department is under significant pressure due to a number of factors including vacancies, sickness gaps and a significant increase in workload with no increase in capacity. This is nationally a difficult specialty to recruit to. Specific supported work is ongoing in the Trust via an improvement plan with the Executive team keeping close oversight. A transformation team is supporting the operational team regarding service improvements. • No risks closed since the last report. • Two risks have changed in score, the first Risk 3896 regarding gynaecology histopathology. This risk has been de-escalated as it is specific to one service with the overall impact being less due to its restricted nature. The risk has reduced from 16 to 12. A risk describing the whole Histopathology service has been added as a risk over 16, due to the impact on gynaecology, breast surgery and renal surgery. The risk concerning	

	gynaecology histopathology was de-escalated as this is specific to one service and the risk has reduced from 16 to 12. • The second Risk 3877 has reduced from 16 to 12 and concerns the management of operational pressures due to Covid backlogs as the Trust is currently performing well. • Following discussion at the Executive team meeting five risks have been noted to be a couple of months beyond their review date. It is expected these risks will have been reviewed as the report is produced in advance of the Academy meeting. • Risk 3810 – This risk will be reduced in score due to the ongoing work in haematology at West Yorkshire Association of Acute Trust (WYAAT) level. Haematology was noted to be a fragile service across WYAAT, with supported and focused work having assisted across WYAAT and significant work internally. RS thanked DH for all her efforts in supporting this work. Discussion ensued around the lowering in score of the gynaecological histopathology risk due to the reduced impact and significance, however, the risk to individual patients is not reduced and questions were raised as to whether this risk should be incorporated into Risk 3309. The gynaecology team wished to keep this risk on their internal Risk Register, the Executive team considered linking all the histopathology risks. The likelihood against impact and the scoring mechanism is taken into account when considering if there should be a reduction in the risk if the risk remains the same. In this case the likelihood is the same but the impact is less as a single specialty. Separate risks will, therefore, remain. CS will provide an update under QA.2.24.10. PR reflected on previous conversations concerning material risks related to the Trust's alliance in pathology with Fordham and the programme of WYAAT migrating to Clinicist. The Trust is reliant to Leeds in relation to two elements of the programme around blood science and microbiology. The programme has been responsible for considerable delays, however, the project go-live is June for Leeds elements resulting in consequences for the Trust. PR agreed to reconsider the consequences and processes and provide further detail to the QPSA regarding the implications around these delays in Leeds against the original trajectory resulting in the Trust being later in the process than initially anticipated. The Academy was content with the report and was assured that all relevant key risks have been identified, reported to the Academy and were being managed appropriately. Having reviewed, challenged and assessed the identification and management of key risks within their remit on the High Level Risk Register and the matters raised by the Executive team at its meeting on 19 February 2024, the Academy noted that the histopathology issues relating to risks will be highlighted to the Board of Directors at its meeting on 14 March 2024.	QA24002 Chief Digital and Information Officer (PR) QA24003 Associate Director of Corporate Governance/ Board Secretary (LP)
QA.2.24.6	**Board Assurance Framework (BAF) – Strategic Risks relevant to the Academy**	
	LP presented the BAF setting out the Trust's strategic risks to achieve the Trust's strategic objectives. Two objectives are	

	currently aligned to the Academy, Objective 1 – To provide outstanding care for our patients, delivered with kindness, and Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation. There are three risks under each objective with no changes having been made since the last update. The highest scoring risk is relating to recruitment to Trust vacancies currently at a score of 16. This risk is also aligned to the People Academy. The overall assurance level is amber for Quarter 4, rather than red, as actions are in place. The amber status has remained throughout the year to reflect the fact that the risks have not reduced to the target scores in the majority of cases. Mitigating actions are in place to address the issues. LB thanked LP for the presentation and the reasons for the current amber status were noted by the Academy. The Academy was assured that all actions are being undertaken and managed appropriately.	
QA.2.24.7	**Quality and Patient Safety Academy Dashboard**	
	RS highlighted the following headlines from within the dashboard providing a single view of the QPSA indicators aligned to the Trust's Strategic Objectives. • Summary Hospital-level Mortality Indicator (SHMI) – Figures have not increased over the last four months, however, this metric has been discussed at previous QPSA meetings and the ongoing work to explore issues which may be affecting the SHMI value continues. • Crude mortality is the number of patients who are admitted to hospital noting how many of those pass. Trust levels are the second lowest in the entire country (1.14%). SHMI is a measure that is adjusted according to what is expected, eg how many patients would expect to die based on their existing co-morbidities. RS noted for the first time the Trust is beginning to finally understand the previous issues discussed around data, however, these are challenging and are being addressed with specific codes being attached to particular groups of patients. A patient's journey through the Trust should be logged as separate episodes of care, however, at present each clinician who enters information appears to have been generating an episode. NHS Digital generate the data from the Electronic Patient Record (EPR) for SHMI and discussions are underway to rectify these errors. PR noted an in depth discussion at a recent Board of Directors' meeting. PR agreed to provide a full update to the April QPSA Assurance meeting and the information will be included in the next quarterly data update. LB questioned the increase in figures in October/November 2023; the forthcoming paper will consider this. Over the next couple of months, Crude mortality will be an additional area to be included and will reference how the Trust compares to other Trusts in WYAAT. • C diff, E coli and MRSA - Within expected Infection, Prevention	QA24004 Chief Digital and Information Officer (PR)

	and Control limits. • Pressure Ulcers - The contributing factors of the increase in numbers over the last couple of months is being considered with pressure ulcers being part of the Patient Safety Incidence Response Framework (PSIRF). All patients who have a pressure ulcer will have a review of care, with patients and families involved; members of the Clinical Service Units are invited to attend the Pressure Ulcer Improvement Group. • Medicines reconciliation – Numbers remain static. Data is provided from a sample where 60 patients are sampled by the Pharmacy team within 24 hours of admission. • Falls with harm – A steady downward trend continues. All falls are reviewed by the Lead for falls improvement and CSU teams are invited to the Falls Improvement group to discuss challenges. KD noted the downward trend including falls with harm to be very encouraging. A twelve month post for a senior nurse lead for falls was appointed to, approximately ten months ago. Quality, financial and activity challenges being faced need to be balanced. JL queried the embedding of good falls practice. KD noted there is an element of education but also an element of clinical expertise and increasing frailty of patients. Education for staff continues, however, there is a requirement for the clinical expert in helping to reduce falls. PR referenced the 'Making Data Count' programme which has been of impact in other NHS organisations in terms of quality of information referred to by Boards and Executive teams. The QPSA will relate to the Making Data Count when considering the implications of the SHMI data. LB noted she recently attended an NHS provider session on Making Data Count that considered how better insight can be obtained from data. Page 7 of the report referred to Datix which is no longer in use in the Trust and this error will be updated in the next report. The Academy noted there were no items for escalation to the Board of Directors' meeting on 14 March 2024 and was assured following the discussions.	
QA.2.24.8	**Quality Oversight and Assurance Profile**	
	LH presented the Quality Oversight and Assurance Profile report and appendices for the period 1 December 2023 to 31 January 2024. LH highlighted the aim of the Quality Oversight system and the process of safety incident escalation. Safety incidents are discussed within CSUs at their daily safety huddle. Where an incident links to the Trust's agreed PSIRF priorities, meets the national response requirements, or where we have identified a potential theme or trend that links to our improvement priorities, these are escalated to the Safety Event Group (SEG) and to the Quality of Care Panel (QuOC) to agree the level of learning	

	response, method and reviewer. Otherwise, these are managed at CSU level so the numbers escalated may seem lower than previously noted at Academy, but this is being monitored. • Eleven safety incidents were escalated in the period from the CSUs and discussed at SEG with five of these escalated to QuOC. • One safety incident declared as an SI in December 2023 and accepted by Maternity and Newborn Safety Investigations (MNSI). • No Patient Safety Incident Investigations (PSII) were declared in the reporting period. • Several concerns escalated to SEG as noted on the slides being reviewed and monitored within the CSU or relevant team. Externally reported incidents reported at QuOC: Two Serious Hazards of Transfusion (SHOT) reportable safety events noted with learning described and cascaded as appropriate. • Four incidents reported under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) – Learning identified where appropriate and details noted. • The Health and Safety Executive (HSE) were notified of an incident relating to the loss of an individual's radiation dose meter reading which had been found to be significantly higher than expected. This safety event has triggered an HSE visit to the Department which is scheduled for 11 March 2024. • Eight Care Quality Commission (CQC) enquiries were received in the period. • There are six ongoing SIs as at 31 January 2024 being led by the Trust and a further two being led by MNSI. • One SI declared during the reporting period. • No PSII investigations declared during January 2024. • Four legacy SIs have been closed during the reporting period. • An overview of the alerts issued via the Central Alerting System was provided, 14 alerts were issued and five of these alerts required a response. • The claims and inquest overview was provided. • Learning from both internal and external sources were shared as appropriate within the organisation. LB thanked LH for the clear summary and report. JC referred to the two incidents for the Academy's attention. The first being a failed renal transplant patient undergoing renal dialysis who tested positive for Hepatitis B. Following the positive result it became apparent 15 patients may have come in to contact with the same unit used to dialyse the patient. A Task and Finish group was set up led by SF and Dr John Stoves, Consultant Renal Physician with the UK Health Safety Agency (UKHAS). Following an intensive piece of work four patients were identified who may have come into contact with the equipment. Those patients along with the dialysis machine were isolated for a period of time and blood samples have been taken, the patients will be monitored for a number of months. The Trust declared a Patient Safety Incident Investigation (PSII) and contacted the CQC. Following advice, there was no requirement for any further communications.	

	The second incident related to the use of a single patient, multiple use insulin pen in the Accident and Emergency Department. It had come to light that over a period of twelve months insulin pens were being used for multiple patients to administer insulin. This identified a potential of 175 uses of the pen cartridges during this period of time, relating to 132 patients and following discussion with UKHSA a Task and Finish group was convened. Following identification of potential patients, known to have a blood borne virus diagnosis this was narrowed down to eleven patients who may have come into contact with the patient. National advice received helped us to calculate the risk of contamination as small, less than 1 in 1000 for Hepatitis C, less than 1 in 7 million for HIV and less than 1 in 1700 for Hepatitis B. UKHSA also advised this is a theoretical risk and as the risk is negligible this was not declared as a PSII. The Task and Finish group will contact the eleven patients. Should this number decrease if the patients are identified to use their own equipment they will be able to be ruled out. The Trust will offer appropriate support in the form of counselling and blood surveillance for a period of time. RS noted that the response from the Trust to both incidents demonstrates good governance, acknowledgement and exemplary practice from the whole team to these two incidents being managed in an open, honest and reflective way involving National agencies to help guide the Trust's response and understanding the risks. RS commended the teams on their actions and response. JL referenced no patient safety incidents were reported in January and raised the issue of how the Trust is aware that processes are being used correctly with no misses. LH noted this oversight report covers two months and the SI report covers one month. Next month's Academy report will reference PSIIs. It is noted that incidents have been identified but due to the reporting period, these have been escalated, with information being gathered and reviewed. JL discussed the legacy SIs noting the differing timescales between the incident and the report dates on the Strategic Executive Information System (STEIS). LH noted some incidents require consent from families prior to investigation which may result in delayed reporting times. JC noted a close track will be maintained following the move to the new incident reporting system Integrated Reporting Learning and Improvement System (IRIS). The Terms of Reference for SEG are being reviewed and a Timeout is being held on 8 March 2024. PSIRF promotes local learning and every caution during the transition period is currently being taken. The Academy noted the comprehensive report and appendices.	
QA.2.24.9	**Legacy Serious Incident (SI) Report and Patient Safety Incident Investigations (PSII) – January 2024**	
	LH presented the report Legacy SIs and Patient Safety Incident	

	Investigations (PSII). The Trust is in a period of transition which began on 1 December 2023 to the National Patient Safety Incident Response Framework (PSIRF), representing a significant shift in the way the NHS responds to patient safety incidents. This is a major step towards establishing a safety management system across the NHS and a key part of the NHS Patient Safety Strategy, safer culture, safer system and safer patients. • The report covers January 2024 including legacy SIs reported under the SI framework and PSIIs will be reported under PSIRF in the future. • SIs declared by the Trust remained within normal cause variation between February to the end of December 2023. In January 2024 there were no incidents reported as PSIIs. • Eight investigations remain ongoing, two of which are being led by MNSI. Five have extensions to the original deadline in place. Four are being led by the Trust and one by MNSI. Two MNSI investigations were concluded in January, SI 2023/6110 and SI 2023/8370 and the safety recommendations were noted. Further information will be provided in the Maternity and Neonatal Services update, agenda item QA.2.24.10. • The timescales continue to be problematic under the old SI framework due to various factors including liaison with external agencies and individual requests to General Practitioners for information. The team continue to focus on expediting the completion of the ongoing investigations and the Academy will be updated on the progress. • The Trust continues to meet the Duty of Candour requirements and no breaches have occurred since August 2016. There were no comments or questions. The Academy noted the current position with full assurance around the raising and management of SIs as reported.	
QA.2.24.10	**Maternity and Neonatal Services Update**	
	CS presented the February update to the Academy. Considerable discussion ensued regarding the risk associated with the delays currently being experienced in the diagnosis of gynaecological cancers and delays in histopathology processing in general. RS noted the specific gynaecology risk on the high-level risk register has been reduced to 12 due to a higher overarching risk around histopathology services in general which reflected the overall number of patients affected. Despite this Obstetrics and Gynaecology requested the risk to remain on their local risk register. The Executives agreed to reduce the risk on the basis of the relatively low number of patients affected in the single specialty of gynaecology. It was assumed that this risk was downgraded with the agreement of the CSU. KD noted the robust process used by Maternity for risks and questioned whether these had increased during the period of the risk register being locked down. Comprehensive discussion at the Executive team meeting on 26 February 2024 was noted. An in-depth piece of work has been commissioned to consider the impact on cancer performance reports and Referral To Treatment pathways.	

JL noted the improvement work in Histopathology was discussed at the Finance and Performance Academy meeting on 28 February 2024 and queried whether the gynaecology issues can be prioritised or is the risk the same across all services that involve Histopathology.

JB noted the crossover between the two Academies and the histopathology improvement project. This service is an issue affecting every specialty in the Trust that uses the Histopathology service. An intensive process is underway in the form of a review and issues are being managed aggressively.

KD noted the similarities between this risk and the nurse staffing risk noting each individual CSU will have a risk around Histopathology linked to their business. One overarching risk is required for Histopathology to be entered on the risk register. CS accepted the recommendation.

With regards incorporating Risk 3896 within Risk 3309, KD informed the Academy these two risks will remain, however, only the overarching risk will be submitted to the Academy/Board of Directors.

Following a national alert re concerns about the current Euroking maternity information system, where maternity/pregnancy data patient information could be back-copied, overwritten, forward-copied and data lost due to overwriting. KP noted an alert had been received and the action would be completed by 7 June 2024.

KP has reviewed the current EPR core maternity digital capabilities framework. There is currently no Oracle Cerner solution, or a timeframe, however, mitigation is in place. Other assessments have taken place and from a Trust perspective compliance was reported with no further issues.

CS presented the January 2024 update for Maternity and Neonatal Services and the following recommendations were noted:

- Following the January Board of Directors' the Maternity Incentive Scheme, Year 5 Board Declaration was approved and this was submitted on 31 January 2024, declaring full compliance with the ten safety actions.
- The final report was acknowledged following the NHS England Neonatal Commissioning Assurance visit in December 2023, including the recommendations. One recommendation was for the Head of Department/Consultant Neonatologist Lead to attend the Board to present a regular report on behalf of the department, however, it was suggested that the QPSA receive a quarterly update report with escalation to the Board as required. This very positive visit was noted, resulting in the report documenting that the BTH neonatal team provide safe, high quality of care to its patients, families and service users.
- Monthly stillbirth position is four, the immediate actions and lessons learned were noted. One Hypoxic-ischaemic

	encephalopathy (HIE) case remains under review, however, the recognised learning identified did not contribute to the outcome. • One case of HIE reported in January. • Two neonatal deaths in January. • There was one maternal death in January of a Bradford woman transferred to Leeds Teaching Hospitals. • There are three ongoing maternity SI/Level 1 investigations, one MNSI and two Trust level. • There are no new or ongoing neonatal SIs. • There were three completed MNSI/SI reports shared with the QPSA and Closed Board in January 2024. • The Academy noted the Quarter 3 Avoiding Term Admissions into the Neonatal Unit (ATAIN) and Transitional Care Unit (TCU) report and action plan. • There were eight occasions in January where the unit was assessed as needing to divert women to other organisations. This has impacted in the provision of one to one care in labour, delayed induction of labour and the experience of some women. • Internal investigations undertaken by Maternity along with the recommendations were noted. KD noted the robust processes for tracking actions and recommendations from HSIB (Healthcare Safety Investigation Branch)/MNSI, however, queried whether paediatrics has the same level of tracking. The presentation noted that the majority of the actions for the second case discussed were for paediatrics. For assurance purposes the actions tracked will be reported through Women's or Children's governance. CS highlighted actions are tracked for the joint specialty action plans, full assurance is available from the Women's perspective that actions are completed and an increased number of meetings are being held with Neonates as a move to work more closely as part of the perinatal service. All learning will be shared within the forum with both teams' actions tracked. Concerning the neonatal SIs of concern a few months ago, JC drew the Academy's attention to the assurance document following the review that NHS England undertook around neonatal incidents in an email dated 20 February 2024. A short summary report will be compiled. The headline was that NHS England did not identify any concerns and the history of the incidents were identified, investigated and shared with clear timelines. LB thanked CS for the report noting the elements of good practice identified within NHS England's visit in December 2023 and noting the recommendation for the Consultant Neonatologist or Head of Department to attend the Board to present a regular report on behalf of the Department as recently occurred. LB queried whether the suggestion that the QPSA receives a quarterly update report was in fact adequate for assurance purposes with this not in fact being the recommendation. KD noted NHS England's discussions around the recommendations. Of the three recommendations the Trust were already undertaking two. NHS England implied it would be useful	

	for the Neonatology team to attend the Board of Directors' meeting as previously. A Task and Finish group is being established to look at/define maternity and neonatal reporting. Due to the inclusion of Maternity and Neonatal Services within perinatal services a Task and Finish group will define representation from the service at the Academy and at the Board of Directors with frequencies confirmed in order full assurance can be provided directly. GE shared the findings of the visit presented at the West Yorkshire Integrated Care Board Quality Committee on 27 February 2024 which were exceptionally well received and the Chief Nurse at West Yorkshire being extremely complimentary about the findings and the analysis that had been taken as part of the review. This well received report was signed off at that meeting. The Academy noted the report and discussed the recommendation as to how the Board is fully appraised of the work of the Neonatal service, as well as Maternity, to ensure full assurance. The Academy was content with the assurance report presented by CS and the numerous appendices accompanying the report.	
QA.2.24.11	**Independent Inquiry – Maidstone and Tunbridge Wells NHS Trust**	
	SB and JW presented the Trust's assurance following an Independent Inquiry into mortuary incidents by Maidstone and Tunbridge Wells NHS Trust. JW described the background to the inquiry that between 2005 and 2020, David Fuller (DF) committed over 140 assault offences on deceased women and girls between the ages of 8 and 100 in Maidstone and Tunbridge Wells NHS Trust, across a two-site hospital mortuary. The offences were carried out both within and out of working hours. DF was later arrested for a different offence, the historical murder of two young girls and the mortuary assault offences were subsequently identified through his videos. DF is now in custody. In October 2021 NHS England requested all Trusts reviewed their Mortuary practices to provide assurance of Trust compliance. Remedial work was undertaken in the Trust to assure the Board of Directors of full compliance to NHS England which included extension of CCTV and a couple of security upgrades within the Mortuary. The recommendations from the Independent Inquiry produced were released in November 2023 containing 17 recommendations and these have been categorised into three categories of Building and security, Personnel and Regulatory compliance and assurance. The main failings for each category, the recommendations and the findings were discussed. JW presented the assurances for each category demonstrating Trust compliance around the recommendations including daily, weekly, two weekly checks required and a three-monthly audit undertaken on access, covering every aspect of entry. JW highlighted that post-mortem examinations are not performed at the Trust but at the Public Mortuary in Bradford.	

	The team assured the Trust's Board of Directors of compliance. A Human Tissue Authority (HTA) Inspection was undertaken in March 2023 and the regulatory compliance and assurance findings were noted by the Academy. SB noted the overall assurance being confident that the Trust provides the assurance for 16 of the 17 recommendations from the Independent Inquiry mortuary incidents although it was discussed that the Trust actually provides the assurance for all 17. In the interests of openness, the seventeenth depended on how the Academy would interpret Recommendation 16 – 'The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that Mortuary management is delivered in such a way that it protects the security and dignity of the deceased.'. SB noted that KD is absolutely sighted on all Mortuary workings, has been very supportive and has worked with the team throughout. The way the recommendation is interpreted queries whether this applies to Maidstone and Tunbridge Wells or whether it should apply to all Trusts. This is the last opportunity to ensure patient experience and dignity for all patients. The team were noted to be extremely proud of the HTA Inspection in March 2023 with the majority of the standards being met. Assurance has been provided that the actions have been completed and processes where necessary are now in place. Capital works necessary are due to be completed by 31 March 2024 providing the additional storage required. KD noted with any recommendations required by the Trust, these are discussed by the Executive team and a Lead is nominated. KD was nominated as the Lead for providing the assurance to the Board of Directors and requested SB and JW to undertake this piece of work. KD noted confidence that full oversight and assurance is now provided to the Board of Directors in relation to this, with full compliance on the 17 recommendations. RS described the significance of this inquiry with much of the work having been undertaken previous to the Maidstone and Tunbridge Wells inquiry, noting the Trust is very fortunate to have JW as an incredibly experienced manager and noted the governance around the Mortuary is now exemplary. SB noted the annual mock inspection is due to be undertaken imminently. RS noted his thanks for all the work undertaken and the excellent governance in place. LB noted the very distressing and upsetting set of events noting the very strong and clear point by point account of how all the Inquiry failings have been addressed by the Trust. The assurance was noted by the Academy and the team thanked for all their work undertaken in relation to the Mortuary services at Bradford Teaching Hospitals NHS Foundation Trust.	

QA.2.24.12	**Equality Delivery System (EDS 2022) Outcome and Next Steps – February 2024**	
	RH summarised the process undertaken and the Trust's approach to implement the Equality Delivery System 2022 for Domain 1 – Commissioned or Provided Services. The report outlines the EDS rating that has been achieved and the next steps considered as part of the Trust's contractual requirements. An overview was provided at the QPSA in November around the refreshed EDS and this is an annual process. The contractual requirement is to collate evidence around the Trust's progress under each of the outcome measures under Domain 1 - To engage with the voluntary and community sectors noting their feedback and ratings on progress and to publish the findings and the Trust ratings under each outcome measure. RH provided a brief overview in terms of the approach for Domain 1. Feedback from engagement identifies actions on key areas of focus where improvements can be made. Bradford and District Craven Health and Social Care partnership chose to focus on respiratory services, an area included in the Core 20+5 initiative and relevant to the recovery of Covid 19 and the three service areas chosen were asthma, sleep services and lung cancer services. A Task and Finish group was developed for Domain 1 with relevant colleagues across the organisation to gather evidence and insights and demonstrate the Trust's performance under each outcome measure. The community engagement event on 1 February 2024 was well attended with a range of participants from across the voluntary and community sectors including representatives from the Trust. The good work across the Trust and the areas for improvement were noted. The Trust was rated as achieving on all outcome measures for Domain 1 therefore meeting the required level of activity and rated as achieving for the organisation as a whole (incorporating the other two domains, around workforce health and wellbeing and inclusive leadership). Feedback was gathered around lived experiences where the majority demonstrated good practice. Some examples of feedback included: A need for consistency across departments is required applying to meeting needs of diverse patients. A great range of services on offer, but a need to increase awareness particularly around the needs of neurodiverse patients and to ensure staff are empowered and trained to meet the needs of patients with additional needs, for example learning disabilities, communication, cognitive, disability and sensory needs. There is a need to raise the profile of what is available to continue with awareness raising and training for staff. Some areas of focus are already a work in progress with good foundations in place. Feedback will be fed back to Clinical Service Units and departments instrumental in the review process (eg Patient	

	Experience/Additional needs team) and through the Health Inequalities work. The QPSA approved the publishing of data and recommendations on the Trust website. LB thanked RH for the update noting the contents of the report and the rating submission. Some areas within Domains 2 and 3 were noted to be close to excelling. RH noted the need to continue to raise awareness with staff across the organisation around patients with additional needs and Policy and Practice will continue to be rolled out and established to ensure all staff have a level of understanding to raise the profile with patients in the community in order to excel further in Domain 1.	
QA.2.24.13	**15 Steps Assurance Programme**	
	The 15 Steps Assurance Programme was presented to the QPSA by NB, providing an update on progress including ward visits completed between August 2023 and January 2024. This challenge compiled of a suite of toolkits exploring different healthcare settings through the eyes of patients and relatives and was launched at Bradford Teaching Hospitals NHS Foundation Trust in August 2023. Observations during visits are recorded using a question and prompt tool covering the four categories of welcoming, safe, caring and involving and well organised and calm with the team encouraged to identify and celebrate the positive aspects observed as well as identifying where improvements can be made. The structure is closely aligned to CQC standards, regulations and processes. A verbal debrief is undertaken during the visit with the ward team to ensure immediate feedback, a report compiled including findings and recommendations and an action plan formulated by the Ward Manager to address any recommendations for improvement. Any immediate risks or concerns regarding patient safety and quality of care are raised and addressed immediately. A Task and Finish group had been established to develop the programme and to ensure any learning from best practice was incorporated and embedded in the system. A number of volunteers from a wide range of staff were recruited to undertake the activities including Executive Directors, Non-Executive Directors and Governors. A seamless process has now been formulated and those undertaking weekend on-call duties are now approached to undertake visits. Packs have been developed for the ward areas, with assistance from Education and thanks were expressed to the Chief Nurse and Quality Governance teams for their invaluable support. There has been a total of 10 visits to wards and departments since the visits were initiated. Areas have been informed the unannounced visits are not for audit purposes but an opportunity for outstanding activities underway in wards and departments to be showcased. A summary of the visits conducted were discussed with particular reference to patient feedback and positive feedback with regards dignity, privacy and compassion. Both positive and	

	negative comments were noted regarding patient food and a lack of communication from staff who had not introduced themselves to patients. Proposals were noted to continue the visits to ensure Trust-wide themes can be built on to identify quality improvement opportunities, to develop the process for sharing learning and good practice, to initiate assurance reviews to ensure actions have been identified and completed, including discussions with other areas for example Estates. Material displayed on information boards will be standardised where data permits. Clinical Service Unit reports will be shared as part of the governance agenda and quarterly updates will continue to be provided to the Moving to Outstanding meeting. A comment regarding staff being unaware of the process to access the interpreter service out-of-hours was queried due to this information being available to all staff having been widely publicised and being available through an icon on all desktops. Interpreters were believed to prioritise patients on a need basis. KB will ensure some further education is provided to ward areas regarding access to interpreters out-of-hours as robust processes are already in place. Assurance was noted that the signage improvement work throughout the Trust is in the process of being actioned. Discussions have also taken place with Accessible who are looking to develop a type of Google map of the Trust's site with implementation expected around April 2024. LB noted the report to provide really valuable information and thanked NB for the report findings, particularly appreciating the invitation for Non-Executive Directors and colleagues to attend and participate in the process. The QPSA noted the assurance provided within the findings of the report.	QA24005 Assistant Chief Nurse – Patient Experience (KB)
QA.2.24.14	**Bradford District and Craven Quality Committee (Highlight Report/Minutes)**	
	JC provided the highlights from the January System Quality Committee (SQC) meeting: • The Integrated Care System is approaching a stage where some of the services are being harmonised in the way the services are delivered, for example Standard Operating Practice and service specifications. • The System Quality Committee requests Trusts ensure that services are delivered in the same manner across West Yorkshire. • Virtual Ward – A presentation was provided with significant discussion around how that is benefitting the patients at Place. Wrightington, Wigan and Leigh's experience of increased admissions to hospital highlighted this has not been seen here. The service will need to be funded in the future on a more financial planning process. The SQC was informed of experiences to understand patient benefits and not to agree	

	what would be delivered in a financial package. This has been escalated. • The 136 Suite at Lynfield Mount Hospital has been reopened following refurbishment and will benefit BTH's patients. GE noted the 136 Suite is a place of safety that people in mental health crisis attend to recover, subject to assessment under the Mental Health Act. The patient is supported by the nursing team whilst they are awaiting for the assessment process to be completed. • Measles – An update was noted. Measles was spreading across the country but the significant numbers being seen elsewhere are not identified in the region at present. LB thanked JC and GE.	
QA.2.24.15	**Any Other Business**	
	There was no other business to discuss.	
QA.2.24.16	**Matters to share with Other Academies**	
	There were no matters to share with the other Academies, however, JL noted it was interesting to see the connections across the three Academies.	
QA.2.24.17	**Matters to escalate to the Board of Directors**	
	Histopathology.	
QA.2.24.18	**Date and time of next meeting**	
	Wednesday, 27 March 2024, 2 pm to 4.30 pm	
	Annexes for the Quality and Patient Safety Academy **Annex 1 – Documents for Information**	
QA.2.24.19	**Freedom to Speak Up Quarterly Update**	
	Noted for information.	
QA.2.24.20	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.2.24.21	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.2.24.22	**Internal Audit Reports relevant to the Academy**	
	BH/21/2024 – Safeguarding: Mental Capacity Act Noted for information.	

Bradford Teaching Hospitals NHS Foundation Trust

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 28 FEBRUARY 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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
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	

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24002	28.02.24	QA.2.24.5	**High Level Risks** PR reflected on previous conversations concerning material risks related to the Trust's alliance in pathology with Fordham and the programme of WYAAT migrating to Clinicist. The Trust is reliant to Leeds in relation to two elements of the programme around blood science and microbiology. The programme has been responsible for considerable delays, however, the project go-live is June for Leeds elements resulting in consequences for the Trust. PR agreed to reconsider the consequences and processes and provide further detail to the QPSA regarding the implications around these delays in Leeds against the original trajectory resulting in the Trust being later in the process than initially anticipated.	Chief Digital and Information Officer	March 2024	
QA24003	28.02.24	QA.2.24.5	**High Level Risks** Having reviewed, challenged and assessed the identification and management of key risks within their remit on the High Level Risk Register and the matters raised by the Executive team at its meeting on 19 February 2024, the Academy noted that the histopathology issues relating to risks will be highlighted to the Board of Directors at its meeting on 14 March 2024.	Associate Director of Corporate Governance/ Board Secretary	March 2024	14.03.24: LP - Raised at the Board of Directors 14.03.24. Completed. **CLOSED.**
QA24005	28.02.24	QA.2.24.13	**15 Steps Assurance Programme** A comment regarding staff being unaware of the process to access the interpreter service out-of-hours was queried due to this	Assistant Chief Nurse – Patient Experience	March 2024	19.03.24: Update from Ruth Tolley, Quality Lead for Patient Experience. Ruth has met with Nazakat Hussain, Interpreting Manager. Nazakat to

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			information being available to all staff having been widely publicised and being available through an icon on all desktops. Interpreters were believed to prioritise patients on a need basis. KB will ensure some further education is provided to ward areas regarding access to interpreters out-of-hours as robust processes are already in place.			review the Standard Operating Procedure (SOP) on the intranet to ensure that it is correct and up to date. Comms have been contacted to ask for their urgent support in adding the Interpreting team to the Patient Experience section of the intranet and requested that there is a quick link to the updated SOP for staff to access without having to trawl through many policies. Once the intranet is updated Medical Illustration will be asked to devise a debit card sized QR code that staff can scan in order they can access the appropriate link directly for booking an out of hours (OOH) interpreter. Comms also advising on the best way for this information to be communicated ensuring staff are aware that the OOH interpreting service is available to all appropriate staff.
QA24004	28.02.24	QA.2.24.7	**Quality and Patient Safety Academy Dashboard** NHS Digital generate the data from the Electronic Patient Record (EPR) for SHMI and discussions are underway to rectify these errors. PR noted an in depth discussion at a recent Board of Directors' meeting. PR agreed to provide a full update to the April QPSA Assurance meeting and the information will be included in the next quarterly data update. LB	Chief Digital and Information Officer	April 2024	

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			questioned the increase in figures in October/November 2023; the forthcoming paper will consider this.			
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 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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						suggested she provides an update on the work being undertaken at the next safeguarding update in June 2024.
QA24006 Next action number						

QUALITY AND PATIENT SAFETY ACADEMY (QPSA)
- LEARNING AND IMPROVEMENT
MINUTES

Date:	Wednesday, 27th March 2024	**Time:**	14:00-16:30
Venue:	Microsoft Teams Meeting	**Chair:**	Professor Louise Bryant, Non-Executive Director / Co-Chair
Present:	**Non-Executive Directors:** - Professor Louise Bryant (LB), Non-Executive Director/Co-Chair - Mr Zafir Ali (ZA), Non-Executive Director **Executive Directors:** - Professor Karen Dawber (KD), Chief Nurse		
Attendees:	- Mr David Smith (DS), Director of Pharmacy - 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 - Ms Judith Connor (JC), Associate Director of Quality - Ms Kay Pagan (KP), Assistant Chief Nurse, Informatics - Mr Kez Hayat (KH), Head of Equality, Diversity and Inclusion - Dr LeeAnne Elliott (LAE), Consultant Paediatric Radiologist - Ms Marianne Downey (MD), Deputy Associate Director of Nursing - Mrs Sally Scales (SS), Director of Nursing / Programme Lead for Magnet - Mrs Sarah Turner (ST), Assistant Chief Nurse, Safeguarding (part meeting)		
In Attendance	- Ms Carly Stott (CS), Associate Deputy Director of Midwifery deputising for Sara Hollins (SH), Head of Nursing, Midwifery - Ms Elizabth Brooks (EB), Quality & Patient Safety Facilitator - Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District Care Health and Care Partnership - Ms Jacqui Maurice (JMa), Head of Corporate Governance - Ms Katie Shepherd (KS), Corporate Governance Manager (part meeting) - Ms Sasha Bhat (SB), Deputy Director of Integration and Transformation, Bradford District Care NHS Foundation Trust (BDCT) and Ms Cheryl Stanfield (CSt), Team Leader, Acute Psychiatric Liaison Service, Bradford, for agenda item QA.3.24.9 - Chris Boyne (CB), Deputy Director Internal Audit, Audit Yorkshire, for agenda item QA.3.24.16 - Ms Linda Preston, Minute taker		
Observers	- Alastair Goldman, Governor		

Agenda Ref	Agenda Item	Actions
QA.3.24.1	**Apologies for Absence**	
	- Mr Mohammed Hussain (MH), Non-Executive Director/Co-Chair - Ms Sughra Nazir (SN), Non-Executive Director/Chair - Dr Paul Rice (PR), Chief Digital and Information Officer - Dr Ray Smith (RS), Chief Medical Officer - Mrs Adele Hartley-Spencer (AHS), Director of Nursing (Operations) - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Mrs Kay Rushforth (KR), Associate Director of Nursing for Children and Neonatal Services - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary - Ms Leah Richardson (LR), Patient Safety Specialist - Mrs Sara Hollins (SH), Head of Nursing, Midwifery - Mrs Sarah Freeman (SF), Director of Nursing (Operations) - Ms Sonya Tetley (ST), Nursing & Midwifery Quality Lead Absent: - Mr Altaf Sadique (AS), Non-Executive Director - Mr Benjamin McKay (BM), Education Manager - Ms Caroline Nicholson (CN), Head of Non-Clinical Risk - Ms Caroline Varley (CV), General Manager, Chief Medical Officer's Office - Mrs Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing - Ms Karen Bentley (KB), Assistant Chief Nurse, Patient Experience - Ms Kavitha Nadesalingam (KN), Rheumatology Consultant/Honorary Senior Lecturer - Ms Kelly Young (KY), Deputy Associate Director of Nursing - Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes - Ms Louise Horsley (LH), Senior Quality Governance Lead - Dr Michael McCooe (MMc), Consultant in Anaesthesia / Associate Medical Director - 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 - Dr Robert Halstead (RH), Consultant in Emergency Medicine/Associate Medical Director - Mr Sean Willis (SW), Associate Chief Nurse, Quality and Workforce - Dr Yaseen Muhammad (YM), Nurse Consultant / Director of Infection, Prevention and Control	
QA.3.24.2	**Declarations of Interest**	
	There were no declarations of interest.	

QA.3.24.3	**Minutes of the meeting held on 28th February 2024**	
	The minutes of the meeting held on 28th February 2024 were approved as a correct record. The meeting reviewed and agreed the outcomes in relation to the following actions: QA23030: **Screens in A&E** Kay Pagan will address at the next meeting or provide information via email. Action to remain open . QA24001: **Patient Experience** A SOP for patient stories is in place and an additional clause is being included around selecting stories of patients who are reflective of the community. Action closed. QA24002 **High Level Risks** - re material risks related to the Trust's alliance in pathology with Fordham and the programme of WYAAT migrating to Clinicist. Action held over – update to be provided by CDIO in April. QA24003: **Histopathology issues** relating to risks to be highlighted at Board. Raised at Board meeting on 14 March 2024. Action closed. QA24004: **Quality and Patient Safety Academy Dashboard re SHMI**: Action held over – update to be provided by CDIO in April.	
QA.3.24.4	**Matters Arising**	
	CQC KD noted due to a concern being raised around the allegations in the Health Service Journal in relation to racism and Islamophobia within the Board, the CQC arrived at the Trust on 13th March 2024 for an unexpected two-day inspection of medicines services on the majority of the medical wards at St Luke's and Bradford Royal Infirmary. There were no escalations on either day and the feedback provided stated all staff were very welcoming, enthusiastic and caring. The CQC Inspectors also attended the first 30 minutes of the Board of Directors meeting and were impressed by the Ramadan Allies presentation given. During the visit the CQC asked staff a suite of questions about the allegations made and if they are able to progress their careers at the Trust. The evidence is now being worked through and will then be submitted back by tomorrow. KD continued that preparations are now underway for the Well Led element of the CQC inspection which is taking place on 16th, 17th and 18th April 2024. There will be eight Inspectors in attendance who will be interviewing all the Board members and those staff with specific roles such as Director of Infection Prevention and Control and Head of Equality, Diversity and Inclusion (KH's role) etc. Help and support is available for all those to be interviewed and calendar invites are being issued in relation to these. KD advised staff focus groups with the CQC took place on 25th and 26th March. No feedback as such is received regarding these	

	however there were no urgent escalations following the sessions. It has been advised however there was a common theme of short staffing mentioned which is already a known risk, and concerns that stroke patients are not receiving the therapy they require resulting in their hospital stays being elongated. As a result of this KD and Saj Azeb (SA), Chief Operating Officer have been working with the clinical teams whereby a risk assessment has been undertaken and mitigation will be implemented. Agreement has been given for a £250,000 investment in the Stroke ESD Service. It has also been agreed to use Locums or agency staff to provide help and support where needed, and a fast-track programme for staff is being looked into. Following a query from LB regarding next steps, KD advised following the Well Led inspection the CQC will provide their report within approximately eight weeks which will then be considered by the Trust for factual accuracy. The final report should then be received around August/September 2024. LB thanked KD for the update. <u>CSU to Academy Engagement Event</u> Following a review of the slide pack as she was unable to attend the event, KD advised the session was an opportunity to undertake a deep dive into the Theatres and MSK & Therapies CSUs are areas which have gone really well and ongoing work are highlighted. All the CSUs will be looked at during the sessions scheduled throughout the year, and the methodology for the events is proving fruitful. KD encouraged members of the Academy is review the circulated slide pack.	
QA.3.24.5	**Patient Story**	
	Due to the absence of JM and EC this item was deferred to the next Learning and Improvement meeting of the Academy. In the meantime however, LB encouraged the Academy to watch the video circulated.	
QA.3.24.6	**Legacy Serious Incident (SI) and Patient Safety Incident Investigations (PSII) Report**	
	In LH's absence JC advised the Trust's last declaration of Legacy SIs was on 29th November 2023 at which time the trajectory was updated to 21st February 2024 for completion of all legacy investigations. Whilst the investigations have taken place, the target has not been met in terms of the writing up of the investigations and agreement of the action plans etc with the various clinical teams. This has been due to a number of issues, particularly around availability of clinical staff, in addition to winter pressures and the effects of ongoing industrial action. JC confirmed the numbers being declared are still within the normal	

	cause variation. There have been technical delays experienced with the STEIS system in the first two months of this year, however it is to be replaced by the Learning from Patient Safety Incidents (LFPSE) system in due course. JC continued that the Trust's position to date is there are eight ongoing serious incident investigations with three being closed during the reporting period, namely: SI 2023/1486, SI 2023/20935, and the recently opened PSII 2024/2217. The latter of these is a Never Event and was turned around very quickly with the staff using the new process of an After Action Review. With regard to the PSII investigation process LAE then discussed the learning and benefits of the new system, the engagement with and feedback received from staff, and their involvement in determining solutions to diminish reoccurrences of incidents. Regarding the Never Event PSII 2024/2217 she advised this was a wrong site interventional procedure within radiology. LAE said the Patient Safety Incident Response Framework (PSIRF) has four aims, and three of these were pertinent to this particular investigation: (1) compassionate engagement involvement of those involved in an incident, (2) a system based approach to learning, and (3) a considered and proportional response to a safety event. In this case an After Action Review technique was utilised within approximately six weeks which encompassed discussing with the staff involved those actions which should have taken place, which actions did take place, why the incident occurred, and what can be done to ensure there is not a repeat occurrence. All staff in the area involved engaged fully with the process, positive feedback was received, and useful learning was gleaned which will be fed back into the area. The patient and their wife have also been kept informed throughout the review and are appreciative of the actions taken. GE acknowledged the benefits of the new patient safety framework, how it will assist improvements to be made quickly, how the early learning will help staff, and also show them it is not for the purpose of being critical. ZA asked how the timelines in relation to PSIRF are determined and if there are expected completion dates in terms of the current SIs. JC advised under the old NHS England (NHSE) SI framework there were strict timeframes of 60 working days for an investigation report to be produced and submitted through the STEIS system to the CCG, and 90 days for a Never Event. Under PSIRF there are no timeframes set and they are locally determined at the Quality of Care Panel (QuOC) meetings dependent on the complexity of the incident being investigated. LB queried what the process is if a timescale we have determined then needs to be extended. JC said the request and justification for it is made to the appropriate Executive lead and this is determined at the QuOC meeting along with the clinical lead, the investigation team and who will provide support within the Quality team. The Academy noted the current position and confirmed they feel	

	assured that the Trust has processes in place to identify, investigate and learn from serious incidents and patient safety incident investigations.	
QA.3.24.7	**Update from Patient Safety Specialist**	
	LAE advised the transition and embedding of PSIRF has been the main focus for the Patient Safety Specialist team. She noted the key workstreams for the next year are how the implementation is assessed and measured, and to review the learning from both the patient safety incident investigations and the improvement programmes. One improvement programme which currently requires work is the development of the medicines safety improvement programme which will be done in conjunction with the new Medicines Safety Officer who is coming into post soon. Despite the change to a new incident reporting system however, LAE noted the level of reporting of safety incidents has remained consistent as can be seen in the run chart included in the presentation pack. LAE added the Patient Safety Partner role requires development and recruitment, PSIRF training of all staff continues, and by the end of next year the plan and policy will have been reviewed. LAE then updated the Academy on the ongoing planning of relevant metrics in relation to PSIRF and the recruitment and development of the role of the Patient Safety Partners workstream as outlined in the circulated presentation. In relation to successes in recruitment GE asked if these have been shared with place colleagues and LAE confirmed this to be the case. JC added a WYAAT peer support group is also being developed. Following a question from ZA it was acknowledged recruitment needs to be representative of the community wherever possible. Following a comment from LB regarding the setting of our own metrics, LAE noted there is the opportunity for consistency across the place and wider West Yorkshire organisations via the various meetings which are held.	
QA.3.24.8	**Maternity and Neonatal Services Update**	
	CS gave an overview of the circulated documentation and highlighted that significant staffing challenges are being experienced within the service as a result of the national requirement for a five-day training programme within maternity services. With regard to the two stillbirths in February, CS advised there was no significant learning from either, and one was sadly a butterfly baby. In relation to the Annual Maternity CQC Survey CS noted since the survey was undertaken visiting times have been increased significantly, and especially during the Ramadan/Eid period. This is having a positive outcome and consideration is being made to making the Ramadan/Eid changes permanent.	

	Regarding the maternal death in January where the lady was transferred to theatre in Leeds, KD asked for assurance that a MNSI investigation is taking place, and any areas of learning are being highlighted to us. CS said an initial MDT case review was undertaken jointly with Leeds and it was felt the care provided overall was well managed and there were no significant safety concerns. A meeting was also held with family members who raised some questions, and a deep dive is currently being performed to address these. With regard to the maternity improvement plan LB asked if the dates can be updated correctly to show the relevant year. In relation to ongoing pharmacy cover, LB asked how the issues around the recent number of medication incidents are to be addressed. KD stated this was picked up during the CQC visit to the maternity wards last year, and a business case was submitted for funding for a Band 7 Pharmacist post. Recruitment proved unsuccessful and therefore the Pharmacist role was changed to jointly cover neonatal and maternity. KD added the longstanding Senior Pharmacist in neonatal has also now left the Trust and so the impact of this is additionally being felt. KD said a deep dive will now take place addressing the medication incidents and an update provided at next month's Academy meeting. DS commented the role has been rebranded to Band 8a however recruitment at the Band 7/Band 8a level is proving difficult at the present time, and options are being explored of utilising the funding in a different way to facilitate successful recruitment/cover into the area. The Academy confirmed they feel assured they have sufficient information and oversight on maternity and neonatal safety.	QA24006 Chief Nurse (KD)
QA.3.24.9	**Acute Liaison Psychiatry Service (ALPS)**	
	SB and CSt joined the meeting and shared the presentation circulated prior to the meeting including the strategy and approach being taken as a district in terms of how the mental wellbeing strategy is being focussed and links in with the learning disability, neurodiversity and substance use strategy. She provided background to Psychiatric Liaison and how outcomes and experiences for patients can be improved. She also highlighted the need for the Core 24 model to be implemented at the Trust as this has been mandatory since 2017. In response to a question from ZA, SB advised in Bradford the first response team is used in relation to providing support for children. In Airedale a business continuity plan is currently being utilised. In terms of if sufficient services are available to young people from a mental health perspective when they present in hospital, SB noted since the pandemic a much higher number of children are presenting in distress without a mental health diagnosable condition, or are presenting on the paediatric wards and currently the required support is not available. Work is being undertaken in conjunction with Kay Rushforth's team, Associate Director of Nursing for Children and Neonatal Services, and with BDCT's social work teams, around the crisis protocol and what the support	

	should look like for children and young people, and how it can be improved. CSt added the referral pathway for children and young people aged 16 and over was rather confusing and this has been changed such that for admittances to A&E or a ward, the initial assessment is done by the ALPS team. For anyone under the age of 16, the assessment is done by First Response. Regarding a further question from ZA as to why performance reduced in 2023 from 2022, CSt said this is because as the service is now Core 24, staff are more aware of it and this has therefore resulted in more referrals and subsequently increased pressure on the service. LB then asked if plans are in place to address some of the difficulties and challenges being faced by the service. SB commented that the work is being shared around the ALPS team and is reported to the Urgent & Emergency Board, which is co-chaired by SA. Meetings are also held with staff members more generally and around the co-location of the team to help with integration and working together. Thanks were given to SB and CSt for their presentation and they then left the meeting.	
QA.3.24.10	**Mental Health Strategy**	
	ST advised the Mental Health Strategy which has been in place for approximately three years is currently under review. The four key areas focussed on are: training, workforce, information sharing, and partnerships. ST noted mental health, learning disabilities and dementia previously sat within safeguarding however they are now situated within the additional needs team, and it is proposed to widen the strategy to incorporate and reflect the healthy minds district wide strategy to include learning disabilities, autism and neurodiversity. KH stated he welcomed the alignment of the Mental Health Strategy and to include the neurodiversity element. ST added a full paper in relation to the strategy will be submitted to the next Academy Learning and Improvement meeting. The Academy noted the update.	
QA.3.24.11	**Final Formal Report from NHS England in relation to Neonatal Incident Timeline**	
	KD gave an overview of the circulated documentation received from NHSE and the recommendations contained therein. She noted good assurance can be taken from the information received which acknowledges the Board of Directors were aware of all three incidents within 10-14 days of occurrence, and reflects incidents were escalated in a timely manner. KD continued on only one occasion was a concern raised in relation to the time taken and there were no further escalations.	

	The contents of the circulated papers were noted by the Academy.	
QA.3.24.12	**High Level Risks**	
	KD reminded the Academy that the InPhase system has now replaced Datix and confirmed all the risks and treatment plans have bee updated. She highlighted that whilst performance figures in A&E can be high, this does not always correlate to good patient experience especially if patients are awaiting a bed, and in some instances there has been a need to transfer mental health patients out of region. There will therefore be a new risk added to the Risk Register in relation to patient experience in the Emergency Department. KD continued risk no 447 is around ReSPECT which is the document used to record end of life decisions, if active resuscitation should be performed, and the ceiling of care for a patient. This risk has been on the Register for a while and is an outstanding action on the internal audit plan as it has not been possible to get an electronic ReSPECT form on EPR, however this now has a go-live date of 23rd April 2024. With regard to risk no 448, KD advised this risk was added to the register when EPR went live (approximately five years ago) due to the validity of the data which was transferred from the old system into the new system, but has evolved somewhat over time. Following a review of the risk at the Executive Team Meeting, it was agreed it would be closed down and a new risk assessment undertaken to truly reflect what the current risk is. The Academy confirmed they feel there is sufficient assurance that all the relevant key risks have been identified, reported to them, and are being managed appropriately. The Academy also confirmed there were no issues in relation to high level risks which require highlighting to the Board of Directors. KD suggested however the rating of risks and when they should be reviewed/rewritten requires consideration at a Board Development session.	
QA.3.24.13	**Quality Account: Quarterly progress update**	
	JC requested the item was withdrawn from the agenda as the information circulated prior to the meeting was incorrect. It was agreed to defer the item to the next Learning and Improvement meeting of the Academy.	
QA.3.24.14	**Deteriorating Patients Policy**	
	As Clare Nandha is unable to attend the meeting, LB asked the Academy to review the Deteriorating Patients Policy outside of the meeting.	
QA.3.24.15	**Bradford Model of Nursing and Midwifery Care, MAGNET**	
	SS provided an update as detailed in the circulated slide pack. She highlighted the work done, attendance at the focus groups, and advised that the celebration event for the strategy will be held 8th	

	May 2024 where the Trust's Nursing and Midwifery Awards for each component of the strategy will take place. SS added ward visits are now taking place talking to staff and distributing leaflets in relation to the strategy and positive feedback is being received. ZA asked how learning and good practise from across the region is included into the strategy. SS advised the Magnet for Europe research study work has involved a number of organisations across Europe supported by hospitals in the US which have Magnet accreditation, to understand how applicable the Magnet standards are and to support the Trust's framework for nursing excellence. There have therefore been several education sessions and sharing of information through that route, and SS will be attending a conference in Leuven to share our work. SS noted she is also involved in NAME-UK (Nursing and Midwifery Excellence UK) which involves quarterly forums where good practise and learning is shared. KH referred to a paper presented at the People Academy by KD and SW regarding staff progression including increasing the diversity of the workforce especially in terms of nursing and midwifery. He suggested this is shared with SS as it provides opportunities and links around succession planning, talent spotting, talent management, and career and personal development. SS confirmed she works closely with SW with regard to the initiative. KD then stated every nursing band has been reviewed and band progression from one band to another can be seen throughout, and BAME representation has also increased. KD referred to the documentation within the bundle of papers discussed at the March People Academy. ZA agreed but noted the gaps at the higher bands still need to be addressed and therefore should remain an area of focus. LB thanked SS for the update provided.	
QA.3.24.16	**Draft Internal Audit Plan 2024/25**	
	As background KD noted there are two sections relevant to the Academy: the Chief Medical Officer section and the Chief Nurse section. The Audit Plan will consider any routine audits and any areas with issues which need to be monitored eg Sepsis or ward accreditation. From the Board Action Plan which included an action to use Internal Audit to review the SI process (now superseded by PSIRF) and the time taken for signoff, KD said she has requested for a line to be added to the Audit Plan noting PSIRF refers to the Well Led Action Plan regarding the audit of SIs and this has now been included. CB discussed the circulated draft Audit Plan which he advised has been discussed and agreed at the Executive Team meeting. To enable a recommendation to be made to the Audit Committee, CB advised the Academy's assurance is sought that the draft Internal Audit Plan includes the appropriate audits. He added the Plan is	

	intended to be flexible to allow changes to be made throughout the year, and these are transacted via the Audit Committee. The Academy provided their assurance regarding the draft Internal Audit Plan. CB then left the meeting.	
QA.3.24.17	**Any Other Business**	
	ZA asked if the papers for the meeting can be provided as soon as possible due to the large number of papers which require reading, and if they can be kept to a minimum where possible. KD noted it was agreed at the January Board of Directors meeting that Task and Finish Groups will be formed to look at the number of papers being presented to Committee/Academy meetings, and this will be discussed further at the Board Development sessions.	
QA.3.24.18	**Matters to Share with Other Academies**	
	There were no matters to share with the other Academies.	
QA.3.24.19	**Matters to Escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
QA.3.24.20	**Date and Time of Next Meeting**	
	Wednesday, 24th April 2024, 2pm to 4.30pm.	
	Annexes for the Quality and Patient Safety Academy	
	Annex 1 – Documents for Information	
QA.3.24.21	**Patient Safety Group**	
	Noted for information.	
QA.3.24.22	**Clinical Outcomes Group**	
	Noted for information.	
QA.3.24.23	**Patient Experience Group**	
	Noted for information.	
QA.3.24.24	**Research Activity in the Trust**	
	Noted for information.	
QA.3.24.25	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.3.24.26	**Quality Account 2023/24 Production Schedule**	
	Noted for information.	
QA.3.24.27	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.3.24.28	**Internal Audit Reports Relevant to the Academy**	
	• BH/28/2024 - Care Quality Commission Maternity Inspection	

	Follow-up – 6 March 2024 • BH/27/2024 - Stakeholder Engagement: Signage, Maps and Accessibility – 5 March 2024 • BH/30/2024 – National Safety Standards for Invasive Procedures Recommendation Follow Up Review – 19 March 2024 The above reports were noted for information.	
QA.3.24.29	**Cancer Board minutes – February 2024**	
	Noted for information.	

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 27TH MARCH 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	April 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. 27.03.24: Response deferred to April meeting due to absence of CDIO.
QA24002	28.02.24	QA.2.24.5	**High Level Risks** PR reflected on previous conversations concerning material risks related to the Trust's alliance in pathology with Fordham and the programme of WYAAT migrating to Clinicist. The Trust is reliant to Leeds in relation to two elements of the programme around blood science and microbiology. The programme	Chief Digital and Information Officer	April 2024	Action held over from March meeting. Update to be provided by Paul Rice at the April meeting.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			has been responsible for considerable delays, however, the project go-live is June for Leeds elements resulting in consequences for the Trust. PR agreed to reconsider the consequences and processes and provide further detail to the QPSA regarding the implications around these delays in Leeds against the original trajectory resulting in the Trust being later in the process than initially anticipated.			
QA24005	28.02.24	QA.2.24.13	**15 Steps Assurance Programme** A comment regarding staff being unaware of the process to access the interpreter service out-of-hours was queried due to this information being available to all staff having been widely publicised and being available through an icon on all desktops. Interpreters were believed to prioritise patients on a need basis. KB will ensure some further education is provided to ward areas regarding access to interpreters out-of-hours as robust processes are already in place.	Assistant Chief Nurse – Patient Experience	March 2024	19.03.24: Update from Ruth Tolley, Quality Lead for Patient Experience. Ruth has met with Nazakat Hussain, Interpreting Manager. Nazakat to review the Standard Operating Procedure (SOP) on the intranet to ensure that it is correct and up to date. Comms have been contacted to ask for their urgent support in adding the Interpreting team to the Patient Experience section of the intranet and requested that there is a quick link to the updated SOP for staff to access without having to trawl through many policies. Once the intranet is updated Medical Illustration will be asked to devise a debit card sized QR code that staff can scan in order they can access the appropriate link directly for booking an out of hours (OOH) interpreter. Comms also advising on the best way for this information to

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						be communicated ensuring staff are aware that the OOH interpreting service is available to all appropriate staff. **Action closed.**
QA24004	28.02.24	QA.2.24.7	**Quality and Patient Safety Academy Dashboard** NHS Digital generate the data from the Electronic Patient Record (EPR) for SHMI and discussions are underway to rectify these errors. PR noted an in depth discussion at a recent Board of Directors' meeting. PR agreed to provide a full update to the April QPSA Assurance meeting and the information will be included in the next quarterly data update. LB questioned the increase in figures in October/November 2023; the forthcoming paper will consider this.	Chief Digital and Information Officer	April 2024	
QA24006	27.03.24	QA.3.24.8	**Maternity and Neonatal Services Update** In relation to ongoing pharmacy cover, LB asked how the issues around the recent number of medication incidents are to be addressed. KD stated this was picked up during the CQC visit to the maternity wards last year, and a business case was submitted for funding for a Band 7 Pharmacist post. Recruitment proved unsuccessful and therefore the Pharmacist role was changed to jointly cover neonatal and maternity. KD added the longstanding Senior Pharmacist in neonatal has also now left the Trust and so the impact of this is additionally being felt. KD said a deep dive will now take place addressing the	Chief Nurse	April 2024	23.04.24: KD confirmed action completed by Jamie Steele, Matron for Neonatal Services and team. **CLOSED.**

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			medication incidents will now take place and an update provided at next month's Academy meeting.			
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	May 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. 27.03.24: In PR's absence KP advised she will ask him to provide an update either via email or at the next Learning and Improvement Academy on 22.05.24.
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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						also task other officers with specific actions where needed. 16.08.23: Update to be provided at the September Academy. 21.09.23: Meetings undertaken with YAS and Police. Police shared their protocols and ST will pull some information together for Trust staff, providing a copy to the Police and YAS. 19.10.23: ST advised that BTHFT is also involved in the districtwide Mental Health and Criminal Justice 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.
QA24007 Next action number						

BO.5.24.28 - CONFIRMED AUDIT COMMITTEE MINUTES

REFERENCES

Only PDFs are attached

Bo.5.24.28 - Confirmed Audit Committee minutes 21.2.24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

CONFIRMED AUDIT COMMITTEE MEETING MINUTES

Date	Wednesday, 21 February 2024	**Time**	14:00-17:00
Venue	Virtual Meeting – MS Teams	**Chair**	Bryan Machin, Non-Executive Director

Present	• Bryan Machin, Non-Executive Director and Chair (BM) • Julie Lawreniuk, Non-Executive Director (JL) • Zafir Ali, Non-Executive Director (ZA)
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) • Nick Rayner, Deloitte (NR) • Helen Higgs, Internal Audit, Audit Yorkshire (HH) • Karina Edwards, Internal Audit, Audit Yorkshire (KE) • 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), ED in attendance & A.2.24.12 • Judith Connor, Associate Director of Quality (JC), for A.2.24.21

No.	Agenda Item	Action
A.2.24.1	**Apologies for absence** • Sughra Nazir, Non-Executive Director (SN)	
A.2.24.2	**Declarations of interest** No interests were declared.	
A.2.24.3	**Minutes of the meeting held 21 November 2023** The minutes of the meeting held on 21 November 2023 were approved as a correct record.	
A.2.24.4	**Matters arising** The Committee noted that the greyed-out items on the action log at Appendix 1 indicated those actions closed at the previous meeting. Regarding the actions due for consideration at this meeting; the following actions were confirmed as closed as indicated on the action log. • A23060 – Estates project management quality manual assurance – action closed • A23059 - Estates project management quality manual assurance – action closed • A23056 – Exception reports: Schedules of losses and special payments – action closed • A23054 – Proposed changes to Scheme of Delegation/Standing Financial Instructions – Schedule of high value approvals under the scheme of delegation – action closed	

	• A23053 – Charitable Funds Annual report and accounts – action closed • A23051 – Annual policy review – use of external audit for non-audit purposes – action closed • A23040 – ISA 260 – Response to sector development recommendations – action closed • A23039 – ISA 260 – Response to sector development recommendations – action closed • A23003 – Internal Audit effectiveness review – action closed **Updates were provided at the meeting as follows:** • A23058 – Assurance: Key IT systems progress report update – This has been added to the list. Board development sessions are to be confirmed with new Chair once in post (early March 2024) - action closed • A23057 – Monitoring compliance with regard to the Policy for the Development and Management of Trust policies – 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 - action closed • A23055 – Proposed changes to Scheme of Delegation/Standing Financial Instructions – Schedule of high value approvals under the scheme of delegation. Item included in the Financial Transaction review – action closed • A23052 – Internal Audit Reports – MQ provided an update on progress to date. The old kit is due to be replaced in March 2024. Until such time we continue to use the old kit and in order to get better imaging quality we need to increase the radiation of the x-ray machine. The overall risk is minimal compared to other diagnostic imaging equipment. The risk will remain on the risk register until the replacement kit is in situ– action closed • A23025 – Partnership arrangements – awaiting publication – action to remain open	
A.2.24.5	**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 audit window. The Committee noted the verbal update.	
A.2.24.6	**External Audit Annual Plan 2023/24** PH advised that the annual planning is underway. He confirmed there may be two significant risks of material misstatements to report relating to our management override of controls and capital additions in year of around £60m. There is a third risk currently being assessed relating to valuations. LP queried if, as in previous years, the Value For Money (VFM) audit and the audit of the accounts will be completed in two stages or was there scope for these to be completed at the same time. PH stated that the consultation on the timeline for the VFM work had not concluded. The rules state that this needs to be completed within three months of the financial	

	statement audit although it isn't unusual for this to be changed at short notice. The Committee noted the verbal update.	
A.2.24.7	**ISA 260 – Charitable Funds** 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 of Directors via e-mail. Approval was confirmed and the documents were submitted to the Charity Commission on 31 January. The Audit Committee noted the approval of Bradford Hospitals Charity's annual report and accounts for 2022/23.	
A.2.24.8	**Use of External Audit to provide non-audit services (standing item)** There was nothing to report on this item.	
A.2.24.9	**Internal Audit progress report** KE provided an overview of the paper which sets out performance against the agreed 2023/24 plan and identifies the scope of work undertaken and the assurances provided. The plan is approximately 66% complete with 8 finalised reports; 1 high assurance report, 6 significant assurance reports and 1 limited assurance report which was BH/26/2024 - IT systems and software management follow up. Two reports are still ongoing as highlighted in the report. Management has requested five amendments (cancellations) to the 2023/24 plan for the reasons identified within the report. ZA queried the rationale for the cancellations particularly the EPRR and People Plan. KE stated that NHSE required organisations to produce an action plan that fed back to the ICB in relation to EPRR. Internal Audit and management agreed that reviewing the EPRR submission again would be a duplication of the assessment work already undertaken by NHSE. Regarding the People Plan; KE advised that the Interim Director of HR was of the view that the People Plan would potentially change and would be developed further over the next 12 months when the new Chief People and Purpose Officer (CPPO) was in post, and it wasn't the right time to undertake an internal audit. This would be included within the 2024/25 plan if any risks were highlighted. Discussion took place around the benefits of the new CPPO having a baseline internal audit to provide them with an independent perspective on the people plan. ZA felt that a good benchmark as to where the Trust is in terms of the people strategy and plans would be more beneficial than waiting. MH agreed to discuss this further with KE and the Interim Director of HR to see if there is a broader rationale that needs to be provided and what value an audit would add at this stage. An update would be circulated via email to the Committee. BM queried the rationale relating to the cancellation of the data warehouse	Director of Finance A24001

	audit. PR confirmed that this piece of work will be undertaken externally by a specialised company due to the scope of the skill base of Audit Yorkshire colleagues. He confirmed that this review can come back to the Audit Committee once completed. KE stated that this was an addition to the Internal Audit Plan via a request from the Audit Committee in November 2023 and was not on the original plan. On review of the scope of the audit it was determined that it required more technical skills than those available within Audit Yorkshire - as such a decision was made by management to source alternative measures. BM felt that the action needs to remain open for management to determine the business case for the scope of the work relating to the data warehouse and to provide assurance to the Audit Committee that the risk identified has been addressed. PR agreed to provide a paper to the May meeting highlighting the risks requiring assurance and the risk levels. ZA queried the number of changes made within the plan and felt these were excessive. KE stated that this issue had been previously discussed at the November 2023 meeting and one of the main reasons for the changes was due to the three-year cyclical review of which this is the third year. As part of the scoping of individual audits it has been identified that other measures and assurance have been provided during that timescale. The plan remains fluid and the risks that emerge during the year are brought back to the Audit Committee. Three of the four key performance indicators (KPIs) for 2023/24 are at 100%. Management responses received within 15 working days of the issue of the draft report to client/member is shown as 88%. KE felt confident that Internal Audit will have sufficient field work completed for the remaining audits to provide a meaningful head of internal audit opinion. ZA queried if a half day was sufficient enough time to undertake the observation and conclusion testing for the ambulance handover audit as he felt that there are several fluctuations depending on the time of day and day of the week. KE agreed to provide further details to ZA via email. BM felt that it was a pleasing report on the level of assurance provided by all the completed audits over this period. KE drew attention to the annual salary overpayments benchmarking report which is provided to the Executive Team and Audit Committee for information. The report shows that Bradford, in comparison to other organisations that took part, is looking more favourable than others. The aim is for the organisation to have zero salary overpayments. A payroll audit is currently underway and any specific recommendations from that sampling will be discussed with management and the actions taken forward. MH confirmed that the benchmarking report will be shared with the payroll consortium to review actions, particularly around the oversight mentioned within the report.	Chief Digital & Information Officer A24002 Internal Audit (KE) A24003

	The Committee noted the report and the assurance provided.	
A.2.24.10	**Follow up of Internal Audit recommendations** KE provided an overview of the report and the work ongoing with Executive Directors to reduce the number of outstanding recommendations and how these are progressed. JL asked if discussions had taken place at Executive Team Meeting (ETM) to support the Chief Operating Officer (COO) and the Chief Medical Officer (CMO) in completing their outstanding recommendations. MH confirmed that regular discussions take place with each Executive Director, and this is further followed up at ETM. MH agreed to pick up the specific issues raised with the CMO and COO. ZA queried what testing is taking place to validate closed recommendations to ensure they are being completed to the standard expected. KE confirmed that a sample of 10 implemented recommendations are reviewed at year end which forms the head of audit opinion. All major and moderate recommendations that form part of limited assurance reports are also followed up by way of a separate internal audit review. Discussion took place around the potential for gaps and completed recommendations not being fully implemented. It was noted that it was the organisation's responsibility to ensure all completed recommendations have been fully implemented and it was not practical for Internal Audit to follow up on all completed recommendations. KE provided assurance that all major recommendations are reviewed regardless of the outcome of the overall report, and she agreed to clarify that point within her report going forward. ZA asked if there were some outstanding recommendations, from the 53% that were 120 days overdue, that Internal Audit felt should have been completed to ensure the organisation is not vulnerable to risk. KE felt that they should all be completed in line with the original agreed target date. She noted that there were no major recommendations overdue but there were a considerable number of moderate recommendations still outstanding. Work is ongoing to clear down the overdue recommendations. The Committee noted the report and the assurance provided.	Director of Finance A24004 Internal Audit (KE) A24005
A.2.24.11	**Internal Audit effectiveness review** MH provided an overview of the recent Executive Director review of Internal Audit effectiveness. The survey contained 25 questions and the overall response was positive with some minor issues reported, relating to Internal Audit's Working Together Protocol and subject matter experts that MH will take forward with the Executive Team. The Committee noted the report and the assurance provided.	
A.2.24.12	**Internal Audit reports (limited assurance)** <u>BH262024 – IT Systems and software follow up</u> KE confirmed that a follow up on the original limited assurance report has	

	taken place. It was noted that several recommendations had been marked as closed but there was no evidence to validate these closures, therefore work is still required to gain a high level of assurance. PR felt that the expectations, articulated by the previous Chair, on the level of assurance required across the whole set of applications and systems the organisation uses has meant that this process has taken a long time to determine. He provided an overview on progress to date on the work being undertaken on the internal audit, confirming that work is ongoing with the procurement team to work through the limited assurance relating to contracts with a proposed target date of 30 June 2024. PR added that the new Chief Technology Officer (CTO) is now in post and is making a positive impact both in terms of the approach and, documenting our levels of assurance. PR confirmed that the Digital and Data Transformation Committee reports to the Quality & Patient Safety Academy. PR agreed to provide an update on progress to the 21 May Audit Committee meeting. The Committee noted the reports and the assurance provided.	Chief Digital & Information Officer A24006
A.2.24.13	**Counter Fraud progress report** RM provided a comprehensive overview of the report. In particular he advised that there are three local proactive exercises ongoing which will be completed by the end of the financial year. This will equate to a total of 10 over the course of this financial year. ZA inquired if there was more that the organisation could do, in relation to the timesheet fraud investigation, and if there were additional controls needed to prevent a recurrence. RM confirmed that the workforce team is working to centralise all rotas/rosters and revenue payments into one point to close the system gap. MH provided reassurance that a centralised rota management team is being set up which will help to mitigate a number of risks that the organisation is experiencing. It is envisaged that the implementation takes pace in June/July 2024 and a Post Implementation Review (PIR) will take place six months hence, reporting to the Finance & Performance Academy. ZA asked if there had been any data exercises undertaken in relation to staff working elsewhere or whilst off sick. RM confirmed that the National Fraud Initiative (NFI) runs yearly and occasionally identifies individuals where the organisation can seek a recovery of funds. The only drawback is that the information provided is retrospective which can prove challenging. RM confirmed that whilst seeking to recoup finances the disciplinary action would be undertaken by HR and dealt with in tandem. He confirmed that the Anti-Fraud, Bribery and Corruption Policy covers fraud but there are no definitive guidelines on prosecution of staff and this would be subjective, on a case by case basis, as to whether a criminal investigation would be warranted. The Committee noted the report and the assurance provided.	

A.2.24.14	**Proposed changes to Scheme of Delegation/Standing Financial Instructions** • Schedule of high-value approvals under the scheme of delegation Item addressed under A.2.24.15 below.	
A.2.24.15	**Exception reports: Schedules of Losses and Special Payments** MQ presented an overview of the Losses and Special Payments and the Tender Waiver Report. With regard to the 'schedule of high-value approvals under the scheme of delegation' MQ advised that the AC had previously requested assurance that SFIs and SOD were followed for high value items. An audit was underway with regard to financial transactions. Once the audit was complete assurance should be provided to the AC on compliance with the SFIs and SOD. Attention was also drawn to the response to a second action from a previous Audit Committee related to overseas debt. The AC noted the completed Internal audit on Overseas Debt (included within the Internal Audit Progress Report under agenda item A.2.24.9). The report had received significant assurance and Audit Yorkshire had identified that there were satisfactory controls in place for identifying overseas visitors, issuing the charge, and then pursuing the invoiced debt for payment. The Committee noted the report and the assurance provided.	
A.2.24.16	**Appropriateness of Single Source Tenders** Item addressed as part of A.2.24.15.	
A.2.24.17	**Trust compliance with Standing Orders, Standing Financial Instructions/Scheme of Delegation (standing item)** There was nothing to report on this item.	
A.2.24.18	**Suspension of Standing Orders/Standing Financial Instructions (standing item)** There was nothing to report on this item.	
A.2.24.19	**Other assurance functions (standing item)** There was nothing to report on this item.	
A.2.24.20	**Partnership arrangements: implications for the Audit Committee** LP advised that there were no updates to report. The AC also noted that the Board was regularly in receipt of updates regarding our partnership arrangements from the Chief Executive Officer, Mel Pickup.	
A.2.24.21	**Estates Project Management Quality Manual Assurance** MH advised that the report presented was provided in relation to an action from the November Audit Committee to provide additional context to the paper presented to the AC in November under agenda item A.11.23.25. This additional report is intended to provide assurance that we have strengthened our management controls and processes. JL confirmed that the Finance and Performance Academy was in receipt of the paper at its meeting on 31 January 2024 and welcomed the additional oversight on the Capital Programme.	

	BM confirmed that this line of enquiry was now closed. The Committee noted the report and the assurance provided.	
A.2.24.22	**Assurance regarding compliance with Risk Management Strategy** LP advised that the AC is required to monitor compliance with the risk management strategy and this bi-annual report supports the Committee in obtaining the appropriate assurance. The risk management strategy was approved in July 2022 and minor amendments are now proposed to reflect the change from CBUs (Clinical Business Units) to the CSUs (Clinical Service Units), and the removal of the former Planned and Unplanned Care groups and associated meetings. LP advised that the updated Strategy (attached at Appendix 1 with track changes) will be presented to the Board for approval in March 2024. JC provided a detailed overview of 'how risk is managed locally and how risks are assessed'; as detailed in the paper. In particular, JC drew attention to the new Integrated Reporting, Learning and Improvement System (IRIS), from InPhase. She advised that Inphase has now replaced Datix to support the Trust in transitioning to the NHS England Patient Safety Incident Response Framework. Training for staff has been developed in-house and all staff with a login to IRIS can access the Risk App training and associated user guides. Risk management training is also being delivered to staff attending the Step Ladder to Success programmes aimed at Band 6 and 7 staff. Training is to be delivered at Trust induction and included in the handbook. A flowchart to aid staff in reporting new incidents is also in progress. ZA queried if risk 'deep dives' take place within the organisation and whether issues logs were maintained to differentiate between risks and issues to manage them accordingly. JC confirmed that one system is used to capture issues as well as risks. She confirmed that the quality dashboard and risks are reviewed at the Quality & Patient Safety Academy Assurance meetings and there are occasions where a deep dive is required to further understand a particular risk. BM referred to the requirement for the AC to 'receive this report as assurance of compliance with the Risk Management Strategy'. BM felt that once the outcome of the internal audit on the risk management strategy is received then the Committee would be in a better position to provide assurance to the Board. There was nothing that he had heard which suggested any issues in this area however, he would welcome the internal audit overview of BTHFT in this area as it would be helpful in highlighting any areas for improvement. BM referred to a comment that JC had made regarding the CSUs and their level of maturity regarding governance discussions and that this was not necessarily embedded throughout all the CSUs equally – this would be the one negativity in all the things heard which the AC should note. JC explained that whilst they had a 'high assurance' internal audit report in the previous year, and there was high assurance in relation to the governance	

	arrangements; JC felt there was a need to review the level of in-depth discussions at those meetings as there was variation in terms of the depth of discussions taking place. JC added the CSUs are working on this with the support of the Quality Team. BM particularly welcomed JC's insights which were useful alongside the assurance that could be taken from the high assurance report from the previous year in relation to the arrangements in the Trust. The proposed amendments to the risk management strategy were noted. The Committee noted the report and the assurance provided.	
A.2.24.23	**UK Corporate Governance Code publication** LP stated that this had now been published. The item was brought to this meeting in response to a matter highlighted in the ISA260. As planned legislation had been stood down, there were not as many changes as had originally been expected. There were minor changes to the code which were listed in the appendix. The AC was asked to note one key amendment, provision 26, regarding the assessment of the effectiveness of risk management and internal control which would be effective 2025/26. LP advised that there were no implications for the Trust and so no changes are expected to what we are currently doing. JL referred to provision 2 - to monitor and measure culture; and asked how we would address this. LP advised that this will be assessed through the People Academy which is expected to consider this in May. The Academy will then report to the Board. The Committee noted the report and the assurance provided.	
A.2.24.24	**Audit Committee annual self-assessment** LP advised that the assessment was usually conducted in line with the template available in the HFMA handbook. Whilst the final version of the revised handbook was not yet available the Trust was in receipt of the draft of that new version. LP advised that usually the assessment has been undertaken by the AC in the autumn. The AC confirmed that it was content to leave the timing of the assessment as it currently stands however noted that BM was used to the assessment being undertaken in conjunction with end of year reporting so as to inform the annual governance reporting. The AC agreed that LP and BM should review the new template (in the draft handbook) and determine the assessment process. JL added that the Academies made use of 'mentimeter' for their self-assessments and completed this together which is something that the AC might like to consider.	Chair and Board Secretary A23007
A.2.24.25	**Audit Committee work plan** LP presented to the workplan to the AC for review. ZA asked for clarification with regard to the Audit Plan being presented to the AC in April as did this not lead to a delay in its implementation. KE explained that by this stage the draft Audit Plan had been reviewed by the Executives at ETM and the Non-Executives at the Academy meetings prior to its presentation to the Audit Committee (as a final document) for sign off. As such the Audit	

	Plan was immediately implemented.	
A.2.24.26	**Any other business** No other business discussed.	
A.2.24.27	**Matters to share with other committees** There were no matters to share.	
A.2.24.28	**Matters to escalate to the Risk Register** There were no matters identified to escalate to the high-level operational risk register.	
A.2.24.29	**Matters to escalate to the Board of Directors** There were no matters identified to escalate to the Board of Directors.	
A.2.24.30	**Items deferred to subsequent meetings** There were no items deferred to subsequent meetings.	
A.2.24.31	**Attendees for subsequent audit committee meeting** • Chief Digital and Information Officer, Paul Rice would attend the May AC meeting. • The AC would continue with the practice of Executive attendance on a rotational basis.	
A.2.24.32	**Review of meeting** The Audit Committee felt that the meeting was productive and well chaired. BM felt that it was imperative that all members have the opportunity to raise points throughout the meeting. BM suggested the possibility of holding one of the meetings face to face and the practicality of this will be considered. 10 mins at the start of each future AC meeting to comprise a private meeting between the AC NEDs, internal audit and external audit.	
A.2.24.33	**Date and time of next virtual meetings:** • 16 April 2024 • 21 May 2024 • 20 June 2024 (extraordinary meeting accounts sign off) • 10 September 2024 • 19 November 2024	
A.2.24.34	**Private meeting with Internal Audit**	

Action log from the Audit Committee Meeting held 21 February 2024

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		Next number in sequence	**A24008**		
21.2.24	A.2.24.9	**Internal Audit progress report** Discussion took place around the benefits of the new CPPO having a baseline internal audit to provide them with an independent perspective on the people plan. ZA felt that a good benchmark as to where the Trust is in terms of the people strategy and plans would be more beneficial than waiting. MH agreed to discuss further with KE and the Interim Director of HR to see if there is a broader rationale that needs to be provided and what value the audit would add at this stage. An update would be circulated via email to the Committee.	**Director of Finance A24001**	April 2024	Follow up emails circulated with expanded rationale – action closed
21.2.24	A.2.24.9	**Internal Audit progress report** ZA queried if a half day was sufficient enough time to undertake the observation and conclusion testing for the ambulance handover audit as he felt that there are several fluctuations depending on the time of day and day of the week. KE agreed to provide further details to ZA via email.	**Internal Audit (KE) A24003**	April 2024	13.3.24 Email sent to ZA from KE. As per the discussions that we had in the February Audit Committee and the associated action captured in relation to the Ambulance Handover review I have now had the opportunity to speak with the auditors who undertook the piece of work. Prior to the on-site visit the auditors had reviewed various documents (policies, procedures, reporting etc.) and had a good understanding of the controls that were in place. There was nothing of concern to highlight prior to the visit. During the testing session, there was nothing identified to suggest that we needed to extend our session and/or go back on a second occasion, therefore with consideration of the pressures that the department were under at the time the test length felt sufficient – action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
21.2.24	A.2.24.10	**Follow up of Internal Audit recommendations.** JL asked if discussions had taken place at Executive Team Meeting (ETM) to support the Chief Operating Officer (COO) and the Chief Medical Officer (CMO) in completing their outstanding recommendations. MH confirmed that regular discussion takes place with each Executive Director, and this is further followed up at ETM. MH agreed to pick up the specific issues raised with the CMO and COO.	**Director of Finance A24004**	April 2024	MH highlighted specific outstanding recommendations to COO & CMO, with request for either completion of audit recommendation or detailed rationale for delay with assurance that plan is in place – action closed
21.2.24	A.2.24.10	**Follow up of Internal Audit recommendations.** KE provided assurance that all major recommendations are reviewed regardless of the outcome of the overall report, and she agreed to clarify that point within her report going forward.	**Internal Audit (KE) A24005**	April 2024	KE agreed to include in her follow up report going forward – action closed
21.2.24	A.2.24.24	**Audit Committee annual self-assessment** The AC agreed that LP and BM should review the new template (in the draft handbook) and determine the assessment process. JL added that the Academies made use of 'mentimeter' for their self-assessments and completed this together which is something that the AC might like to consider.	**Chair and Board Secretary A24007**	April 2024	
21.2.24	A.2.24.12	**Internal Audit reports (limited assurance) – BH262024** PR agreed to provide an update on progress to the 21 May Audit Committee meeting.	**Chief Digital & Information Officer A24006**	May 2024	Update provided at April meeting – action closed
21.2.24	A.2.24.9	**Internal Audit progress report – data warehouse** BM felt that the action needs to remain open for management to determine the business case for the scope of the work relating to the data warehouse and to provide assurance to the Audit Committee that the	**Chief Digital & Information Officer A24002**	May 2024	Update provided at April meeting – action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		risk identified has been addressed. PR agreed to provide a paper to the May meeting highlighting the risks requiring assurance and the risk levels.			
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 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 February 2024

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). Action 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. Action 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	**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
		work is currently underway however the audit has not 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.11.23.6	**Annual policy review – use of external audit for non-audit purposes** • 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.	**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
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.
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	21.2.24 – MQ provided an update on progress to date. The old kit is due to be replaced in March 2024. Until such time we continue to use the old kit and in order to get better imaging quality we need to increase the radiation of the x-ray machine. The overall risk is minimal compared to other diagnostic imaging equipment. The risk will remain on the risk register until the replacement kit is in situ– action closed

BO.5.24.29 - CONFIRMED CHARITABLE FUNDS COMMITTEE MINUTES

REFERENCES

Only PDFs are attached

Bo.5.24.29 - Confirmed Charitable Funds Committee minutes - 7 March 2024.pdf

Bradford Hospitals Charity

DRAFT MINUTES - CHARITABLE FUNDS COMMITTEE

Date:	Thursday 7th March 2024	**Time:**	15:30-17:00
Venue:	Via Microsoft Teams	**Chair:**	Altaf Sadique, Non-Executive Director (AS)
Present:	**Non-Executive Directors:** - Sarah Jones, Chair (SJ) - Altaf Sadique, Non-Executive Director, meeting Chair (AS) - Karen Walker, Non-Executive Director (KW) - Julie Lawreniuk, Non-Executive Director (JL) **Executive Directors:** - 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) - Jacqui Maurice, Head of Corporate Governance (JM)		
Minutes:	- Mel Lomas, Executive Assistant		

No.	Agenda Item	Action
C.3.24.1	**Apologies for Absence** Apologies were received from Professor Mel Pickup, Chief Executive.	
C.3.24.2	**Declarations of Interest** JL mentioned a potential change of trustees when discussing the case for change to independent status. It was agreed that this wouldn't constitute a conflict of interest.	
C.3.24.3	**Minutes of the Meeting Held on the 7th of November 2023** The minutes were accepted as an accurate record of the meeting. The action log was reviewed and updated as below. • C23006 C.11.23.9 Bradford Hospitals Charity Policy. Policy amendments regarding expenses. Committee noted that developments would depend on the outcome of the 'case for change'. If supported, the charity would develop its own range of policies. Action closed. • C23005 C.11.23.8 Operational Committee Report. Proposal for a separate Charity Risk Register. Committee noted the inclusion of a section within the 'Case for Change' document on page 20 under section six of the report. Action closed.	

	• C23004 C.11.23.5 Investment Report. Discussion of portfolio and returns in detail when Rathbones are next in attendance. Committee noted that Rathbones will next attend in April. Action to remain open.	
C.3.24.4	**Matters Arising** AS welcomed SJ, the new Foundation Trust Chair.	
C.3.24.5	**2023/24 Finance Report** MQ shared that the budget included in this paper was approved by the Charity Committee in March 2022. An updated budget paper will be presented in April. • At Month 10, the total fund value was £2.1 million, which is around £1 million less than plan. • Fundraising is £101,000 behind plan as attention has been focused on the case for change and the Neonatal Unit business case. • Investment gains are behind plan by £171,000. • The value of the fund is forecast to be £1.3 million less than planned. • The rate of investment is around 57%, meaning for every £1 spent on fundraising, around £1.75 is raised, with the target being £4 raised for every £1 spent on fundraising. The case for change will hopefully help address this gap. SM added context around challenges in recruitment, infrastructure building and rebranding. AS praised the good work done. JL commented that the poor rate of investment makes the case for change more compelling and it is important to question if the targets are realistic. SM pointed out that there have been extraordinary circumstances to factor in and it is time to do something different. MH queried the level of confidence that the fundraising income will improve. SM cited a lack of clarity around the Neonatal Unit plans resulting in little to promote. This should change when the team understands their remit and is inspired by a capital campaign, such as the Neonatal Unit project. SM also mentioned challenges with recruitment and timescales and stated that independence should enable work to move more quickly and enable more effective decision making. The Committee noted the report.	
C.3.24.6	**Investment Report** MH stated that Rathbones will be asked for more detail on what the implications of this report are for the Foundation Trust when he next attends the Commitee. Over the three months to the 31st of January 2024, the portfolio rose by 3.6% compared to the benchmark of 3.3%. MQ shared that there will be an opportunity to review the portfolio before the contract is due for renewal to assess the risk appetite.	

	The Committee noted the report.	
C.3.24.7	**Bradford Hospitals Charity Annual Report & Accounts/ISA 260** MQ shared that the accounts were virtually approved in January 2024. They were submitted on time and now there is a contract with the new external auditor in place, the process should be completed more quickly going forward. The Committee noted the Annual Report and Accounts/ISA 260.	
C.3.24.8	**Case for Independence** SA presented the outline business case. A five cases model was used to assess the viability of independence. This was assessed against affordability, increased fundraising and continued benefit to the organisation. The case recommends a move to independent charity status, with the process estimated to take around 12 months to complete. SM added that initial discussions took place during January to March 2023. There was an agreement in principle from the Board in April 2023 and preparation of the outline business case between October and November 2023. A final decision from the Board is due in March 2024. The case for change covers five areas; autonomy, governance, fundraising, agile and workforce. In terms of the legal framework, a charitable company limited by guarantee is the most established model in the sector. In terms of income and expenditure, the 2026/27 forecast shows an improvement in total funds of £485,000 and the same in 2027/28, showing an overall positive financial outlook by moving to independent statusThis is in part due to certain fundraising activities not being open to trustee model charities. Some set-up costs are involved of around £115,000 in year one to pay legal fees, but it is believed that harnessing the expertise of a dedicated charity CEO and bringing in relevant experience from the sector will lead to higher returns. In summary, the move to independent status will result in a net benefit of £1.113 million by April 2028. AS queried the benefits of a Company Limited by guarantees. SM replied that the new trustees would be directors and registered with Companies House. JL was supportive of the proposal, mentioned how specialised trusts are able to make their fundraising more emotive and queried the amount of confidence in the projections. SM responded that some risk has been reduced by bringing in the Sick Children's Trust, who will assist with fundraising. SJ noted that most NHS Trusts have experienced a rise in income since becoming independent and suggested rebranding the charity and promoting the link to the hospital. SM shared that the charity has gone	

	through a recent rebrand from a grant awarded by NHS Charities Together. SM also stressed the importance of the charity strategy aligning with the Foundation Trust and how important the MOU was in terms of everyone being happy with the way forward. Funding is allocated in the plan for a new policy writer. There is a list of policies required and strong support from the Leeds Hospital Charity in terms of sharing their existing policies due to the strong relationship already formed. MQ pointed out that it's beneficial to end a set of accounts on the 31st of March and re-open them on the 1st of April to cover a full 12 months. AS noted that the specialised trustee model works well for other charities, but queried the potential conflict of interest with a Foundation Trust Board member sitting on the charity governance structure. SJ cited the Sheffield NHS Trust children's charity as having one Executive Director and one Non-Executive Director from the Trust in the constitution with full voting rights. This will be decided as the governance arrangements are finalised. MQ pointed out that any Foundation Trust Board member who also sat on the board of an independent charity would need to disclose this relationship. The Committee approved the recommendation for moving to independent charity status and this will be put forward to Board for formal approval.	
C.3.24.9	**Neonatal Unit Parental Accommodation Business Case** SA presented the business case. As one of 4 neonatal units in the network, the Bradford service covers a large area. There are currently five parental bedrooms, two of which are based on the NICU, two on the maternity ward and one in Field House. National guidance states the requirement to offer parental accommodation in close proximity to the NICU. The proposal is to create another five rooms in a purpose built unit on the BRI site to avoid parents having to travel between home and hospital or book hotels. Around £1.5 million is to be funded by the Sick Children's Trust, meaning fundraising will be required for the outstanding £1.5 million. Some ongoing revenue costs will be incurred for cleaning and heating of around £30-50,000. The accommodation will include a kitchen and lounge, multi-faith room and outside area. JL asked about contingency plans if the costs were to increase. SA responded that tight project management and holding the contractors to account will be required. The build classifies as a residential build and the VAT can therefore be reclaimed. In terms of mitigation, additional funds would need to be raised if the costs escalated beyond the anticipated £3m in total. SJ mentioned that those who will benefit most from the unit will be families who live the furthest away from Bradford and asked how the appeal could be made more relevant to them. It was suggested that families who have used the service could be approached to be public advocates and SM confirmed that this will be discussed. Work continues with the Sick	

	Children's charity around video content and making use of the local and national press. KW queried if the ongoing maintenance costs would be funded by the charity or the Foundation Trust and SA confirmed that this will be for the charity to fund. The Committee approved the business case which would now be put forward to the Board of Directors for their approval.	
C.3.24.10	**Charity Operational Committee Report** SA provided an overview of the meeting on the 20th of February 2024: • The case for independence was supported. • The workplan was discussed. • The finance report was received. • Rationalising trust funds was discussed. • The latest 100 Club event was discussed. The Da Vinci robot was demonstrated in the concourse with four surgical specialities and two new sign-ups were made. • Upcoming events were discussed, including a soft launch of the Neonatal Unit appeal for £20,000 at the annual ball, the Great North Run and schemes with Barclays and Whitaker and Leach. The Committee noted the update.	
C.3.24.11	**Charity Operational Committee Terms of Reference** LP provided an overview of the annual Terms of Reference review. There have been a few minor changes in relation to membership and job titles. The frequency of meetings has changed to four times a year in line with this Committee and a line has been removed regarding scrutinising the use of funds. The Committee approved the amendments to the Terms of Reference for the Charity Operational Committee.	
C.3.24.12	**Charitable Funds Committee Workplan** LP stated that this will need to be reviewed if the independence proposal is approved by the Board and in light of the outcome of the Committee effectiveness review.	
C.3.24.13	**Committee Effectiveness Review** JM presented a Slido poll for the attendees to answer. SJ didn't participate due to being new in post. The results and recommendations will be discussed at the next meeting.	
C.3.24.14	**Any Other Business**	

	KW asked if there was a plan to forge any strategic partnerships with local businesses. SM stated that a corporate fundraiser is to be recruited and a fundraising plan will be shared in April. SA shared that a new Charity Director will be sought as SM had tendered her resignation and is due to leave the Trust in May 2024. The Chief Executive is currently exploring replacement options with the local voluntary and community sector and a specialist recruitment agency will be engaged to find an individual with the relevant skills and experience. It was agreed to a seek a substantive replacement rather than interim to make the appointment more attractive to candidates. SA thanked SM for her work. SJ praised the Neonatal Unit and independence papers and thanked all involved for their work. AS thanked the attendees for their time and closed the meeting.	
C.3.24.15	**Date and Time of the Next Meetings - all 3.30-5pm** • 30 April 2024 • 2 July 2024 • 5 November 2024	

Bradford Hospitals Charity

Actions From the BTHFT Charitable Funds Committee 7 March 2024

Action ID	Date	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	April 2024	07.03.24 – Rathbones to attend the meeting twice per year/on request. Next due to attend in April. Investment Report item included on April Agenda. Action closed.
C23007						