Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS OPEN

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11 July 2024

09:30 GMT+1 Europe/London

Listening for Life Centre, BRI

AGENDA

AGENDA -11.7.24

REFERENCES

Only PDFs are attached

Bo.7.24.0 - Open Board Agenda 11.7.24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	Thursday, 11 July 2024	**Time:**	09:30 – 12:20
Venue:	Meeting Room, Listening for Life Centre	**Chair:**	Sarah Jones, Chair

Attendees

- 09:45-10:05 - Carly Stott – Bo.7.24.6 - Maternity and Neonatal Services Update
- 10:05-10:15 - Ruth Tolley – Bo.7.24.7 – Engagement Strategy annual update
- 10:15-10:25 - Yaseen Muhammad – Bo.7.24.8 – Infection prevention and control annual report
- 10:35-10:45 - Sue Franklin & LeeAnne Elliott – Bo.7.24.10 – Freedom to Speak up annual report (attending via MS teams)
- 10:50-11:00 - Catherine Shutt – Bo.7.24.12 – Staff survey results action plan

Observers

Helen Wilson and John Waterhouse, Governors

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.7.24.1	Apologies for Absence • Paul Rice, Chief Digital & Information Officer (represented by Adam Griffin, Deputy Chief Digital & Information Officer) • Laura Parsons, Board Secretary (represented by Jacqui Maurice, Head of Corporate Governance) • Mohammed Hussain, NED	Chair	For information	Verbal
Bo.7.24.2	Declarations of Interest	Chair	For information	Bo.7.24.2
Bo.7.24.3	Minutes of the meeting held on 9 May 2024	Chair	For approval	Bo.7.24.3
Bo.7.24.4	Matters arising	Chair	For information	Verbal
09:35 Section 2: Patient Care				
Bo.7.24.5	Report from the Chair of the Quality and Patient Safety Academy - May and July 2024 - Adults & Children Safeguarding Annual Report	Chair of the Quality and Patient Safety Academy	For assurance	Bo.7.24.5
Bo.7.24.6	Maternity and Neonatal Services Update	Chief Nurse	For assurance	Bo.7.24.6
Bo.7.24.7	Engagement Strategy Annual update	Chief Nurse	For assurance	Bo.7.24.7
Bo.7.24.8	Infection Prevention and Control Annual Report 2023/24	Chief Nurse	For assurance	Bo.7.24.8
10:25 Section 3: People				
Bo.7.24.9	Report from the Chair of the People Academy: - May and July 2024 - Workforce report - Medical Appraisal & Revalidation annual report - Annual Fire Safety report	Chair of the People Academy	For assurance	Bo.7.24.9
Bo.7.24.10	Freedom to Speak up Annual Report	Chief Nurse	For assurance	Bo.7.24.10

Bo.7.24.11	Nursing & Midwifery Staffing Establishment Review	Chief Nurse	For assurance	Bo.7.24.11
Bo.7.24.12	Looking after our People - Staff Survey results action plan	Chief People & Purpose Officer	For assurance	Bo.7.24.12
Bo.7.24.13	Equality & Diversity Council update	Chief Executive	For assurance	Verbal

BREAK 11.15 – 11.30

11:30 Section 4: Finance and Performance				
Bo.7.24.14	Report from the Chair of the Finance and Performance Academy – May & July 2024	Chair of the Finance and Performance Academy	For assurance	Bo.7.24.14

11:40 Section 5: Audit & Assurance				
Bo.7.24.15	Report from the Chair of the Audit Committee	Chair of the Audit Committee	For assurance	Bo.7.24.15

11:45 Section 6: Business Reports				
Bo.7.24.16	Report from the Chair	Chair	For information	Bo.7.24.16
Bo.7.24.17	Report from the Chief Executive - Integrated Dashboard - Finance Report - Performance Report	Chief Executive	For information	Bo.7.24.17

12:00 Section 7: Governance				
Bo.7.24.18	Board Assurance Framework, risk appetite review and High-Level Risks	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.7.24.18
Bo.7.24.19	Academy/Committee annual reports, terms of reference and work plans	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.7.24.19

12:15 Section 8: Board Meeting Outcomes				
Bo.7.24.20	Any other business	Chair	For information	Verbal
Bo.7.24.21	Issues to refer to Committees/Academies or elsewhere	Chair	For approval	Verbal
Bo.7.24.22	Review of meeting	Chair	For information	Verbal
Bo.7.24.23	Date and time of next meeting: • 19 September 2024 – 9.30am	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 11 July 2024

Annex 1: For Information				
Bo.7.24.24	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.7.24.24

Annex 2: For Information: Board Committee/Academy Governance				
Bo.7.24.25	Confirmed Academy minutes: • Quality & Patient Safety Academy – 24 April & 22 May 2024 • People Academy - 24 April & 22 May 2024 • Finance & Performance Academy - 24 April & 22 May 2024	Chairs of Academies	For information	Bo.7.24.25
Bo.7.24.26	Confirmed Audit Committee minutes – 22 April 2024	Chair of the Audit Committee	For information	Bo.7.24.26

BO.7.24.1 - APOLOGIES FOR ABSENCE

BO.7.24.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.7.24.2 - Declarations of Interest.pdf

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21,2021/	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency.Key customers NGH	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08/12/2021	2021/22,2022/	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01/09/2022	2022/23,2023/	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	04/05/2023	2023/24	Gifts		Free course;Creating Safe Systems including Human Factors	HC-UK Conferences	300
Bryan Machin	Non-Executive Director	04/02/2020	2019/20	Outside Employment		Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01/09/2023	2023/24	Outside Employment		Zero hours contract as a Senior Project Manager	Community Ventures Ltd	0
Carolyn Bullock	Chief People & Purpose Officer	08/04/2024	2024/25	Nil Declaration				0
Christopher Smith	Deputy Director of Finance	04/04/2022	2022/23,2023/	Loyalty Interests		Married to Ruth Taunton-Smith, General Manager at BTHFT. Still valid.	Bradford Teaching Hospitals NHS Foundation Trust, Ruth Taun	0
Dorothy Bryant	Non-Executive Director	01/09/2023	2023/24	Nil Declaration				0
James Rice	Chief Digital & Information Officer	22/03/2021	2020/21	No Change to existing declarations				0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	Loyalty Interests		wife is employee of Rotherham Doncaster and South Humber NHS Trust	Rotherham Doncaster and South Humber NHS Trust	0
James Rice	Chief Digital & Information Officer	01/06/2019	2019/20,2020/	Loyalty Interests		member of the strategic advisory board	Strategic Advisory Board of the Yorkshire & Humber AHSN	0
James Rice	Chief Digital & Information Officer	01/07/2020	2020/21,2021/	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Netwwork national	0
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/	Loyalty Interests		Son is now an employee of Yorkshire Ambulance Services.	Bradford Teaching Hospitals NHS Foundation Trust	0
James Rice	Chief Digital & Information Officer	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
James Rice	Chief Digital & Information Officer	09/05/2024	2024/25	Hospitality		Invited to sit on the Apira table at the Leeds Digital Ball.	Apira	30
James Rice	Chief Digital & Information Officer	11/06/2024	2024/25	Hospitality		Meal at Australasia in Manchester.	IBM	30
Julie Lawreniuk	Non-Executive Director	11/03/2021	2020/21,2021/	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		board member	Incommunities housing association	0
Julie Lawreniuk	Non-Executive Director	01/07/2022	2022/23,2023/	Outside Employment		Board member and chair of system finance and performance committee	Bradford District and Craven Partnership	0
Karen Dawber	Chief Nurse	01/09/2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12/11/2022	2022/23	Loyalty Interests		Member of Professional Body	Member of the Royal College of Nursing	0
Karen Dawber	Chief Nurse	01/11/2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the PPE hub	Ellie Dawber	0
Karen Dawber	Chief Nurse	10/09/2023	2023/24	Hospitality		Due to my role as Honorary Professor at the University of Bradford and as my role of Chief Nurse at BTHFT, I was invited to visit Pakistan on a shared learning journey to see how the healthcare system is operating i	University of Bradford	4362.73
Karen Dawber	Chief Nurse	10/09/2023	2023/24	Hospitality		Due to my role as Honorary Professor at the University of Bradford and as my role of Chief Nurse at BTHFT, I was invited to visit Pakistan on a shared learning journey to see how the healthcare system is operating i	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/	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 and Integration	01/05/2024	2024/25	Nil Declaration				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
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/	Outside Employment		Trustee of a charity which is a nil remuneration post.	Pharmacist Support (Charity)	0
Mohammed Hussain	Non-Executive Director	26/07/2023	2023/24	Outside Employment		Digital therapeutics lead for Viatris	Viatris	0
Raymond Smith	Medical Director	10/10/2018	2018/19,2019/	Clinical Private Practice		Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/	Clinical Private Practice		Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	01/12/2019	2019/20,2020/	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
Sarah Jones	Chairman	01/10/2020	2020/21	Outside Employment		Chair of Realise Education & Training	Realise Education & Training	0
Sarah Jones	Chairman	04/03/2024	2023/24	Loyalty Interests		Brother MD of the Cheshire & Merseyside Cancer Alliance	Cheshire & Merseyside Cancer Alliance	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Outside Employment		Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Loyalty Interests		Parish councillor Sandy Lane Parish Council	Sandy Lane Parish Council	0
Sughra Nazir	Non-Executive Director	01/10/2023	2023/24	Outside Employment		associate with Social Care Institute of Excellence	Social Care Institute of Excellence	0
Zafir Ali	Non-Executive Director	01/11/2016	2016/17,2017/	Outside Employment		Various roles including:Deputy Head of Internal Audit – Department of Health & Social 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.7.24.3 - MINUTES OF THE MEETING HELD ON 9 MAY 2024

REFERENCES

Only PDFs are attached

Bo.7.24.3 - Unconfirmed Minutes of the meeting held on 9 May 2024 - Chair approved.pdf

Bradford Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday 9 May 2024	**Time:**	09:30 – 12:45
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) - Professor Louise Bryant (LB) - Zafir Ali (ZA) (via MS Teams) **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) - Mark Hindmarsh, Director of Strategy and Transformation (MHi)		
In Attendance:	- Dr Paul Rice, Chief Digital and Information Officer (PR) - Renee Bullock, Chief People and Purpose Officer (RB) - Laura Parsons, Associate Director of Corporate Governance & Board Secretary (LP) - Emma Clinton, Matron A&E (EC) *for item Bo.5.24.5 only* - Sara Hollins, Director of Midwifery (SH) *for item Bo.5.24.7 only* - Rosie McEachan, Born in Bradford (BiB) Director (RM) *for item Bo.5.24.8 only* - Carl Stephenson, Associate Director of Performance (CSt) *for item Bo.5.24.13 only* - Tabitha Lawreniuk, Personal Business Manager as Secretariat - Katie Shepherd, Corporate Governance Manager (KS)		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.5.24.1	**Apologies for Absence** Apologies were noted as follows: - Mohammed Hussain (authorised absence), Non-Executive Director	
Bo.5.24.2	**Declarations of Interest** No declarations of interest were raised in relation to the items on the agenda.	

No.	Agenda Item	Action
Bo.5.24.3	**Minutes of the Meeting held on 14 March 2024** The minutes of the meeting held on 14 March 2024 were approved as a true and accurate record.	
Bo.5.24.4	**Matters Arising** The following actions were reviewed, and the outcomes confirmed. • Bo23013 Digital Strategy Annual Report: Update included on the May Board agenda under matters arising. Action completed. • Bo23008 Report from the Chief Executive: – Sexual Safety Charter: This was discussed as proposed at the People Academy. Action completed. • Bo24006 Declarations of Interest: Any changes will be highlighted on the register of interests. Action completed. • Bo24007 Board Assurance Framework and High Level Risks: Trend analysis added to the 'risks on a page' appendix. Action completed. • Bo24008 Capital Programme 2024/25: Information provided as part of preparation for the well led review. Action completed. • Bo24011 Issues to Refer to Board Committees/Academies or Elsewhere: Session took place on 18 April 2024. Action completed. **Plans to Improve Depth of Coding** The Board noted the paper and was assured by the update.	
Section 2: Patient Care		
Bo.5.24.5	**Patient Story** KD welcomed EC to the Board to discuss the video of Rebecca Latz and her experience of being an A&E patient with 'functioning neurological disorder', which colleagues had watched prior to the meeting. EC provided a brief description of the condition and how this may present in patients as shown in the video. The video had supported team improvements in relation to reducing health inequalities. The team had also implemented a bi-annual refresher assessment on trauma informed care to ensure continued learning and improvement. KW recognised the importance of continued learning given the high level of new information that is regularly being made available. JL queried how the Trust can better support patients that perhaps aren't as articulate as the patient in the video. EC commented that all staff should be creating a forum where patients can express their needs and feel listened to, enhanced further by the increase in the number of trauma informed practitioners. EC advised that whilst there was a national push for all A&E staff to become trauma informed practitioners, she was unsure of the level	

No.	Agenda Item	Action
	of training available. She undertook to contact NHS England to investigate submitting this particular case as a case study which may be of benefit to colleagues across the country. MP also confirmed that the concept of trauma informed systems is becoming a focus across West Yorkshire with the aspiration for all Trusts to sign up to the trauma informed charter. KD would work with EC on the charter for BTHFT and bring this back to a future meeting. LB commented that the trauma informed approach was becoming much more prominent and sought thoughts from EC on how this would be of benefit to patients. EC noted that there were six key principles of trauma related care but they are not necessarily trauma specific and should be followed in relation to all patients as they represent good practice. It also encourages an acceptance that not all patients present in the same way and their behaviour may be impacted by their experiences. The Board thanked EC for joining the meeting and to Rebecca Latz for sharing her story.	**Chief Nurse Bo24012**
Bo.5.24.6	**Report from the Chair of the Quality and Patient Safety Academy – March and April 2024** LB gave an overview of the reports which provided an update of the Quality and Patient Safety Academy (QPSA) meetings held in March and April 2024. There were no issues to alert to the Board following the meetings. KD and RS provided some follow up information to a number of areas noted in the report: • Following the successful and welcomed expansion of visiting times during Ramadan and Eid, this would be replicated during other bank holiday and celebrational events. Data sampling remained ongoing to help inform a decision on whether visiting should be permanently expanded further. • The Trust was still transitioning to the new incident reporting system, the Patient Safety Incident Response Framework (PSIRF), and the Academy had received notice of one 'never event' relating to a patient receiving a biopsy on the wrong kidney. This had not resulted in patient harm as cancerous cells were found as a result. KD would provide a more detailed update on incidents at the next Board meeting. • Histopathology remained an area of concern, and RS highlighted an increasing demand of histopathology services combined with an increase in complexity of samples. The service is also under-resourced but there is a national shortage of histopathologists therefore a quick fix was not possible. Breast histopathology was a particular area of concern and there is a weekly meeting attended by RS/SA to identify any specific cases of concern and to consider how the pathway can be sped up. • Pharmacy aseptics is still a risk on the risk register, but a mobile unit had been delivered to the St Luke's site and was now in	**Chief Nurse Bo24013**

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	commissioning phase. Once commissioned the risk would be reduced / closed from the risk register. • Maternity staffing was close to the established position but despite this there were challenges in staffing due to increased training requirements and a larger than average sickness absence rate. The biggest impact was being seen in the birth centre which has been closed to prioritise the labour ward. Further consideration was needed to support managers dealing with staff sickness absence by way of improving policies and wider access to occupational health, for example. • Sue Franklin, Freedom to Speak Up Guardian was keen to attend a Board meeting to update on Freedom to Speak Up and the Board welcomed this. The Board was assured by the update. **Guardian of Safe Working Hours Quarterly Report** The report was noted by the Board. RS commented that he did feel that the Trust was under-doctored given it is an incredible busy Trust with high acuity and high attendances to A&E which resulted in a pressured Junior Doctor workforce and he would continue to feed back this message. There were no changes in reporting trends. The Board was assured by the update.	**Associate Director of Corporate Governance / Board Secretary Bo24014**
Bo.5.24.7	**Maternity and Neonatal Services Update** SH gave a brief update on maternity and neonatal services and confirmed that there were no areas of escalation. There had been low harms over the last two reporting months which was positive but this would continue to be monitored monthly. The internal audit of the CQC improvement plan for Maternity had been rated as 'significant assurance'. The perinatal mortality review quarterly report had been presented to the QPSA and subsequently to the Board and demonstrated a good trajectory towards meeting the required standard overall. The report did include some improvement actions such as the documentation of previous pregnancies and rectification of faulty equipment in a timely manner. The Board thanked SH for the update and was assured by the report.	
Bo.5.24.8	**Research activity in the Trust** RS introduced RM to the meeting to provide an update on some of the key research activities in the Trust, including the Born in Bradford (BiB) research study, the involvement in 2025 Bradford City of Culture, and the Age of Wonder study. RM updated the Board on the BiB research study, set up in 2007 to help respond to challenges within the community.	

No.	Agenda Item	Action
	BiB started with 12,500 families and the health and wellbeing of the children has been studied since then, with data collected from primary and secondary care providers. A key priority for 2024 was the development of the BiB Age of Wonder, a seven-year project capturing the journeys of up to 30,000 Bradford teenagers during adolescence, using quantitative and qualitative methods. Since September, 30 schools have been recruited for this academic year. RM reflected that it would be good to increase integration with the hospital and increase awareness of research activity across the directorates. MHi also supported this integration which would be particularly beneficial in informing some transformation services. ZA queried if there was evidence of the impact research studies have had, and how this is shared across the community and partners. RM advised of the directive for Bradford to implement a clean air zone, and research supported this in partnership with the council which resulted in maximum funding from the government to implement this. JL referred back to the mention of 30 schools recruited for the Age of Wonder study, and the position of the other schools across the district that weren't yet recruited to this. RM confirmed that 8 schools had declined due to funding or capacity issues, but the research team continued to work with them to try to encourage them to participate. The Board thanked RM for the helpful presentation and was assured by the update.	
Bo.5.24.9	**Paediatric Audiology Service** RS gave a brief overview of the paper in relation to the paediatric audiology service which had been developed in response to a request from the CQC for Trust's to consider the assurance that they have about the safety, quality, and accessibility of its children's hearing services and whether services are accredited by IQIPS. RS confirmed that at present, the BTHFT service is not IQIPS registered but is not an outlier as only 23% of services are accredited nationally. The paper set out a number of options to help inform a decision on whether to seek IQIPS accreditation, with the preferred approach being to 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. Whilst the Board was supportive of the drive of the service to gain accreditation, LB reflected on the current financial position and challenges, and whether this would have an impact on other	

No.	Agenda Item	Action
	services. RS recognised the position but also the need to take a risk based approach, and given that this has been highlighted by NHS England and the CQC, there would be a need to respond and act accordingly. The Board approved the preferred approach to work towards IQIPS accreditation by registering with IQIPS at a cost of £1,685 + vat.	
Section 3: People		
Bo.5.24.10	**Report from the Chair of the People Academy – March and April 2024** KW gave an overview of the reports providing updates on the People Academy meetings held in March and April 2024. The Board was alerted to some very slight changes in dashboard metrics (a slight increase in turnover rates and sickness absence), which were not significant but would be an area for close oversight by the Academy in the coming months. There also continues to be a gender pay gap with women continuing to earn less than men and under-represented at senior levels, and men significantly under-represented in Nursing and Midwifery roles and typically female roles. A gender equality reference group was being established, chaired by RB, and would develop a refreshed action plan to ensure progress is made in reducing gaps. The Board was also alerted to progress against the sexual safety charter, with a plan to implement the ten standards across the Trust by July 2024. There has been a new high-level risk relevant to the Academy in relation to the current Non-Surgical Oncology model of care and the workforce being unable to support this which could cause harm to patients. KW made mention to two particular people who have made a significant difference over this last twelve months – Faeem Lal, the Director of HR, for his leadership in the absence of the Chief People and Purpose Officer and Amandeep Singh, the Partnership Lead (Unison), for his support, contribution and fair challenge. The report from the April Academy meeting made reference to the staff survey, and it was confirmed that the action plan was planned to be brought back to the next public Board meeting for review. In relation to the gender pay gap, LB reflected that this was reducing in society in general and so queried how the Academy can be assured that the steps being taken to reduce the gap are having an impact rather than the gap reducing in line with the societal trend. LB is leading on the sexual safety charter for the University of Leeds, and she suggested that the Trust and the University work together on this. LB and KD would pick up further offline for shared learning. The Board was assured by the update.	**Chief Nurse Bo24015**

No.	Agenda Item	Action
	Gender pay gap reporting – March 2024 The report was noted by the Board.	
Bo.5.24.11	**Equality & Diversity Council update** MP noted the paper which provided an update on the work of the Equality and Diversity Council (EDC). MP made particular mention of the reordering of the EDC meeting agenda to have staff network updates at the start of the meeting, which had allowed for rich conversation. They had also considered the concept of an executive sponsor for each network to provide high level support, and subsequently a lead had been identified per network. MP also updated on the discussions held in relation to health inequalities. A self-assessment of the Trust had been completed against published good practice, and improvement opportunities had been identified which would inform an action plan that would be presented to the Quality & Patient Safety Academy. The EDC had also discussed the 'Too Hot to Handle' report and the subsequent survey by the Brap charity on experiences of racism within organisations, and agreed to a range of actions to ensure that areas such as policies, progression opportunities, programmes are equitably applied and happening in practice. The Board was assured by the update.	
Section 4: Finance and Performance		
Bo.5.24.12	**Report from the Chair of the Finance and Performance Academy – March and April 2024** JL gave an overview of the reports which provided an update of the Finance and Performance Academy meetings held in March and April 2024. The Board was alerted to the financial budget for 2024/25 and the significant challenges faced by the Trust in responding to this. There had been progress regarding the governance arrangements with the Closing the Gap programme being developed, and as the lead for this programme, MHi would join the Academy to ensure they retained oversight of assurance. JL highlighted that the national staff survey identified the BTHFT finance team as the most improved in the country. The Board congratulated MH and his team for this achievement. The Board was assured by the report.	
Bo.5.24.13	**Health inequalities & waiting list analysis – access focus** SA introduced CSt to the meeting to present on Health Inequalities through the lens of 'Access to Care'. CSt highlighted that it was important to consider the impact of health inequalities in all aspects of patient pathways and the presentation shared with the Board	

No.	Agenda Item	Action
	included this wider focus as well as the specific actions taken in relation to access data. The presentation also detailed specific findings in a number of areas (referrals and OPA; DNA rates; treatment; cancer demand) in relation to CORE20, and overall updated findings as follows: • CORE20 patients are more likely to be on routine pathways and therefore have a longer wait time and higher DNA rates • CORE20 DNA rates are higher than other patients across all referral priorities • CORE20 patients seem less likely to be referred on a cancer pathway • No evidence of variance in clinical prioritisation of surgical waiting lists for CORE20 patients and treatment dates are given fairly within surgical priority groupings • Fewer referrals from the CORE20 cohort result in an admitted treatment There were a number of areas for further improvement including linking with Act as One and BIHR colleagues to discuss next steps in analysis and use of the findings, and linking the findings with patient experience data as the actual experience of service users may be different to that shown by the aggregated analysis. 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, and targeted work on increasing referrals and improving OPA attendance would be built into operational excellence plans. RS asked that, in terms of cancer, if there was a difference in the stage of presentation for CORE20 / non-CORE2020 patients. CSt advised that data analysis on this is not yet available, but for urology and gynaecology cancer, CORE20 patients are less likely to be referred but more likely to be prioritised as a P2 patient which would suggest this is the case. KW made reference to the data which shows that young people have higher DNA rates. CSt advised that work is ongoing to seek feedback from the community as to why they do not attend. She also questioned if the CORE20 demographic has changed and therefore needs updating. JL suggested that this data could be shared with the research team to connect the work that is being done. SA confirmed the belief that clinical prioritisation is fair and equal once admitted onto a hospital pathway, but work is required with the community to identify why CORE20 patients are not presenting on some of the higher clinical priority pathways. The Board thanked CSt for the presentation and was assured by the update.	

No.	Agenda Item	Action
Section 5: Audit & Assurance		
Bo.5.24.14	**Report from the Chair of the Audit Committee – February 2024** BM gave an overview of the report which provided an update from the Audit Committee meeting held in February 2024. He recognised that there had been a previous concern regarding the follow up of internal audit recommendations in the Trust, but he had received assurance from MH of an updated process to ensure oversight of this. The Board was assured by the report.	
Bo.5.24.15	**Report from the Chair of the Charitable Funds Committee – April 2024** SJ introduced the report which was taken as read. There were no further comments and the Board was assured by the report. **Draft Charitable Fund TOR** SJ advised of minor changes to the Charitable Fund terms of reference and in particular noting Board representation. The draft terms of reference were approved by the Board subject to clarification on the wording of 'Corporate Trustees'. LP and BM would discuss offline and update the terms of reference as appropriate.	**Associate Director of Corporate Governance / Board Secretary Bo24016**
Section 6: Business Reports		
Bo.5.24.16	**Report from the Chair** SJ introduced the report which was noted which had been shared with the Board for information. She recognised that her focus was mostly internal at the moment but over time this would become more inclusive of partners and place. The Board noted the report.	
Bo.5.24.17	**Report from the Chief Executive** MP introduced the report which was noted. **Integrated Dashboard** MP advised colleagues that the Integrated Dashboard visual had been updated and the content and metrics remained a work in progress. The Board noted the high performance across the Trust and recognised the achievement in delivery of a surplus finance position at the end of 2023/24. **Finance Report** The report was noted by the Board.	

No.	Agenda Item	Action
	Performance Report The report was noted by the Board.	
Section 7: Governance		
Bo.5.24.18	**High-level risks** LP introduced the high-level risk register report, and updated on all changes (new risks, closed risks, and changes in score) that had occurred since the last Board meeting. The following risks were discussed in further detail: • Risk 448 relating to incorrect recording of activity on EPR – PR advised that a new risk assessment was being developed to reflect the current context, focusing on EPR optimisation, as the initial risk was now out of date. • Risk 35 relating to lack of 24/7 security supervision – this risk had recently decreased due to successful recruitment to vacancies in the security team. However, KD noted the increased incidents in A&E over the last few weeks and as a result a full risk assessment was being undertaken and so this risk may be updated further in the next iteration of the report. The Board confirmed their assurance 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.	
Bo.5.24.19	**NED Academy/Committee membership and champion roles** The change in NED Academy / Committee membership and champion roles was approved by the Board with immediate effect.	
Bo.5.24.20	**Bradford Hospitals Charity – supplemental deed** LP introduced the Bradford Hospitals Charity supplemental deed which was approved by the Board.	
Bo.5.24.21	**Data security & protection toolkit** PR gave a brief overview of the paper which sought to update the Board on the expected final position and sets out the recommended Data Security and Protection Toolkit (DSPT) annual assessment rating. He noted that 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 was asked to note the 'Standards Met' forecast rating. The Board noted the position and delegated approval of the DSPT submission to the Digital and Data Transformation Committee	

No.	Agenda Item	Action
	(DDTC)/SIRO on behalf of the Board prior to submission on the 30th of June 2024.	
Section 8: Board Meeting Outcomes		
Bo.5.24.22	**Any Other Business** No other business was discussed.	
Bo.5.24.23	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no particular issues to refer elsewhere.	
Bo.5.24.24	**Review of Meeting** SJ invited Board members to share a review of the meeting offline. She confirmed that work was ongoing to try and reduce the number of papers and improve the timeliness of distribution but it was noted that this would be an iterative process.	
Bo.5.24.25	**Date and Time of Next Meeting** 11 July 2024 – 09:30am	

ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 9 May 2024

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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 reviewed and agreed during May 2024. Action closed
Bo23003	Bo.3.23.10	**Health Inequalities & Waiting List Analysis:** KD endorsed the work that has been undertaken and suggested an expansion of this to look at other areas. It was agreed to add this as a discussion point for a future board development session.	Associate Director of Corporate Governance and Board Secretary	May 2024	A new Board development programme is being developed. Action closed
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. Action closed
Bo24004	Bo.1.24.16	**Performance Report:** A further stroke update would be brought to the Board in 6 months detailing progress made, and improvements seen as a result of opening the ward 9 beds.	Chief Medical Officer	July 2024	An update has been circulated to Board members via email. The CMO will take any additional questions, if required, at the meeting.
Bo240013	Bo.5.24.6	**Report from the Chair of the Quality and Patient Safety Academy – March and April 2024:** KD would provide a more detailed update on PSIRF incidents at the next Board meeting	Chief Nurse	July 2024	
Bo240014	Bo.5.24.6	**Report from the Chair of the Quality and Patient Safety Academy – March and April 2024:** Sue Franklin, Freedom to Speak Up (FTSU) Guardian was keen to attend a Board meeting to update on FTSU and the Board welcomed this.	Associate Director of Corporate Governance and Board Secretary	July 2024	Sue Franklin is attending the Board meeting on 11 July 2024. Action closed

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo240015	Bo.5.24.10	**Report from the Chair of the People Academy – March and April 2024:** LB is leading on the sexual safety charter for the University of Leeds, and she suggested that the Trust and the University work together on this. LB and KD would pick up further offline for shared learning.	Chief Nurse	July 2024	
Bo240016	Bo.5.24.15	**Report from the Chair of the Charitable Funds Committee:** LP and BM would discuss offline and update the terms of reference as appropriate to clarify the wording of 'Corporate Trustees'.	Associate Director of Corporate Governance and Board Secretary	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	
Bo240012	Bo.5.24.5	**Patient Story:** KD would work with EC on the trauma informed charter for BTHFT and bring this back to a future meeting.	Chief Nurse	November 2024	

BO.7.24.4 - MATTERS ARISING

BO.7.24.5 - REPORT FROM THE CHAIR OF THE QUALITY & PATIENT SAFETY ACADEMY

REFERENCES

Only PDFs are attached

- Bo.7.24.5 -Report from the Chair of Quality and Patient Safety Academy - May 2024.pdf
- Bo.7.24.5 - Report from the Chair of the QPSA July 2024.pdf

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.5

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy (QPSA)

Date of meeting: 22nd May 2024

Key escalation and discussion points from the meeting
Alert:
New HLR (Risk 2542, score16). A Haemonetics Blood Track Kiosk in Maternity linked to the blood fridges is broken and cannot be repaired or replaced. The kiosk requires patient details to be scanned prior to fridge opening to obtain the correct patient's blood. Mitigating actions are in place. The entire system will require replacement, a software upgrade and a change required as to how the Trust's blood products are managed. Further details have been required and any replacement will be high cost.
Advise:
Infected Blood Inquiry. It was believed no enquiries or concerns in relation to infected blood had been received since the publication of the report. CQC Inspection to Maternity and Neonates (full inspection for Neonates and a Safety and Well-led inspection for Maternity) on 15/16 May 2024. No urgent escalations were received at the time
Assure: *ensure that any relevant learning/improvements are highlighted in this section*
Serious Incident Report and Patient Safety Incident Response Framework (PSIRF) No Never Events or Patient Safety incidents (PSII) required reporting. One maternal (Maternity and Newborn Safety Investigation) was declared. There are 2 legacy serious incidents (SIs) with approved extensions in place beyond the 60-day deadline. Two HSIB/MNSI (Maternity and Neonatal Safety Investigations) investigations are beyond the 120-day deadline with extensions agreed by Bradford District and Craven Health and Care Partnership. The team are focussed on concluding all these incidents. Four patient safety investigations were concluded and learning highlighted. In one, the investigation found no opportunity where staff could have prevented the patient's death. Most Trust led SIs were concluded outside the Health and Care Partnership timelines but with agreed extensions. Under PSIRF (Patient Safety Incident Response Framework), it is expected that no investigation should take more than 6 months and it is envisaged that the new approach will reduce responding time and improve conclusion times. There is a programme of training planned for 2024/25 to support PSIRF implementation and compliance with Patient Safety Incident Response Standards. The Academy noted the current position and future steps and confirmed that there is sufficient assurance that BTHFT has processes in place to identify, investigate, and learn from patient safety investigations.

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Maternity and neonatal services

From the report the Academy noted the position for April 2024

- 4 stillbirths. Any learning identified has been shared with staff
- 1 case of Hypoxic-ischemic Encephalopathy MNSI reportable
- 0 maternal deaths
- 6 ongoing maternity SIs/Level 1 investigations, 3 M (MNSI) and 3 Trust level (same as for March, 0 completed investigations this month or learning reported
- 0 occasions where the unit assessed as needing to divert women to other trusts.
- 3 neonatal deaths, all anticipated due to prematurity/congenital anomalies
- No new or ongoing neonatal SIs

The Academy was assured members were receiving information related to maternal perinatal quality and safety issues and associated learning in a timely manner.

The Academy received a verbal update on concerns the Maternity & Neonatal Voices Partnership raised with the CQC (Care Quality Commission). The FTSU (Freedom to Speak Up) Guardian is meeting staff to consider Black, Asian and Minority Ethnic staff progression. Following safety concerns raised around the birth centre & labour ward staffing it was reported that staff are satisfied to carry on with the current staffing model with continued support. The Academy was assured that concerns raised are being taken very seriously and followed up.

Infection prevention and control quarterly report

The Trust exceeded current targets for E coli bacteraemia (by 8 cases) and Klebsiella bacteraemia by (12 cases). Bacteraemia reduction measures were noted.

The Trust's position re. National and Regional data for MSSA, E coli, pseudomonas and Klebsiella was reported. Targets were discussed with comparisons made to 2022/23. C difficile and E coli cases were below the 2022/23 target. MSSA and Klebsiella cases were slightly increased on 2022/23. Cases are being scrutinised for consideration of interventions for improvement. A comprehensive improvement plan updated regularly with immediate review of cases for quick learning and triangulation of cases using PSIRF was presented.

The Trust is fully compliant with 52 of the 54 IPC (Infection Prevention and Control) BAF (Board Assurance Framework) standards and two standards are partially compliant: mitigation and appropriate actions have been taken. Standard 2.4: the Water Safety plan should be approved at the next Water Safety group meeting. Patients with airborne isolation are prioritised in negative pressure rooms and a plan is in place for more negative pressure side rooms in Ward 1. Standard 3.6: a business case has been written for another Pharmacist with antimicrobial stewardship responsibilities.

The QPSA was assured by the Quarter 4 report noting monitoring of the activity by IPC and the annual work programme. The recommendations in the report were approved.

High level risks relating to the Academy (in addition to Risk 2542 in Alerts section)

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- No other HLRs have been added to the register and no risks have been closed
- Risk 3660 (maternity staffing) and Risk 3404 (Pressure on paediatric services) are expected to remain on the list for some time as they are not easy to resolve.

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

Patient Experience Bi-annual Report

Highlights of Patient Experience work was presented. The *Patient Experience and Engagement Strategy 2023-2028 Kindness at every step. No decision about you without you* has been well received. National and local awards have been received for some of our patient experience work. The Trust has an 87% score for the Friends and Family Test (FFT) rating the service good/very good and above the national average.

Future improvement work was noted:

- A shared learning repository for complaints is under consideration.
- Implementation of new Health Service Ombudsman standards around early resolution.
- A patient experience dashboard providing an easy update of work is underway.

QPSA were assured by the report and commitment to patient experience improvement.

Getting it Right First Time (GIRFT) update

The main priority for 2024/2025, is the 'Further Faster' programme that brings together clinicians and operational teams to transform pathways using GIRFT methodology to rapidly adopt best practice across a range of clinical pathways. Further Faster focuses on 16 specialties and there are plans for this to extend into additional specialties that have not already been covered.

An ongoing Pancreatic Cancer Review focuses on improvement at Network level to achieve excellent clinical outcomes for patients with pancreatic ductal adenocarcinoma. However, these goals were discussed in relation to Risk 2549 (Workforce constraints within Non-Surgical Oncology) currently scoring 16, where the principal risk is failure to maintain the quality of patient services at BTHFT and WYAAT. A meeting on 24 May 2024 is scheduled with Professor Tim Briggs, Chair of the national GIRFT (Getting It Right First Time) programme to consider concerns raised from the pancreatic peer review.

Update on Health Inequalities (HI)

The Trust Lead for HI presented the NHS Providers guidance, 'What Good Looks Like', informed by NHSE's policy and publications describing some of the best practice observed. The guidance includes a self-assessment tool to assess maturity across four domains (five levels: not started, emerging, developing, maturing and thriving) can be assessed. For BTHFT:

1. *Building public health capacity and capability* concerns understanding the needs of the local population, availability of HI training and support provided to operational clinical teams around inequalities. Rated as **Emerging**

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2. *Data, insight, evidence and evaluation*, concerns data engagement and research, performance and business intelligence. Rated as **Maturing.**
3. *Strategic leadership and accountability* concerns leadership, existing reporting arrangements, commitment and CORE20PLUS5. Rated as **Developing.**
4. *System Partnership* concerns Place level work. Rated as **Maturing.**

Areas for improvement include HI training for the Board of Directors and staff, the use of population health data and focusing on outcomes and equality of experiences.

The QPSA were assured on the work underway and intended actions.

Hospital at Night Huddle Update

The night Safety Huddle meeting has taken place daily since November 2023 in the Command Centre. It is attended by outreach, critical care, medicine, and Command Centre colleagues. Attendance was reported as very good. The Huddle enables discussion of in-patients of concern and at risk of deterioration overnight. The night Huddle links in with the morning Trust Safety Huddle and operational meetings to ensure continuous risk oversight.

In over half of huddles, a patient at risk of deterioration who the group was not previously aware was detected, ensuring appropriate care and escalation, as necessary. Ward visits avoid patient deterioration ceilings of care and resuscitation orders put in place thus avoiding inappropriate cardiac arrest calls for patients for who this is inappropriate due to palliation. There has been a reduction in the number of Crash calls for cardiac arrests per month since the inception of the Huddle.

Evaluation suggests the Huddles have improved staff confidence through knowing the colleagues on shift including the Crash team, improved communication and function during emergencies, better role allocation, identifying learning needs for junior staff, allowing leadership development and educational skills during the situation, and improving confidence of junior doctors in escalating to their seniors, to ICU or to the outreach nurses. Average length of stay for all unplanned ICU admissions from 1 January 2023 to 30 April 2024 has decreased from seven to five days. Other harder to measure outcomes may include the wellbeing of junior doctors and the building of effective working relationships.

The Academy noted this positive and important piece of quality improvement work and the QPSA were assured by the findings.

The Chair noted the documents for information appended to the Academy papers and drew attention to the Internal Audit Reports relevant to the Academy: BH/39/2024 VTE (Venous Thromboembolism) Assessment – 15 April 2024. BH/40/2024 Risk Management Framework and Strategy.

Report completed by:

Louise Bryant
Academy Chair and Non-Executive Director

30th June 2024

Meeting Title	Board of Directors		
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Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy/Committee

Date of meeting: 2nd July 2024

Key escalation and discussion points from the meeting
Alert:
Nothing to escalate to the Board and nothing to share with other Academies.
Advise:
The Academy was updated on the current round of industrial action by Junior Doctors. The Trust now has very good processes in place to deal with this but despite this, there was some cancellation of non-urgent activity. The Monday of the strike period saw the 2nd highest ever numbers of ED attendances, but high Trust performance in ED was maintained. The cost associated with consultants covering Junior Doctor activity was noted. Our crude mortality rate continues an overall pattern of reduction and we continue to have the lowest crude mortality rate in West Yorkshire. SHMI is still high at 117.5, but collaboration between the Learning from Deaths Team and Business Intelligence has seen SHMI reduce by over 4 points since last month. Work continues on coding issues which will continue to reduce our SHMI moving forward. The new QPSA dashboard is still work in progress and in some cases statistical representation and insight could be improved. New presentation of data, for example in relation to increased pressure ulcers on Ward 26, gave better insight associated with quality improvement actions were noted as being much improved and the kind of presentation the dashboard could provide.
Assure: *ensure that any relevant learning/improvements are highlighted in this section*
<u>Quality Oversight and Assurance Profile & Serious Incident Report and Patient Safety Incident Response Framework (PSIRF)</u> The Academy report provided oversight of Safety Incidents (internal and external) and Safety Events. Escalations to SEG and QuOC are currently being monitored within the CSU/relevant team: Five emerging themes were identified. 1. Increase in pressure ulcers as noted above with improvement work noted 2. Re-admission of patients >65 (silver traumas) with injuries not identified at first ED visit (under review) 3. Delays in breast histopathology results from outsourced services. A risk assessment has been completed

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4. Increased incidents relating to delays in Speech and Language Therapy (under review, with known capacity issues within team).
5. Delayed referrals from AED to stroke services. MDT approach and learning identified

Two emerging risks were identified:
1. Timely completion of clinical reviews. A watching brief is being maintained
2. Management of Estates and Facilities alerts. A process adopted by Estates and Facilities to alert SEG and/or QuOC of any such alerts

Central Alerting System
All alerts were shared with the Academy

Claims and Inquests
14 claims were referred to NHS Resolution; 4 claims formally settled for a combined total of £73,000. Alleged negligence surrounding Caesarean Section - settled for £40,000. Updates on inquests attended and forthcoming were provided.

Patient safety investigations:
All legacy investigations have been completed (final 2 this period) and learning shared with staff and the Academy in the report
No PSIIs agreed for StEIS reporting between 1st April and 31st May 2024.No Never Events have been identified as occurring between 1st and 31st May 2024

The Trust continues to meet the Duty of Candour requirements and no breaches have occurred since August 2016. However, in relation to one death, the coroner identified where candour could have been improved. More work will be done with clinicians to improve understanding of the legislation and how this is applied in terms of openness and transparency with patients and families and how it is recorded in the EPR.

The Quality Oversight System reviews all SIs and triangulate themes and learning with other sources of intelligence/insight. Next steps are to (1) provide further staff training to improve knowledge, confidence and expertise to effectively respond to PSIs under PSIRF. (2) Further develop the assurance report for the QPSA and Board to reflect the new PSIRF process highlighting learning as well as providing assurance on the effectiveness of actions taken in response to safety events.

The Academy noted the current position, emerging themes, risks, work to mitigate and noted the next steps. It confirmed that there is sufficient assurance that BTHFT has processes in place to identify, investigate, and learn from patient safety investigations

<u>Insights Report (formerly Complaints Litigation Incidents & Patient Experience (CLIP) Quarters 3 & 4 plus annual report 2023/24</u>

The Insights report reflects changes in processes and investigation processes namely PSIRF and the new IRIS system. It aims to provide richer insights into the quality of care the Trust provides, demonstrate how learning informs improvement work and share examples of good and excellent practice.

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The report detailed *Incidents, Complaints and PALS, Litigation and claims* including costs awarded*, inquests* and *CQC enquiries*. In order to monitor and learn from CQC enquiries a thematic review of all enquiries from January 2023 to date was conducted. The key themes related to Patient Safety e.g. falls and medication errors, Safeguarding issues involving children and vulnerable adults, Staff concerns e.g. behaviour, Patient Experience e.g. environment in ED, and Estate and Facilities, e.g. fire safety.

The Academy approved the changes to the reporting approach and confirmed the quarterly reporting period. Academy reported they were assured on the management and monitoring of safety incidents, complaints, claims and litigation and external enquiries from key regulatory bodies.

<u>High level risks relating to the Academy</u>

Two risks reduced in score from 16 to 12.Two risks are past their target mitigation dates and scores have been increased so they now appear as new HLRs this month.

- 605: risk to haemoglobinopathy services. National problems with recruiting to this speciality were highlighted and that score increase is as a result of an inspection by the British Haematological Society, a non-statutory body (score 16).
- 2509: Average waiting time for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks with a risk that delays in diagnosis may impact on long term development (score 16).

One additional new risk was added to the HLRR, which is also an existing risk that has increased in score

- There is a risk to the provision of a consistent Stroke Service due to a number of underlying issues (score 16) including vacancies, staff sickness,and provision of therapy services.

Two further new risks were added to the HLRR during June 2024 but will be combined with Risk 2542 (The Haemonetics Blood Track kiosks at BTHFT are now 'end of life') reported in last QPSA and already on the HLRR:

- Risk 810: risk of patient harm caused by administration of the wrong blood/blood component
- Risk 1280: risk that patients requiring blood transfusion might receive blood with the wrong blood group as a result of the wrong patients' blood being in the tube sent for G&S/cross match tests.

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

<u>Safeguarding Adults Annual Report & Safeguarding Children's Annual Report</u>

Adult safeguarding
Attendances by patients requiring detention under the Mental Health Act (MHA) has increased. Closer work with the police is taking place to ensure that section 136 detentions are applied appropriately. Specialist advisors on domestic and sexual

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violence have joined the team. Ther have been significant increase in request for information in relation to domestic homicide and adult safeguarding reviews, stretching the limited specialist resource. Safeguarding adult training compliance is over 95% (levels 1 & 2). Current compliance with Prevent basic training is 94% (NHS England minimum is 85%).

Further work including additional training, development and support for staff working in crisis situations is in progress. The Additional Needs Care Navigator has evaluated well, with feedback from families and carers of the impact and difference this role has made. This is being considered as a permanent role

Child safeguarding
BTHFT is the top performer of Trusts who responded to a RCPCH national audit of 'Good Practice Service Delivery Standards for the Management of Children Referred for Child Protection Medical Assessments' achieving 99 of the 103 standards. Improvements were noted included working with ED colleagues to introduce a template into EPR to record the mobility of babies attending with an injury and assure that the West Yorkshire Procedures to Safeguard Children are being followed. There is increased & increasing recognition of child behind the adult as evidenced by the number of Paediatric Liaison Forms from the ED.
The Academy were asked to note:

1. The main risk remains children/young people with poor mental health or in crisis. Improvements are required to achieve better outcomes for these children and reduce their length of stay on an acute ward. BTHFT does not employ a children's specialist MH professional and this was identified as a priority.
2. Trust EPR and paper records hamper safeguarding assurance as systems cannot automatically communicate with each other and information cannot easily be shared or found. The team are working with IT to mitigate this risk and with Cerner to explore how best to make safeguarding documentation more visible in-patient records.

The Academy confirmed there was sufficient assurance that both adult and children's safeguarding processes and services are being managed appropriately and that learning and improvement are shared appropriately.

<u>Maternity and neonatal services</u>

From the report the Academy noted the position for May 2024

- 1 stillbirth (Butterfly baby)
- 0 cases of Hypoxic-ischemic Encephalopathy
- 0 maternal deaths
- 0 MNSI referrals or internal SIs
- 5 ongoing maternity SIs/Level 1 investigations: 3 MNSI and 2 Trust level
- 3 completed investigations this month with learning and action taken reported
- 1 occasions where the unit was assessed as needing to divert women to other trusts; 4 women diverted.
- 2 neonatal deaths, both anticipated due to extreme prematurity/congenital anomalies
- 0 new or ongoing neonatal Sis

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The Chief Nurse and Director of Midwifery had a concern raised regarding safety in the Birth Centre from 1 staff member around staffing, and women not being offered the Centre as a choice of place of birth. They met with colleague, listened to concerns and suggestions for improvements. Since then there has been an improved position in the Centre during May. Initiatives to actively promote the Centre as a choice for women are ongoing. Predicted newly qualified midwife numbers, due to start in October, will also provide a more robust and sustainable staffing model to be consistently applied.

Training compliance showed 37/47 training compliances are within target, 3 areas where compliance is between 75-85% and 7 with compliance below 75%. Explanation and actions for competencies below target were provided.

Key points from CQC inspection reported:

1. Exemplary neonatal service
2. Operational improvements identified: temperature of rooms where drugs stored higher than optimal, management of outpatient prescription pads could be improved, corridors/fire door blocked by equipment. Mitigating actions were shared.
3. Some staff were unable to articulate learning from MNS. Actions to improve include find additional ways to share learning, develop a digital platform to share learning, release more staff to governance meetings where learning is discussed (when staffing levels improved)
4. More detail requested about management of delayed inductions. Improvement work in progress was shared.

The Academy were assured they were receiving information related to maternal perinatal quality and safety issues and associated learning in a timely manner.

Report completed by:

Louise Bryant
Academy Chair and Non-Executive Director

7th July 2024

ADULTS & CHILDREN SAFEGUARDING ANNUAL REPORT

REFERENCES

Only PDFs are attached

- Bo.7.24.5 - Safeguarding Adults Annual report 2023-24 (cover).pdf
- Bo.7.24.5 - Safeguarding Children Annual Report (cover).pdf

Meeting Title	Quality and Patient Safety Academy		
Date	2nd July 2024	Agenda item	QA.7(1).24.12

SAFEGUARDING ADULT ANNUAL REPORT 2023-2024

Presented by	Sarah Turner, Assistant Chief Nurse Vulnerable Adults	
Author	Sarah Turner, Assistant Chief Nurse Vulnerable Adults	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	This paper is the Annual Safeguarding Adult Report	
Key control		
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

This annual report provides information regarding activity within adults safeguarding at Bradford Teaching Hospitals NHS Foundation Trust between April 2023 and March 2024.
Key risks are: -

- The increase in patients with a mental health diagnosis attending the Trust and requiring support and detention under the Mental Health Act (MHA) has increased. There remain ongoing concerns regarding the care of mentally unwell patients within an acute hospital and delays in identification of appropriate mental health provision. Monitoring of section 136 detentions attending the Trust has commenced during 2023, with work in progress to understand the impact of this and how we can ensure, as a Trust, we are more prepared to provide safer services for people who may require mental health support who access our services. Work is underway in relation to the implementation of Right Care Right Person (RCRP) and the implications it will have on services.

- During the period 2023/24, the frequency of MARAC meetings continued at the increased rate instigated during the previous years. Weekly meetings have been in place for a couple of years, due to the increase in referrals and recognition of the need for multi-agency discussion of cases to happen sooner. The addition of the HIDVA to the team was extremely beneficial and provided increased support to both patients and staff. The further training of a Safeguarding adults specialist practitioner as an IDVA / ISVA has strengthened the response we can provide to victims of domestic abuse, however the hosting of a HIDVA means there is a level of independence from the Trust which staff who disclose report finding beneficial. The funding for this post is external and is only in place until July 2025, consideration for how this post can continue to be funded is ongoing.

- The increase in activity in relation to Domestic Homicide Reviews / Safeguarding Adult Reviews (DHR's / SAR's) should be noted as there has been a significant increase in the requests for information and involvement in both these processes. This is a risk in relation to the identification of appropriately trained staff to undertake the necessary parts of the process, specifically the authoring of the Independent Management Reports (IMR's). It is recognised there is currently a very limited amount of staff who have had experience of these, and this is reflected across the District.

Analysis

The Trust also submits a self-declaration to the Clinical Commissioning Groups (CCGs) on an annual basis:

Meeting Title	Quality and Patient Safety Academy		
Date	2nd July 2024	Agenda item	QA.7(1).24.12

Key Achievements:

- Continued participation and attendance in multi-agency district wide safeguarding meetings.
- The development and hosting of the district wide Safeguarding conference in relation to coercion and control
- Development of process relating to Section 136 detentions.
- Re levelling of staff to ensure appropriate training level for Safeguarding Adults is applied.

Recommendation

- Audit and review of the self-declaration for training compliance and further development of learning opportunities for staff to ensure a richer opportunity for learning and embedding into practice.

  On going training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs), to ensure staff are aware of their responsibilities and the Trust is compliant with regulatory requirements. Audit of the new 'best interest' discussions template within EPR.

- Further development of the additional needs team, to ensure staff are clear and supported regarding their role. Consideration of making the Additional Needs Care Navigator post a permanent role as this has evaluated well, with feedback from families and carers of the impact and difference this role has made.
- Ongoing development and support for staff regarding mental health and supporting patients in crisis/distress. Development of a training post for conflict resolution, de-escalation, and breakaway training to support the clinical response to restraint workstream. Also, simulation training for staff in relation to managing patients in mental health crisis.
- Presentation and participation in the District Safeguarding week. As in previous years the Safeguarding Adults team will be actively promoting Safeguarding week in June and representing the Trust across the District. This is in conjunction with partner agencies.
- Ongoing and further development of the Trust response, in collaboration with partners, to Section 136 detentions and the implications of these attending the Trust with no medical requirement to do so and how although a 'place of safety' within the legislation the Trust is not necessarily a safe place for persons experiencing significant mental health distress. Work has started in relation to how we can utilise the skills of the newly qualified dual trained nurses.
- Development of specific learning relating to DHR's specifically in relation to non-fatal strangulation.
- Implementation of the Right Care Right person work and continued work with partners as to minimising the impact on all services.

Meeting Title	Quality and Patient Safety Academy		
Date	2nd July 2024	Agenda item	QA.7(1).24.12

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be 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: Safe
Care Quality Commission Fundamental Standard: Safeguarding from abuse
NHS Improvement Effective Use of Resources: People
Other (please state):

Meeting Title	Quality and Patient Safety Academy		
Date	2nd July 2024	Agenda item	QA.7(1).24.12

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

Meeting Title	Quality and Patient Safety Academy		
Date	2nd July 2024	Agenda item	QA.7(1).24.12

Safeguarding Adult Annual Report 2023-2024

1 PURPOSE/ AIM

This Annual report provides information regarding activity within Safeguarding Adults in Bradford Teaching Hospitals NHS Foundation Trust between April 2023 and March 2024.

2 BACKGROUND/CONTEXT

All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998), to intervene proportionately to protect their right as citizens (ADASS 2005, Safeguarding Adults). The Care Act 2014 came into effect in April 2015; and was the first legislation specifically relating to the responsibilities to safeguard vulnerable adults. The Act not only addresses and recognises the importance of reducing risk, preventing harm and stopping abuse or neglect, but most significantly promotes involvement in the process of the adult concerned. Making safeguarding a collaborative process undertaken with someone rather than a process we do 'to' somebody.

Safeguarding is everyone's business; all staff have a responsibility to help prevent abuse and to act quickly and proportionately to protect people where abuse is suspected. Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) has a responsibility to ensure that arrangements are in place to ensure that staff are able to meet their obligations with regard to Safeguarding Adults. The principles and values as laid out in the Care Act are Empowerment, Protection, Prevention, Partnerships, Proportionality and Accountability

The Trust's policies and procedures are in line with the West Yorkshire, North Yorkshire and York Safeguarding Adults Policy and Procedures. This policy was produced by Bradford Safeguarding Adults Board in collaboration with.

- Calderdale Safeguarding Adults Board
- Kirklees Safeguarding Adults Board
- Leeds Safeguarding Adults Board
- North Yorkshire Safeguarding Adults Board
- Wakefield Safeguarding Adults Board
- York Safeguarding Adults

Safeguarding adults within Bradford Teaching Hospitals NHS Foundation Trust remains a high priority. The Trust has seen a continued increase in the scope of safeguarding adult's activity throughout the past year within all areas.

Section 42 of the Care Act 2014 outlines when enquiries must be made and sets the definition of an Adult at Risk (AaR) and a Person alleged to have caused harm (Patch)

Section 42 is met if the person

- has care and support needs (whether or not the local authority is meeting any of thse needs)

- Is experiencing or is at risk of abuse or neglect.

And

- As a result of these needs is unable to protect himself / herself against the abuse or neglect, or the risk of it.

Figure 1 outlines the areas of work included within the responsibility of the Safeguarding Adults team.

Figure 1

2	DELIVERY OF SAFEGUARDING ACTIVITY AGAINST TRUST OBJECTIVES

This report will evidence delivery of the activity relating to the Trusts statutory responsibilities under safeguarding adults and Trusts objectives.

2.1 To provide outstanding care.

2.1.1 Safeguarding Adult Activity

For the year 2023/24, the safeguarding adult team received **735** referrals for support in relation to safeguarding adults' concerns. This is an increase of **306** on the previous year.

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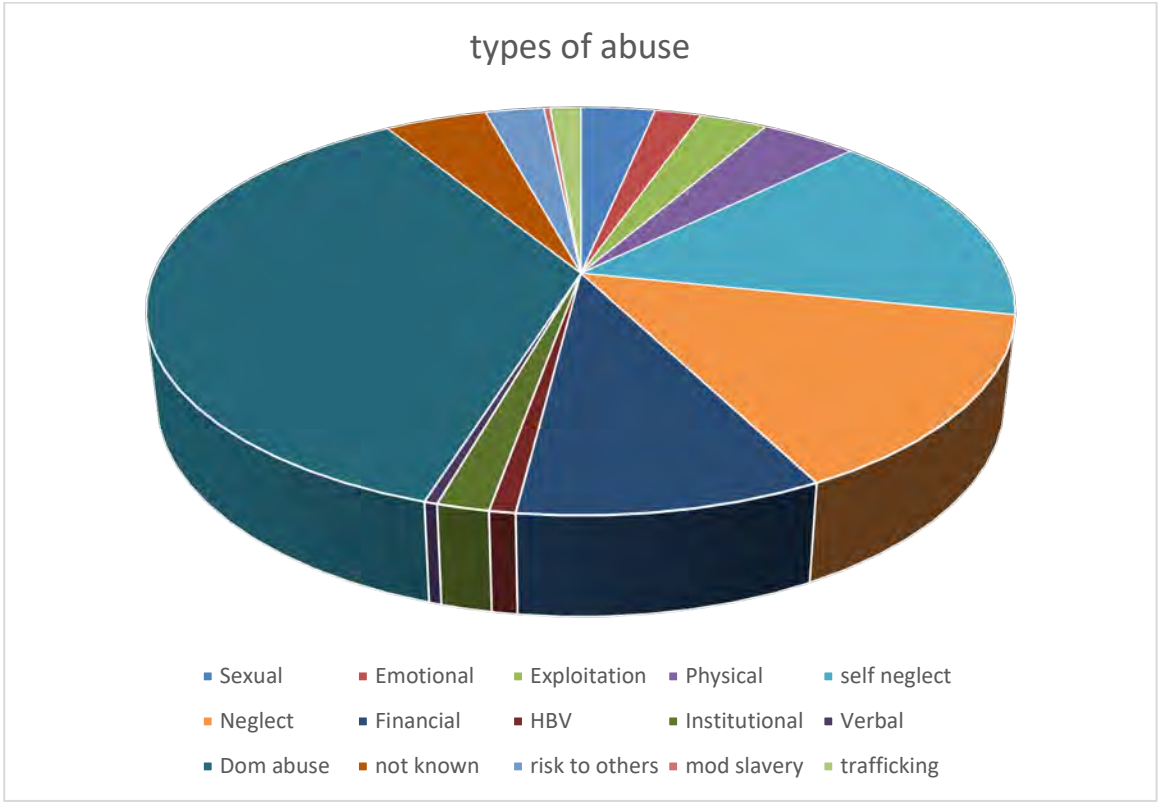
Making Safeguarding Personal (MSP) is an approach to safeguarding set out within the Care Act. This identifies a requirement for taking the views and wishes of the Adult at risk (Aar) in relation to the abuse. In line with MSP the Safeguarding Adults team within BTHFT always discuss with the Aar what they wish to happen as a result of disclosing the abuse. Some patients do not wish any action to be taken and in cases where the Aar has capacity to make this decision and there is no risk to anybody else, this wish would be respected. This decision is revisited during an individual's stay and any change is acted upon in line with procedures**.** If further action is required, this can take many forms such as referral to a specialist service, referral to the local authority safeguarding team for a multi-agency response, reporting to the Police and liaison with carers and families.

Figure 2 shows referral rates by types of abuse.

Fig. 2



The highest referral rate to the safeguarding team has been in relation to domestic abuse, second highest referral rate being neglect.

2.1.2 Referrals to the Local Authority Multi Agency Safeguarding Hub (MASH)

The Safeguarding Adults Team within the Trust work closely with the Multi Agency Safeguarding Hub (MASH) within Bradford Metropolitan District Council, (formerly the Adult Protection Unit (APU). As part of their remit, they receive concerns regarding Adult Abuse and ensure that the appropriate measures are taken by sharing the information with the relevant people to enable an investigation to be undertaken. Anyone who suspects that abuse of an adult has occurred can raise a concern to the Local Authority Safeguarding Adults Team / MASH who will make enquiries and co-ordinate the response. Further information may be requested from the local authority, this is done on a delegated enquiry and is completed by the Matron of the responsible area and the Safeguarding team. The numbers of delegated enquiries is low in comparison to general safeguarding activity as often the necessary safety plans/ measures have been taken and therefore the risk of further abuse has been reduced.

Concerns involving staff members would always be reported and investigated in line with criminal proceedings and Person in a Position of Trust (PiPOT) procedures, with primacy for investigation always being with the Police. The Safeguarding Adults team have a close working relationship with the safeguarding team within the Police and communicate frequently in relation to ongoing cases.

2.1.3 Domestic Abuse and Multi Agency Risk Assessment Conference (MARAC)

Domestic abuse is category of abuse as outlined in the Care Act 2014, however it is often not reported to the MASH as the victim does not have a care support need which is one of the requirements for a local authority referral. This is often referred to as the Section 42 requirement (as outlined above). The Safeguarding Adults team provide support to patients and staff who disclose domestic abuse and provide information for support services in the community. The Safeguarding Adult Team in conjunction with Safeguarding Children Team and the Safeguarding Midwife gather and collate information in relation to patients who are discussed at the Multi Agency Risk Assessment Conference (MARAC). MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the district. Each case involves a minimum of 2 people but can often involve more, including children.

The MARAC meetings are held weekly and are attended by representatives from agencies across the Bradford District including, police, Childrens Trust, the Probation Service, domestic abuse support services, health and adult social care. As well as providing information as to relevant attendances at BTHFT services, the Safeguarding Adults Team are also responsible for ensuring appropriate flags are placed on and removed from patient records in a timely manner. The flags are placed on the Electronic Patient Record (EPR). This ensures staff are alerted to the potential risk these individuals are at and provides staff with an opportunity to broach the subject of domestic abuse and provide targeted enquiry and support. The flags enable staff to potentially look at attendances through a domestic abuse lens and apply professional curiosity to what they are told or see on presentation.

In the period 2023/24, there were a total of **1087** cases referred to MARAC, this is a decrease of **111** on the previous year. There has been a noticeable increase in domestic abuse incidents both across the district and nationally since 2019. Sadly, the increase continues and is believed to be in part due

to the willingness of victims to report and the ability of services to respond more effectively. (Domestic abuse in England and Wales overview: November 2022). As a direct result of this increase, discussions were undertaken with partner agencies in exploring opportunities for further assistance. The Domestic Abuse Manager within the Local authority secured funding for a fixed term post for a Hospital Independent Violence Advocate (HIDVA).

A HIDVA commenced in the Trust in April 2021, they responded to concerns regarding domestic abuse for both staff and patients and supported them with onward support in the community, delivered training and assisted with attendance at MARAC. Further funding was secured, which has extended the pilot period until July 2024. During the period 2023/24, **140** referrals for domestic abuse were received by the Safeguarding Adults Team. The referrals were following disclosures from patients and staff. In recognition of the increase and to ensure the Trust can provide a timely and specialist response, one of the safeguarding adult specialist practitioners was supported to undertake their Independent Domestic Violence Advocate (IDVA) training. They also subsequently were supported to undertake and complete their Independent Sexual Violence Advocate (ISVA) training.

Figure 3, 4 & 5 shows the referral number and demographic data relating to domestic abuse.

Fig 3.

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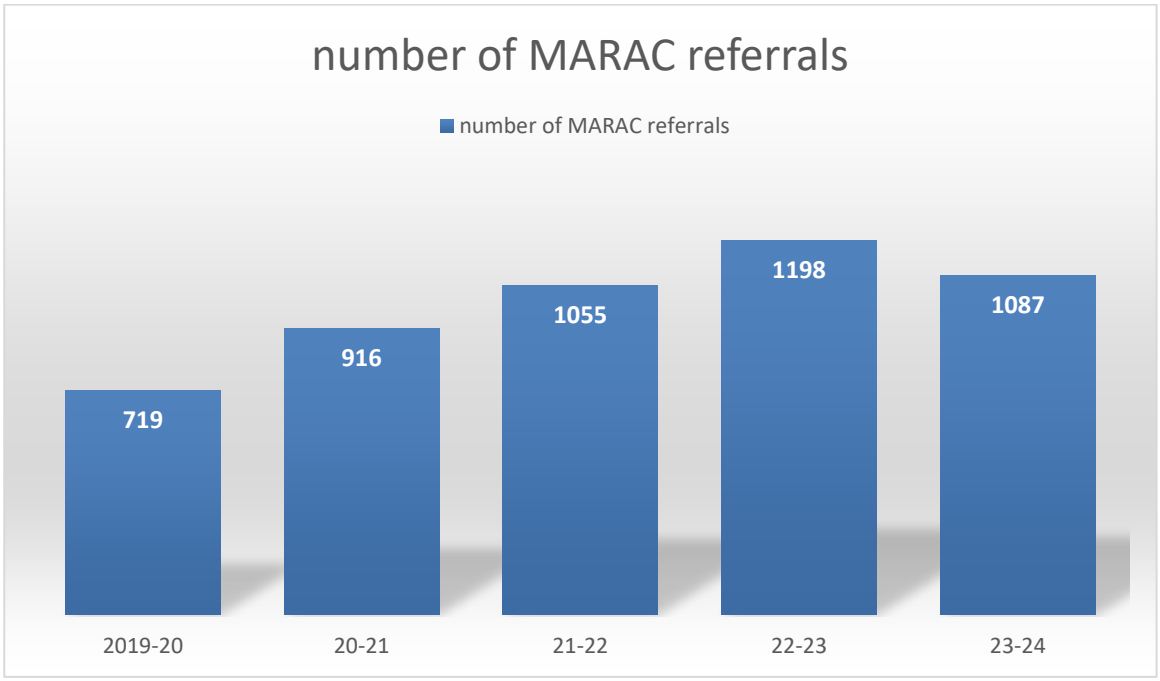


Fig.4

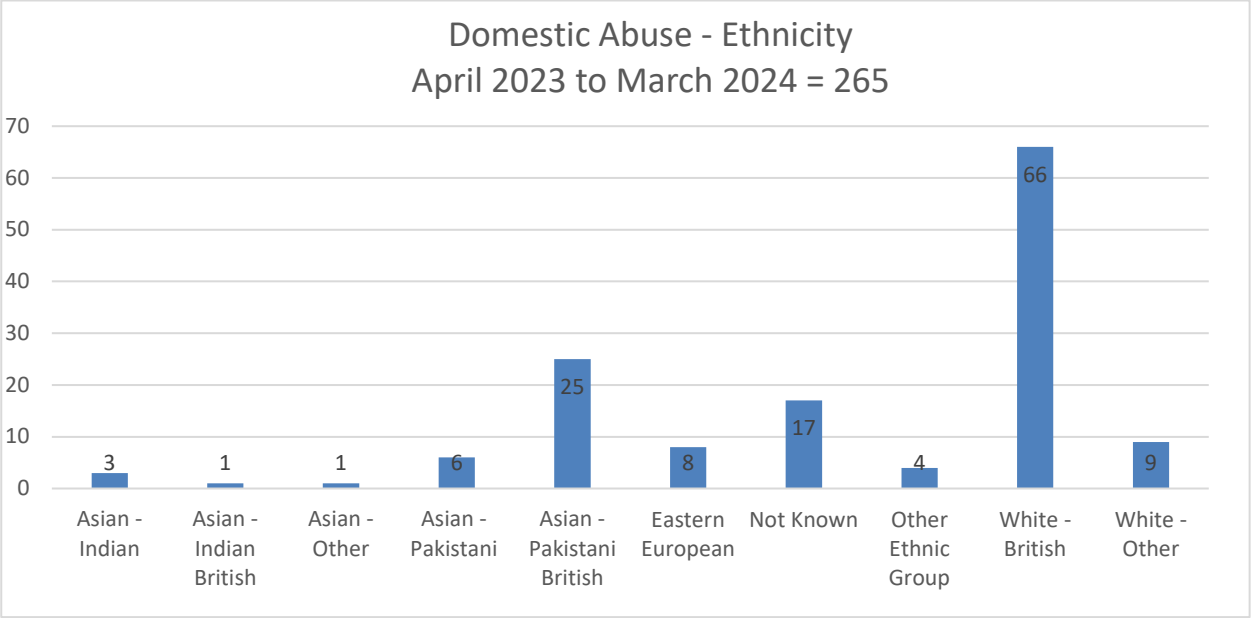
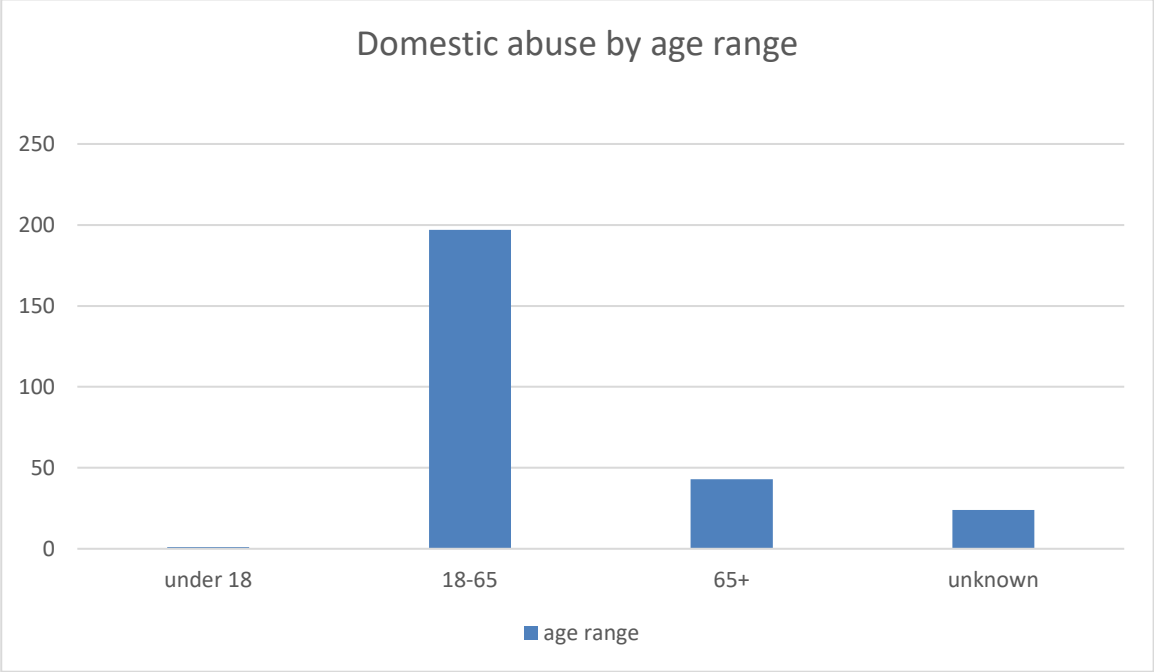


Fig. 5



2.1.4 Mental Health Act compliance

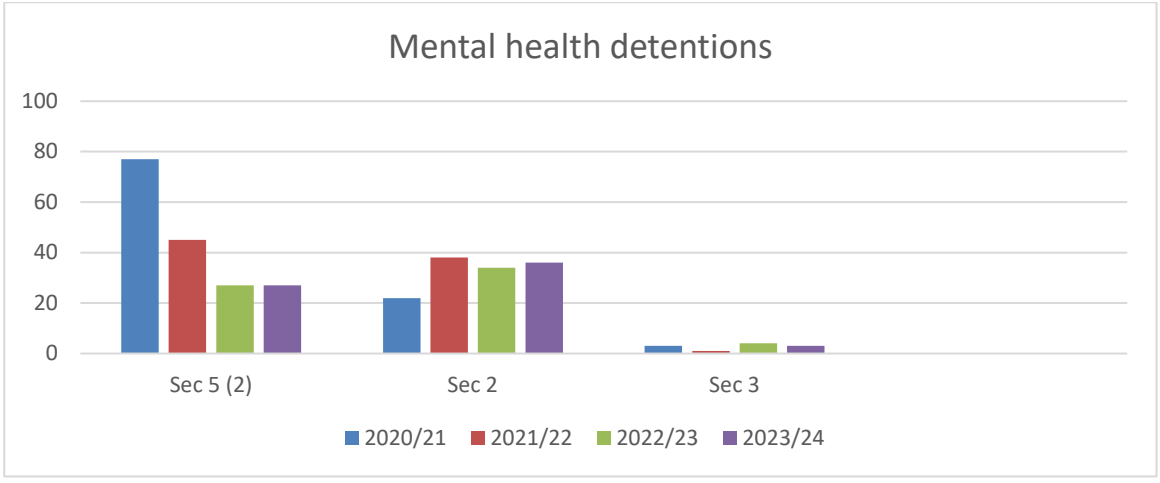
A service level agreement with Bradford District Care Foundation Trust (BDCFT) continues to be in place to ensure that BTHFT is compliant with all aspects of work in relation to the statutory responsibilities of the Mental Health Act. This includes scrutiny of documents, training and access to

an appeals panel hosted by BDCFT if patients wish to appeal their Mental Health Act section. The Safeguarding Adult's Administrator meets monthly with the Mental Health Act Administrator from BDCFT to ensure that records are accurate and to feedback any areas of concern/change. The Mental Health Specialist Practitioner came into post on February 2021 and offers specific advice to staff, liaises with BDCFT to ensure effective communication and handover of patients subject to the Act and supports the Safeguarding Adult's Administrator with monitoring of compliance.

Monitoring of detentions under the Act has previously not included section 136 which is the section of the Mental Health Act 1983 used by the Police to take a person to a place of safety for assessment of a believed mental disorder. Section 136 data is now collected and monitored, as there is recognition of the impact of persons subject to section 136 being brought to AED as a place of safety without a medical need to attend hospital. The police must stay with the person for the duration of the detention under section 136. It must be highlighted that although AED is a 'place of safety' within the legislation, it is not necessarily a safe place for persons experiencing acute distress related to a mental health concern. This is because it is not a therapeutic environment (often busy, noisy and overstimulating) and does not have staff specifically trained in dealing with acute mental illness.
The monitoring of this data has increased significance, since the introduction of Right Care Right Person. Right Care Right Person (RCRP) is an operational model developed by Humberside Police that changes the way the emergency services respond to calls involving concerns about mental health. It is aimed at making sure the right agency deals with health-related calls, instead of the police being the default responder. It has been shown to improve outcomes for the person and reduce demand on all services and makes sure the right care is being delivered by the right person/ agency.
The Assistant Chief Nurse Vulnerable Adults attended and now chairs the regional meeting regarding this work as part of the Criminal Justice and Mental Health work streams for the West Yorkshire Combined Authority.

Figure 5 shows the numbers of application for detention over the last three years.

Fig 5



Of the **66** applications made for detention under the Act, **27** were for Section 5(2), doctors holding power, which detains and holds patients for up to 72 hours whilst an assessment of their mental health by an Approved Mental Health Practitioner (AMHP) is undertaken, this is the most common section of the Mental Health Act used within acute care settings. Of the remaining detentions, **36** were a Section 2, which is a section for assessment of mental disorder and **3** were for a Section 3, which is a section for treatment of mental disorder.

It is to be expected in an acute medical setting that the most prevalent detention used is Section 5(2). This is often because people may be in an increased heightened state due to illness and therefore present in a way that can appear unusual. It is worth noting that the numbers in 2020/21 were unusually high, this in part was due to the pandemic and lockdown restrictions so people had limited access to their usual support mechanisms and general levels of anxiety were increased.

The Mental Health Specialist Practitioner joined the team in 2021 and has worked closely with ward staff to ensure training regarding mental health as well as support for staff and patients has been offered. In early 2023, specific work in relation to section 136 was undertaken by the Mental Health Specialist Practitioner with AED staff to ensure detentions were lawful and the police had access to the necessary paperwork.

2.1.5 Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are intended to ensure that patients who lack mental capacity are kept safe and that any restrictions imposed are in their best interests and are authorised through the appropriate process. The Mental Capacity Act and DoLS legislation was not intended to replace the Mental Health Act and there are often occasions when deciding which legal framework is most appropriate to deliver care can prove a challenge for staff. This is recognised nationally, and the Safeguarding Adults Team provide assistance with this as required.

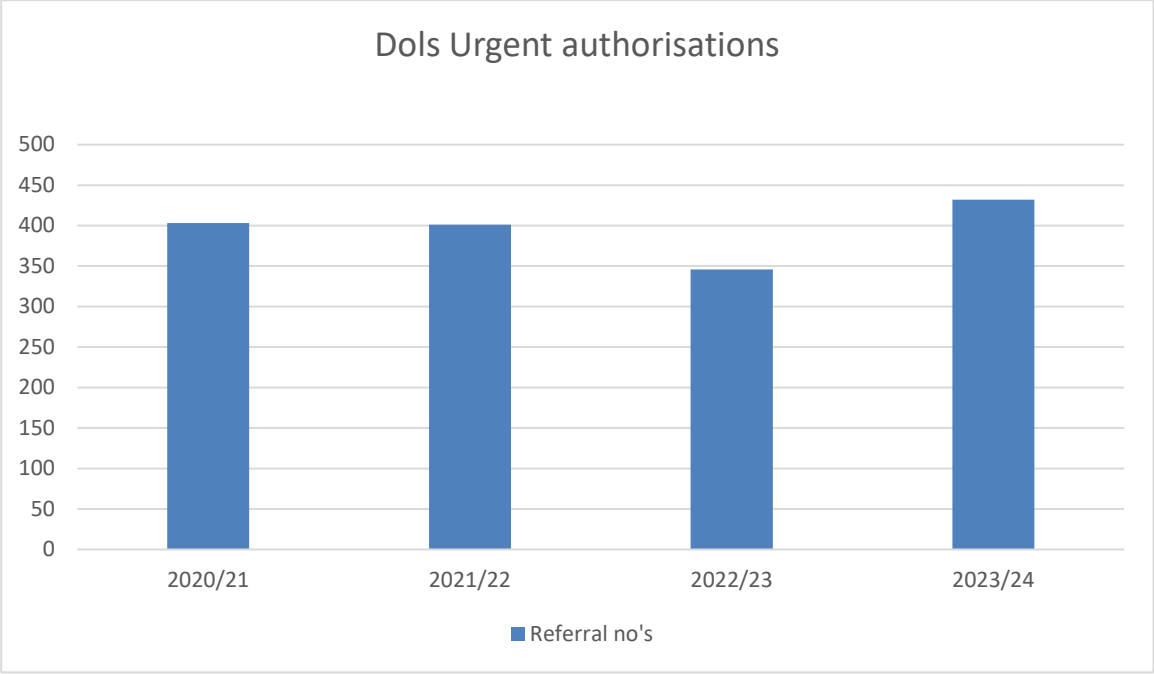
The Safeguarding Adults Team, Learning Disability Lead Nurse, and Mental Health Specialist Practitioner have continued to work closely with all wards areas to ensure they have appropriate knowledge in relation to the MCA and DoLS. Paperwork is scrutinised for accuracy and liaison with the Local Authority DoLS team when escalation for assessment needs to occur. This ensures the best Interests of the patient are maintained and any deprivations of their liberty are lawful. The outcomes of DoLS authorisations are audited and cases are discussed directly with matrons should concerns arise. Cases are also discussed when there have been differences in opinion between whether a patient should have been detained under the Mental Health Act or an application for a DoLS authorisation.

The threshold for a DoLs authorisation to be made is referred to as the ‘Acid test’ and was a result of the Supreme Court judgement on the ‘Cheshire West Case’, which since then has included patients:

- who lack capacity.
- are not allowed to leave hospital (even if they are not asking to leave);
- are subject to supervision and control (even if this is to enhance their freedom);

Figure 6 illustrates the number of DoLS applications each year since 2020.

Figure 6



In 2023/24, **432** applications were made, an increase of **86** on the previous year.

It is a statutory duty under the Mental Capacity Act (2005) that the Foundation Trust has a system in place to appoint and instruct Independent Mental Capacity Advocates (IMCAs). This applies for all patients who lack capacity to make important decisions about serious medical treatment, changes of accommodation or safeguarding concerns and who have no family or friends with whom it would be appropriate to consult.

This process for referral for an IMCA used to be undertaken by the Safeguarding Adults Team however due to changes within the IMCA service, this is now done directly by the ward staff via an electronic online referral form. The link for which is on the Safeguarding Adults intranet site.

Deprivation of Liberty Safeguarding (DoLS) and Liberty Protection Safeguards (LPS)

The proposals regarding changes to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), received Royal assent in 2019, the transition to LPS was due to come into force in 2020, however this was delayed. Work has been undertaken both within the Trust and in conjunction with

partners in the district to understand the implications of these changes. During the period 2022/23 the Assistant Chief Nurse Vulnerable Adults has represented the Trust at districtwide meetings. An announcement was made in April 2023 that the proposed LPS implementation would be delayed "beyond the life of this government". Therefore, work has continued in relation to DoLS and ensuring the existing processes are robust. This includes plans to revisit the basics of the Mental Capacity Act with training planned from the ICB lead and legal services, and work undertaken to further improve recording within EPR by the inclusion of a formal 'Best Interest' template.

2.1.6 Learning Disabilities

The Safeguarding Adults Team were previously informed of all patients admitted to the Trust who have a learning disability. The purpose of which is to ensure staff have support, advice and access to specialist services and can make reasonable adjustments where necessary to ensure appropriate care is provided.

The introduction of the national Learning Disability Standards and national audit placed increased scrutiny on provision of services for patients with a learning disability. This resulted in the Trust appointing a Lead Nurse for Learning Disabilities. The Lead Nurse sits alongside the Safeguarding Adults Team.

The Learning Disability Lead Nurse has worked directly with patients and their carers, supporting staff to understand the needs of the patients by encouraging the use of the VIP passports, providing engagement and distraction activities, providing alternative communication methods such as picture boards and liaising with specialist services to ensure safety both in the Trust and when returning to their homes. They have also ensured where concerns are highlighted regarding the care of a patient with a Learning Disability, this was addressed in a timely manner, ensuring direct feedback to staff involved and escalation of any themes or trends to the Deputy Director of Nursing for the division or the Medical Director.

To support with this work, an Additional Needs Care Navigator post was established and recruited to, which has facilitated a more consistent presence on wards supporting patients with additional needs such as a learning disability or mental health diagnosis. The purpose of this role is to ensure a smooth transition into and out of hospital for patients with a learning disability or mental health diagnosis. It includes contact prior to a planned admission to ensure necessary plans for attendance at hospital are in place, contact and support whilst in hospital and follow up post discharge to address any concerns and make sure follow up appointments are made and received.

The Health and Care Act 2022 introduced a requirement that all regulated service providers must ensure their staff receive learning disability and autism training with the preferred training package being the Oliver McGowan training. The Lead Nurse for Learning Disabilities has been attending regional and district meetings regarding the development of this and how this can be implemented within the Trust. As part of the role out of this training in December 2023, all staff had the level 1 mandated onto their training requirement, with current compliance being at 68% at the time of writing this report.

2.2 To deliver our financial plan and key performance targets.

The Safeguarding Team staffing is within budget with no additional costs in staffing being incurred.

Key performance targets of the Safeguarding Adult Team and Trust safeguarding adult activity is monitored by the Safeguarding Adult subgroup. There are no highlighted areas of concern. The team KPIs are: -

- Trust safeguarding training levels.
- Attendance at BSAB (Bradford Safeguarding Adults Board) meetings.

2.3 To be a continually learning organisation.

2.3.1 Training

Safeguarding adult training compliance is a key performance indicator and monitored through the Safeguarding Adult's subgroup for assurance. These compliance figures are monitored monthly to ensure staff are identified and have access to training where there is a drop in compliance.

For the period 2023/24, compliance has remained at over **95%** across levels 1 and 2, with level 3 reducing due to changes to the recording system within ESR and the movement of staff. The identification of the reduction enabled further examination of the detail of the levelling, and this has been an ongoing piece of work to relevel staff and ensure more staff who require level 3 are identified. The new requirement for Level 3 compliance is for anyone who may have a managerial responsibility within the safeguarding procedures. Previously, there were only 23 members of staff identified as needing Level 3, however, following the re levelling work this will increase to 230, with the planned change over to occur in August 2024. Work has been underway with the Education Team, to ensure training is available and the development and use of a self-declaration form is available for staff to use.

The volume of referrals to the team highlights that staff are still aware of their responsibilities and know who to access for support. There is an action plan in place to support delivery of the new compliance requirements. The opportunity to deliver training in ways other than face to face has ensured that the Safeguarding Adults Team are able to deliver bespoke training in areas where specific concerns are identified.

The implementation of a 'self-declaration' document for staff to complete to ensure and record compliance has been piloted. This will enable staff to use a wider and richer source of training to improve the compliance figures.

All staff must have Prevent basic awareness and staff identified as level 3 and 4 for safeguarding adults must also undertake the Workshops Raising Awareness of Prevent (WRAP) or Level 3 e-learning. The current compliance for this is **94%.** The NHS England minimum expected compliance rate is 85 %.

A conference was held within the Trust in December 2023 relating to non-fatal strangulation. This was identified as an emerging theme from recent Domestic Homicide Reviews (DHR's) and in response to the regional work being undertaken to raise awareness regarding this.

With an increased focus on 136 detentions under the MHA, it is noted that further work needs to be undertaken in relation to helping staff feel confident with managing patients who may in a mental health crisis. This work has started with simulation sessions facilitated by the mental health specialist practitioner. During these sessions staff have identified that they do not always know what to say to someone and feel they occasionally inadvertently make the situation more challenging. Further work is underway to identify provision of further training in relation to de-escalation and breakaway. De-escalation training would give staff practical skills and confidence to prevent and de-escalate conflict in ways that are respectful and safe for all involved.

2.4 To collaborate effectively with local and regional partners.

2.4.1 Multiagency working

2.4.1.1 Bradford Safeguarding Adults Board (BSAB)

The introduction of the Care Act 2014 made the Local Authority Safeguarding Adults Boards statutory. The Foundation Trust provides assurance to the Bradford Safeguarding Adults Board through the membership and attendance of the Chief Nurse. During 2022-23, the Assistant Chief Nurse Vulnerable Adults attended the Safeguarding Adults Board's subgroups quarterly.
The current subgroups are:

- Performance, Quality and Assurance Group (PQAG)
- Communications and Engagement
- Training
- Safeguarding Adults Reviews (SAR)
- All age exploitation

As part of the commissioning standards for provider organisations, the Safeguarding Adult Team previously had ensured a proportionate contribution to the delivery of local multi-agency training programmes, as required by the Safeguarding Adult's Board.

2.4.1.2 Serious Adult Reviews (SARs)

A SAR is a multi-agency review process that seeks to learn from the death of vulnerable adult where there has been concern of abuse or neglect. It is not to apportion blame. There is consistent representation at these meetings from the Safeguarding Adults team and any actions for the Trust are monitored through the Safeguarding Adult subgroup.

2.4.2 Domestic and Sexual Violence Board

The Assistant Chief Nurse Vulnerable Adults is a member of the Domestic and Sexual Violence Strategy Board with the Safeguarding Adults Specialist Practitioner attending a number of the subgroups. Work from these groups is discussed at the Trust's Safeguarding Adults Subgroup.

2.4.3 Transforming Lives Partnership

The Board oversees the Bradford Learning Disabilities Transformation Plan which is an all-age change programme focusing on improving services for people with learning disabilities who may have autism, who display behaviour that challenges, including those with a mental health condition. Work from this Board is considered at the Safeguarding Adults subgroup.

2.4.4 Community Safety Partnership

2.4.4.1 Domestic Homicide Reviews (DHRs)

In accordance with statutory guidance (the Domestic Crime and Victims Act 2004), the Foundation Trust is required to participate in the Domestic Homicide Review process if contact has been made with either the victim or the perpetrator. The Safeguarding Adults Team receives initial notification and is required to provide information about any contact with named individuals, and where this has been the case, the relevant records are secured. Progress of the investigation is then determined by the Chair of the Domestic Homicide Review Overview Panel who is appointed by the Local Authority, as the timescale may be influenced by the police investigation and any court proceedings. Each partner organisation, who has had contact with the victim or perpetrator is required to undertake an independent management review (IMR), consisting of a chronology of contact and analysis of whether or not there were any indications of domestic abuse identified and if so, whether appropriate measures were put in place, as well as identifying if there are any lessons to learn.

On completion of the IMR, the author and a senior manager is required to attend as a panel member on behalf of the Trust. The latter is currently the Assistant Chief Nurse for Vulnerable Adults.

In 2022, new guidance was introduced regarding the consideration of death by suicide where domestic abuse had been a feature of a person's life within the DHR scope. Domestic Homicide Reviews have now been re titled Domestic Abuse Related Death Reviews (DARDR) to reflect the inclusion of these.

Progress of any reviews is monitored by the Safeguarding Adults subgroup and any actions identified for the Trust are disseminated via the group.

All Safeguarding adult activity in the Trust is monitored through the Safeguarding Adult subgroup, which in turn reports to the Integrated Safeguarding Sub-committee. The overall governance is held by the Quality and Patient Safety Academy. The key aims of the Safeguarding Adult subgroup for the forthcoming year are:

1. To continue to monitor and maintain training compliance across all levels through the Safeguarding Adult subgroup.
2. To further develop reporting data to highlight themes and trends relating to patient demographics and develop training relating to identified areas of development.
3. To continue to support the multi-agency partnership in the progression of key work areas in Bradford to ensure adults are effectively safeguarded. To include participation in Multi agency training and consistent representation on all subgroups of the BSAB.

3 BENCHMARKING IMPLICATIONS

There is no model hospital data relevant to this paper.

4 RISK ASSESSMENT

- The increase in patients with a mental health diagnosis attending the Trust and requiring support and detention under the MHA has increased. The Mental Health Strategy was launched in 2021, with the focus being on partnership working and addressing barriers to service, in line with Act as One. The development and implementation of the Core 24 service standard, which is the standard for adult liaison mental health services has assisted with addressing some the challenges faced, however there remain ongoing concerns regarding the care of mentally unwell patients within an acute hospital and delays in identification of appropriate mental health provision. There has been work undertaken to look at what, as a Trust, we can develop to ensure we are not neglecting or causing harm to patients with a mental health diagnosis through lack of provision or delayed access to appropriate services. Monitoring of section 136 detentions attending the Trust has commenced during 2023, with work in progress to understand the impact of this and how we can ensure, as a Trust, we are more prepared to provide safer services for people who may require mental health support who access our services.

- There is often a belief that patients with a Learning Disability or Mental Health diagnosis need 'safeguarding'. In its widest sense this is true, however they often don't require a statutory safeguarding response. The work of the Safeguarding Team has similarities and shared responsibilities in some key areas with the Lead Nurses for Learning Disabilities and the Specialists Practitioner for Mental Health. The Lead Nurse Learning Disabilities and the Mental Health Specialist Practitioner were moved from the wider safeguarding team and established a separate Additional Needs Team to provide a clearer boundary between the two teams, which will provide some clarity for ward staff regarding their roles and ensure appropriate referrals are made to relevant services.

- During the period 2023/24, the frequency of MARAC meetings continued at the increased rate experienced during the previous years. Weekly meetings have been in place for a few years, due to the increase in referrals and recognition of the need for multi-agency discussion of cases to happen sooner. This over time has meant that the number of cases discussed

has also increased with, on occasions, there being two meetings per week. This is an increased expectation on the team regarding the activity in relation to this and if it continues will need to be reviewed and potentially resourced differently. The addition of the HIDVA to the team was extremely beneficial and provided increased support to both patients and staff. The further training of a Safeguarding Adults Specialist Practitioner as an IDVA has strengthened the response we can provide to victims of domestic abuse, however the hosting of a HIDVA means there is a level of independence from the Trust, which staff who disclose abuse, report finding beneficial. The funding for this post is external and was initially only in place until July 2024. Further funding has been agreed until July 2025, however it is envisaged after this point the post should be incorporated into standard business within the Health Sector. Consideration for how this post can continue to be funded is ongoing at both Trust and District level.

- The increase in activity in relation to DHR's / SAR's should be noted, in particular as there has been a significant increase in the requests for information and involvement in both these processes. This is a risk in relation to the identification of appropriately trained staff to undertake the necessary parts of the process, specifically the authoring of the Independent Management Reports (IMR's). It is recognised there is currently a very limited number of staff who have had experience of these, and this is reflected across the district. The Domestic and Sexual Violence Strategy Board funded training in 2023, however there were only 2 places per agency and further training needs to be commissioned to meet the demand.

5 RECOMMENDATIONS/FUTURE WORK

- Audit and review of the self-declaration for training compliance and further development of learning opportunities for staff to ensure a richer opportunity for learning and embedding into practice.

- On going training relating to the Mental Capacity Act and DoLs to ensure staff are aware of their responsibilities and that the Trust is compliant with regulatory requirements. Audit of the new 'best interest' discussions template within EPR.

- Further development of the Additional Needs Team, to ensure staff are clear and supported regarding their role. Consideration of making the Additional Needs Care Navigator post a permanent role, as this has evaluated well, with feedback from families and carers of the impact and difference this role has made.

- Ongoing development and support for staff regarding mental health and supporting patients in crisis/distress. Development of a training post for conflict resolution, de-escalation, and breakaway training to support the clinical response to restraint workstream. Also, simulation training for staff in relation to managing patients in mental health crisis.

- Presentation and participation in the District Safeguarding Week. As in previous years the Safeguarding Adults team will be actively promoting Safeguarding week in June and representing the Trust across the District. This is in conjunction with partner agencies.

- Ongoing and further development of the Trust response, in collaboration with partners, to section 136 detentions and the implications of these people attending the Trust with no medical requirement to do so, taking account of the fact that although a 'place of safety' within the legislation, the Trust is not necessarily a safe place for persons experiencing significant mental health distress. Work has started in relation to how we can utilise the skills of the newly qualified dual trained nurses to improve the service offered to these people.

- Development of specific learning relating to DHR's specifically in relation to non-fatal strangulation.

- Implementation of the Right Care Right Person work and continued work with partners as to minimising the impact on all services.

6 Appendices

Appendix 1 - Self-assessment of Provider Safeguarding Standards 2024.

Appendix 2 - Self-assessment of ICS Provider MCA Standards 2024.

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Date	2nd July 2024	Agenda item	QA.7(1).24.13

SAFEGUARDING CHILDREN BOARD AND ANNUAL REPORT 2023-24

Presented by	Liz Ward, Named Nurse Safeguarding Children	
Author	Liz Ward, Named Nurse Safeguarding Children, Jo Sims & Lauren Hill, Named Doctors Safeguarding Children, Eileen McArdle-Robinson, Named Midwife.	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	This paper is the Annual Safeguarding Children Report	
Key control	Yes	
Action required	For assurance	
Previously discussed at/ informed by	*Details of any consultation / previous meeting discussions*	
Previously approved at:		**Date**

Key Options, Issues and Risks

This annual report provides information regarding activity within children's safeguarding team at Bradford Teaching Hospitals NHS Foundation Trust between April 2023 and March 2024.

Headlines

1. Referrals to the team and requests for child protection safeguarding medicals have remained at a similar level to 2022/23. Although the numbers are high (5757) the anticipated rise during the winter months did not occur.

2. The team screened 35083 records for children under 18 years attending the emergency department. An options paper was presented and agreed by the Chief Nurse to trial RAG rating attendances and screening those records meeting most at risk criteria, this commenced on 1st April 2024.

3. The team were involved providing information for 10 Rapid Reviews and 6 Child Safeguarding Practice Reviews (CSPR) for the Bradford Safeguarding Children's Partnership where a child has suffered significant harm or died.

4. Four of the six Child Safeguarding Practice reviews have been published up to 31st March 2024 and the team have developed a comprehensive joint action plan for BTHFT to address the recommendations.

5. Staffing in the team remains stable which is a real positive for the organisation. The additional named doctor post has become permanent.

6. Children in mental health crisis or who are suffering significant trauma, often from historical abuse, and who require admission remains a significant issue for the organisation. The safeguarding team are spending a significant amount of time supporting our colleagues within BTHFT, CAMHS and Bradford Child and Family Trust to ensure these children and their families are managed and cared for safely. Not all children in mental health crisis have safeguarding concerns.

7. Level 1, 2 & 3S training figures have remained static throughout the year. Training is now being delivered in a multi-disciplinary way with a mix of virtual and face to face sessions.

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Analysis

The statutory requirements for the Trust are governed by Section 11 of the Children Act, which places a duty on the Trust to ensure that the functions and any services contracted out to other organisations are carried out with the purpose to safeguard and promote the welfare of children.

Key Achievements:

1. The team won the Team of the Year at the Celebrate as One Awards. This was a partnership award with our Bradford District Care Trust Child & Adolescent Mental Health Service and BTHFT paediatric colleagues for working in partnership when children are in mental health crisis.

2. BTHFT is the top performer of all the Trusts who responded to a RCPCH national audit of 'Good Practice Service Delivery Standards for the Management of Children Referred for Child Protection Medical Assessments' achieving 99 of the 103 standards.

3. A single point of contact has been established for our Child and Family Trust partners to book safeguarding medicals for children and also to invite paediatricians to strategy meetings.

4. The team continue to support the establishment of the Child and Family Trust, who replaced Bradford's Children's Social Care Service following the Ofsted review in December 2022. Good relationships have been developed with the Integrated Front Door and senior managers, which supports professional challenge and open and honest discussion leading to improved outcomes for children. The team represent BTHFT at the MAID group (multi-agency improvement and development) and are included in the review of the Early Help strategy for the district.

5. Training has been delivered on the implementation and use of the guideline for the clinical management of distressed, agitated and violent patients under the age of 18 years.

6. A second consultant was appointed into the post of Named Doctor following the successful business case.

7. Work continues to embed the training strategy and the move to self-declaration of training for those staff requiring Level 3 and above training. The team had a training time out to agree new packages, thus providing assurance of consistency in delivery and focussing topics in line with CSPR recommendations. We have also delivered joint training with our adult safeguarding colleagues.

8. The team continue to strive to be more visible within the Trust. We are now part of the daily paediatric huddle, attend the paediatric ward, neonatal unit and emergency department weekly to meet with staff and offer advice and support. A member of the team is on the rota daily to offer verbal and written advice and support.

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9. The whole Team have undertaken training in trauma informed and restorative practice this learning will support training and advice and support work.

10. The team have contributed to research into the Roma community and their understanding of child exploitation. We have also contributed to West Yorkshire wide work on pathways for children and young people in mental health crisis who are in acute settings.

11. The team have worked in partnership with our Emergency Department colleagues to introduce a Non-Mobile Baby template into EPR to record the mobility of babies attending with an injury and assure BTHFT that the West Yorkshire Procedures to Safeguard Children are being followed.

12. It is clear from the receipt of Paediatric Liaison Forms from the Emergency Department that there is increased & increasing recognition of child behind the adult.

Recommendation

The Quality and Patient Safety Academy are asked to note the following:

1. The main area of risk remains children and young people with poor mental health and those in crisis. There have been positive developments, however further improvements need to be made in order to achieve better outcomes for these children and young people and reduce their length of stay on an acute ward. The Trust does not employ a children's specialist Mental Health professional and given the rise in attendance and the complexity of the CYP suffering with poor mental health this needs to be a priority.

2. It remains the case that there are a number of electronic patient record systems and paper records in use across the Trust and these hamper safeguarding assurance as these systems aren't able to automatically communicate with each other. The risk is that information cannot easily be shared or found. This still needs a review as the team believe it was agreed Cerner would interface with SystmOne and the locally published 'Harry' CSPR (Child Safeguarding Practice Review) highlights the risks associated with the use of different record systems.

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

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

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

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

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

Meeting Title	Quality and Patient Safety Academy		
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Safeguarding Children Annual Report 2023 -2024

1	PURPOSE/ AIM

This annual report provides information regarding activity within children's safeguarding at Bradford Teaching Hospitals NHS Foundation Trust between April 2023 and March 2024.

2	BACKGROUND/CONTEXT

The Trust safeguarding children's statutory requirements are regulated in a number of ways to ensure that the functions and any services contracted out to other organisations are carried out with the purpose to safeguard and promote the welfare of children. These regulations are set out by:

- Children Act 1989, 2003.
- Working Together to Safeguard Children 2023.
- Accountability to The Bradford District Safeguarding Children Partnership (via Section 11 of the Children Act).
- Accountability to the Bradford District and Craven Health and Care Partnership for safeguarding contracts and activity.
- SAFE CQC domain as part of Bradford Teaching Hospitals NHS Foundation Trust overall inspection process, to provide assurance that safeguarding policy and procedures are deeply embedded into the Trust's operating practice.
- Joint Targeted Area Inspection (JTAI) – The joint inspection process for safeguarding children services carried out by:
  - Ofsted- for Children's Social Care.
  - Care Quality Commission for Health.
  - Her Majesty's Inspectorate of Constabulary for Police.
  - Her Majesty's Inspectorate of Probation for Probation Services.

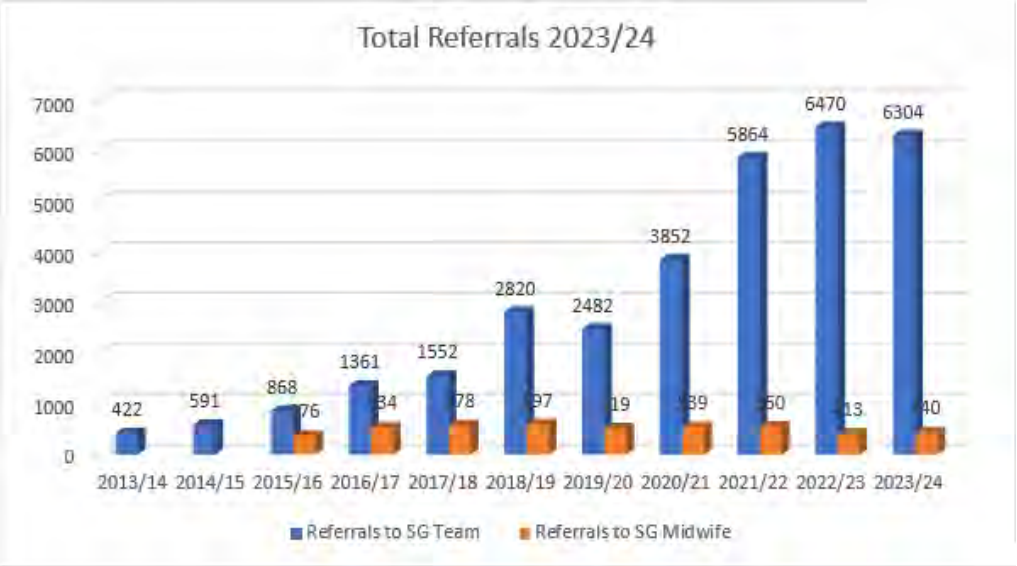
Safeguarding children within Bradford Teaching Hospitals NHS Foundation Trust remains a high priority.

2.1 To provide outstanding care

2.1.1 Safeguarding Children Activity

For 2023/24 the whole data set shows that quantitively the safeguarding children's referrals and activity has stabilised following a lengthy period of increases. In fact, the figures in the chart of just referrals appear lower than last year but this is the first year we have a full year of figures for Advice and Support. There is an increase in the complexity of safeguarding concerns for children across all areas. Social circumstances, the cost of living, increasing child poverty and mental health of both adults and children, along with increasing risk factors for vulnerable families all contribute to higher risk and often safeguarding concerns. (See Figure 1).

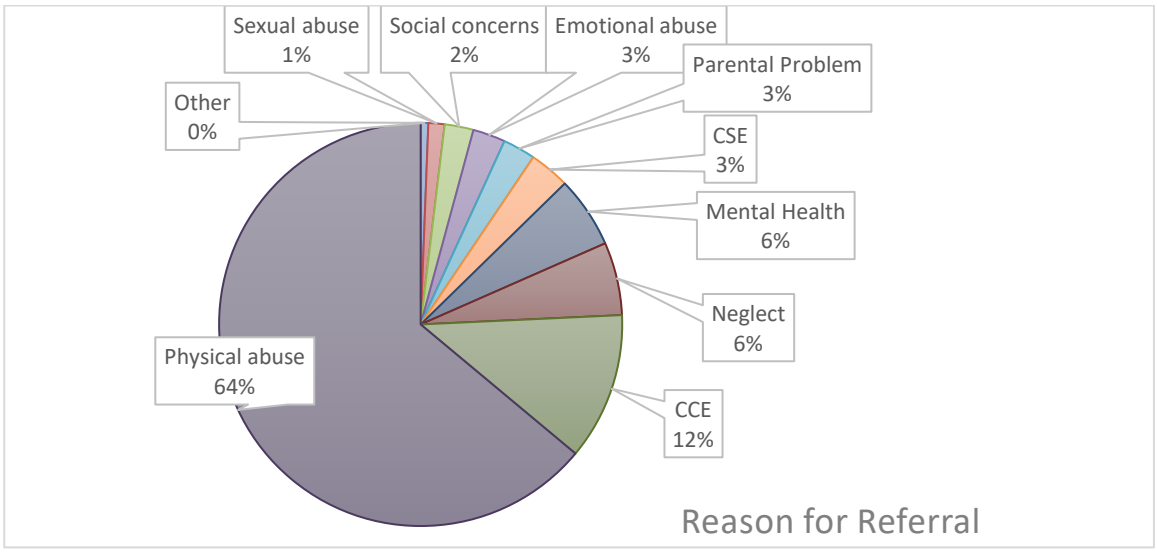
Figure 1. Total Number of Referrals per Year to Children's and Midwifery Safeguarding



In the main the percentages in the categories of abuse recorded have changed little from the previous year. Physical abuse remains the largest category but notably there has been an increase in the numbers of children where the reason for referral to the BTHFT safeguarding team is related to child exploitation. There is a reduction in the numbers of referrals categorised as other which is good news as it suggests the referrals are being more accurately categorised. (see Figure 2).

There are still a high number of children and parents who are referred to the team suffering with mental health concerns. Nationally it is being recognised there is an increased demand for mental health support and service provision.

Figure 2. Reason for Referrals



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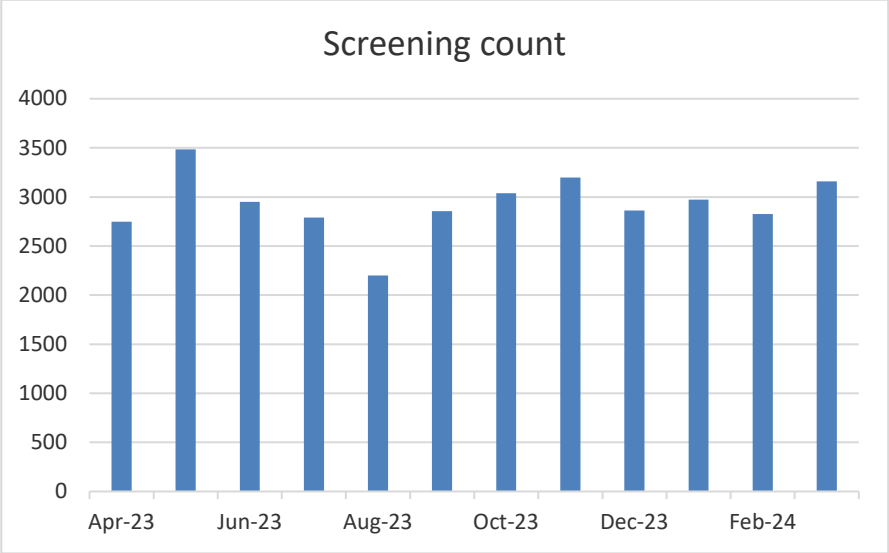
The Emergency Department (ED) is the clinical area undertaking the most acute safeguarding assessments of child patients and the child behind the adult. It is important that the ED recognise that the reason for attendance of an adult may impact on their ability to safely parent and safeguard the children in their care, this applies to both men and women. It is therefore heartening to note that the team have anecdotally seen an increase in the paediatric referral forms received for adults. It is proposed that this information will be captured formally going forward.

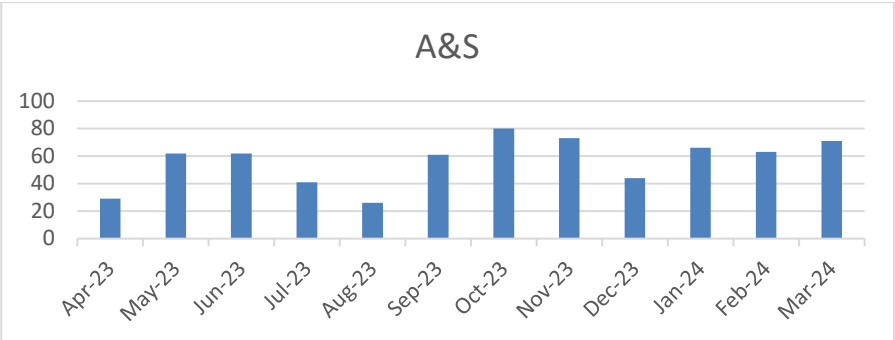
In 2023/24 the safeguarding children's team have screened 35,083 attendances in ED, this is not sustainable with all the plans to increase visibility of the team and the other commitments and priorities of the team. An options paper has been written and presented to the Chief Nurse to reduce the numbers of attendances screened by use of a RAG rating system, this commenced on 01.04.24. The safeguarding team continue to produce a fortnightly email recognising good practice in ED, highlighting areas for improvement and sharing learning in a timely way and there is a plan to roll this out wider across the BTHFT. (See Figure 3).

Figure 3 – Numbers Screened by Month



There has been another year without seasonality in terms of numbers of ED attendances – with huge volumes of children attending ED throughout the year. It should be noted that the previous system of data recording did not separate the advice and support offered to teams via the different contact methods, this has been improved for this year. (See Figure 4).

Figure 4 – Numbers of Advice and Support Contacts



The team have attended 39 strategy meetings with partners to discuss plans for children at risk of significant harm.

The team has remained stable throughout the past 12 months which has provided opportunities to develop the service. The appointment of a second Named Doctor has been a positive addition to the team and offers additional support to paediatricians and the safeguarding team. One member of the specialist practitioner team is from a mental health background and has been invaluable in supporting the Trust with children in mental health crisis and working in partnership with CAMHS colleagues. In addition, the Trust has appointed a Mental Health Champion 1 day per week for children and young people funded and supported by NHSE and hosted by paediatrics.

2.1.2 Children protection medical activity 2023/2024

Safeguarding Medicals

Once again, 2023 saw a high number of child protection medicals, however more in keeping with annual numbers we have previously seen. There was a dip in medicals in 2021 and an extremely high number of medicals in 2022. However, in 2023, we also started to record details of requests for child protection medicals that we declined, as not felt to be indicated. There were 66 such requests in 2023. Many of these were multiple-sibling groups and requests for “neglect medicals”. Other reasons were delays in request (where injury so long ago that a medical would not be helpful), referrals for sexual abuse (redirected to SARC- Sexual Assault Referral Centre), history or disclosure of episode but no injury to see, further info requested, and subsequent strategy meeting decided against medical. Child Protection Medicals for neglect are only really useful if there is an acute situation (for example the child has just been removed on Police Protection Order from the family home and still wearing same clothes etc). The Named and Designated Doctors are exploring an alternative way to gather information about potential unmet health needs via the 0-19 health team in BDCFT and the GP. On two occasions, a medical was arranged and the child did not turn up.

It is possible that previously we have accepted more requests and this year there has been greater discussion/challenge about the benefit of having a medical. We did note in 2022 that there were increasing numbers of sibling groups being brought for neglect medicals and there is much more robust debate about the benefit in these cases now. Putting the number of medicals done together with number declined/not brought, this comes to 505 which is only just under last year’s figure.

Total number of safeguarding medicals per year

Year	Total
2016	334
2017	389
2018	448
2019	414
2020	429

2021	**392**
2022	**522**
2023	**437 & (66 requests declined)**

Overall, however, demand remains high, and we continue with a rota system for paediatric consultant safeguarding cover on Monday to Friday afternoons.

Consistently with previous years, approximately a quarter of child protection medicals take place out of hours, often during the night, in order to take the correct action to safeguard the child. This can be particularly challenging during the winter months when the consultant is often already in the hospital dealing with a sick patient or assisting with senior decision-making and patient flow.

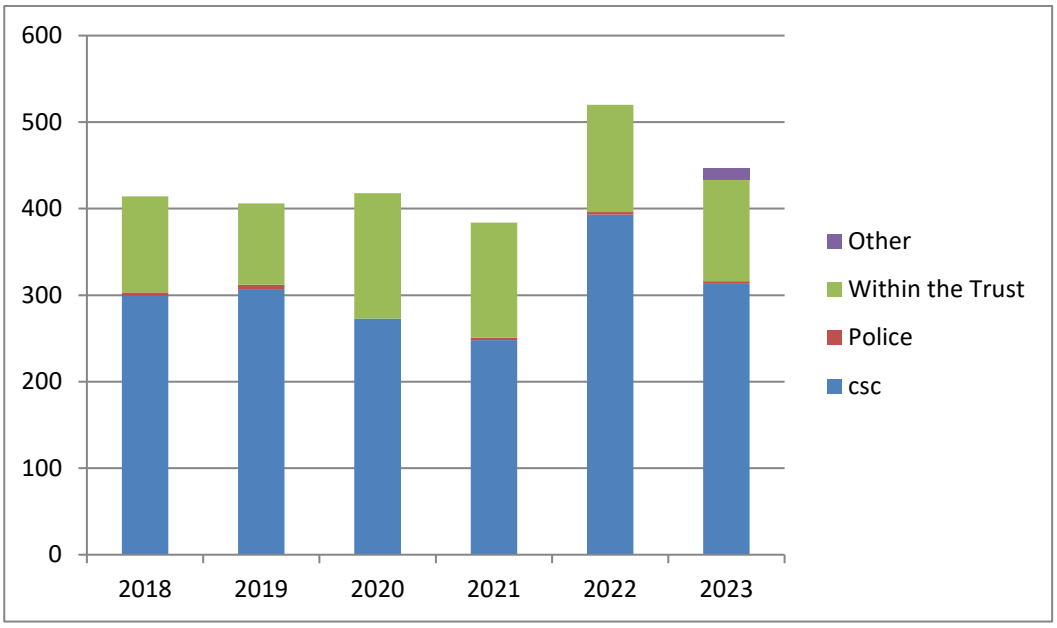
The paediatric consultants continue to see highly complex and challenging safeguarding cases, both for medicals and also in day-to-day practice. Social circumstances, cost of living, increasing child poverty and mental health of both adults and children, along with increasing risk factors for vulnerable families all contribute to higher risk. This is an issue running through clinics, ward admissions, the ambulatory nursing team care at home (ACE team), the child development centre and specialist nursing. In order to support the staff, the Named Doctors for Safeguarding continue to run twice monthly peer review plus dedicated supervision sessions for the Child Development Centre, Allied Health Professionals and specialist nurses and ad hoc advice and supervision for clinicians as required.

The number of medicals carried out by trainees is disappointingly low at only 23. It remains challenging to create opportunities due to ongoing staffing pressures and at times, gaps in the middle grade rota and loss of clinic time for trainees. Regionally, the Yorkshire Deanery are moving towards a competency-based passport for safeguarding training for paediatric trainees and so we will be required to ensure they complete a set number for placements. One of our Named Doctors is directly involved in this work with the Deanery.

Source of referrals

The spread of referrals is very similar to previous years, with the majority coming from social care as expected. After a spike in referrals the previous year (large numbers of sibling medicals in particular), in 2023 numbers reverted to a pattern seen more usually.

Figure 5 - Source of Referrals

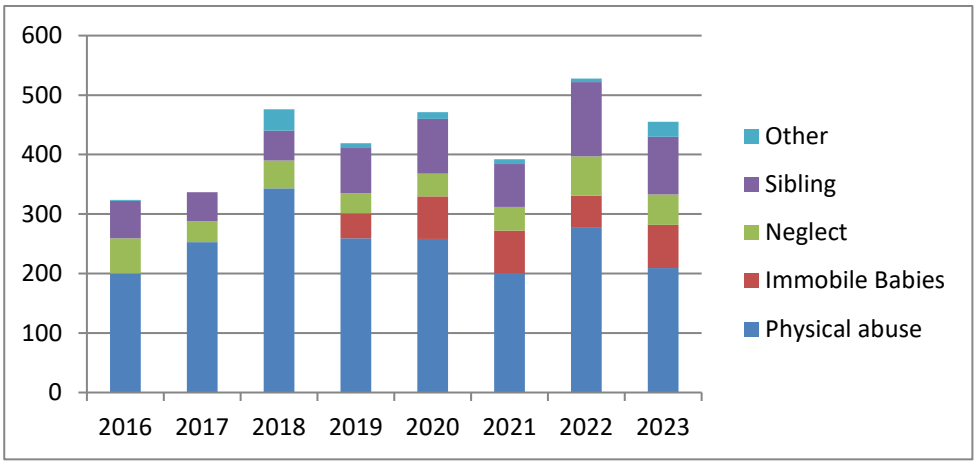


Reason for referral

Concerns around physical abuse and injuries to non-mobile babies continue to constitute the majority of referrals. We have seen less children for neglect this year, on the back of proactive steps to explore a different way of gathering information for these children when they have often been in the care of extended family or foster care for some time. Sibling medicals are still considerable in number and whilst we do not find large amounts of physical abuse in siblings, we do sometimes find neglect.

	Physical abuse	Immobile babies	Neglect	Sibling	Other
2016	200		59	63	2
2017	253		35	49	
2018	343		47	50	36
2019	259	42	34	76	8
2020	258	72	38	92	11
2021	200	72	40	72	8
2022	278	53	66	125	6
2023	209	73	51	97	25

Figure 6 – Reason for Referral for a Safeguarding Medical

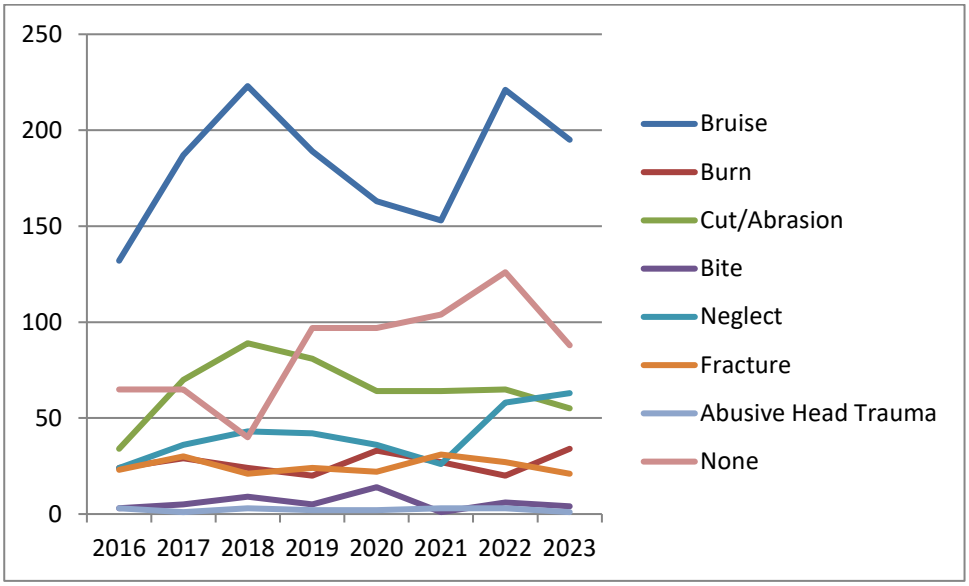


Types of injuries

In terms of the type of abuse found, bruising is most common, but we see many children with multiple injuries and sometimes of various types e.g., burn and bruising. There are still a significant number who do not have any physical sign of injury - this was on the rise through to 2022 but has seen a drop-off in 2023, possibly because there is more discussion with social care about when a medical is appropriate/what can be gained from a medical.

It should be noted that many of the group who did attend and had no physical injury to see, did have a worrying history/disclosure and the report was able to focus on this to support social care's actions.

Figure 7 – Types of Injuries



Non Mobile babies

The Trust, like most areas of the UK, has a guideline for non-mobile babies with injuries, which is aligned with the West Yorkshire Multi-agency Procedures. This means that due to their elevated

risk and high index of suspicion, (supported by research evidence), all of this group (not walking/crawling/cruising independently) will undergo a medical and a professional discussion with children's social care will take place.

37 of 73 (approximately 50%) had full medical investigations i.e. CT head looking for abusive head trauma, ophthalmology review for retinal haemorrhages and skeletal survey for bony injury (includes two sets of X-rays 10-14 days apart). This is also therefore a high burden for our radiology colleagues, particular in dealing with children who are not brought for their 2nd set of images resulting in .

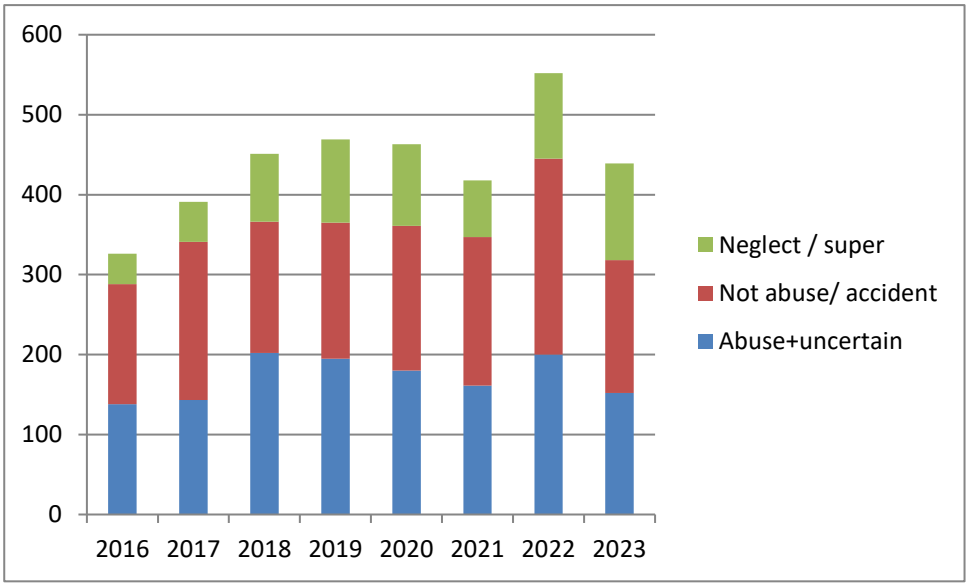
Outcomes

As in previous years, just over half are felt to be abuse or likely/possible abuse with a smaller number felt to be due to lack of supervision. Much of the time, outcomes overlap particularly between physical abuse and neglect or lack of supervision/accidental injury and neglect. The number of serious injuries, fractures and abusive head trauma remains high for our population.

24 children were recorded as having poor dentition/dental neglect. This is less than in previous years - this would suggest we are either not looking for it or not recording it. We know that dental neglect is a huge problem in the children of Bradford as a whole, and this contributes to the holistic assessment.

	Total	Abuse	Uncertain	Poor supervision	Not abuse/ accident	Neglect
2016	334	74	64		150	38
2017	389	85	58		198	50
2018	448	127	75	22	164	63
2019	414	120	75	47	170	57
2020	429	102	78	49	181	53
2021	392	77	84	36	186	35
2022	522	108	92	38	245	69
2023	437	83	69	36	166	85

Figure 8 – Outcomes of Safeguarding Medicals



These statistics are obtained through the annual completion of a medicals database by the Named and Designated Doctors for Safeguarding Children. This also gives an opportunity for further quality assurance in terms of reports. All of the paediatricians carrying out these medicals use a standard template for reports to ensure consistency and an annual dip sample audit of reports is carried out every year. This is presented at the paediatric clinical governance meeting, and this is an opportunity for feedback and learning.

RCPCH Standards

In October 2020, the Royal College of Paediatrics and Child Health (RCPCH) published "Good Practice Service Delivery Standards for the management of children referred for child protection medical assessments". In April 2023, the RCPCH commenced a national audit of these standards. The Named Dr has completed this and BTHFT ranks top of the responders throughout the country. We were compliant with 99 of 103 standards and action has already been taken for two of the four remaining, one is outside our influence and the final action relates to obtaining *written* consent for child protection medicals - this is not straight forward for a number of reasons but there is intention to explore and consider practice in other Trusts.

2.1.3 Safeguarding the Unborn Activity 2023/2024

Maternity services referral to the Children's Foundation Trust (CFT) with outcomes.

In the year from April 2023 to March 2024 maternity services supported 440 women and families with a heightened level of need, leading to potential safeguarding or child protection issues. The number of babies removed from their parents on discharge from hospital remains consistent. The number of babies subject to a child in need (CIN) plan has not changed but there has been a 40% increase in new-borns who were discharged subject to a child protection plan (CP). There was a 43% increase in families who received Early Help support from the local authority.

Figure 9. Safeguarding Outcomes for Maternity

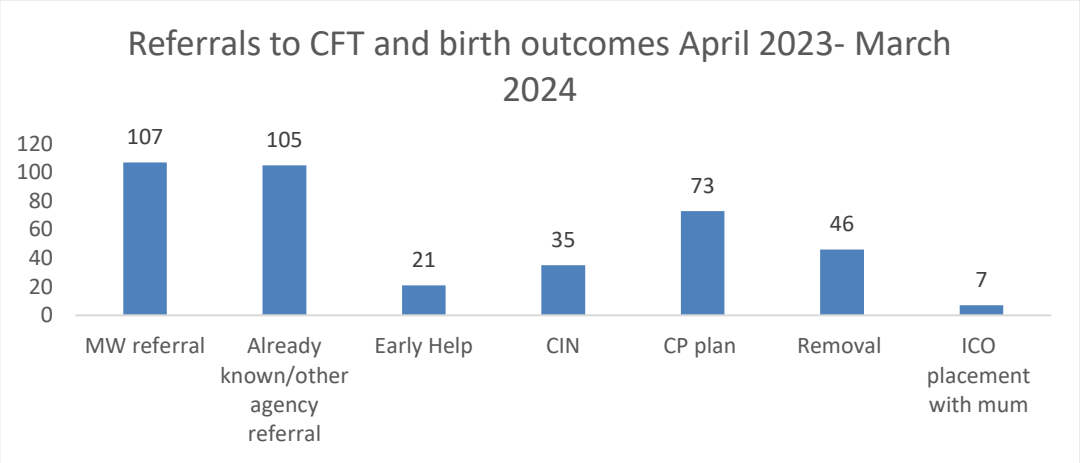
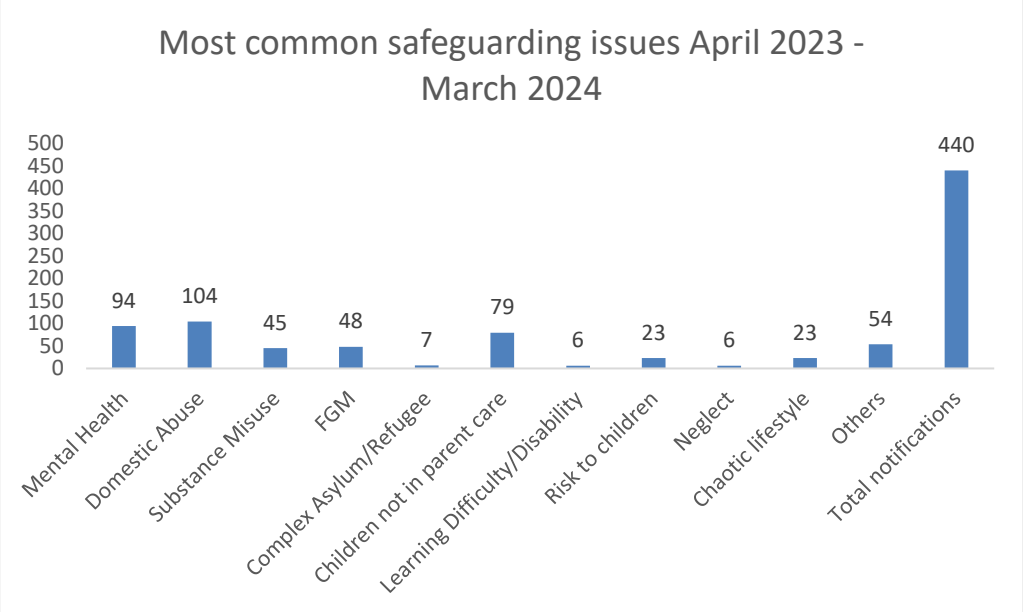


Figure 10. Most common safeguarding issues April 2023-March 2024



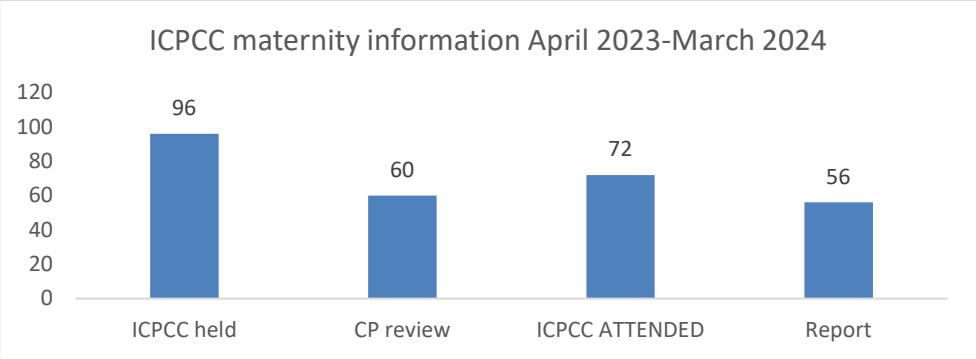
NB. Many women have multiple complexes and are included in several categories. There were other concerns highlighted such as CSE/CCE, honour-based violence, <16 years, asylum/ immigration, historical concerns, family issues and housing but are not included in this graph.

Attendance at Initial Child Protection Case Conference (ICPCC)

Over the last year CFT, working with maternity services, has accepted referral for pre-birth assessment as soon as a child protection concern is identified. This is usually between 8- and 12-weeks' gestation. An assessment commences immediately and if deemed appropriate, an ICPCC can be held as early as 20 weeks gestation. The rational is to provide the parents and family of the unborn baby sufficient time to meet the plans requirements and demonstrate they can protect their child from significant harm. If an unborn baby becomes subject to a child protection plan, a review conference must be held within 3 months.

The table below reflects an increased participation in 60 additional statutory meetings to include the review conference. Attendance at ICPCC was 75% and a report was provided for 58% of the meetings.

Figure 11. ICPCC attendance and report provision



Adoption medical paperwork

There has been a marked increase in local authority requests for maternal and infant birth information as part of the adoption process. In 2022-2023 there were 23 requests which was consistent with previous years. There were 75 requests in the current reporting period. There were no out of area requests for information.

Innovation in 2023-2024

Pre-birth assessment panel

The pre-birth assessment panel (PBA) is a weekly meeting introduced in February 2023. Its membership is between maternity services, 0 -19 services, CFT and the voluntary sector to have overview of all unborn babies who are subject to a pre-birth assessment. It tracks progress and ensures assessment is conducted in a timely manner. This enables families to have sufficient time to meet the terms of a child protection plan and be supported in their journey by services available to the panel.

Turning the Curve

The Turning the Curve Programme for babies has been developed jointly with the Bradford Children and Families Trust, partner Health colleagues and other organisations who deliver specific projects in relation to the programme such as ‘Pause’ and ‘For Babies Sake’, this is in conjunction with national research from the University of Leicester to inform areas of focus. The overall ambition is to reduce the number of babies removed from their mothers by 20% within the next 24 months in Bradford. 109 babies were removed from their mother from January to October 23.

Neurodiversity

An increased awareness and understanding of neuro diversity suggests that people with neurodiverse conditions may experience aspects of pregnancy and childbirth differently to the general public, and may face some unique challenges, including navigating interaction with health

and social care professionals. Women and partners are supported by the complex care specialist midwife, Acorn vulnerability midwifery team and 1:1 parenting and preparation for birth. Early Help is offered along with Doula support.

Birth Charter

The Birth Charter was published in November 2023 and sets out how services and systems in England should support all women involved with children's social care from conception to their child's second birthday. The Charter provides principles to inform and shape policy, commissioning, and professional practice; and to support advocacy. It shows how implementing best practice and upholding women's rights will ensure fair treatment and better outcomes for mothers and their babies. Many elements of the document have been introduced by maternity services to ensure women receive support that is woman-centred, holistic and culturally appropriate.

DadPad application

This application is promoted in maternity services in patient areas and is include in all parent education packages including partners classes. It has been developed with the NHS and real-life dads. It provides information and support to new dads as they adjust to their role and provides guidance on how they can get the most out of this new experience.
The app covers topics such as:

- Feeding, holding and changing baby.
- How to survive without sleep.
- What to do when the crying won't stop.
- Safer sleeping.
- Home safety and first aid.
- How best to look after yourself and partner.

Future projects for 2024

Complex care panel

Multi-Agency Training for and with CSC

2.1.4 Work Plan and Audit Strategy

The Safeguarding Children's Team has a work plan and audit strategy that are both dynamic allowing them to be updated in line with highlighted and emerging risks and themes. The Trust can be assured that both documents aim to improve children's care and safety.

The work plan is informed by Trust and district wide activity along with local and national learning from serious case reviews and inspections. In 2023/24 the work plan highlights include:

- A review of the Safeguarding Children's Policy to include the David Thorpe Model way of working in the Child and Family Trust.
- Engaging with the newly established Child and Family Trust to ensure new email addresses are secure and information can be shared securely.

- New ways of working within the team to screen ED attendances most efficiently, this led to the options paper to change to a targeted screening approach.
- A review of the BTHFT SOP for non-mobile babies attending with injuries.
- Review and revision of the Advice and Support model used within the team, including the role of the team administrator.
- The relaunch of the quarterly safeguarding children's newsletter
- Regular review and update of the safeguarding children intranet page
- Increasing work and training with the BTHFT Safeguarding Adult team as both teams model the 'think family' approach.

The audit strategy provides further evidence of focus on learning and improvement within the Trust, and the results of all audits are routinely shared with the Bradford Health Safeguarding Children Group. All audits are presented at the Safeguarding Children Steering Group, which in turn reports to the Integrated Safeguarding sub-group through the governance of the Quality Committee.

The list of completed audits is below:

- Organisational Safeguarding Assessment – Previously Section 11 audit.
- Annual Quality Audit of Child Protection reports, undertaken with senior social work colleagues.
- Audit of Child Protection Medicals against RCPCH national standards.
- Audit of the quality of clinician taken photographs for child protection medicals.
- Audit of user experience of medical peer review and safeguarding supervision.
- Audit of local knowledge of Child Exploitation.
- Audit of the recording in EPR of accompanying adults for children attending ED.
- There is an ongoing audit of the Safeguarding Practice in ED – Identifying missed flags, missed paediatric liaison forms, missed opportunities to complete safeguarding actions.
- Audit of CP-IS checks undertaken in ED and on CCDA.
- Audit of safe discharge from ED for under 18's.
- Audit of children with high risk flags for CE.

The Safeguarding Team continually review our previous action plans and revisit the learning from historical serious case reviews, lessons learnt reviews and challenge panels that we attend as part of the partnership work to ensure learning remains embedded within the Trust.

2.1.5 Visibility in BTHFT

Currently the team have a weekly presence in ED and the on the Paediatric Ward. In ED the child and adult teams work together and have delivered PERL (Patient Experience and Reflection Learning) sessions focussing on safeguarding. On the paediatric ward the team attend the medical handover sessions twice a week to offer support and improve communication. The team take part in the meetings to discuss High Impact Users in ED.

In addition, the Named Nurse now attends the Paediatric Huddle daily which includes the paediatric wards, ED, the community paediatric teams and the Neonatal and Transitional Care teams. This has

improved management communication and allows for early identification of safeguarding concerns. The Named Nurse was invited to attend the NHS England Commissioning Quality Team visit to the Neonatal Unit in December 23.

A daily huddle has been introduced within the safeguarding children's team to improve communication and ensure the Named Nurse has oversight of ongoing concerns and workloads.

The safeguarding team also held a stall on the main concourse to raise awareness of the team and share the jointly produced child/adult contact cards.

2.1.6 Children and Young People with Mental Health Needs

There are still high numbers of children attending ED where the primary reason for attendance is their acute and chronic mental health needs and the team are aware this mirrors the National picture. The lack of appropriate provision to manage mental health concerns and trauma related behaviour can result in the children being admitted to paediatric and adult wards. The safeguarding team, work in partnership with our paediatric, social work and mental health colleagues to expediate discharge to suitable accommodation when it is not safe for the child to return home. The team act as advocates for the child and ensure their voices are heard. The team highlighted concerns regarding a care provider for children with mental health needs following frequent attendance in ED of the out of area children who were placed in a care setting in Bradford. In the time period covered by this report this remains under review. Having a safeguarding specialist practitioner whose professional background is mental health has been invaluable.

The West Yorkshire Consortium have undertaken an exploration of children and young people with mental health needs in acute settings. As part of the ongoing exploration the Named Nurse has worked closely with the Associate Director of Nursing for Paediatric and Neonatal Services and the Training and Development Manger from NHS England whose remit includes children's mental health services, to understand the demand and service provision in Bradford. We are in the process of benchmarking in-reach provision of CAMHS services in Bradford in comparison to our geographical neighbours.

The CAMHS Crisis pathway requires review, this was highlighted by the Named Nurse and this review is now being led by the Integrated Care Board as part of the Act as One work.

Training sessions were offered across the Trust relating to the implementation of the guidance document detailing the management of distressed, agitated and violent patients under the age of 18.

2.2 Delivery of Financial Plan and Key Performance Indicators

2.2.1 Financial Plan

The Safeguarding Team staffing is within budget. During the last year we have had a safeguarding practitioner on maternity leave and her vacancy has been filled by our safeguarding practitioner on a fixed term contract, which has worked well and provided the continued mental health support that has been required. The team's long-term administrator retired, and they have been replaced on slightly reduced hours by the administrator who covered the role when the original post holder retired and returned, this has provided stability and continuity for the team.

2.2.2 Key Performance Indicators

The key performance indicators are discussed and monitored by the Safeguarding Children Steering Group with any concerns raised to the Trust Integrated Safeguarding Committee. Currently the key performance indicators for the team remain:

- Trust training levels.
- Safeguarding team quarterly supervision.
- Mental Health Enquiry in Maternity Services.
- Routine enquiry regarding domestic abuse in Maternity Services.
- Attendance at the Bradford District Children's Partnership meetings.

2.3 To be in the top 20% of NHS employers

2.3.1 Supervision

Safeguarding supervision is an opportunity for support, challenge and learning around safeguarding cases. A theme from recent local Child Safeguarding Practice Reviews has again recommended the need for good safeguarding practice to be subject to critical discussion and reflection.

Safeguarding supervision is offered and supported by the safeguarding children's team. Supervision sessions are delivered individually or in groups and these sessions continue to use a combination of online and face to face methods. A safeguarding specialist practitioner has begun to explore the supervision offer across the Trust and will create an options paper for possible expansion of the offer. The Named Doctors surveyed staff's experience of supervision and peer review the feedback was positive.

The whole safeguarding team engage in supervision as part of their own practice as per the KPI. Trust psychology colleagues have been able to offer and facilitate sessions for the whole team to help reduce the risk of 'burn out' and maintain the team's emotional health and wellbeing so they can continue to fulfil their roles providing assurance through advice and support and supervision to others within the Trust.

The Named Doctors attend the Named Professionals supervision session with the Designated Doctor. This is a joint session with the Named Doctor from Airedale, the Named GPs and Named Dr for CAMHS.

2.3.2 Policy Review and Updates

All policies remain in date and current. Planned changes to ways of working within the Safeguarding Team mean that new Standard Operating Procedures and Guidelines will be developed throughout the coming year.

Policies and Guidelines that have been reviewed are:

- The Safeguarding Children Policy – this has been updated again in 2023.
- The BTHFT guidelines for Assessment of Non-mobile Babies with injuries including bruises burns and scalds.
- Review of SOP - Radiological investigation of Physical Abuse in children.
- New Terms of Reference have been written and agreed for Safeguarding Peer Review in the Trust.
- The public facing internet document Key Principles of Safeguarding has been updated.

There is a plan to review the safe discharge SOP for ED with a focus on 16- and 17-year-olds who attend independently in the next year.

The team are planning to work with our HR and adult colleagues to review the management of staff allegations.

A guidance document is to be written and presented for consideration with regards to the management of legal statement requests relating to children received by nursing teams across the Trust.

The Named Nurse is working with the Named Nurse for Adults to develop the Sexual Safety Charter for use across the Trust.

2.4 To Be a Continually Learning Organisation

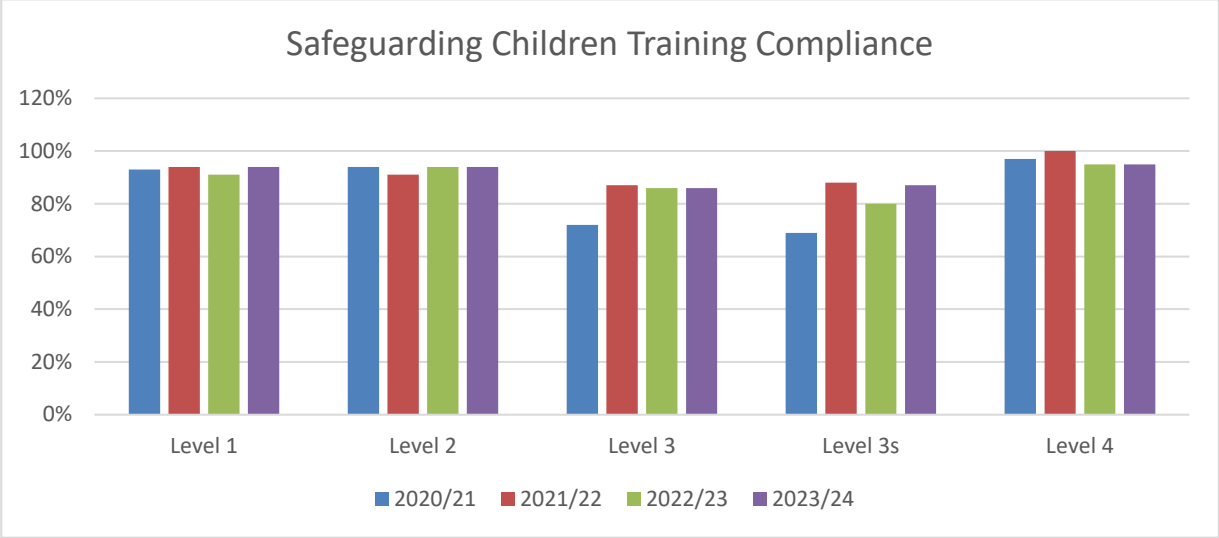
2.4.1 Training

Trust safeguarding training compliance is monitored through the Safeguarding Children's Steering group as a KPI. Training levels are set for staff roles according to the Intercollegiate Document –

Roles and Competences for Healthcare Staff. The Intercollegiate document is due for National review in the next 12 months.

There has been a sustained improvement in the training figures across all levels of training. Level 1 and Level 2 training have returned to being offered face to face as part of the Trust induction for new starters. In practice this means all new starters regardless of role will commence their post with level 2 training. (See Figure 12).

Figure 12. Training Compliance Levels



The way training is delivered has changed slightly to improve engagement and transfer into practice. All training is now delivered in multi-disciplinary groups, there is the offer of one level 3 session per week, the majority are face-to-face but there is one virtual session per month and once a quarter a session is delivered on the St. Lukes site. The sessions are designed around the latest themes from Child Safeguarding Practice Reviews and there are 4 different sessions on offer so staff can select their most relevant one or attend multiple to achieve the required hours to maintain Level 3 Speciality compliance. The team meet twice a year to agree the content of the sessions, and this means any team member can deliver all of the sessions. The format of all the sessions is what is the issue, what is staff's responsibility and what can support them to address safeguarding concerns. We have introduced a QR code for training evaluation and this has increased the feedback we receive; we have used this feedback to help develop our latest packages.

In addition, the safeguarding team have worked with external partners to deliver training in the Trust as part of Safeguarding Week. This has included lived experience sessions from the St. Giles Trust and the Palm Cove Society. Our partner agencies offered sessions for Trust staff relating to children in the youth justice system and health support available for children involved in exploitation.

Joint training with the Adult Safeguarding Team has been well received, initial sessions have included non-fatal strangulation and safeguarding expectations for international nurses.

The team have developed and delivered a training session utilising the sims suite to allow practitioners to practice having difficult conversations with parents relating to professional curiosity and identification of safeguarding concerns.

The Named and Designated Doctors continue to deliver PG Dip (Child Health) module in safeguarding for University of Leeds and they continue to deliver Child Protection Recognition and Response (CPRR) course for ALSG (The Advanced Life Support Group).

Professional Practice Sessions were run by the Named and Designated Doctors for The Bradford Partnership which were deliverd to a multi-disiplinary audience. Training was provided for frontline social workers and managers around health aspects of safeguarding and medicals.

A Grand Round session was delivered sharing learning from the National Review into the murder of Star Hobson, and this evaluated well.

Since April 2023 staff have been required to complete self-declaration forms to demonstrate their level 3 and level 3S compliance. One of the planned audits for this coming year is to dip sample 10% of the self-declaration forms in order to be able to assure the Trust of compliance.

2.4.2 Risk

The Named Nurse attends the weekly Paediatric Risk meeting and takes an active role in reviewing and investigating incidents reported through BTHFTs internal incident reporting system. The team have also begun attending meetings with the ED team regarding patients who are frequent attenders to ensure they receive the care required and any support that can be offered is identified. These meetings have included discussions relating to children and young people attending due to mental health concerns.

The team have helped develop and introduce a Non-Mobile Baby template into the electronic patient record to reduce the need to recall babies with an injury where mobility has not been recorded.

2.5.1 Multiagency Working

Working Together to Safeguard Children (2018) identifies the key stakeholders in safeguarding as the CCGs (now the Integrated Care Board) Police and Local Authority; the BTHFT Safeguarding team continue to work closely with these stakeholders individually and through the Bradford District Safeguarding Children Partnership as required.

The safeguarding children's team continue to represent the Trust at the following quarterly meetings:
HCSG – Health Children's Safeguarding Group
Health and Children's Social Care meeting
CDOP – Child Death Overview Panel
MACE – Multi-agency Child Exploitation
And the following subgroups of the Bradford District Safeguarding Children's Board:

- All Age Exploitation

- Learning and Improvement
- Performance Management
- Safeguarding and Professional Practice
- Case review
- Newly established Neglect subgroup

The newly established Neglect subgroup has a number of task and finish groups including the development of a reduced Neglect Toolkit for use in acute setting.

The team attend the MACE meetings at a strategic and practitioner case related level and have also contributed to MACE timeline meetings. In the timeline meetings a multi-agency deep dive is completed into a child who has been identified as being at risk of child exploitation with a view to identify missed opportunities and learning.

A new independent Children and Family Trust (CFT) was established from 01.04.23 and the team have worked to support the change and development this change has necessitated. The Named Nurse is a member of the MAID (Multi-agency Implementation and Development) group which meets quarterly to identify any opportunities or concerns and share any learning from the establishment of the CFT. Being part of this group has strengthened district wide strategic partner relationships. The safeguarding team continue to work with local and regional health partners to share information and best practice. Safeguarding supervision to our health colleagues in partner agencies and a reciprocal arrangement is in place with partners providing supervision for members of the safeguarding team.

The Children's and Adult's safeguarding teams have worked more closely over the reporting period, providing joint training, working on Trust wide policies and providing support to staff in the Emergency Department jointly. There are plans to continue to develop this joint working to assure the Trust we are addressing the 'Think Family' agenda.

The Named Nurse is involved in the 'Roma Voices for Change research project and there are plans to share the findings relating to understanding of CE (Child Exploitation) across the Trust.

2.5.2 Child Safeguarding Practice Reviews

The team have undertaken 10 formal Rapid Reviews during 2023. These are requested by the Partnership and used to make the decision to proceed to Child Safeguarding Practice Review (CSPR).

2023 saw the publication of the CSPRs for Child A, The Siblings, The Thematic Review – Babies who Sustained Injuries and Sara Edvina and Danuka. Many of the recommendations from the reviews were the same and have been themed by the Bradford Safeguarding Partnership, the team have created a joint action plan, which forms part of the planned work plan for the coming year. The action plan for the National Panel Review into Star Hobson and Arthur Labjino Hughes is complete for the Trust and a Grand Round session was delivered sharing the learning from the review.

There are currently 2 ongoing Child Safeguarding Practice Reviews where the Trust has had some contact with the children at the centre of the reviews. Once these reviews are published the safeguarding team will be instrumental in actioning and supporting any recommendations for BTHFT and also in creating and reviewing any internal action plan. Learning from all reviews will be captured as part of the ongoing safeguarding teamwork plan and progress reported through the Safeguarding Children's Steering group and Integrated Safeguarding sub-group.

3 PROPOSAL

All Safeguarding children activity in the Trust is monitored through the Safeguarding Children Steering group, which in turn reports to the Integrated Safeguarding Sub-committee. The overall governance is held by the Quality Committee. The key aims of the Safeguarding Children Steering group for the forthcoming year are:

- Monitoring and identifying opportunities for the increased physical visibility of the Safeguarding Children's Team across the Trust via formal events, face to face training, attending departments to provide advice and support, offer supervision and work with champions.
- Joint review of the CAMHS Crisis pathway and care needs of children attending the Trust where their primary reason for attendance is Mental Health related.
- Review of the safeguarding supervision offer and expectation for staff in the Trust.
- To continue to develop the joint working with our Trust Adult Safeguarding Team.
- Monitoring of the compliance with the self-declaration process for recording safeguarding training.

4 BENCHMARKING IMPLICATIONS

BTHFT is the top performer of all the Trusts who responded to a RCPCH national audit of 'Good Practice Service Delivery Standards for the Management of Children Referred for Child Protection Medical Assessments' achieving 99 of the 103 standards.

5 RISK ASSESSMENT

The Safeguarding Children Team complete risk assessments as and when required for the areas of concern. The team attend the weekly paediatric risk meetings.

There have not been any serious incidents reported during this reporting period for safeguarding children.

6 RECOMMENDATIONS

1. The team have remained heavily involved in the care of children accessing BTHFT for their mental health needs, many of these children are known to children's social care. The team plan to review how best to utilise the skills within the team to support the oversight and safe discharge for these young people.

2. Continued work with IT colleagues to ensure the risks associated with the use of different record systems are mitigated. In addition, the team will work with Cerner to explore how best to make safeguarding documentation more visible in-patient records.

3. The team will work to deliver the joint action plan developed from the recommendations from the 4 recently published CSPRs.

4. The team will continue to work closely with internal and multi-agency partners to ensure the Trust is contributing to the system approach to safeguarding children in Bradford.

7 Appendices

Appendix 1 - Work Plan (Attached separately)

Appendix 2 - Audit Plan (Attached separately)

Appendix 3 - Links to documents and websites

https://saferbradford.co.uk/media/dh3f3lpv/thematic-child-safeguarding-practice-review-bradford-publication-version.pdf

https://saferbradford.co.uk/media/o5ejkltm/final-report-sara-edvina-and-danuka-updated.pdf

https://saferbradford.co.uk/media/k44hmjpy/child-a-final-report-for-publication.pdf

https://saferbradford.co.uk/media/c3nmjc4i/a-local-child-safeguarding-practice-review-the-siblings.pdf

BO.7.24.6- MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

Only PDFs are attached

- Bo.7.24.6 - Maternity and Neonatal Service Board.Presentation.JulyFinal.pdf
- Bo.7.24.6 - Maternity and Neonatal Services Board Assurance Report AprilMay2024 4.3FINAL.Formattedfinal.docx_.pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App1 (PERINATAL)April2024 (cover).pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App2 (PERINATAL)May2024 (cover).pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App5 Listening to Women and Families.Birth TraumaMNVP update.Final.pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App5a.Appendix 1.Listening to Women and Families.Birth Trauma Inquiry Report for Publication_May13_2024 (1).pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App5b.Appendix 2.ListeningtoWomen and Families.PRN01359_Matandneoservices-listeningtowomenandfamiliesletter_170524.pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App6 Escalation of Concern Bradford.pdf
- Bo.7.24.6 - MatandNeoServicesUpdate.App7 MNSI Escalation of concern response June 2024.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors
11 July 2024

Maternity and Neonatal Update
April and May 2024

Carly Stott, Head of Midwifery

Together, putting patients first

Highlights April and May

Bradford Teaching Hospitals NHS Foundation Trust

- The April and May perinatal update papers were presented to May and June (July) 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.
- 3 completed MNSI/Internal Investigation reports including recommendations and learning, were presented at June QPSA.

Additional Items

Bradford Teaching Hospitals NHS Foundation Trust

- 4 Items not yet received by QPSA for Trust Board attention:
  - A review of the May 2024, All Party Parliamentary Group report on Birth Trauma, and any implications for the Maternity Service at BTHFT.
  - Information regarding a formal ‘Escalations of Concern’ letter from MNSI regarding Maternal Early Warning Score (MEWS) and the service response.
  - Summary of the Bi-Annual Midwifery Workforce paper, a requirement of the Maternity Incentive Scheme, Year 6.
  - Early escalation of 2 maternal deaths in June.

Discussion Points

Bradford Teaching Hospitals
NHS Foundation Trust

- 3 Completed MNSI/Internal investigation reports, including recommendations and learning (appendices 4a, b and c) available to Closed Board.
- Trust Board is informed that the service did not agree with 4 points included in the final MNSI report, 4c.
- There were a significant number of inaccuracies raised during the first factual accuracy review by the service. Multiple amendments were made by MNSI, except for 4 points which they declined to amend despite additional information and evidence provided.
- The report has been shared with the family. We hope to meet the family to discuss the report findings. We will sensitively discuss the points we disagree with MNSI on. If the family decline to meet, we will retain the additional information with the archived report in the event of further scrutiny.

Birth Trauma Report

Bradford Teaching Hospitals NHS Foundation Trust

- All-Party Parliamentary Group report on Birth Trauma published 13 May 2024.
- 28 recommendations, many of which are for the government and NHSE to implement and roll out.
- Other recommendations are aligned with existing recommendations included in the Three-Year Delivery Plan for Maternity and Neonatal Services, and the Priorities and Operational Planning Guidance 2024/25.
- Continued focus on reducing inequalities in maternity care, particularly amongst Black and Asian women.
- The key risk on initial review of the report, is the Trust's ability to meet the service specification for Perinatal Pelvic Health Services.
  - Gap analysis of the service specification.
  - Joint risk assessment between the Women's and Musculoskeletal (MSK) CSUs.

Escalation of Concerns letter

Bradford Teaching Hospitals NHS Foundation Trust

- Escalation of Concerns letter received from MNSI regarding the assessment and management of the Maternity Early Warning Score (MEWS).
- Requesting Trust assurance that if a mother's condition deteriorates, the team can detect this and react with effective escalation in a timely manner.
- A written response containing evidence and information to assure MNSI of the systems and processes in place, was returned within the 5 working days requested.
- MNSI have confirmed receipt of the information and have informed us that an outcome will not be agreed until the investigation report which has highlighted this concern, is concluded.

Bi-Annual Midwifery Workforce paper

Bradford Teaching Hospitals NHS Foundation Trust

- Safety Action 5 of the Maternity Incentive Scheme, Year 6, requires a Bi-Annual Midwifery Workforce Staffing Report is to be presented to Trust Board and formally recorded in the minutes.
- The report is an appendix to the overarching Nursing and Midwifery Staffing paper.
- There are no requests of Trust Board.
- To note that the Birth Rate Plus review is in the process of being finalised and will be presented to People Academy in August/September.

Maternal Deaths

Bradford Teaching Hospitals NHS Foundation Trust

- Trust Board notified of 2 maternal deaths in June
  - 8 days postnatal suicide: Joint investigation with BDCT. No immediate learning identified for BTHFT following initial case review.
  - Antenatal death in the community, 28 weeks pregnant. Postmortem has not revealed a cause of death. Case referred to MNSI.
- 4 Maternal Deaths in 6 months. Previous year's average is 3 in 12 months.
  - Cases are all very different and there does not appear to be any emerging trends or themes of concerns.
  - Service proposes a thematic review to assure that this is accurate.

Maternal Deaths

Bradford Teaching Hospitals
NHS Foundation Trust

Ethnicity	Baby delivery date	MBRACE reportable	MPI Date of Death	comments
Pakistani	09/09/2021	yes	04/03/2022	suicide
Eastern European	Antenatal	yes	04/05/2022	Sudden Adult Death Syndrome
White British	IUD	yes	22/06/2022	Sepsis inpatient death
Total 2022: 3				
Pakistani	17/05/2022	yes but not progressed	02/01/2023	died in Pakistan-pneumonia
British Pakistani	13/12/2022	yes	02/02/23	Suicide
Eastern European	12/04/2023	Yes	19/07/2023	Suicide- died on ITU
Black African	27/05/2023	Yes	18/08/2023	UNKNOWN
Total 2023: 3 (+1 abroad)				
British Pakistani	29/01/2024	yes	29/01/2024	27.4w Fatty Liver
White British	07/08/2023	yes	26/03/2024	cardiac arrest, known DVT
British Pakistani	30/05/2024	yes	07/06/2024	Suicide -community
Black African	Antenatal	yes	21/06/2024	UNKNOWN
Total 2024 to date: 4				

Questions?

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.6

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – APRIL AND MAY 2024

Presented by	Carly Stott, Head 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 (QPSA), 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 approval	
Previously discussed at/informed by	Details of any consultation	
Previously approved at:	e.g. Academy / ETM / CSU group	**Date**
	Quality and Patient Safety Academy	May and June 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

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addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Serious Incident (SI) reports.

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

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

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

Analysis

The Director of Midwifery and the Chair of QPSA provide Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to April and May 2024 activity, was presented and key elements discussed including:

- The number of harms occurring in April and May, 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 April and 3 in May for the attention of Closed Board.
- The report presented to June (held on 2 July) QPSA included that the Perinatal Leadership Quad joined the May bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.

This paper also includes:

- A review of the May 2024, All Party Parliamentary Group report on Birth Trauma, and any implications for the Maternity Service at BTHFT.
- Information regarding a formal ‘Escalations of Concern’ letter from MNSI regarding Maternal Early Warning Score (MEWS) and the service response.
- Summary of the Bi-Annual Midwifery Workforce paper, a requirement of the Maternity Incentive Scheme, Year 6.

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- Early escalation of 2 maternal deaths occurring in June, which have not yet been presented to QPSA.

Recommendation

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the April and May 2024 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 April and May 2024 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 4a, b and c, completed investigation reports including recommendations and learning.
- Closed Trust Board is informed that the service did not agree with 4 points included in the completed MNSI investigation report, 4c.
- Trust Board is asked to note that the contents of the April update paper have been discussed at the June Perinatal Oversight Group, attended by representatives from the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board. The May update paper will be presented and discussed in July.
- Trust Board is informed that the Perinatal Leadership Quad joined the May bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- Trust Board is asked to note appendix 5, 'Listening to Women and Families' summary and recommendations, presented to Executive Team Meeting, 10 June 2024.
- Trust Board is informed of an 'escalation of concerns' letter from MNSI (appendix 6) and the response provided by the service (appendix 7).
- Trust Board to minute that a bi-annual midwifery workforce staffing report has been received. This is a requirement of the Maternity Incentive Scheme, Year 6.
- Trust Board is informed of 2 maternal deaths occurring in June and that the number of deaths so far this year has already exceeded the average annual number.

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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.

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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)
☐	☒	☐	☐

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 LMNS, 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.

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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 April and May 2024 (Appendices 1 and 2):

The April and May updates and associated appendices were respectively discussed at the May and June QPSA. To note: June QPSA was held on 2 July.

The key elements of the papers discussed included:

- The number of harms occurring in April and May, 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 April and 3 to share for May (appendices 4a, b, and c). QPSA were informed that the service did not agree with 4 points in the completed MNSI report 4c. Multiple changes were made following the service's first factual accuracy checking process, but MNSI did not agree with the remaining 4 points and included them in the final report. The service is hoping to meet with the family and for transparency, will explain the points in question.
- June QPSA was informed of the unannounced CQC inspection of Maternity and Neonatal Services in May, and of the high-level feedback. Of note, there were no immediate safety actions or concerns escalated at the time of inspection or following the submission of additional requested information. Neonatal Services were described as exemplary.
- June QPSA was asked to note that the Perinatal Leadership Quad joined the May bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.

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- May and June QPSA reported and recorded that they were assured by the papers, presentation, and discussion. There was nothing identified requiring escalation to Board.

In addition to the papers presented to QPSA, the service would like to update Trust Board on several other items:

- May 2024, saw the publication of the All-Party Parliamentary Group report on Birth Trauma. Appendix 5, is a copy of the briefing paper presented to ETM on 10 June, summarising the report and describing any key steps and risks following the recommendation. The service is in the process of benchmarking the 28 recommendations, many of which are for the government and NHSE to implement and roll out. Of the recommendations at Trust level, the majority are aligned with existing recommendations included in the Three-Year Delivery Plan for Maternity and Neonatal Services, and the Priorities and Operational Planning Guidance 2024/25. There is a continued focus on reducing inequalities in maternity care, particularly amongst Black and Asian women, which is a long-standing key priority for the service. The key risk identified following initial review of the report, is with the Trust's ability to meet the service specification for Perinatal Pelvic Health Services, in part due to a national lack of specialist physiotherapists. Gap analysis of the service specification is underway, and an associated risk assessment is being completed jointly between the Women's and Musculoskeletal (MSK) CSUs.
- Trust Board is informed of the receipt of a formal escalation of concerns letter (appendix 6) from MNSI on 7 June, in relation to the assessment and management of the Maternity Early Warning Score (MEWS). In particular, whether the Trust is assured that if a mother's condition deteriorates, the team can detect this and react with effective escalation in a timely manner. A written response (appendix 7) containing evidence and information to assure MNSI of the systems and processes in place, was returned to MNSI within the 5 working days requested. MNSI have confirmed receipt of the information and have informed us that an outcome will not be agreed until the investigation report which has highlighted this concern, is concluded. To meet compliance with Safety Action 5 of the Maternity Incentive Scheme, Year 6, a Bi-Annual Midwifery Workforce Staffing Report is to be presented to Trust Board and formally recorded in the minutes. This is an appendix to the overarching Nursing and Midwifery Staffing paper and there are no requests of Board at this time.
- The service wishes to inform Closed Board of 2 maternal deaths occurring in June. The detail will be included in the June update paper to July QPSA. However, due to the timing of the next Trust Board, an earlier escalation is preferred. The 1st case is the death of a woman in the early postnatal period following suicide. This case will be investigated jointly with BDCT. The 2nd case is an unexplained death of an antenatal

woman in the community, which meets the MNSI criteria, and has been referred. Both cases have been referred to MBRRACE as per the National reporting criteria.

- With the exception of 2021 where there were 0 maternal deaths, since 2020 there have been 3 deaths a year, including direct and indirect deaths. So far this year there has been 4 deaths in Bradford, and whilst the cases are all extremely different and do not appear to have any themes, the service plans to undertake a more detailed analysis of the cases as a thematic review when all investigations have been completed.

3 RECOMMENDATIONS

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the April and May 2024 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 April and May 2024 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 4a, b and c, completed investigation reports including recommendations and learning.
- Closed Trust Board is informed that the service did not agree with 4 points included in the completed MNSI investigation report, 4c.
- Trust Board is asked to note that the contents of the April update paper have been discussed at the June Perinatal Oversight Group, attended by representatives from the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board. The May update paper will be presented and discussed in July.
- Trust Board is informed that the Perinatal Leadership Quad joined the May bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- Trust Board is asked to note appendix 5, ‘Listening to Women and Families’ summary and recommendations, presented to Executive Team Meeting, 10 June 2024.
- Trust Board is informed of an ‘escalation of concerns’ letter from MNSI (appendix 6) and the response provided by the service (appendix 7).
- Trust Board to minute that a bi-annual midwifery workforce staffing report has been received. This is a requirement of the Maternity Incentive Scheme, Year 6.
- Trust Board is informed of 2 maternal deaths occurring in June and that the number of deaths so far this year has already exceeded the average annual number.

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4 Appendices

- Appendix 1 - Maternity and Neonatal Services Update Paper, April 2024.
- Appendix 2 - Maternity and Neonatal Services Update Paper, May 2024.
- Appendix 3 - Closed Board Harms April 2024.
- Appendix 4, 4a, 4b and 4c - Closed Board Harms May 2024 and completed investigation reports.
- Appendix 5, 5a and 5b - 'Listening to Women and Families' summary and recommendations, presented to Executive Team Meeting, 10 June 2024.
- Appendix 6 - Escalation of Concerns Letter.
- Appendix 7 - Service response to escalation of concerns letter.

Meeting Title	Quality and Patient Safety Academy (QPSA)		
Date	22 May 2024	Agenda item	QA.5.24.13

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE APRIL 2024

Presented by	Carly Stott, Head 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

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Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Academy on behalf of Board as an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

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

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

Analysis

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

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

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

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

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

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Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, April 2024.
- Academy is informed that the Maternity (and perinatal) Incentive Scheme, Year 6, was published in April and that the service has noted the content and is working towards compliance.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 4.
- Academy is asked to note that there was 1 case of HIE reported in April.
- There were 3 neonatal deaths in April.
- There were 0 maternal deaths in April.
- 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 April.
- Quality and Patient Safety Academy is asked to note that there was 1 MNSI reportable cases and 0 reportable Serious Incidents (SI) declared in April.
- Academy to note that there were 0 occasions in April where the unit was assessed as needing to divert women to other organisations.
- QPSA is informed that the Maternity and Neonatal Voices (MNVP) Leads have had a number of escalations of concerns from staff, in addition to raising concerns regarding their own capacity to undertake their role. A number of meetings are planned to discuss safety concerns in more detail, and to address capacity issues.

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	

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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)		
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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. Stage 2 of the pilot is now in progress, which involves reviewing the automation process. If the automation process is successful, the PCP will then be rolled out to a larger number of women accessing the Shipley Community Midwifery team, within the next 4-6 weeks.

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 William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

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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 plan is due to be updated in May and will be presented to June 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.

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.

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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 first bi-annual midwifery staffing paper of 2024 is currently being prepared and will be presented alongside the overarching Nursing and Midwifery Staffing paper, prepared by the Deputy Chief Nurse. It is anticipated that this will be presented to May 2024 People Academy followed by July Board. A separate paper and recommendations following the 2024 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. This is expected to be presented to June People Academy following the service's receipt of the final report.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 10.34 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 2.12 WTE within the maternity theatre scrub team, is occasionally further compromising safe staffing levels in that area, as midwifery staff are required to provide emergency scrub cover.

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The overall staffing position appears to have improved during April, with improved fill rates in most of the clinical areas. Anecdotal feedback is that staff welcomed the Wagestream, scheme, which enables staff to receive a proportion of their bank shift salary almost immediately, rather than waiting until the following month.

Despite some shifts triggering an amber risk assessment escalation tool, due to increased activity and acuity, the need to divert services has been avoided during 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 35.76 WTE.

Maternity leave is currently 13.07 WTE.

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

A daily system wide safety huddle to assess the need for mutual aid and support across the 6 West Yorkshire and Harrogate Local Maternity and Neonatal System, remains in place.

Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week. We do have a strain on the consultant body with 2 Gaps, one for short term sickness and one for maternity. There is no significant update from the previous month.

Neonatal Staffing

Medical:

- New consultant started in April. Now at full establishment.
- Some sickness at Consultant level, which is being mitigated by the team
- Tier 2 junior medical staffing continues to be a challenge due to various rota gaps.

Nursing:

No significant update from last month.

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Maternity Improvement Plan and CQC rating

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

The final report was received in May 2023 and reflects the positive improvements made and since the 2019 inspection. Whilst the overall rating remains 'Requires Improvement', the 'Well-Led' domain has improved from 'Inadequate' to 'Good', with 'Safe' remaining as 'Requires Improvement'.

An action plan addressing the 2 'Must Do' actions and 5 'Should Do', was returned to the CQC and presented to May QPSA, July Board and progress is monitored through 'Women's Core Governance Group' and QPSA.

The Improvement plan was updated in 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. 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.

Maternity (and perinatal) Incentive Scheme, Year 6

The Year 6 scheme was published in April and continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The ten safety action titles remain unchanged, and equally, the required standard for each action remain largely unchanged, with a few minor amendments which have been noted by the service.

In addition to the scheme, NHS Resolution has produced an accompanying action tracker, which can be used to track progress with compliance throughout the reporting period. The service plans to utilise this and to share with Integrated Care System (ICS) and Local Maternity and Neonatal System (LMNS) colleagues as part of the regular assurance processes.

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The submission deadline for the Board declaration form is 12 noon on 3 March 2025.

Stillbirth Position

There were 4 stillbirths in April.

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. Details are available to QPSA and Closed Board in Appendix 1.

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
April	4	10		0

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby diagnosed with HIE in April. See Appendix 1.

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 April (HIE case) 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.

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Ongoing Maternity SIs:
Appendix 1 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 April and no ongoing neonatal SIs under investigation.

Neonatal Deaths (NND)
There were 3 neonatal deaths in April. See Appendix 1 for details.

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)
April	3	7	2	0

Maternal Deaths

There were no maternal deaths reported in April.

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 April.

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

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

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

Coroner Regulation 28 made directly to Trust

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

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

Perinatal Bi-Monthly Safety Champion meetings

There was no planned meeting in April. The next meeting is in May.

The Chief Nurse, Director and Head of Midwifery, met with a member of the Birth Centre team in April, to listen to her safety concerns regarding the impact of reduced staffing levels on the consistent opening of the Birth Centre, and the effect this is having on women's choice of place of birth. A number of solutions were offered which are being explored further.

Monthly staff feedback from Safety Champions and walk-rounds

The April meeting was brief, with 1 concern raised regarding ongoing challenges with the connectivity and operability of Fetalink (remote central fetal monitoring). The Safety Champion requested to be notified of any further escalations so that she could support any barriers to resolving.

Maternity Unit Diverts

There were 0 partial/attempted unit diverts/escalations in April recorded on the closure log.
This reflects the improved staffing position experienced during April.

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
APRIL	0	0	0	0
Total	0	5	7	6

Maternity Dashboard

The Maternity Dashboard has not been updated significantly since it was presented last month.

Training Compliance

PROMPT training is on trajectory to meet the Maternity Incentive Scheme Year 6 compliance standard, although there is a noted decrease in anaesthetic compliance due to the addition of new staff who are required to attend the training. This is being monitored and will be escalated if meeting the trajectory becomes a concern.

7 competencies below 75%

- 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. Compliance has increased marginally this month.
  - Organising Receipt of Blood.
  - Preparing to Administer/Administering Blood.
  - Collecting Blood.

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- 1 of the competencies 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. We are still waiting for confirmation of additional places.
- 1 of the competencies Resuscitation (Level 2) Adult Basic Life Support is covered in PROMPT. One of the sessions was cancelled due to faculty illness which has impacted on compliance. There have also been some inconsistencies with updating attendance registers in the Professional Development Midwife's absence which has also affected compliance- this has been escalated again to the training team.
- 1 of the competencies Safeguarding Adults Level 3 applies to band 8 and above only. 2 staff members have just become out of date and are aware.
- 1 of the competencies The Oliver McGowan mandatory training for staff was only added in Feb 2024 and compliance has increased each month.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 3 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 next MNVP main meeting is in quarter 2.

The service has received an escalation of concern from the MNVP in relation to their capacity to undertake their role and responsibilities, and concerns raised anonymously by members of staff. Details of the concerns have been minimal, to the extent that the Director of Midwifery and senior team have insufficient information to actively investigate.

The Director of Midwifery and the Chief Nurse are meeting with the MNVP leads to discuss the concerns in more detail and ascertain if there are any immediate safety concerns. Meetings are also in place to address the ongoing capacity issues.

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.

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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, April 2024.
- Academy is informed that the Maternity (and perinatal) Incentive Scheme, Year 6, was published in April and that the service has noted the content and is working towards compliance.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 4.
- Academy is asked to note that there was 1 case of HIE reported in April.
- There were 3 neonatal deaths in April.
- There were 0 maternal deaths in April.
- 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 is no new neonatal SIs or ongoing neonatal SIs.
- There are 0 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for April.
- Quality and Patient Safety Academy is asked to note that there was 1 MNSI reportable cases and 0 reportable Serious Incidents (SI) declared in April.
- Academy to note that there were 0 occasions in April where the unit was assessed as needing to divert women to other organisations.
- QPSA is informed that the Maternity and Neonatal Voices (MNVP) Leads have had a number of escalations of concerns from staff, in addition to raising concerns regarding their own capacity to undertake their role. A number of meetings are planned to discuss safety concerns in more detail, and to address capacity issues.

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7 Appendices

- Appendix 1 - Maternity and Neonatal Harms April 2024.
- Appendix 2 - Mandatary Training Report April 2024.
- Appendix 3 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.

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MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE MAY 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 the Quality and Patient Safety Academy (QPSA) and the Trust Board of Directors (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 the Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

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

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

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Recommendation
• Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, May 2024. • Academy is informed of the unannounced CQC inspection of maternity and neonatal services in May 2024 and to note the high-level feedback. • Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 1. • Academy is asked to note that there were 0 cases of HIE reported in May. • There were 3 neonatal deaths in May. • There were 0 maternal deaths in May. • There are 5 ongoing maternity SIs/Level 1 investigations, 2 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level, plus 1 MNSI investigation referred by Leeds regarding a Bradford woman. • Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs. • There are 3 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for May. • QPSA and Closed Board are informed that there were 4 points within the completed MNSI report which the service did not agree with. This will be discussed with the family. • Quality and Patient Safety Academy is asked to note that there were 0 MNSI reportable cases and 0 reportable Serious Incidents (SI) declared in May. • Academy to note that there was 1 occasion in May where the unit was assessed as needing to divert women to other organisations.

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

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

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

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

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

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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 the Trust 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 Trust 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 the Trust 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 the Trust Board to have oversight of key elements of the NHS Resolution Maternity

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Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool 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 2023, to review progress on the Ockenden actions and to celebrate successes and achievements. The visit was overwhelmingly positive, with complimentary comments regarding the passion, enthusiasm and commitment of staff sharing and describing the learning journey, despite a backdrop 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. Stage 2 of the pilot is now in progress, which involves reviewing the automation process. If the automation process is successful, the PCP will then be rolled out to a larger number of women accessing the Shipley Community Midwifery team, within the next 4-6 weeks

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 Elizabeth The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

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A precis of the report and actions for the maternity service and Trust Board was presented to the November 2022 Board of Directors meeting. 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 2023, 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 2023 paper presented to October 2023 QPSA and November 2023 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 2024 shared with February 2024 QPSA. The plan was due to be updated in May 2024, but this was delayed due to the CQC inspection and subsequent information requests. It will be included in the June 2024 update to be presented at July 2024 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.

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 first bi-annual midwifery staffing paper of 2024 is currently being prepared and will be presented alongside the overarching Nursing and Midwifery Staffing paper, prepared by the Deputy Chief Nurse. It is anticipated that this will be presented to June People Academy followed by July Board. A separate paper and recommendations following the 2024 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. This is expected to be presented to June People Academy following the service's receipt of the final report.

Based on the revised tabletop calculations the current vacancy against the safe staffing establishment is 10.59 WTE which includes the agreed uplift for maternity leave.

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

Current vacancy against the revised funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 36.01 WTE.

Maternity leave is currently high at 15.62 WTE.

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

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.

There has been an extremely positive response to the newly qualified midwife recruitment and we have offered posts to 38 students qualifying in the autumn.

Obstetric Staffing

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

We will have 4 consultant gaps starting early July due to lead gynaecology oncology consultant leaving, a maternity leave, a sabbatical leave and another gap due to long term sickness.

2 out of these gaps are of consultants with obstetric focus and high-risk obstetrics skills.

A gap created by maternity leave was initially successfully filled with a fixed term locum. The appointed locum colleague has secured a substantive post in a different organisation. This will create an additional gap as of the end of September early October. We are planning to advertise a locum post for the remaining of the maternity leave.

A colleague will be starting a sabbatical leave the first week of August. A fixed term 12-month locum in Obstetrics and gynaecology is due to start end of August 2024.

We are planning to advertise a substantive obstetrics and gynaecology post to partially fill the gynaecology oncology lead gap. The rest of the responsibilities are going to be covered internally.

The fully funded cost neutral consultant in Obstetrics and gynaecology post was interviewed for and a conditional offer made. The new colleague is due to start in the first week of August.

Obstetric only consultant post – previously advertised and not recruited to. This job was re advertised and no suitable candidate found. This job was converted to a 12 month fix term locum in Obstetrics and Gynaecology and a consultant has been in post since February 2024.

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

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1) The additional sessions requiring cover during industrial action.

2) The increased referral for Gynaecology including general Gynae, hysteroscopy, colposcopy and fertility.

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-call work provided. Every consultant is exceeding their flexible sessions.

There are no job planned activities except for theatre lists. All other sessions are job planned. Additional sessions in hysteroscopy and colposcopy to assist with the increasing demands in these areas.

We have tested the use of super clinics to help address the significantly growing demand on fertility referrals.

This has proven to be a very effective option to reduce waiting times. This is however another additional strain on our consultant body.

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. Two 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 term 12 month SAS doctor posts. 2 have withdrawn their applications due to change in circumstances. We have re-advertised and a further post is secured.

An additional round of recruitment is in progress to recruit on additional SAS doctor and 3 fellows to mitigate future confirmed gaps.

Escalated rates to cover the gaps have been continued and agreed by HR until end of September 2024.

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

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Neonatal Staffing

Medical:

- No significant changes to staffing position or concerns escalated.
- Some nervousness regarding pending Junior Doctor industrial action in June, but nothing to escalate at present.

Nursing:

- No significant updates or concerns escalated

Maternity Improvement Plan and CQC rating

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

The final report was received in May 2023 and reflects the positive improvements made and since the 2019 inspection. Whilst the overall rating remains 'Requires Improvement', the 'Well-Led' domain has improved from 'Inadequate' to 'Good', with 'Safe' remaining as 'Requires Improvement'.

An action plan addressing the 2 'Must Do' actions and 5 'Should Do', was returned to the CQC and presented to May QPSA, July Board and progress is monitored through 'Women's Core Governance Group' and QPSA.

The Improvement plan was updated in 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. 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.

The CQC undertook an unannounced inspection in May, focusing on the Safe and Well Led domains in both Neonatal Unit and Maternity.

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There were no immediate safety concerns or actions required following the inspection.
All additional requests for information/evidence have been submitted.

Maternity and Neonatal services reports will be included within the overarching Trust inspection report which is not anticipated to be published before the autumn.

High Level feedback/requests for further information:

- Management of outpatient prescription
  - Checking process in place
  - Trust wide approach being progressed through medicines forum
- Temperature of rooms where drugs are stored
  - Thermometers in rooms
  - Escalation to estates in event of raised temperatures
- Corridors/fire doors blocked by equipment
  - Intentional rounding introduced in areas specifically focusing on placement of equipment when not in use
- Learning from maternal and neonatal incidents- some staff unable to articulate when asked
  - Multiple ways of sharing learning in place
  - Develop digital platform to include more learning from incidents
  - Improved staffing will hopefully result in the ability to release more staff to attend governance meetings where learning is discussed
- Delayed Inductions
  - More detail requested regarding how we manage induction delays
  - Improvement work already in progress
  - Daily LMNS sitrep and escalation for mutual aid
- Maternity staff were found to be approachable, friendly and happy at work and were described as showing a willingness to learn and improve
- Neonatal services were described as demonstrating exemplary practice

Stillbirth Position

There was 1 stillbirth in May.

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. Details are available to QPSA and Closed Board in appendix 1.

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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
April	4	10		0
May	1	11	1	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies diagnosed with HIE in May.

Serious Incidents (SI) and serious harms

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

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity and Neonatal System (LMNS). There were 0 MNSI reportable cases occurring in May 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 1 includes a position summary of ongoing maternity SIs. There are 3 completed reports including learning (appendices 1a,1b and 1c), for the attention of Quality and Patient Safety Academy and Closed Board this month.

Academy and Closed Board are asked to note that there were 4 points in the appendix 1 report, which the Trust did not agree on during the factual accuracy checking process. The MNSI panel declined to amend the report after reviewing additional evidence and information provided by the Trust.

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The report has been shared with the parents and the service plans to sensitively explain the points we do not agree on if the parents accept a follow-up meeting. If they do not wish to meet, the points of discrepancy are clearly described and explained and are archived with the final report for future reference.

There are 5 ongoing maternity PSIIs/Level 1 investigations, 2 MNSI and 3 Trust level. Plus, an MNSI case led by Leeds but involving Bradford (included in the table).

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

Neonatal Deaths (NND)

There were 2 neonatal deaths in May. See appendix 1 for details. 1 additional baby born in Bradford and received care in Leeds died at 4 months of age. This is no longer PMRT reportable.

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)
April	3	7	3	0
May	2	9	2	0

Maternal Deaths

There were no maternal deaths reported in May.

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 May.

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

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

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

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

Unfortunately, the Non-Executive Director's were unable to attend the May meeting. Pre-populated discussion points were provided before the meeting and no comments or queries were received.

The Avoiding Term Admissions Into Neonatal Unit (ATAIN) quarter 4 report was discussed and the group were updated on the changes to the Maternity Incentive Scheme (MIS) requirements for this safety action.

The Quarterly PMRT report and learning, presented to April QPSA, was also discussed by the group.

The annual CQC Maternity Survey results were shared with the group, including the update on the development of an improvement plan, co-produced with the Bradford MNVP leads.

The group briefly discussed some of the ongoing challenges regarding insufficient funding for the MNVP leads to fulfil the role specification. This has been escalated to the Regional Chief Midwifery Officer by the Leads themselves, and on-going discussions are in progress to identify any additional funding available to resolve this challenge.

The MNVP Leads have also escalated safety concerns from 3 members of staff who have approached them directly. The Director of Midwifery has met with the Leads to establish more information and has been able to provide some assurance on the action taken to address.

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Since the last Safety Champion Meeting, the Chief Nurse and Director of Midwifery have also had an escalation of concern regarding safety on the Birth Centre, from 1 staff member, particularly around staffing and women not being offered the birth centre as a choice of place of birth. They have met with the staff member, listened to concerns and suggestions of how improvements can be made.

Reassuringly, following this escalation, the wider staff ward to board meeting described an improved position on the birth centre during May. The ward manager is also working on several initiatives to actively promote the birth centre as a choice for women. Predicted newly qualified midwife numbers, due to start in October, will also provide a more robust and sustainable staffing model to be consistently applied.

Members of the Perinatal Leadership Quad were also in attendance and did not have any concerns requiring Board level escalation.

Monthly staff feedback from Safety Champions and walk-rounds

There were no safety escalations or concerns raised from neonatal or maternity staff attending the May meeting. General discussion regarding the improved staffing and functioning of the Birth Centre.

Maternity Unit Diverts

There was 1 partial unit divert in May recorded on the closure log.

4 women were diverted to neighbouring organisations over a 12 ½ hour period. The divert was required due to increased acuity versus staffing and the number of beds available.

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
APRIL	0	0	0	0
MAY	0	1	0	4
Total	0	6	7	10

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Maternity Dashboard

The new Digital Midwife commenced in post in May and is settling into the service. She has significant experience as a digital midwife in another organisation, which is a huge benefit, but has not worked with Cerner prior to this post and is navigating a new system.

Appendix 2 is a copy of the updated maternity dashboard. The data set for May is not complete with some domains requiring validation.

- There is a slightly improved position for 1:1 care in labour which reflects the improved staffing position. The Birth Rate Plus acuity app is due to be rolled out in June and it is hoped that this will further support the delivery of 1:1 care.

Training Compliance

Current training records shows **37 of 47 training compliances are within agreed target**, 3 areas of training where compliance is between 75-85% and 7 with compliance below 75%

- 6 competencies below 75%
- 1 of the competencies Blood Transfusion theory (2 Year) was previously included on Maternity Workshop but discontinued in 2022 as only required every two years, this is why compliance dropped. The session is now 3 hours so too long to include on Mat Day 1. Line managers book their own staff.
- 3 of the competencies relate to Blood Transfusion practical assessments. Due 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. Compliance has increased marginally this month.
  - Organising Receipt of Blood
  - Preparing to Administer/Administering Blood.
  - Collecting Blood.
- 1 of the competencies Safeguarding Adults Level 3 applies to band 8 and above only. 2 staff members have just become out of date and are aware.
- 1 of the competencies The Oliver McGowan mandatory training for staff was only added in Feb 2024 and compliance has increased each month.

4 Competencies between 75-85%

- 1 of the competencies Dangers of Misplaced Naso Gastric tube applies to obstetrics- all non- compliant doctors have been notified and asked to complete. There are only 3 outstanding and they have been emailed repeatedly. Consultant lead informed as this has not changed over the year.

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- 1 of the competencies 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 82.01% and has moved from Red to Amber.
- 1 of the competencies Safe Administration and Preparation of Injectables (General) applies to obstetrics. There were 3 non-compliant staff but recruitment of an additional consultant means there are now 4 who need to complete so compliance has dropped under 85%.
- 1 of the competencies 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. We are still waiting for confirmation of additional places.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 3 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 next main MNVP meeting is in June.
There have been several conversations between the MNVP leads and the Director of Midwifery during May, in relation to ongoing capacity challenges and escalation of concerns as already described. There has been agreement regarding how we communicate and work together more cohesively in the future, with the aim of fully integrating and embedding the MNVP Leads within the governance structure.

Planning is in progress for a Maternity Service Open Day on 15 June.

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.

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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, May 2024.
- Academy is informed of the unannounced CQC inspection of maternity and neonatal services in May and to note the high-level feedback.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 1.
- Academy is asked to note that there were 0 cases of HIE reported in May.
- There were 3 neonatal deaths in May.
- There were 0 maternal deaths in May.
- There are 5 ongoing maternity SIs/Level 1 investigations, 2 Maternity and Neonatal Safety Investigations (MNSI) and 3 Trust level, plus 1 MNSI investigation referred by Leeds regarding a Bradford woman.
- Academy is asked to note that there are no new neonatal SIs or ongoing neonatal SIs.
- There are 3 completed MNSI/Internal Serious Incident reports to share with QPSA/ Closed Board for May.
- QPSA and Closed Board are informed that there were 4 points within the completed MNSI report which the service did not agree with. This will be discussed with the family.
- Quality and Patient Safety Academy is asked to note that there were 0 MNSI reportable cases and 0 reportable Serious Incidents (SI) declared in May.
- Academy to note that there was 1 occasion in May where the unit was assessed as needing to divert women to other organisations.

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7 Appendices

- Appendix 1 - 1a, 1b and 1c - Maternity and Neonatal Harms May 2024 and completed internal investigation report
- Appendix 2 - Maternity Dashboard
- Appendix 3 - Mandatary Training Report May 2024
- Appendix 4 - Perinatal Quality Surveillance Model minimum data set for Trust Boards

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.6 (Appendix 5)

MATERNITY AND NEONATAL SERVICES - LISTENING TO WOMEN AND FAMILIES' RESPONSE JUNE 2024

Presented by	Carly Stott, Head of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To update and brief Executive Team Meeting and Trust Board following the publication of the All-Party Parliamentary Group (APPG) report on Birth Trauma	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For information	
Previously discussed at/informed by	Details of any consultation	
Previously approved at:	e.g. Academy / ETM / CSU group	**Date**
	Executive Team	10.06.24
Key Options, Issues and Risks		

The APPG report on the United Kingdom Parliament national enquiry on Birth Trauma, was published at in May 2024 (Appendix 1).

This was followed up with a letter from Ruth May, Stephen Powis and Emily Lawrence on 17 May 2024 (Appendix 2), urging all Boards, and those that work in maternity and neonatal services to read the report and how its themes and recommendations inform existing local plans to implement the three-year delivery plan for maternity and neonatal services.

Analysis

The report has been read by key members of the Maternity Senior Leadership Team, noting key themes and trends which remain consistent with the findings of other high profile, national maternity reports and align with the existing recommendations of the Three-Year Delivery Plan for Maternity and Neonatal Services, and the Priorities and Operational Planning Guidance 2024/25. There is a continued focus on reducing inequalities in maternity care, particularly amongst Black and Asian women, which is a long-standing key priority for the service.

The report has 28 recommendations, many of which sit outside of Trust's to implement and provide. The service plans to undertake a benchmarking exercise against the APPG report recommendations. However, one recommendation immediately stands out as a delivery risk potentially requiring Executive support:

- Maternity units to implement NHS England's (NHSE) Perinatal Pelvic Health service specification, which includes providing information for women in antenatal period, such as the importance of pelvic floor exercises; increased education for health professionals including

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GPs; and early access to care for symptoms of incontinence. Women with perineal injuries to be seen by specialists in pelvic health clinics.

The Trust does not currently meet the specification, primarily due to a lack specialist physiotherapists. To address this, Women's CSU will need to meet with senior leads for Musculoskeletal services to explore solutions with escalation to Executive colleagues as required. A joint risk assessment regarding this issue is currently in progress.

The accompanying letter also referred to an increased funding allocation for ICBs to appropriately resource and fund Maternity and Neonatal Voices Partnerships (MNVP).

The current MNVP funding allocation for Airedale and Bradford does not meet what is required to meet the national guidance. This is actively being addressed with the West Yorkshire Association of Acute Trusts (WYAAT) Chief Nurse.

Recommendation

- Service to benchmark against the 28 APPG report recommendations.
- Service to continue provide Quality and Patient Safety Academy (QPSA) and Trust Board with a quarterly update on progress with the Three-Year Delivery Plan for Maternity and Neonatal Services.
- Trust Board to continue to have regular, robust oversight of maternity and neonatal services in line with the perinatal quality surveillance model. This will continue to be achieved via the monthly update paper presented to QPSA and Bi-monthly assurance paper to Board.
- Women's CSU to meet with MSK to review the Perinatal Pelvic Health service specification and escalate any gaps/risks to executive colleagues.
- Joint risk assessment regarding the delivery of Perinatal Pelvic Health services at BTHFT to be completed.

Appendices

- Appendix 1- 'Listen to Mums: Ending the Postcode Lottery on Perinatal Care' A report by The All-Party Parliamentary Group on Birth Trauma.
- Appendix 2 – NHS England Letter PRN01359.

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	

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

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

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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)			
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Listen to Mums:

Ending the Postcode Lottery on Perinatal Care

A report by The All-Party Parliamentary Group on Birth Trauma

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About

About the Birth Trauma Inquiry

On 9 January 2024, the All-Party Parliamentary Group (APPG) on Birth Trauma established the first national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma. Seven oral evidence sessions took place on consecutive Mondays between 5 February and 18 March 2024 in the House of Commons.

The Inquiry was also informed by written submissions which were received following a public call-for-evidence.

About the Author

The report was written by Dr Kim Thomas, Secretariat of the APPG on Birth Trauma and CEO of the Birth Trauma Association. She has also published two books about birth trauma: "Birth Trauma: A Guide for You, Your Friends and Family to Coping with Post-Traumatic Stress Disorder Following Birth", and "Postnatal PTSD: a Guide for Health Professionals".

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The APPG on Birth Trauma would like to thank the following individuals without whom this Inquiry would not be possible:

Birth Trauma Inquiry Special Advisory Group: Gill Castle, Rhiannon Evans, Chloe Oliver, Laura Seebohm, Kim Thomas and Nikki Wilson.

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Report production: Max Austin, Hannah Farrimond, James Fisk, Beth Holloway, Elliott Malik, Lily Leigh-Matthews and Avnish Popat

About the All-Party Parliamentary Group for Birth Trauma

Theo Clarke MP – Chair

Theo was elected as the MP for Stafford in 2019 and set up the APPG for Birth Trauma following the difficult birth of her daughter. She led the first debate on birth trauma in the House of Commons. The public response to her speech led her to launch this inquiry. Theo was previously a member of the Women and Equalities Select Committee in Parliament. She serves as one of the Prime Minister's Trade Envoys and as Parliamentary Private Secretary to the Department of Education. Theo chairs the sub-committee of the International Development Select Committee on the work of the Independent Commission for Aid Impact.

Rosie Duffield MP – co-Chair

Rosie was first elected as MP for Canterbury in 2017. She has served on the Environment, Food and Rural Affairs select committee since 2020 and was previously chair of the Women's Parliamentary Labour Party and a member of the Work and Pensions select committee. Rosie is a vocal advocate for women's rights, having spoken in the House of Commons about her own experience of domestic abuse, and representing her constituents affected by the deaths of mothers and babies at the East Kent University Hospitals NHS Trust.

Cherilyn Mackrory MP – Vice-Chair

Cherilyn has represented Truro & Falmouth since 2019. Before her election She was a Cornwall Councillor. Before moving to Cornwall, Cherilyn worked as an IT project manager.

Cherilyn is Co-Chair of the APPG on Baby Loss where she fights for better and safer maternity services and aims to develop policies that support families dealing with the grief and loss of a baby. She is Co-Chair of the Women's Health APPG**,** aiming to ensure women are listened to and make informed choices. She is married to Nick, and they have a young daughter.

Bell Ribieiro-Addy MP – Vice-Chair

Bell has represented her home constituency of Streatham in South London as a Labour MP since the 2019 General Election. Bell is a dedicated feminist, anti-racist and trade unionist, who has campaigned extensively on the issue of Black maternal health currently sits on the Women & Equalities Committee and Joint Human Rights Committees in Parliament. She also chairs the All Party-Parliamentary Groups for Black Maternal Health, Afrikan Reparations, and Endometriosis.

Mark Pawsey MP

Mark has represented Rugby since 2010. Before entering politics, Mark obtained a degree in Estate Management from the University of Reading, before moving into business and becoming a local Councillor.
Mark has been a member of Select Committees and acted as a Parliamentary Private Secretary to the Departments of Defence, BEIS, and Work and Pensions. He chairs the All-Party Groups for Packaging and Manufacturing. Mark is married to Tracy, and they live in the village of Grandborough, close to Rugby.

Darren Henry MP

Darren has represented Broxtowe since 2019. Before entering politics Darren spent 26 years in the Royal Air Force. Darren has been Trade Envoy to the Caribbean, as well as an Assistant Government Whip. He began campaigning to ensure that parents who lose their partner in childbirth have an automatic right to leave in 2022 following a surgery with a constituent who found himself unable to do so. Following his work, this Bill is now set to become law this year. Darren is a father to twins, who themselves had difficult births so is passionate in helping others through this report.

Helen Morgan MP

Helen has represented North Shropshire for over two years during which she has campaigned continuously for improved maternity services. Unfortunately, in Shropshire, preventing avoidable baby loss is an extremely poignant cause for many people so shortly after being elected, Helen became a Co-Chair of the APPG for Baby Loss. By holding debates and events, Helen has worked to be a voice for bereaved parents and urge the Government to act on staffing issues in UK maternity services.

Sally-Ann Hart MP

Sally-Ann has represented Hastings and Rye since 2019. Before entering Parliament, she went to university in London and qualified as a lawyer specialising in corporate finance law with a City of London law firm. After taking a career break to bring up her children, Sally-Ann later became a local Magistrate in Hastings and a District Councillor at Rother. Sally-Ann has a drive to support rough sleepers and the homeless, as well as vulnerable children, young adults and families.

FOREWORD

For any parent, having a child will be one of the most momentous and memorable occasions of their life. When something unexpected happens during a pregnancy or birth it can lead to lifelong physical and psychological consequences that often remain unknown and unspoken about.

This Birth Trauma Inquiry is, in its simplest form, an attempt to break this taboo and share the stories and experiences of mothers and fathers publicly and start a public discussion on the realities of giving birth and how we can practically improve maternity services.

Our key conclusion has been on the need to introduce a base standard in maternity services across the United Kingdom. **Currently there are several strategy documents relating to maternity but no single overarching document. We believe that maternity strategy should be brought into a single, living document, hosted on the UK government website and continuously brought up-to-date.**

To this end, the All-Party Parliamentary Group on Birth Trauma calls on the UK Government to publish a National Maternity Improvement Strategy, led by a new Maternity Commissioner who will report to the Prime Minister, which will outline ways to:

1. Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services and provide mandatory training on trauma-informed care.
2. Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery.
3. Offer a separate 6-week check post-delivery with a GP for all mothers which includes separate questions for the mother's physical and mental health to the baby.
4. Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.
5. Oversee the national rollout of standardised post birth services, such as Birth Reflections, to give all mothers a safe space to speak about their experiences in childbirth.
6. Ensure better education for women on birth choices. All NHS Trusts should offer antenatal classes. Risks should be discussed during both antenatal classes and at the 34-week antenatal check with a midwife to ensure informed consent.
7. Respect mothers' choices about giving birth and access to pain relief and keep mothers together with their baby as much as possible.

8. Provide support for fathers and ensure nominated birth partner is continuously informed and updated during labour and post-delivery.
9. Provide better continuity of care and digitise mother's health records to improve communication between primary and secondary health care pathways. This should include the integration of different IT systems to ensure notes are always shared.
10. Extend the time limit for medical negligence litigation relating to childbirth from three years to five years.
11. Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women. To address this NHS England should provide funding to each NHS Trust to maintain a pool of appropriately trained interpreters with expertise in maternity and to train NHS staff to work with interpreters.
12. NIHR to commission research on the economic impact of birth trauma and injuries, including factors such as women delaying returning to work.

Over the past three months, we have been privileged to hear from parents from across the United Kingdom. They have trusted us with some of their most personal reflections and thoughts, often relating to deeply troubling memories and experiences. This, the first Parliamentary Inquiry into Birth Trauma, is as much their report as it is ours.

Our special thanks also go to all those who have supported the Inquiry and most especially to Kim Thomas who has authored this report. The issues and stories contained in the following pages may be difficult to read but underline that this issue transcends party lines and it will be up to whoever forms successive Governments to listen and act.

Theo Clarke MP
Chair
APPG on Birth Trauma

Rosie Duffield MP
Co-Chair
APPG on Birth Trauma

EXECUTIVE SUMMARY

The inquiry received more than 1,300 submissions from people who had experienced traumatic birth, as well as nearly 100 submissions from maternity professionals. It also held seven evidence sessions, in which it heard testimony from both parents and experts, including maternity professionals and academics.

The stories told by parents were harrowing. They included accounts of stillbirth, premature birth, babies born with cerebral palsy caused by oxygen deprivation, and life-changing injuries to women as the result of severe tearing. In many of these cases, the trauma was caused by mistakes and failures made before and during labour. Frequently, these errors were covered up by hospitals who frustrated parents' efforts to find answers.

There were also many stories of care that lacked compassion, including women not being listened to when they felt something was wrong, being mocked or shouted at and being denied basic needs such as pain relief. Women frequently felt they were subjected to interventions they had not consented to, and many felt they had not been given enough information to make decisions during birth. The poor quality of postnatal care was an almost-universal theme. Women shared stories of being left in blood-stained sheets, or of ringing the bell for help but no one coming.

The inquiry also heard, both from the submissions and the evidence sessions, accounts of the short-term and long-term impact of birth trauma. This included difficulties in bonding with the baby, stress on the relationship with their partner and wider family and, often, an inability to return to work.

Some of the most devastating accounts came from women who had experienced birth injuries, causing a lifetime of pain and bowel incontinence. Many of these women said they could no longer work, and described their injuries as having destroyed their sense of self-worth. Other women wrote movingly of having to provide round-the-clock care for children left severely disabled as a result of birth injuries.

Women from marginalised groups, particularly those from minoritised ethnic groups, appeared to experience particularly poor care, with some reporting direct and indirect racism.

The inquiry also heard from partners who had been psychologically distressed after witnessing traumatic birth, but whose emotional needs were disregarded, both during the birth and postnatally.

Many women wrote of their difficulty in accessing maternal health services, either facing long waiting lists or being told they didn't meet the criteria for help. There were, however, some positive stories from women who had successfully accessed therapy and been helped to recover.

We also heard from maternity professionals who reported a maternity system in which overwork and understaffing was endemic. Some referred to a culture of bullying.

The picture to emerge was of a maternity system where poor care is all-too-frequently tolerated as normal, and women are treated as an inconvenience. We have made a set of recommendations that aim to address these problems and work towards a maternity system that is woman-centred and where poor care is the exception rather than the rule.

Introduction

Why an inquiry into birth trauma?

While many women in the UK have a positive experience of birth, resulting in a healthy baby, this is not always the case, and this inquiry has focused on the times when birth has been traumatic, leading to poor outcomes for the mother or baby. In the past 10 years, there have been three major investigations into failings in maternity care at specific NHS trusts: Morecambe Bay[1], Shrewsbury and Telford[2], and East Kent[3]. A fourth is underway at Nottingham University Hospitals. These reports all led to recommendations to improve maternity care, but a current programme of inspections by the Care Quality Commission (CQC) has resulted in nearly half of maternity units in England being rated as either "inadequate" or "requires improvement".[4] Current policy on improving maternity care is fragmented. Although there are several national policy documents that address the need to improve maternity care, the inquiry heard that there is no single overarching strategy document.

Donna Ockenden, who is chairing the inquiry into maternity care failings in Nottingham, told the inquiry: "Leaders across maternity services report continuous requests for information from multiple bodies responsible for 'oversight' of maternity care in the UK. Frequently the requests are duplicated or only very slightly different showing that there is ineffective coordination between these multiple bodies. This is not efficient and wastes time. The system of maternity service oversight must be streamlined & this made more effective."

Research evidence shows that 4-5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth[5], amounting to approximately 30,000 women in the UK, while about a third of women experience birth as traumatic.[6]

It is clear that this could have significant social and economic consequences, including: the cost to the NHS of treating PTSD and birth injuries; the cost to the NHS of litigation; of the effect on women's relationship with their baby and partner; and the effect on women's ability to return to the workplace. Yet the data on the impact of birth trauma is sparse. We welcome the UK government's decision to include birth trauma in the Women's Health Strategy, an important step in recognising the importance of birth trauma and making it possible to take steps to address it.[7]

Inspired in part by a parliamentary inquiry into birth trauma in New South Wales, Australia, launched in 2023, the aim of this inquiry was to look at the reasons why women experience birth trauma, how the condition affects them, the wider social impact and the steps we can take to prevent birth trauma.

The inquiry was guided by a Special Advisory Group (SAG) consisting of representatives from five organisations that campaign on issues relating to maternity (the Birth Trauma Association, MASIC, Make Birth Better, the Maternal Mental Health Alliance and Mumsnet), as well as birth campaigner Gill Castle.

How we gathered and analysed evidence

Our inquiry invited written submissions both from parents about their experience of traumatic birth and from maternity professionals. The call for evidence was published on Theo Clarke MP's website and advertised widely through social media. Witnesses were asked to provide their evidence as free-text submissions, up to 1,500 words in length.

The window for submissions ran from 9 January to 20 February 2024. We received 1,311 personal submissions from parents, and 92 from professional bodies, charities, campaign organisations and individuals working in maternity, such as midwives and obstetricians.

The inquiry also carried out seven oral evidence sessions, each with a different theme, which ran on consecutive Mondays from 5 February to 18 March. The inquiry heard from many NHS professionals as well as parents.

Apart from the second session, which heard from international experts and was held online, all the sessions were held in parliament in front of members of the all-party parliamentary group (APPG) of MPs, and were open to the public. The parliamentary sessions consisted of two 45-minute panels, with one panel consisting of expert witnesses, and the other of parents with lived experience of birth trauma. The final question for each panel was about the policy steps they'd like to see the UK government take to improve maternity care in the area discussed in the session. Their answers helped us shape our final recommendations.

Finally, Chair Theo Clarke MP held a separate online meeting with parents affected by failings in care at Nottingham. A short report on this meeting is included in Chapter 1.

Both the professional and personal written submissions were read by a team of volunteers linked to the organisations represented on the SAG.

The team reading the submissions kept a record on a spreadsheet of each account, including quotes and key details of the birth (such as the year it took place, whether it was a caesarean section, whether the baby was induced, whether the woman experienced tearing and so on).

We also used an open-source statistical package using R software to help us identify some of the word clusters and hence, key themes, to be found in the submissions. For example, the words "pain", "agony" "screaming" and "paracetamol", "epidural" and "finally" were often clustered together, leading us to stories where women were offered paracetamol for serious pain. Similarly, "husband," "Covid", "hospital" and "home" often appeared together, pointing to stories where partners were sent home from hospital during the pandemic. The words "forceps," "bladder", "stitches," "incontinence" and "surgery" also appeared together, telling their own story.

The oral evidence sessions were all transcribed, and, along with the written submissions, informed the findings of this report.

The structure of this report

We begin with a section on the key themes to emerge from the written submissions from parents. The following seven chapters map on to the themes of the seven inquiry sessions:

1. Birth trauma: an overview
2. What we can learn from other countries
3. Birth injuries
4. Birth trauma and mental health services
5. The wider impact of birth trauma
6. Partners' perspectives
7. Marginalised groups

Each chapter draws on research evidence, as well as evidence from the personal written submissions, the professional written submissions and the oral evidence. We conclude the main body of the report with a Vision chapter, which describes what we think a good maternity care system would look like. Appendix 1 lists recommendations for improvement in maternity care. These were drawn up by SAG members and are largely based on the recommendations made by witnesses in the oral sessions in answer to the question about policy changes.

Note on quotations

Unless otherwise stated, the quotations in this report come from the written evidence, and, except for one standalone case study in Chapter 5, who gave permission to be named, they have been kept anonymous. Names are used for quotations from the oral evidence sessions.

Thanks

We are immensely grateful to everyone who wrote in, particularly those who shared personal stories, many of which shared intensely distressing experiences. Every single story was read, and, although we were unable to acknowledge each one individually, they all provided valuable insights that have gone to inform the findings in this report.

KEY THEMES

Although the majority of personal submissions related to medical emergencies, the emergency itself typically only formed part of the trauma. Many spoke of feeling fearful that they or their baby would die: the word "terrified" appears in 266 submissions. Words like "shame," "humiliation" and "embarrassment" also come up repeatedly, while the word "broken" appears in 328 submissions. The overwhelming narrative was one of distress at being neglected, ignored or belittled at a time when women were at their most vulnerable.

Below are some of the most common themes to emerge.

Failure to listen

A failure to listen to women when they said that something was wrong was a feature of many, if not most, of the written submissions. Often, they were told they were being over-anxious. One woman who was in extreme pain for the last few weeks of her pregnancy, had "anxious mother" recorded on her notes. In fact, she was bleeding internally as the result of spontaneous hemoperitoneum, a rare and often fatal complication of pregnancy whereby tissue had torn behind her uterus.

Another woman wrote of how she kept calling the hospital for a scan:

"My bump height had dropped 8 days before and my midwife had sent for a growth scan, but nobody contacted me to tell me the scan had been refused. I called up chasing it 44 times on one day, but was just told there was a note saying 'scan refused, bring induction forwards', which nobody did. My midwife kept reassuring me it was her head in my pelvis, so I didn't know whether to be worried or not so I pushed for the scan to see if there was something wrong."

Had she been given a scan, as recommended in National Institute for Health and Care Excellence (NICE) guidelines, it would have identified that her baby was experiencing growth restriction and appropriate action taken. Her baby died during labour.

This failure to listen continued postnatally. One woman who experienced "horrendous urinary and faecal incontinence" was told by a consultant that there was nothing physically wrong with her, and that the symptoms were a result of her poor mental health. Another described reporting her concerns about her baby:

"I was concerned that my baby was looking 'yellow' and asked the midwife. She told me I was being overly anxious and he was fine. She wrote in my notes that I was an overly anxious mother and my baby was NOT jaundiced. My husband intervened and a doctor confirmed my baby was jaundiced and he was treated. The next day the page written by the midwife had been torn out."

One woman described how her severe physical symptoms, including fatigue and tremors, were wrongly diagnosed as psychological in origin, leading her to receive eight sessions of electroconvulsive therapy. After several years, she was diagnosed as having a rare thyroid condition.

Lack of informed consent

The problems with consent start antenatally. Although the case of Montgomery v Lanarkshire[8] established that patients should be informed about risks, this is often not happening in practice.

Many women told us that they were not informed that they had raised risks of particular complications, such as tearing, which would have enabled them to make more appropriate decisions. One woman was told she had a bicornuate uterus, but was not told that this put her at risk of premature birth. She went into labour at 28 weeks, and her baby died shortly after birth. Another wrote:

"Nobody informed me of the tear or in fact any risks associated with episiotomies and forceps deliveries, and when it became clear to me, due to daily incontinence, that extended well beyond 6 weeks postpartum that I had suffered some major injuries, it took constant emails to the midwives and my GP before anyone would refer me to gynaecology where they eventually, after months and months on a waiting list, diagnosed the tear, multiple organ prolapse, cysts caused by infected stitches, and nerve damage."

During labour itself, numerous women told us that they had procedures such as vaginal examinations or cervical sweeps performed without consent. This caused a lot of understandable distress. One wrote:

"Whilst contracting and alone a doctor came to examine me. She did a vaginal examination and without consent broke the rest of my waters."

There was also a clear problem with consent when interventions such as forceps or caesarean sections were being carried out. Many women said that, at the point when they were required to

sign a consent form, they were in no position to give informed consent, either because of the urgency of the situation, or because they were too ill:

"Feeling slightly delirious and with tears streaming down my face I kept asking [my partner] where the doctor was. I became more hysterical by the minute and felt nauseous and disoriented from all the gas and air. Finally the doctor arrived to tell me that a theatre was being prepared and to talk me through the consent form. I had absolutely no interest in going through anything, and I could barely talk properly anyway. I took the gas and air attachment out of my mouth, nodded my consent then scribbled my signature on the form and stuck the mouthpiece straight back in again. I closed my swollen, tear-stained eyes and just wished for the whole experience to be over."

A number of women also reported having their request for caesarean section denied, either before labour or during labour. One wrote:

"I had stated I felt my little boy was stuck and that I was not going to be able to get him out myself. I was only getting pain on my right side which was so intense. I had to wait for what felt like forever for an epidural and begged them for a c-section as I just knew something wasn't right. She laughed at me and told me it doesn't work like that."

Poor communication

Many women described not being told what was happening during labour, with some only finding out that they had a particular condition when they read their medical notes or had a birth debrief months later.

In other cases, there were unfortunate communication mix-ups. Heather Simmons, giving oral evidence in session 5, told the inquiry that, after an intensely traumatic birth, in which her baby was taken to the neonatal intensive care unit (NICU) and she herself was barely able to walk, she was told by the midwife that her blood results showed she had been taking drink and drugs in her pregnancy. As a result, her daughter was given an HIV test, without Heather's consent. In fact, the midwife had been reading from someone else's notes.

One woman described in a written submission how her daughter was born poorly. Although she was well cared for, the neonatal team did not give clear information about her prognosis:

"They were saying her condition could cause anything from mild dyslexia to severe cerebral palsy, and in the same conversation they were talking about end-of-life care. How is a discussion about mild dyslexia compatible with deciding on end-of-life care?"

Her daughter was transferred to a specialist unit at a different hospital, where she received good care until she died when she was five days old. The first hospital, however, had informed the health visitor team of the birth, but not the circumstances, so the day before she died, the mother received a call: "Congratulations on your baby! When can I come and see you?"

At her daughter's inquest, the hospital repeatedly called their daughter by the wrong name.

Lack of pain relief

A high proportion of the submissions referred to a lack of pain relief, with women left to labour in agony. In many cases, women in acute pain were offered paracetamol. One woman who turned down paracetamol because she thought it was insufficient says the midwife responded by throwing the paracetamol in the sink:

"I was literally left lying on the ground in pain wanting to die as the pain was so intense and unbearable. Although I was not dilated enough to push, I was having intense contractions every 2 minutes and the pain was excruciating and exhausting. My partner kept asking for help but was dismissed."

During her 36-hour labour, she was also denied an epidural because her platelets were too low. She remembers being violently sick, and jolting from the pain of having her waters broken. She sustained a third-degree tear:

"Without an epidural the pain was intense, but the midwife nonetheless chastised me for flinching in pain when he had a go at stitching me up when in fact surgery was necessary."

Lack of kindness

The overwhelming majority of written submissions referred to a lack of kindness or compassion on the part of the health professionals looking after them:

"My husband was sent home. It was after visiting hours. I was moved to the ward. I could not stand or walk. I had a catheter. I was covered in blood and my own faeces but there was no one to help

me wash. A plastic sheet was put on the bed and I lay on it in my filth. Around midnight I was woken up by a woman (I don't know who she was? A nurse? A midwife?) who reprimanded me for not feeding my baby. He was asleep. I didn't know what to do and I couldn't pick him up. I tried to get out of the bed but when she saw I was covered in blood and shit and hooked up to a catheter, she told me to get back in and said she'd hand him to me. I didn't know how to breastfeed. She told me if I didn't get it, she would take my son and give him a bottle. I felt like I was failing at mothering and I'd only been a mother for a few hours."

This lack of kindness was apparent even in cases where the baby died. Giving oral evidence in session 4, Emily Barley told the inquiry that staff ignored red flags during her labour, including meconium-stained waters. After her baby was found to have died, Emily pleaded for a caesarean, but the consultant obstetrician refused, and then walked out, without explanation, followed by all the other midwives and obstetricians who had been in the room:

"I was around eight centimetres dilated. The baby was imminent. But I was left without care for over half an hour. Just my mum. I remember asking 'Where has everyone gone? Where are they?'"

A few written submissions mentioned how much women valued kindness from health professionals when it was displayed, with one writing: "The kindness of midwives/nurses where it exists stands out for its rarity – and there were, both times for me, some truly wonderful staff."

Breastfeeding problems

A large number of women referred to problems with breastfeeding as major contributory factors in their trauma. There were stories about being forced to attempt breastfeeding when it was impossible (for example because they had a severe postpartum haemorrhage), or being made to feel like a failure for not being able to breastfeed.

Frequently, women were pressured to breastfeed, but not given help to do so:

"As my baby lay crying, waiting for a feed that I had no idea how to give, covered in my own blood, without even a glass of water by the bed, I have never felt so alone. I had no idea how to breastfeed – ringing the bell brought no one during the night, and attempts to ask midwives during the day were brushed off."

"When the midwife returned I said I wanted to breastfeed my baby, she just lifted my top and flipped my breast up and said 'You've got no milk in there'. I was completely blindsided and humiliated, I couldn't process what was happening to me."

Postnatal care

Poor postnatal care was mentioned in nearly all the personal submissions. On the postnatal ward, women described being left alone, often unable to move after an emergency caesarean or difficult forceps birth, but with no one to help them go to the toilet or lift their baby. Many wrote of ringing the bell to call for help and having no one come:

"About 6 hours after [my son] was born, I experienced a heavy bleed. I could see my white hospital bedsheets going red and I thought I was haemorrhaging again. I pressed my bell, nobody came. I pressed it again harder and nobody came. Another mum opposite me saw the sheets going red and my distress and went to get somebody. In that moment, I believed I was dying and my baby was going to be there in the hospital alone, with his mother dying next to him and nobody there who loved him or even knew his name. I was terrified."

Several had stories of being left to lie in their own blood, urine or excrement, or even berated by midwives for having soiled themselves. One woman said that after an emergency caesarean she developed sepsis and was put on an antibiotic drip, restricting her mobility. Her husband was sent home. Her baby, having been taken away and given antibiotics for suspected meningitis, was brought back:

"I was not only expected to try and calm her but also change her as she had been sick and was soiled on arrival. Staff pushed her in to the end of the bed, told me to clean the baby up because she'd been sick and was soiled and walked off. I could hear the staff all outside the bay sat at the nurses' station laughing and planning on ordering a Chinese takeaway before they closed."

The poor care typically continued once women had gone home. In some cases, women reported having birth injuries that went undiagnosed. Mental health symptoms as the result of a traumatic birth were ignored or treated dismissively. The six-to-eight week GP check, if it happened at all, was often cursory, and frequently focused on the baby rather than on the physical or mental health of the mother.

Giving evidence to the enquiry, Professor Angie Doshani, a consultant gynaecologist and obstetrician, quoted an American obstetrician, Alison Stuebe on the lack of postnatal care: "The baby is the candy, the mum is the wrapper, and once the baby is out of the wrapper, we cast it aside." This felt particularly pertinent in the stories we read.

The impact of Covid

Surveys of women in England after they had given birth showed a sharp increase in the proportion experiencing postnatal post-traumatic stress (PTS) in 2020.[9] The most plausible explanation is that restrictions during pregnancy and birth (for example, partners not being allowed to attend throughout the labour or remain on the postnatal ward, and the absence of mental health support or networks postnatally) raised the likelihood of women becoming traumatised by birth.

We had numerous submissions from women who gave birth in 2020 and 2021. They typically spoke of feelings of isolation and fear when their partners were not allowed to be with them during the early stages of labour, or sent away after the birth. One woman experienced a postpartum haemorrhage on the postnatal ward after her husband had been sent home, and was given a manual clot removal. "It was the scariest and most painful experience of my life," she wrote. "My daughter lay nearby, but I couldn't reach her. I felt like a failure... My husband was contacted, and he came back, but I'd already experienced my trauma alone."

Another woman who gave birth during lockdown, found herself left alone after a traumatic birth:

"I cried. I cried and cried. I couldn't walk, I had no strength to hold my baby, I had no breast milk yet, I had no help, no aid, no support. This was the most vulnerable state I'd ever been in. The magic and joy of having your first child, experiencing the hardship yet pride of childbirth had been brutally removed."

The midwife told her to "stop being a baby" and that it was "time to grow up."

She added: "I felt bullied, humiliated and dirty. As I was wheeled away, covered in dried blood stains, oily hair, dirty skin, smelly sweaty clothes, pants still covered in my birth water. I felt disgusted and embarrassed."

For some, the pandemic reawakened memories of earlier trauma. A woman whose traumatic birth happened in 1990 has been left with long-term anxiety, flashbacks and intense needle phobia. She

wrote that the pandemic "was unbearable, it was like living in my own hellish mind. Who would have thought that the whole world would become reliant on the NHS, and a needle delivering a vaccine? The continuous news stories, images, publicity campaigns and conversations tormented me to the point of a breakdown. I had multiple triggers every single day. I had to have 6 months off work." She now despairs of ever overcoming her trauma:

"My life is like a never-ending horror show, with triggers every day. It is often unbearable. I took an overdose in December 2023 out of pure desperation, and I was disappointed that I survived it."

Complaints and medical negligence

Many written submissions described how the experience of birth trauma was made worse by a failure of hospitals to deal sensitively with complaints about poor care. A common theme was that complaints were often treated dismissively, with failings in care unacknowledged. Birth notes were often falsified or lost.

One woman gave birth to a stillborn baby. At 36 weeks she reported that her baby's movements had slowed, and she says she was told that this was "normal for this stage in pregnancy". Her notes incorrectly stated that she had said the baby's movements were normal. In labour, she was denied a caesarean section and administered a morphine injection that she did not consent to. Later she agreed to a post-mortem for her daughter "with the expectation and assurance that my placenta would also be analysed." The placenta, however, was "lost due to midwife admin errors resulting in no details as to why my daughter died."

Some women struggled to take legal action because, by the time they felt well enough to go to law, they had passed the three-year time limit. In other cases, hospitals challenged the woman's version of events. One husband wrote:

"The hospital basically discounted her account, and seemingly tried to find flaws, even saying that someone suffering with PTSD could not have mentally written the complaint. The eventual outcome was the hospital admitted failures and settled out of court, after stringing her along for over a year, I believe in the hope she would give up."

It is clear that the statutory duty of candour, introduced in the wake of the Francis report, is not being applied effectively. The government's decision, announced in December 2023, to review the statutory duty of candour may help to change this.

Chapter 1: Birth trauma: an overview

Drawing on research evidence, testimony from the first oral evidence session and written testimony from parents and maternity professionals, this chapter offers an overview of the causes and effects of birth trauma, and highlights the key themes to emerge from the inquiry. It also has a section looking specifically at stillbirth and neonatal death, because these were a feature of many of the personal submissions. It concludes with an account of concerns reported by parents affected by poor maternity care in Nottingham in a meeting with Theo Clarke MP. Later chapters will explore in more detail the wider consequences of birth trauma for the NHS and for the economy.

What is birth trauma?

Birth trauma can be defined as "a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short- and/or long-term negative impacts on a woman's health and well-being."[10] Some people also use the term to describe injuries the mother may have sustained during birth, such as third- or fourth-degree tears. Traumatic birth experiences are subjective – it is the woman's perceptions of threat that are most important. About 4-5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth, equivalent to approximately 30,000 women in the UK.[11]

Women with postnatal PTSD are also at greater risk of developing depression.

Symptoms and diagnosis

Birth trauma presents on a scale. At the most severe end, women may meet the clinical diagnosis of PTSD, a severe and debilitating mental illness. Even those who would not meet the diagnostic criteria, however, can struggle intensely with their symptoms.

To be diagnosed with PTSD, someone has to have been exposed to actual or threatened death, serious injury or sexual violence. Women who develop postnatal PTSD have almost all had an experience of childbirth where they believed that they or their baby were going to die. There are four symptom categories: intrusions; avoidance; changes in cognition and mood; and arousal and reactivity (such as becoming hypervigilant). A diagnosis of PTSD requires someone to experience all four symptoms for at least one month. [12]

Intrusion symptoms typically encompass flashbacks and nightmares, while arousal symptoms take the form of a feeling of intense anxiety or being on high alert. Avoidance means that an individual avoids

any reminder of the trauma, such as television programmes about birth or appointments with health professionals. Characteristic changes in cognition are feelings of guilt or low mood.

Causes of birth trauma

Research has identified particular risk factors for developing PTSD. Women who have preterm births, stillbirths, or severe complications are more likely to develop PTSD (16%-19%).[13] Other risk factors include a negative subjective birth experience, an assisted vaginal birth (forceps or Ventouse) or caesarean, and psychological dissociation. Support during birth is a protective factor.[14]

Certain factors not related to the birth also increase the likelihood of a woman developing PTSD. These include depression in pregnancy, fear of childbirth, poor health or complications in pregnancy, previous trauma (such as sexual assault), or previous therapy for pregnancy or birth-related problems.[15] Survivors of sexual abuse, for example, are 12 times more likely to experience birth as a traumatic event.[16]

People are twice as likely to develop PTSD after a traumatic event caused by another person (such as rape) than after an impersonal trauma such as a natural disaster.[17] Research into postnatal PTSD suggests that for most women, it is not simply the birth complications, but the combination of complications with poor care from health professionals, that leads to psychological distress.[18]
This was supported by the first-hand personal accounts we received in written submissions, as well as the evidence we heard in the oral inquiry sessions from both experts and women.

Am analysis of the personal submissions highlighted some of the most common features of women's birth experiences:

- 694 gave birth by caesarean section (in almost all cases, this was an emergency rather than planned)
- 378 women gave birth by forceps
- 247 had a baby who spent time in intensive care or special care
- 106 experienced a third-degree tear
- 41 experienced a fourth-degree tear

In most cases, then, there was an objectively traumatic element – a baby who was born poorly, for example, an emergency resulting in caesarean or forceps, or a physical injury. On their own,

however, these don't necessarily mean that a woman will develop postnatal PTSD. In practice, the vast majority of evidence, both in the written submissions and in the oral testimony, spoke of poor and sometimes negligent care as major contributory factors to the trauma, as we already saw in the Key Themes section.

In session 1, Rachael McGrath gave oral evidence about her twin pregnancy, which ended with her being rushed to hospital with an abrupted placenta, and believing that she was bleeding to death. Her babies were born by caesarean section under general anaesthetic and then taken to special care. Rachael went into renal failure and on day five postpartum experienced a complete dehiscence (disintegration) of her C- section scar. "Nobody treated the fact that my insides were now on the outside," she said. "They stuck a sanitary towel over my abdomen and left me there for 10 days until eventually…I became gravely ill again."

Rachael described being treated as "a birthing vessel" and "a slab of meat." She added: "It was so impersonal…I would have somebody holding a blood pressure cuff taking my blood pressure and on their phone giggling and texting with the other hand. I was in for such a long time and some of the staff would come and get in my room and talk about other patients unkindly and talk about other staff members unkindly."

Many of the personal submissions talked about feeling unprepared for childbirth, with many women unaware of the possible adverse outcomes, such as third- or fourth-degree tearing. Dr Ranee Thakar, president of the Royal College of Obstetricians and Gynaecologists, told session 1 of the inquiry that women commonly asked her why they hadn't been told that perineal tearing was a possibility: "We often don't talk to them because we think that women will be frightened and they will want to have a caesarean section if we tell them about birth trauma, but research that we have done has actually shown us that women want to know, they want to know the details and they will be the people who will make the decisions."

How birth trauma and PTSD affect women

At a time when a woman is already dealing with the difficulties and stress of looking after a newborn, PTSD is debilitating. Women may avoid mother-and-baby groups because they fear being triggered and experiencing flashbacks. They may be so fearful of the baby coming to harm that they refuse to leave the house or let anyone else hold the baby. Rachael told the inquiry how postnatal PTSD made her terrified her babies were going to die: "If I don't check that the babies are still breathing, they will stop. If I go and get a shower, the babies will be dead by the time I get out. If I go downstairs the

dog is downstairs, the dog is dirty, the babies will catch a bug." Her marriage nearly broke up, and because she couldn't go back to work, for a while faced financial ruin. Eleven years on, she still experiences the mental and physical health consequences of what happened to her.

While the majority of the submissions we received described births that happened in the past 5-10 years, a minority of submissions came from women still affected by a traumatic birth that happened decades ago. These were profoundly moving. Women in their 60s and 70s wrote about how the memory of the birth was still vivid, and how the experience of writing it down had affected them emotionally. Some of these stories were heartbreaking accounts of baby loss, often compounded by a lack of care and compassion. One woman who gave birth in 1973, for example, wasn't allowed to see her stillborn baby, or told whether it was a boy or a girl. In other cases, it was the trauma of the birth itself that continued to affect them.

There were other women who had given birth in the past 10-25 years who were deeply affected, physically and psychologically, by their traumatic birth. In many cases, they continued to suffer depression or PTSD. Often their marriages had broken up, or they had chosen to have no more children, supporting the findings of a joint survey carried out by the APPG on birth trauma and Mumsnet in 2023. This survey, which received 1,042 responses, found that more than half of the mothers who replied said they were less likely to have more children because of their experience.[19]

Some women had had to give up work. Many spoke of having their self-confidence, and their sense of worth, destroyed. Others wrote of living with constant physical pain or incontinence as a result of damage sustained during the birth. One woman provided a list of injuries she had sustained as a result of birth, and which continued to affect her many years afterwards. These included a broken hip, broken pelvis, multiple internal injuries and infections, a twisted bowel, damage to the base of her spine and damage to her glutes. She can no longer carry out simple tasks such as standing to wash dishes.

Kate Lough, a pelvic health specialist physiotherapist, told the inquiry that she sees women in their 60s and 70s who have developed prolapse many years after their birth, but are able to vividly describe the events of their birth decades earlier: "They can still tell you exactly what went on, how they felt, the language that was used."

Some women described how the memory of the birth continued to affect them. One wrote:

"I've tried, but at times I'm transported back to that darkened room where I'm held down as someone cuts me open without my consent and then belittles me for daring to show that I was in excruciating pain. Fifteen, nearly sixteen years down the line, and that feeling of being dehumanised is still as fresh in my mind as the day it happened. Mothers are frequently described as heroes, but how much of our heroics are only necessary because our pain is dismissed?"

Stillbirth and neonatal death

Some of the most concerning stories in written submissions came in those (a sizeable minority) that recounted stories of babies who were stillborn or died shortly after birth. These stories were almost all characterised by two things: mistakes made during labour and a lack of compassion towards the mother. One wrote:

"The scenes in theatre can only be described as chaotic and these along with subsequent events have left me traumatised and suffering with PTSD. During the operation I could hear phrases such as 'where the bloody hell is the consultant', as well as other panicked comments."

There were several stories from women who experienced signs of labour in the second trimester but were told that they were mistaken. One woman carrying twins, who went into premature labour at 19 weeks, was initially disbelieved. After she lost the first baby, she wrote:

"I was told by one of the consultants to stop my crying, calm down and try to save the other baby. His words were: 'This baby was dead a long time anyway so you should stop stressing over it and let's try to save the other one.'"

The other baby also died, however, and 17 years later she is still "traumatised by this whole experience that has left me suicidal. I am unable to move on with a normal life, while still struggling with my mental health…I don't know if I will ever be myself again. Animals are treated better than the way we were treated in hospital."

In another case a woman who had a high-risk pregnancy started having period-type pains at 23 weeks. Initially the hospital told her they were "growing pains" and gave her paracetamol. A few days later, a midwife told her the pains were caused by thrush. Shortly afterwards, it became clear that she was in labour. She gave birth to a little boy who died 11 days later.

Other women mentioned being put on a ward with other women who were labouring. One woman, who gave birth three years ago, was advised to terminate her pregnancy because her baby had an

abnormality that meant she would likely die before birth. She describes having an injection to stop the baby's heart and then being admitted to the labour ward for an induction:

"I was ultimately there for 11 days trying to deliver my dead baby, listening to other women's labouring noises and baby's cries. They had a 'bereavement suite' which we were able to move into partway through but it was still on labour ward."

In some cases, the neglect continued after the birth. One woman, who gave birth to a stillborn baby at 23 weeks in 2023, described being told by her GP that she wasn't entitled to a six-week check because she didn't have a living baby.

Almost all the women who had lost a baby, whether recently or decades ago, said that it had permanently affected them psychologically, with many reporting feeling suicidal.

What does good care look like?

It is clear that some problems in maternity arise from under-staffing, resulting in overworked staff experiencing burnout. As Gill Walton, president of the Royal College of Midwives, told session 1 of the inquiry, having a "fully-staffed and highly-trained workforce that have time to work with women antenatally to provide the right care during labour and birth" is a prerequisite to preventing birth trauma.

Donna Ockenden, chair of the Independent Review of Maternity Services at Nottingham, told session 4 of the inquiry that there was a particular problem with retention, which was not easily solved by recruiting junior midwives: "If we are losing midwives with 20, 30, 35 years' experience, if they are leaving the NHS in their fifties, early sixties because they can't cope with the physicality of the role, and if they are then being replaced by a more junior workforce who are not being supported in those early days of their career…two going out doesn't equal two coming in."

Without addressing the issue of retention and recruitment, improving care will be challenging. Some women who wrote to the inquiry were able to provide examples of good care, however, despite the birth itself being traumatic. One contrasted the care she received at her local hospital with the care she later received at a tertiary care hospital. Initially, she was told by a consultant that one of her twin babies would likely die, thereby causing the death of the other. He recommended "selective feticide". She decided to keep the babies, and from that point had shared care between her local hospital and the tertiary hospital 160 miles away.

The care at her local hospital was poor (for example, she was kept waiting up to 12 hours for regular blood tests), but her babies were delivered "safely and calmly" at the tertiary hospital, at 27 weeks, 5 days of pregnancy. While the birth was traumatic, there was "a strong sense of solace and comfort that here…they clearly had done this many times before and they knew what to do. I felt as a patient, actively heard and firmly and safely 'caught.' The delivering consultant proudly telling me hours before the birth, 'This is the safest place in the world for your girls to be born today.' And I believed and trusted her. I remember her."

This sense of being heard, and being cared for, seems to be the key to good care, and the element that is missing from so many of the other stories we received. Having a premature baby is a traumatic and anxious experience, and she describes her twins' 150 days in NICU as "filled with major surgeries, ventilation and many blood transfusions." Two years on, she reflects that she is "one of the lucky ones", because her babies came home, but her maternity journey was a bumpy one, and she has not found an NHS service to provide her with the emotional support she needs. She adds: "We have to provide safety netting universally throughout the whole passage."

Nottingham families

After the formal inquiry sessions were over, Theo Clarke MP met with seven families affected by failings in maternity care at Nottingham University Hospitals Trust. Currently nearly 1,900 cases are being investigated by Donna Ockenden as part of her review into maternity services at the trust.

All the families shared stories in which medical neglect led to the deaths or injuries to their babies, or in one case, injury to the mother. The neglect was compounded by a cover-up on the part of the trust, who failed to acknowledge mistakes, falsified notes and lied to families about what had happened.

The stories were uniformly horrifying. Jack and Sarah Hawkins spoke of how Sarah had experienced contractions for six days but was refused admission to the maternity unit. Their baby Harriet was stillborn, because of staff's failure to perform basic checks. The hospital then falsely told the parents that Harriet had died from an infection. Because Harriet was stillborn, there was no inquest. "The reason she was a stillbirth was because I had such negligent care that she couldn't take a breath," Sarah said.

In another case, Natalie Needham's son Kouper died of respiratory problems one day after being born. Natalie told the meeting that a midwife had wrongly stated on Kouper's discharge papers that

she'd seen him have a four ounce bottle and that she was "happy and content that he was established feeding." Natalie and her husband were initially arrested on suspicion of murder, and not told for six months that they were in the clear. She was also mistakenly sent pictures of Kouper's postmortem in the post.

During an emergency caesarean, Felicity Benyon had her healthy bladder removed, and was wrongly told that the placenta percreta had enveloped the bladder, and that she would have lost it anyway. It was a urologist who blew the whistle and told her that the mistake had been covered up.

Sarah Sissons's son Ryan suffered brain damage at birth. Again, the hospital tried to avoid taking responsibility for his injuries, and at one point Sarah was accused of having Munchausen's by Proxy – in other words, of inventing his injuries.

Kimberley Errington's son Teddy died after the hospital failed to carry out monitoring for post-natal hypoglycaemia. Carly Wesson and Carl Evlington had a test that indicated their baby had a condition that meant she wouldn't survive much beyond birth and were advised to terminate the pregnancy. After they made a complaint about aspects of their treatment, the hospital carried out a further investigation and told them that tests showed there had been nothing wrong with their daughter. No one has been held accountable for the errors.

Sarah Andrews's daughter Wynter died after numerous mistakes were made during labour, including a failure to monitor the baby's heart rate.

The parents felt it was important that hospitals should be subject to greater accountability than they are at present. Jack Hawkins said: "Not a single person has been held to account in any way whatsoever by the regulatory bodies…All of these are manslaughter, failure of duty of care, failure of duty of candour. "

Chapter 2: What we can learn from other countries

Introduction

In session 2 of the inquiry, we heard evidence on birth trauma from experts based in Australia, Switzerland and the Netherlands.

Access to, and provision of, maternity care varies widely across the globe. Women in low and middle-income countries (LMICs) generally have poorer access to maternity care and higher levels of socio-economic disadvantage, leading to worse maternal and infant outcomes.[20] Information gathered during the UK-led INTERSECT study (www.intersectstudy.org), which publishes its first results later this year, is expected to highlight vast differences in access and type of maternity care across countries.

Most research on traumatic births and postnatal post-traumatic stress disorder (PTSD) has been conducted in high-income countries, such as the UK, Australia, USA and some European countries. Research on postnatal PTSD in LMICs is sparse but largely suggests a higher rate than that in developed countries (29% in Iran, for example[21]), though a study from Sri Lanka reported a rate of 3.6%.[22]

In Europe, collaborative work has resulted in a set of recommendations for reducing traumatic birth, including respecting women's rights before, during, and after childbirth; preventing maltreatment and obstetric violence; and integrating principles of trauma-informed care across maternity settings.[23]

Initial work on prevention by Professor Antje Horsch at the University of Lausanne found that, by engaging women who'd experienced a potentially traumatic birth in a visuo-spatial game, Tetris, it was possible to interrupt the laying down of traumatic memories and stop the development of PTSD.[24] This proof-of-principle study is now being followed by a double randomised controlled trial with 100 women, in which women are asked to come back to the hospital where they had a traumatic birth, having avoided it for up to several years afterwards. "If they play Tetris for 20 minutes as part of a procedure that we carry out with them, we are actually able to reduce the already established post-traumatic stress and symptoms," Professor Horsch told the inquiry in the oral evidence session.

Support for women with birth trauma is limited, however. A 2021 mapping exercise of 18 European countries, which looked at policies on prevention and support for traumatic birth, found that only

one, the Netherlands, had a national policy relating to screening, treatment and prevention of a traumatic birth. The exercise "highlighted a lack of national policy guidance on the prevention, care, and treatment of a traumatic birth experience."[25] In a small number of countries, the gap is filled by charities, notably the UK's Birth Trauma Association, founded in 2004, the Australasian Birth Trauma Association (ABTA) and New Zealand's Birth Trauma Aotearoa.

Australia

Australia's Birth Experience Study (BESt), a national survey of more than 8,500 women who had given birth in the previous five years, found that 11% responded "yes" or "maybe" to a question asking whether they had experienced obstetric violence, which refers to abusive behaviour or forced intervention on the part of a maternity professional. Many of these reported feeling violated, dehumanised or powerless.[26] Complaints from dozens of women about traumatic births experienced as a result of poor care at Wagga Wagga Base Hospital led to a decision by the New South Wales parliament to hold an inquiry into birth trauma. The inquiry, whose results have not yet been published, received more than 4,000 submissions and heard oral testimony from many deeply traumatised women.[27]

ABTA's submission to the New South Wales inquiry, based partly on its own survey of women with birth injuries, included stories in which physical injuries combined with poor care to cause psychological trauma. Women in severe pain as a result of injuries found it difficult to access medical treatment, with one saying: "I also presented to an emergency department on multiple occasions in extreme pain, being barely able to walk. The medical staff laughed at my extreme reaction of pain to a physical examination and dismissed me as a stupid woman who should see her GP."[28]

Amy Dawes, CEO of ABTA, told the UK inquiry that the Australian maternity care and training system are largely modelled on the UK and therefore have similar outcomes. One of the themes to come out of the New South Wales inquiry was a lack of informed consent. Ms Dawes said that women were not informed antenatally about the risks of instrumental birth. This includes obstetric tearing and ani levator avulsion, when the ani levator muscle separates from the pubic bone, creating a risk of urinary and bowel incontinence and pelvic organ prolapse. She said it was impossible to "provide informed consent if the first time you're hearing about an induction is in that moment, and you're not being given the facts and the risks and the potential outcomes of a cascade of intervention."

Ms Dawes said that birth injuries could have a major impact on women's ability to lead a normal life. They may be unable to engage in physical activity, for example, return to work, or enjoy a sexual relationship. Often women's self-esteem suffers, and women with these injuries have higher rates of suicidal ideation, Ms Dawes added. She highlighted her concerns about the normal birth policy, "which is really adopting that one size fits all approach to birth and not looking at individualized care and bringing it down to an individual's unique set of wants and needs."

ABTA, Ms Dawes told the inquiry, recommended a model of care "where we have midwives and doctors and pelvic health, physios and mental health clinicians working collaboratively to provide information that's relevant to their expertise so that women can be empowered with information and make the choices that best suit their individual wants and needs."

Emma Hurst, an MP in the New South Wales Parliament, who chairs the Australian inquiry into birth trauma, said that she had also heard stories from sexual assault survivors who had been given physical examinations during birth without consent being sought, retraumatising them: "It's made them feel as though they were sexually assaulted again, so we need to make sure that trauma-informed care goes across the entire healthcare system."

Some women who had experienced stillbirth gave accounts of being left in a birthing suite where they could hear other mothers giving birth. Others reported being denied pain relief, or of being subjected to inappropriate comments, such as being mocked for not knowing how to breastfeed their babies. Many said that they felt they were not listened to.

Like the UK, Australia has a high proportion of women giving birth whose first language isn't English, with 30-40% of birthing women having immigrated from another country. Ms Hurst said that while there were interpreters available, they weren't always expert in health care: "This adds more stress on the marginalised women that are entering hospitals to give birth as well."

Dr Hazel Keedle, senior lecturer and director of academic programmes for midwifery at the School of Nursing and Midwifery, Western Sydney University, added that the BESt study had found that First Nations communities had a birth trauma rate of 37%, higher than non-Indigenous women, whose rate was about 28%.[29] Among Indigenous groups, one in six said they had experienced obstetric violence, compared to one in 10 of non-indigenous women.

Dr Keedle said she would like to see the implementation of a continuity of care model, in which a woman is supported during birth by a midwife who knows her personal history and what her expectations are for the birth. Women would also be better able to provide informed consent, because they would have had conversations with their midwife during pregnancy.

Europe

Across Europe, there is variation in the incidence of birth injury, particularly obstetric anal sphincter injury (OASI), also known as a third- or fourth-degree tear. The association between OASI and postnatal PTSD is well-established,[30] so efforts to reduce OASI rates could also reduce the incidence of PTSD.

OASI is much more common with forceps births and, to a lesser extent, Ventouse (also known as vacuum) births. In England, approximately 7.5% of all births are by forceps, while 5.1% are by Ventouse.[31] Forceps can result in damage to a woman's pelvic floor, anus and perineum leading to urinary and bowel incontinence and pelvic organ prolapse, in which the uterus, for example, bulges out of the vagina.[32] In some cases, the prolapse occurs many years after the birth.[33]

In certain European countries, such as Sweden and Austria[34], the incidence of forceps use is much lower, and some countries have abandoned its use altogether.[35] These countries use Ventouse as the main instrument of delivery, leading to much lower rates of OASI. One plausible explanation for the differential use of forceps is that in the UK, the failure rate with Ventouse is high – about 25%, compared to a 2% failure rate for forceps.[36] If a Ventouse delivery fails, then the obstetrician is likely to move either to forceps or to a more risky emergency caesarean section (compared to one planned or performed earlier in labour). For this reason, anecdotally, many obstetricians prefer to avoid Ventouse in favour of forceps.

In contrast, the Netherlands has a 3% failure rate for Ventouse.[37] If we could identify why some countries have a lower failure rate for Ventouse, that could help improve Ventouse success rates in the UK, and reduce the use of forceps, thus lowering the number of women experiencing birth injuries and developing PTSD or birth trauma. Jan Willem de Leeuw, a Dutch obstetrician, told our inquiry that in the Netherlands, only 7% of births used instruments, and in the vast majority of cases, this was Ventouse rather than forceps. At the same time, caesarean rates are much lower than the UK – about 18% to the UK's 28%. Leeuw attributed the difference in rates of forceps use between the Netherlands and the UK to "tradition", adding: "I had discussions with colleagues from the UK

who denied my thesis that it is possible to perform modern obstetrics almost entirely without the use of forceps."

One woman's written submission to this inquiry contrasted her experience of giving birth in the UK with that of giving birth in Switzerland. After her baby was born she developed a prolapse, but the physiotherapist she sought help from did nothing other than to perform a "very rough" internal examination, announce she was "fine" and advise her to do some Kegel exercises. She noted that she had not been informed of the possibility of prolapse antenatally. In Switzerland, however, she was given help from a psychiatrist to help her process her first birth and a consultation with an anaesthetist to discuss pain relief options. In the waiting rooms there were leaflets about common postnatal difficulties such as prolapse, and after birth women are offered sessions to rehabilitate their pelvic floor. The new Perinatal Pelvic Health Initiative (PPH) is now making this available in England.

Chapter 3: Birth injuries

This chapter addresses the topic of perineal tearing, drawn on personal testimony from women in written submissions, and oral testimony from both experts and women with lived experience given in session 3. It goes on to look at work in Norway that shows how we could reduce the rates of birth injury.

During vaginal birth, many women experience perineal tearing. In most cases, these tears are minor and heal quickly. Some women, however, experience third- or fourth-degree tears, also known as obstetric anal sphincter injuries (OASI). These can cause lasting problems, including urinary and bowel incontinence, chronic pain and pelvic organ prolapse, when an organ such as the uterus or bladder descends into the vagina. Professor Mike Keighley, a colorectal surgeon, told the inquiry that he and his colleagues saw a high referral rate in women aged 50-60, "in whom incontinence or prolapse had either emerged for the first time or has become worse, all due to an injury during childbirth that becomes unmanageable in later life."

Financial cost of OASI to the NHS

There has been little research on the financial cost to the NHS of anal sphincter injuries sustained during childbirth, though it can be partly measured through litigation costs. NHS figures show:

- The highest rate of litigation in clinical practice is for childbirth injuries.
- The value of maternity claims doubled between 2016/17 and 2022/23.[38] In 2022/2023 the total cost of maternity payouts was £1.1bn.[39]

The value of the average damages awarded for these claims has increased significantly. In 2006/2007 the average maternal injury claim was worth approximately £82,011 and in 2022/2023 it averages at £301,492.

Other costs to the NHS (GP appointments, repeated surgeries, physiotherapy and counselling) have not been measured – though Professor Keighley told the inquiry that he estimated the cost to the NHS of one woman's repeated procedures over 20 years to be approximately £80k. His "guesstimate" of the overall cost to society was £100-400m a year.

Incidence of OASI

There is a shortage of good quality data about OASI incidence, but the most recent available figures suggest that 3.1% of all vaginal births result in OASI – roughly 14,000 a year in the UK.[40] This is likely to be an underestimate, however, because so many tears are missed, with one study estimating the incidence as about 10% of all women who give birth vaginally.[41] This is important, because if an OASI is diagnosed and repaired shortly after birth, it is possible for women to make a full recovery. In the past 12 years, Professor Keighley told the inquiry, he had seen more than 200 women with third- or fourth-degree tears, and in 60% of cases, the tear had been missed when the baby was born.

Risk factors for OASI

The two biggest risk factors for OASI are first vaginal birth and instrumental (assisted) birth. Amongst first-time mothers giving birth instrumentally, 7.5% experience a severe tear, compared with 1.6% of those who have a spontaneous, non-instrumental vaginal birth, and have given birth before.[42] The risk of OASI is nearly six times higher with forceps, and three times higher with Ventouse, than with spontaneous vaginal delivery.[43]

Canadian research found that more than a quarter of successful forceps births involved maternal trauma. In nearly nine out of 10 of those cases, the injury was an OASI, but other injuries included cervical tears, vaginal lacerations and damage to the urethra or bladder.[44] Forceps birth is also associated with a greater risk of pelvic organ prolapse.[45]

As we saw in Chapter 2, one likely reason for the UK's high incidence of OASI is the preference amongst obstetricians for forceps: 7.5% of all births in England are by forceps, compared with 0.5% in Sweden and Austria.[46,47]

Currently a collaborative group led by the two main obstetric societies and including representatives of the royal colleges, is producing a consensus statement on assisted vaginal birth, which aims to ensure the safety of mother and baby. The statement may help obstetricians to make decisions about when forceps or Ventouse may be more appropriate.

While first-time vaginal birth and forceps use are the two principal risk factors for OASI, others include[48]:

- Prolonged second stage of labour
- Persistent occipito-posterior position (baby is "back-to-back")
- Baby's birthweight is greater than 4kg
- Older maternal age
- South Asian ethnicity
- Baby is born quickly (precipitate labour)
- Shoulder dystocia (the baby's shoulder gets stuck behind the pubic bone)
- Short maternal stature

OASI risks and informed consent

There are good arguments for making women aware of their individual risk profile during pregnancy, taking into account factors such as age and ethnicity. One study has found, for example, that Asian women have an OASI risk nine times higher than that for Caucasian women.[49]

The 2015 Supreme Court Montgomery ruling states that clinicians should disclose risks of childbirth with patients.[50] Yet many women told us that their care providers did not discuss the risks of OASI with them before giving birth. Geeta Nayar, a South Asian woman who gave oral evidence to the inquiry, said that she had not been informed antenatally of her higher risk.

We saw many other examples where informed consent was not sought. In a written submission, one woman described telling a community midwife that, as a sexual assault survivor, her biggest fear was a forceps birth, and that in the case of an emergency, she would prefer a caesarean. The midwife told her a caesarean would be dangerous, without further explanation. In the event, she experienced a frightening forceps birth that led to a complex third-degree tear and two organ prolapses leaving her in constant pain. She feels that if she had been informed of the comparative risks, she would have requested caesarean. She describes feeling "broken" and "permanently damaged," adding: "I used to think I was a resilient and strong woman. Birth showed me I am not."

Diagnosing and treating OASI

If OASI is diagnosed shortly after birth, and treated appropriately through a repair of the tear followed by a course of physiotherapy with a specialist, then women can make a full recovery. We received dozens of submissions, however, from women who wrote of their distress at their tear either going undiagnosed or being misdiagnosed (for example, as a second-degree tear), leading to

significant long-term problems. They then found it difficult to access support, as Sarah Embleton told session 3 of the inquiry:

"GPs are the gatekeepers to any referrals. So, first of all you have got to have a GP that understands there is something wrong and acknowledges it and understands it and can send you somewhere else. Then there is: where do you go? Do you go to the gynaecologist? Do you go to a colorectal surgeon? Do you go to physio? You know you probably need a multidisciplinary team, but I couldn't get referred. I couldn't get anyone to understand there was something wrong with me."

One woman described in a written submission how her fourth-degree tear was misdiagnosed by a midwife as a second-degree tear and repaired accordingly. Her later bowel incontinence was then wrongly diagnosed as irritable bowel syndrome, while a consultant at the hospital where she gave birth told her simply that her symptoms were the result of being "psychologically traumatised". Over the course of 21 years she had 18 surgical procedures, the last being a colostomy in 2019.

In a number of cases, health professionals seemed ill-equipped to give even basic guidance about managing a tear. One was given a booklet that said she should not wash her wounds, until a gynaecologist told her otherwise. She wrote:

"For three months, with urinary and faecal incontinence as well as post-partum bleeding, I hadn't been washing properly. Sometimes I think I can still smell myself, on days where my mental health is really low."

This theme was echoed in many of the submissions. Twenty-two women experienced rectovaginal fistula (a hole between the rectum and vagina), yet some reported being disbelieved by health professionals. One wrote:

"In the months that followed I suspected I wasn't healing well. I had many trips back and forth to the GP practice and to the local hospital, nobody seemed to appreciate my concern that stool was leaking from my vagina. My GP questioned the direction I was wiping, which felt really condescending. I was told by one gynaecologist that what I was describing was 'extremely rare and normally only seen in third world countries.' I felt dismissed and unheard again."

Much of the problem stems from a lack of understanding on the part of many health professionals, including midwives and GPs, of the causes and impact of OASI – a midwife who assisted at a birth is unlikely to see a woman again and therefore may not be aware of the long-term impact. Midwife Posy Bidwell told the inquiry that midwives currently receive little undergraduate training in pelvic

health anatomy and the impact of tearing on a woman's pelvic health. She recommended that there should be an annual "mandatory perineal health update day for every midwife on the shop floor."

The planned introduction of pelvic health clinics, as part of NHS England's new perinatal pelvic health initiative (PPHI), which offer a one-stop shop for women with problems such as incontinence and prolapse, aim to address the difficulty women have in accessing expert help. There is also a case, argued Professor Pauline Slade, for linking the pelvic health clinics with maternal mental health services so that women can receive integrated care.

Impact of OASI

In both the written submissions and oral evidence, women spoke movingly about the lasting impact of OASI on their lives. This included:

- Ongoing physical pain
- Bladder and bowel incontinence
- Sexual dysfunction and difficulties in their relationship with their partner
- Effect on body image
- Difficulties in bonding and developing a relationship with their child
- An inability to return to work, because of incontinence and the need for multiple surgeries over the course of many years
- Financial problems, resulting from the inability to work and the cost of treating the injury
- Psychological distress, including depression and suicidal feelings, as well as a loss of confidence
- An inability to carry out normal everyday activities such as going shopping, taking exercise or socialising with friends

In written evidence, one specialist pelvic health physiotherapist described the emotional impact of OASI as "isolation, loneliness, shame, disgust, depression and anxiety." This was confirmed by women who highlighted the profound psychological impact OASI had on their self-confidence. Geeta, a high-flying lawyer at the time her daughter was born, described how, as a result of her birth injury, she "went from being a resilient, independent young woman to needing significant help, not able to leave the house, enduring multiple repair procedures."

A number of women found that an OASI affected their ability to work. Jenny Tighe told session 3 of the inquiry: "I was having daily episodes of bladder incontinence, bowel incontinence. My job initially was quite supportive, but I got demoted and that just destroyed my self- esteem and confidence, so in the end I just resigned and then I didn't work properly for several years."

Many women described in written evidence how her fourth-degree tear affected their ability to lead a normal life. The following experience described in a written submission is typical:

“I still had accidents. I had to take spare clothes with me at all times. I had to strip off in disabled toilets with my children watching as I cleaned the faeces off me. I was scared to be intimate with my husband, as the risk of soiling myself was so high. I would never have another child. I was ‘tutted’ at for using the disabled toilets by strangers and acquaintances. I eventually had to leave a job that I loved. I was teaching children with complex needs, but I couldn’t control my bowels during a lesson and would have to take the children back to their classes so I could get changed. I could only wear black jeans, otherwise the staff would know I had soiled myself again.

"The pain was chronic and still is after 10 years. Being in constant pain and soiling myself had a huge effect on my mental health. I was diagnosed with severe depression and anxiety, was given more medication. I didn’t want to leave the house. I didn’t want to socialise, I was constantly thinking about where the closest toilets are and I still am. My pain was stopping me being able to do basic functions in the house, like cooking for the family, walking the dogs or sorting out the laundry. The pressure on my husband and our relationship took its toll and there were times we were close to divorce.

“I had to reduce my hours at work and we decided that we would make adaptations to the house so I could have more independence. We had to re-mortgage our house to do so. Financially we were close to bankruptcy, so I applied for PIP. I had to go to tribunal, where the doctor on the panel said to me ‘why don’t I just a stick an anal plug in and get on with my day,’ one of the many comments from healthcare professionals that don’t understand the complexities of a birth injury. In 2023 alone, I have had three gynaecologist appointments, two pessary fittings for my prolapse, three pelvic floor physio sessions, two colorectal appointments and surgery planned again for a few months’ time.”

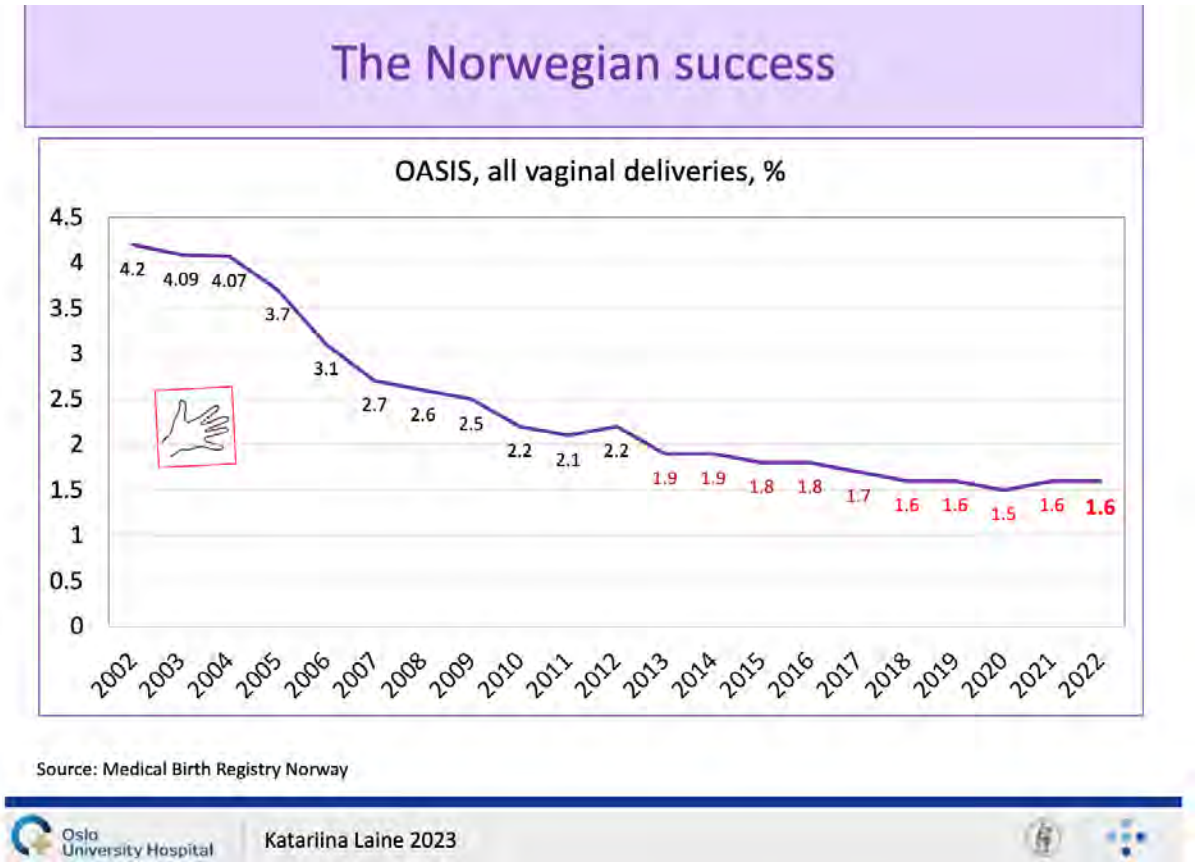
Addressing OASI

OASI can best be tackled through prevention, as well as better diagnosis and treatment. One method is to adopt a risk assessment tool such as UR-CHOICE, which can calculate a woman’s risk of developing symptoms in the long-term after pelvic floor injury and enable women to make decisions based on that information.[51] Risk calculators are routinely used to assess risk in other areas of health care, such as prostate and breast cancer and heart disease.

Several Scandinavian studies have shown it is possible to cut OASI rates by manually supporting the perineum during the pushing stage. In Norway, this change in practice has cut rates of OASI by 50%.[52] In the UK, an OASI care bundle developed jointly by RCOG and RCM incorporates:

- Antenatal education that informs women about OASI and how to reduce the risk of it occurring
- Manual perineal protection during birth
- Episiotomy when indicated
- A rectal examination after birth, provided the woman consents

It has been piloted in 16 maternity units, which saw OASI rates fall in over 50,000 women by 20%.[53] In Norway, the two pilot hospitals showed a rapid reduction of 50%. When rolled out more widely, however, the reduction was more gradual, and it took a number of years before a national reduction of 50% was achieved (see graph). In total, however, the policy has led to approximately 16,000 women avoiding OASI between 2005 and 2022.



Despite the successful pilot, the OASI care bundle has not been implemented in all maternity units, partly because it has not been recommended by the National Institute of Health and Care Excellence (NICE).

Chapter 4: Birth trauma and mental health services

Introduction

This chapter looks at the mental health support available for parents with birth trauma. It includes evidence from experts and people with lived experience of birth trauma from session 4 of the oral evidence session, as well as testimony provided in written evidence from women and mental health organisations.

After birth, about one in 10 women develop postnatal depression, while one in 25 develop post-traumatic stress disorder (PTSD).[54] A larger number develop symptoms of psychological distress such as intense anxiety as the result of traumatic birth. While not meeting the full criteria for a PTSD diagnosis, these women may still be in need of mental health support.

Postnatal PTSD is more common in women who have had previous trauma or pre-existing health challenges.[55] About half of women who develop postnatal PTSD also develop postnatal depression.[56] About one or two in 1,000 women develop postpartum psychosis, the most severe form of postnatal mental illness. It is characterised by symptoms such as mania, delusions and low mood, and is considered a psychiatric emergency.[57]

Mental health problems after birth can be debilitating and need to be taken seriously. Suicide is the leading cause of maternal death six weeks to a year after birth.[58] Left untreated, PTSD symptoms can continue to affect women for many years: the inquiry heard from women in their 60s, 70s and even 80s, who still felt traumatised by their experience of giving birth decades earlier. One mother wrote in to describe, tragically, how her daughter had taken her own life, having been profoundly affected by a traumatic twin birth nine years previously. Many others wrote that they had attempted suicide or were plagued by suicidal feelings.

Postnatal PTSD and other symptoms of trauma can, in the majority of cases, be treated effectively by two therapies, both recommended by NICE: trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR). In people with PTSD, the experience of the trauma feels ever-present: they continually relive the traumatic event. Both trauma-focused CBT and EMDR are intensive therapies that involve going over and over the trauma until it is stored in long-term memory, the same as any other memory. Typically, these therapies require eight to 12 sessions with a specially-trained therapist. Other treatments are available, but lack the strong evidence base of trauma-focused CBT and EMDR.

Peer support has also been shown to be effective in helping people experiencing trauma symptoms after a traumatic birth.[59]

Mental health services in the UK: current provision

Specialist perinatal mental health community services support women and their families experiencing the most severe mental health problems, during pregnancy and for the first year after birth.

Money for these services is now administered at the local level, as part of the general allocation to integrated care systems, but 73% of teams in England reported a shortfall in funding for 2022/23.[60] Workforce-related issues were the most frequently cited reason for underspending against budgets.

Between 2019 and 2024, NHS England set up regional Maternal Mental Health Services (MMHS) that provide treatment for serious mental health problems arising as a result of a woman's maternity experience, including stillbirth, postnatal PTSD, tokophobia (fear of childbirth), neonatal death, pregnancy termination and loss of custody. These offer support up to two years after birth. Susan Ayers, professor of maternal and child health at City University, London, told session 1 of the inquiry that in providing these services, England was "ahead of the rest of the world".

The services face challenges, however. There is significant variation in size and therefore the support they are able to provide.[61] Some have not secured ongoing funding. An NHS workforce census in 2023 concluded that the rapid set-up and expansion of these services mean there are workforce challenges that are likely to remain for some time.[62] Similarly, a report by the Maternal Mental Health Alliance in May 2023 found that many women still face long waiting lists for therapy, through a combination of high demand and under-staffing.[63]

A joint submission to the inquiry from Oxford Specialist Perinatal Mental Health Services (OSPMH) and Oxfordshire Maternal Mental Health Service (MMHS) spoke of a lack of funding to recruit permanent staff, resulting in staff burnout. Women were having to wait six months for a psychologist appointment, and nine months for a debrief. The submission also reported challenges in integrating with maternity wards that do not see mental health as a primary concern.

Another challenge mentioned in submissions from MMHS organisations was of communication being fragmented across services, because of the use of different electronic record systems. A submission from the Perinatal Parent Infant Mental Health Service) and TULIP/Maternal Mental Health Service in North East Foundation Trust mentioned problems caused by the 28-day window midwives have for

making a referral, which meant that some women were being referred too soon after birth, when often their symptoms resolve on their own without the need for specialist input.

Women who want to access a mental health service can ask for a referral from their community midwife, health visitor or GP. In practice, while new guidelines[64] state that GPs should ask women about birth trauma at the six-to-eight week postnatal check, some women report that GPs ask little, if anything, about mental health.[65]

Other specialist services

In England, women experiencing mental health problems postnatally can also self-refer to NHS Talking Therapies (formerly IAPT). The therapies offered vary locally and not all have specialists in perinatal mental health. Waiting lists are often long. There are also specialist perinatal mental health midwives and consultants who work within maternity teams or the local perinatal mental health team to make sure that there are clear integrated pathways of care for women with perinatal mental illness.

Many maternity units run birth debriefing services, which offer women the opportunity to review their maternity notes with a clinician (usually a midwife) to better understand their birth experience. Research shows a wide variation in how the services are run, however, and there is currently no published standard for how a debriefing service should be carried out.[66] One specialist debriefing midwife said in written evidence that women were often referred inappropriately to the debriefing service when they should have been referred to the complaints service, with the debriefing experience then leaving them frustrated and angry.

A number of voluntary organisations also offer peer support services, including SANDS, the Birth Trauma Association and MASIC. In their written submissions, some women reported being supported by these charities when they could not access help elsewhere.

Devolved nations

Scotland, Wales and Northern Ireland all offer community-based perinatal mental health services. There are examples of good practice, such as Scotland's introduction of a participation officer role, working with health boards and the Scottish government to gather feedback from women and family members to improve the service. Nonetheless, provision is patchy in each of the devolved nations, and all face workforce challenges.[67]

Accessing mental health services: barriers to care

The inquiry heard evidence that mental health provision is very much a postcode lottery.

We received many submissions from women who had been unsuccessful in accessing appropriate mental health help. Reasons included a failure on the part of GPs or other health professionals to recognise PTSD symptoms, long waiting lists, or a refusal by services to accept women because they were not ill enough or, in some cases, too ill, or because they were past the cut-off point of one year after birth. One woman whose baby was stillborn wrote that in the area in which she lives, there was no specialist maternity loss and trauma service:

"The final kick in the teeth after she died and I was feeling intensely suicidal was that the perinatal mental health team wouldn't take me on because I had no living baby."

Dr Rebecca Moore, a consultant perinatal psychiatrist, told the inquiry of her concern that some services were "tailored to diagnoses, so to fit this service you have to have PTSD, whereas in reality you can have seven of the 11 symptoms of PTSD and be significantly affected and traumatised day-to-day, and that might persist for years and flare up in the next pregnancy."

In oral evidence, Natalie Tasker told the inquiry that when she described her obsessive anxiety about the baby to her GP, the GP responded with: "I just don't...sorry, what's the actual issue here, because you've had this beautiful baby. Are you depressed? Are you upset? I don't really get what you're saying is wrong." Even though Natalie's husband explained that she wasn't depressed, but was experiencing intrusive thoughts, the GP wrote a prescription for anti-depressants.

Emily Barley, whose daughter was stillborn after failings of care during labour, was told by the perinatal mental health team that they were unable to help her. However, her GP was able to refer her to the local mental health trust's specialist suicide prevention team. She had her first session within two days of referral, and in all had nine weeks of treatment. Giving oral evidence, Emily said: "They did save my life. They were amazing." The service was a pilot project, however, available in only a few areas of the country.

One written submission describes a woman's difficulty accessing support after a traumatic birth, which had left her psychologically distraught:

"I was crying uncontrollably daily; suffering flashbacks multiple times a day; nightmares; screaming in my sleep; unable to leave my son and hypervigilance; lost contact with friends; no socialisation with

other parents; unable to go to or past the hospital; panic attacks when seeing ambulances; unable to travel down certain roads".

When she eventually decided to seek professional help, she was given a diagnosis of severe complex PTSD with severe anxiety and moderate depression, but because her son was more than 12 months old, she was not eligible to be fast-tracked. After spending time on a waiting list, she was assigned a trainee counsellor, and, later, a trauma-focused CBT counsellor who had no experience of birth, which meant she had to explain to him some of the practical elements of childbirth. This was so distressing that her trauma scores increased. She decided to seek EMDR, which involved being discharged, completing a second self-referral and starting the whole assessment process from the beginning: "By the time I received EMDR it was approximately 18 months after my first self-referral. I had no support at all whilst on the waiting lists. At no point did I receive therapy from any one with experience of birth trauma."

Other women told us they had no option but to turn to private therapy. Neera Ridler-Mayor, who experienced nightmares and intense anxiety after she lost seven litres of blood in a postpartum haemorrhage, told session 4 of the inquiry that she had spent over £6,000 for more than 50 hours of mental health support after she was unable to access NHS therapy.

Barriers to access for marginalised groups

Giving oral evidence, Honey Attridge said that she had been frightened that if she admitted to mental illness, her baby would be taken away from her. Since becoming a peer support worker for an NHS perinatal mental health team, she had found that many other women have a similar fear. These fears may be particularly prevalent among ethnic minority women, younger women and women from disadvantaged communities, who are (often with reason) distrustful of people in positions of authority. Some women may feel that seeking specialist help is a sign they have failed as a mother. Dr Moore told the inquiry that peer support could play an important part in bridging the gap for women who felt reluctant to access professional help.

Dr Moore also noted that, among the women who have died by suicide, very many are young women with multiple disadvantages, who have been let down by fragmented services: "Often when you look at the women that have died, they have been involved with numerous services, none of whom have been communicating with each other and they have often had lots of different support, but nobody has really looked at it as a whole. Then when you see the story afterwards, you see that everybody held a vital piece of information but no one shared it together."

Good practice

We saw examples of good practice in some of the written submissions. Several women said they received excellent support from their perinatal mental health team and were helped to recover by referral to appropriate therapy. One woman said that the care she received from the perinatal mental health team had been "second to none" and that "I truly believed they saved my life."

For women who have had a traumatic birth, a subsequent pregnancy can be a very fearful time, and it is important that they are supported through the pregnancy and birth. One woman described in a written submission how she had developed PTSD after experiencing poor care during a long, painful labour, followed by a retained placenta and postpartum haemorrhage. In her second pregnancy, however, she was well looked after:

"As a result of my prior experiences, I was placed under the case of the perinatal health team during my pregnancy, and I was allowed to carefully plan my delivery and chat through my concerns in advance with a specialist midwife and anaesthetist. The team looking after me during and before my son's birth spoke to me with kindness and compassion, always explaining their actions and seeking consent. I can say that my son's birth was the happiest day of my life."

Chapter 5: The wider impact of birth trauma

This chapter looks at the impact of birth trauma, not just on the individual who experiences it but on those around them. It includes evidence heard in session 5 from experts and people with lived experience of birth trauma, as well as testimony provided in written evidence from women and health professionals.

Birth trauma can have a profound psychological impact, with flashbacks, nightmares and feelings of intense anxiety. This means that birth trauma can affect every aspect of a woman's life, including her bond with her baby, her relationship with her partner, her older children and her friends and family. It can also affect her ability to work. All of this ripples out into wider society, with the cost felt in NHS treatment, family breakup and the removal of women from the workplace.

Relationship with the baby

Research suggests that birth trauma makes it harder for some women to bond with their babies, while others become excessively protective, sometimes to the extent of refusing to leave the house with their baby.[68,69] Traumatic birth is also associated with low birth weight and lower rates of breastfeeding,[70] and there are suggestions that postnatal PTSD "may be associated with an increased number of problems in mother-infant attachment and child behaviour."[71]

The inquiry received submissions from a number of women who found their relationship with their child had suffered as a result of traumatic birth, though some also wrote that it had improved with time. Feelings of guilt are common. One woman wrote: "I struggled with sleep deprivation and I started to become really tearful and have negative thoughts about putting my baby up for adoption as I felt that I couldn't do it. I couldn't be a mum."

Four years on, she has "the most special bond" with her child, but is still "haunted" by the birth trauma, which included losing four litres of blood: "I continue to struggle with anxiety and depression and feel that I will never be the person I was prior to this experience. I am now trying to navigate life as a mum with a mental illness and I am at last hoping to start some trauma-based therapy in the near future."

Physical injuries can also affect the mother-child bond. A survey of 325 women by the charity MASIC, which supports women with third- and fourth-degree tears, found that 85% believed their injury had affected their relationship with their child, with 14% saying the damage to the relationship was irrevocable.[72] In a written submission, one woman said that her third-degree tear had affected

her ability to mother effectively: "I am now just over a year postpartum and still unable to actively play with my children. I can't lift or chase my eldest child, the tear has completely limited the mother I want to be for my children."

Relationship with partner and family

A mother's relationship with her partner may be affected in several ways after a traumatic birth.[73] Some report that, because their partner did not advocate for them effectively during birth, they no longer trust them.[74] Others find that their partner discourages them from talking about the birth, telling them to "move on" or "focus on the baby", making the woman feel isolated. Postnatal PTSD can make people feel irritable or lead to outbursts of anger, further damaging the relationship. Many women avoid sexual intimacy, in some cases because a birth injury has made it too painful, or because sex triggers flashbacks to the birth, or because they fear becoming pregnant again.[75] One woman wrote: "Even though I'm on birth control I am so scared it won't work and I will end up pregnant I won't go anywhere near my husband which is starting to put a strain on our marriage."

A number of women said in written submissions that their birth experience affected relationships with friends and wider family as well as with their partner. This was particularly the case for those whose babies were born with brain injuries caused by being deprived of oxygen at birth (see box-out).

In cases where a child has a severe disability, siblings live with the knowledge that when their parents die, they may be expected to take over the care of the child, Suzanne White, head of clinical negligence for law firm Leigh Day, told the inquiry: "That's a huge responsibility that they live with all their life."

Economic cost

There is currently no research on the economic cost of birth trauma. Professor Susan Ayers of City University, London has suggested that NHS Resolution data on litigation claims could be used as a proxy measure, and that there is a lack of current funding to analyse the data.

A government cost-benefit analysis of the women's health hubs notes that the average cost of a maternity claim is about £293,000, and that if the harm leads to brain injury at birth the average cost of a claim is about £9.4 million. This economic impact applies only to cases where there has been a physical injury leading to litigation, however. We know that the majority of women psychologically affected by traumatic birth will not make a negligence claim.[76]

It is clear, however, from the numerous submissions we received from women either unable to go back to work, or delaying going back to work, as a result of PTSD triggers, that there must be a wider economic cost.

In other cases, women felt that financially they had no choice but to return, even if they were too ill to do so. Heather Simmons, giving oral evidence to session 5 of the inquiry, described how her traumatic birth had led to her child having a hypoxic brain injury. Before the birth she'd worked in a hospital as an ophthalmic technician. She described how her "place of safety," where she'd always felt comfortable, became her "place of trauma". When her daughter was six months old, Heather was in the middle of a "full breakdown," but returned to work for financial reasons. It was, she said, a "horrific" experience: "I had panic. I couldn't concentrate. I couldn't bear to be away from her."

Heather left the NHS and took a private job working nights so she could be with her daughter during the day. Ultimately, however, the culture of workplace bullying was too traumatising and she left, later becoming a full-time carer for her husband when he fell ill.

Women with birth injuries may also find their physical ill-health prevents them from returning to the workplace, with one survey finding that one in five women with birth injuries said it had affected their ability to work.[77] Even those who do go back to work say that their trauma has had an impact on their working life. The woman with a third-degree tear, quoted earlier, wrote in her submission that she "spent thousands of pounds on private appointments, gynaecology, and pelvic floor physiotherapy".

Ms White noted that, even if a woman returns to work after a birth injury, the effect of the injury can re-emerge at menopause. One professionally successful client was "likely to be incontinent after menopause because the perineum deteriorates at that stage, and that is something that she is dreading throughout her whole life."

Case Study: Helen

Helen's son Julian was born with a hypoxic brain injury as a result of proven medical negligence during his birth, which the hospital tried to cover up. (Helen won substantial damages against the hospital to pay for the care of her child.)

Her son's injury has affected every aspect of Helen's life.

"My marriage broke down as he [her husband] could not handle a disabled child. He more or less had a breakdown and ran away to start a new life," she says. He has not seen his child for nine years.

Her own life has been turned upside down: "I am now a single mother, doing this alone. Julian will always be dependent on me. I had my elder children young and always thought that I would be able to live life when they were older, but now I have Julian as a forever dependant."

Her other children have been affected too: "They are all fantastic with their little brother but ongoing sleep and behavioural issues have caused disruption with exams and schooling through lack of sleep for instance."

Helen still suffers mental and physical pain, and has never been able to heal. Having to explain what happened to her over and over again during a six-year litigation was particularly mentally draining. She adds: "My life will never be as it should be. I never returned to work, I live a very secluded life, as friends and family shun you when you have a disabled child that they might not understand or are scared of."

Maternity staff

Evidence suggests that midwives in particular experience high levels of stress and burnout, with data showing that they have the highest rate of absences for mental health reasons of any group in the NHS.[78] One large-scale survey of midwives found significant levels of emotional distress, with two-thirds saying they had considered leaving the profession.[79]

Several studies have looked at the incidence of PTSD in maternity professionals. A review of research that looked at studies of midwives, nurses and obstetricians found that the proportion of participants meeting the diagnostic criteria for PTSD ranged from 3.1%-46%.[80] Authors of a scoping review of research found that "witnessing abusive care was associated with more severe post-traumatic stress than other types of trauma events" and concluded that "adverse events during childbirth have a serious impact on care providers."[81] An Australian study found that staff of black or minority ethnicity were at increased risk.[82]

Amongst the submissions we received from midwives, common themes included under-staffing, a poor physical environment and a harmful working culture. Some found it difficult to see how women were treated in the system: one midwife wrote that she and her colleagues "are witness daily to the devastating impact of poor staffing, poor provision of resources, poor care and poor communication, which result in people lacking confidence in the service and the standard of care they will receive."

Another former midwife described how she'd left the NHS in 2022 after 15 years as a result of "accumulated vicarious trauma and moral injury". She described working in a particularly hierarchical maternity unit where one consultant obstetrician behaved aggressively towards staff and treated the women in his care inappropriately. In one instance, during repair of a second-degree perineal tear, the woman "was leaping up the bed and groaning in agony due to his stitching. I asked him to stop and provide more pain relief; he shouted at me in front of the woman and told me that 'women do not have nerves in their vagina'." She also described an extraordinary incident when the same doctor "dragged another outspoken midwife by her hair along an antenatal clinic corridor."

In her final NHS shift, she described caring for a mother whose baby was stillborn before being called to an emergency forceps birth in which "the woman was screaming with fear and panic in her eyes, the obstetrician was useless in her communication and didn't gain consent for the episiotomy or the forceps." The result was "another unnecessarily traumatised mother and father starting parenthood."

Chapter 6: Partners' perspectives

This chapter looks at the impact of traumatic birth on partners, using evidence from written submissions and oral testimony to session 6 of the inquiry.

Partners can be affected in two main ways by a traumatic birth:

- They may develop psychological symptoms of trauma, as a result of experiencing the terror of believing that they are going to lose both mother and baby. A review of research has found that 1.2% of fathers develop PTSD after witnessing their partner give birth – approximately 7,000 people every year in the UK.[83] It is likely that many more develop some trauma symptoms.
- They may be required to support – practically, emotionally and financially – a woman who is experiencing the physical and psychological consequences of traumatic birth.

Yet there is very little help available for partners. After birth, the focus is on the mother, and her partner will not normally be asked by health professionals whether he (or she) is coping psychologically. Many partners feel that, because they did not go through the traumatic birth themselves, they are not entitled to ask for help. They may also feel that they have a responsibility to be strong and hold the family together.

The impact of traumatic birth on partners

The small amount of research on the impact of witnessing traumatic birth on partners has identified recurring themes, such as feelings of helplessness as the trauma unfolds, a fear that the mother or baby are going to die, a sense of abandonment if the mother and baby are taken to a different room and a lack of communication from staff.[84]

Dr Andrew Mayers, an academic psychologist at Bournemouth University, told the inquiry that his research had found that "fathers who are in that birthing room when it all starts going so dramatically wrong feel utterly helpless." He added: "They are witnessing potentially the loss of their partner, wife and/or baby and yet what we were finding consistently was that they were not being informed." Conversely, his study found, when health professionals communicated effectively, this acted as a protective factor against the father developing postnatal mental health problems.[85]

Dr Mayers's findings were echoed in the submissions the inquiry received from fathers. One man wrote that his wife experienced an obstetric emergency that resulted in the death of their baby daughter. Describing the "chaos" in the operating theatre, he wrote:

"As a father I was sat at the head end of the table with my partner and had no explanation as to what was happening or going on. When my partner started feeling sick and shaking I was literally presented with an anaesthetist sat to my left on her mobile phone and handed a sick bowl and told she will be all right in a minute…Prior to that any other requests for information were ignored, all I knew was that alarms were going off and people were running into theatre. No support was offered to myself or my partner. This experience has left me with regular flashbacks, mental health issues and a diagnosis of PTSD."

Scott Mair, whose son was taken to intensive care after the birth, had to visit him alone while his wife lay ill in bed. That was traumatic enough, he told session 6 of the inquiry, adding: "My biggest trauma came from the fact that I was then told to go upstairs and break that news to my wife that our baby might not make it. There is no support, there was nobody to come with you to have that conversation."

One man told us in a written submission that after he had witnessed his wife receiving abusive treatment during birth, he found himself reliving the birth in the form of flashbacks and nightmares. He added:

"I developed avoidance behaviours in the form of avoiding any conversation about birth or hospitals, avoiding friends, family and isolating myself from the outside world. During conversations I would completely tune myself out to the point I could not hear or take in what was being said. Having another baby felt like an impossibility."

He also experienced "heightened feelings of a sense of threat in the form of over sensitivity to sounds, feeling jumpy, extremely irritable, worried about losing my wife or daughter."

In some cases, both partners are affected. Mark Williams and his wife both developed mental health problems after her traumatic birth experience 20 years ago in which he feared that she and their baby would die. The effect has been long-lasting: Mark told the inquiry that even recently he had woken up in "in sweats, thinking my wife and baby died."

The impact of traumatic birth on the couple relationship and family life

We saw in Chapter 5 the impact a traumatic birth could have on the partner relationship, often creating tension and anxiety, with women sometimes blaming their partner for not advocating effectively for them during labour. [86]

Physical injuries such as OASI can, as we have seen, have a devastating impact. One man said that his wife's birth injury, sustained before they met, had affected every aspect of their lives: "where we can

go, our careers, the additional financial outgoings associated with treatments, our sex life, not being able to have further children, our health and wellbeing." Before each of his wife's surgeries, he had had to prepare himself for the possibility that she might die on the operating table, adding: "I'm just grateful that she has shown the resilience and courage to keep going."

There may often be a financial impact. Paternity leave is only two weeks, but if a mother is too ill to look after herself and the baby, the partner may have to take unpaid leave to take care of her or sometimes drop out of employment altogether. Lucy Allen-Goss, whose partner was unwell after a traumatic birth, told the inquiry she was unable to return to her academic post, leaving a year-long gap on her CV that she couldn't easily explain – which led, ultimately, to a change of career.

Same-sex partners

There is a dearth of research on the impact of traumatic birth on same-sex partners. Laura-Rose Thorogood of LGBT+ Mummies told the inquiry that there was an assumption in the NHS that same-sex partners were less important, even though in some case, the partner may be genetically related to the child through egg donation. There was, similarly, a lack of awareness amongst health professionals that some same-sex couples will have a history of trauma in overcoming barriers to conception, such as repeated attempts at IVF.

Lucy told the inquiry of witnessing her female partner have a traumatic emergency c-section, after which both mother and baby developed sepsis: "One of the things that went wrong was that people didn't know who I was. So I kept getting shut out of the room she was in and they tended to think I was another nurse or another midwife."

This happened both during the birth and postnatally. While she was in the postnatal ward with her partner Emma, staff assumed that she was a health professional taking care of her: "My partner was catheterised, she was bleeding very heavily, she was very high on morphine, she didn't know where she was. And she was being expected to change and also to tube feed this very fragile newborn we'd got, and a lot of the time I couldn't get to her. We realised quite a bit later that we nearly killed our daughter because they had expected both of us to tube feed this baby without actually having told us how to do it."

When they returned home, Lucy found that the midwives and health visitor who attended Emma seemed to resent her presence: "I remember at one point the health visitor saying, 'You know you can tell her to go away' to my partner about me, and my partner said, 'I don't want her to go away.'"

Laura-Rose and her wife have both given birth twice, and their experiences echoed Lucy's, with the non-birthing mother being asked to leave the room and make tea while the health professional was talking to the birthing mother.

Mental health support for partners

The lack of support for partners continues postnatally. Scott shared with the inquiry his experience of leaving his sick wife and baby in the hospital: "The worst thing is after all of that you get in the car and you go home. Nobody helps with that transition out to the car park, nobody sits you down and says 'Is everything okay? That was rough'. You don't get any sort of debrief."

Currently, neither mothers nor fathers are screened postnatally for PTSD, though the means to do so is available – researchers at City, University of London have devised separate scales to measure postnatal PTSD in mothers and partners.[87] Whereas mothers are routinely screened for postnatal depression, and have opportunities to mention mental health difficulties to health professionals, fathers and non-birthing mothers are not offered mental health screening after the birth. The NICE guideline on antenatal and postnatal mental health does not mention fathers at all.[88]

The only time partners have the opportunity to share their mental health difficulties with a health professional is if they choose to accompany the mother to a birth debrief. Otherwise, a father who wants mental health support must actively seek it. In England, this will typically be by self-referring to the local NHS Talking Therapies service. In the other UK countries, it will entail asking for a GP referral. Kieran Anders, operations manager for Dad Matters, told the inquiry that, while new mothers with psychosis are treated as a blue-light emergency with direct treatment, a father with psychosis may have a three month wait for treatment, even though the risk to the child is the same.

Research suggests that fathers would welcome the opportunity to share their experience of the birth. In one study, fathers expressed the view that healthcare professionals were unconcerned about fathers' mental health, and that support is only offered once "you try to harm yourself or you have a breakdown."[89] Fathers, another study found, "specifically wanted healthcare professionals to sign-post them to someone they can talk to for emotional support, and to be taught coping strategies which would help them to support both their partner and baby."[90]

Since 2018, NHS England has been gradually expanding its perinatal mental health services to include partners, so that if a woman has a perinatal mental health problem, her partner is also offered a mental health check and signposted to professional support if necessary. The limitation of this, as Dr Mayers pointed out, is that it does not identify those fathers who have developed mental health problems, but whose partners are not in contact with perinatal mental health services.

There is a postcode lottery to the support available. Dr Mayers noted that, when he helped develop local mental health services for fathers, in Hampshire and Dorset these were provided through the local mental health trust, but in London, they were provided through the charity Mind.

There are areas of good practice, however. Leeds Perinatal Mental Health Service, for example, has set up a Partners Peer Support Service to support new fathers. These include face-to-face sessions, dads and kids pram walks, baby sensory sessions and Zoom games nights to help new fathers gain confidence as parents and talk about their mental health.[91] In Greater Manchester, the NHS funds Dad Matters as part of their peer support offer alongside Home Start and other charities. Dad Matters takes referrals from professionals who see fathers, and offers attachment and bonding support, as well as signposting fathers to Talking Therapies if necessary.

Financial and economic costs

A 2014 report calculated that perinatal health problems in women cost the country £8.1bn a year, and that an investment of £280m annually could offset much of that cost.[92] Similar figures are not available for partners, but Dr Mayers told the inquiry that he believed that investment in caring for partners, coupled with extended paternity leave and greater support in the workplace, could reduce the likelihood of PTSD and subsequent problems for the child.

Chapter 7: Marginalised groups

This chapter looks at the experience of birth trauma on marginalised groups, using evidence drawn from written submissions and oral evidence given by experts and parents in oral sessions, particularly session 7, of the inquiry.

There are approximately 700,000 births a year in the UK.[93] Regular reports from the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) programme, however, show that maternal outcomes vary widely according to demographic factors such as age, ethnicity and deprivation. These outcomes include maternal deaths during pregnancy, childbirth and the postnatal period, as well as stillbirths and neonatal deaths.

Evidence suggests that marginalised groups also have a poorer experience of maternity care. As well as ethnicity, deprivation and age, other factors that may affect an individual experience of maternity care can include neurodiversity, sexuality and gender identity. Some factors may, of course, interact.

Maternal outcomes

The most significant variations in maternal outcomes relate to ethnicity and deprivation.

In 2021, 28% of babies in England were born to mothers of non-white ethnic minority origin.[94] MBRRACE's most recent report, which analysed data from 2020-22, showed that Black women were almost four times as likely as white women to die during pregnancy, childbirth or the postnatal period, while Asian women were twice as likely to die as white women. Similarly, the maternal mortality rate for women living in the most deprived areas of the UK was more than twice as high as that of women living in the least deprived areas. [95]

Ethnic disparities can also be seen in stillbirth rates, which are significantly higher for babies of Black ethnicity (7.52 per 1,000 total births) and babies of Asian ethnicity (5.15 per 1,000 total births) than for babies of white ethnicity (3.30 per 1,000 total births). Again, there are striking disparities relating to socioeconomic status, with rates of 2.37 stillbirths per 1,000 total births in the least deprived quintile compared with 4.69 in the most deprived quintile.[96]

Although Black and Asian mothers are more likely to live in deprived areas, and are therefore particularly affected by the socioeconomic disparity, MBRRACE found that stillbirth rates for babies of Black and Asian ethnicity are higher than for babies of white ethnicity in all five socioeconomic categories.

Black women are also one-and-a-half times more likely to develop pre-eclampsia than white women, and six times more likely to develop pre-eclampsia superimposed on chronic hypertension.[97]

Gypsy, Roma and Traveller women are not included in the MBRRACE statistics, but a review of research suggests they have worse maternal outcomes than other groups.[98]

Certain other marginalised groups experience strikingly poor outcomes. Women in prison are five times more likely to have a stillbirth,[99] while young women who have been through the care system are far more likely to die by suicide in the perinatal period.[100] Women aged 19 and under are more likely to have premature babies and extremely low birthweight babies than women aged 20-35.[101]

Disparities in experience of maternity care

The reasons for the disparities in maternal outcomes are not clear – apart from suicide, the causes of maternal deaths are not broken down by ethnicity or socioeconomic status. Research provides some clues, however. Studies show that risk factors vary between ethnic groups. For example, Black women are more likely to have a history of cardiovascular disease than white women,[102] while South Asian women have higher rates of gestational diabetes than white women,[103] and six-to-nine times the risk of anal sphincter injury.[104] Yet, as Professor Angie Doshani, a consultant obstetrician gynaecologist, told the inquiry, women are not routinely informed antenatally of their greater risk.

Similarly, Black and South Asian women are at greater risk of Vitamin D deficiency, which leads to a greater risk of diabetes, miscarriage, pre-term birth, high blood pressure and pre-eclampsia. This could be addressed by a simple campaign to take Vitamin D in pregnancy, Carol King-Stephens, the equality, diversity and inclusion lead midwife at Walsall Healthcare NHS Trust, told the inquiry.

A 2022 report by campaign group Five X More, based on a survey of 1,320 Black or mixed heritage women, found three areas where maternal health care fell short: attitudes, knowledge and assumptions. These included, for example, using racially discriminatory language, poor awareness of Black women's physiology (one woman was told that "black people are more stretchy") and an assumption that Black women were being over-dramatic. Some reported that health professionals did not understand how particular conditions such as jaundice might appear differently on black skin.[105]

One South Asian woman, Neera Ridler-Mayor, told session 4 of the inquiry that the reason her major obstetric haemorrhage was initially missed was because of her skin colour: "A Caucasian lady who has a postpartum haemorrhage would go pale. I don't go pale. I will go grey and ashy." It was Neera's mother who spotted that her skin colour had changed, but her medical notes had been amended to state, incorrectly, that the midwife had noticed she had a haemorrhage because she had gone pale.

A survey on the experiences of Muslim women in maternity found many reported being patronised and having decisions made without their consent.[106] Describing a focus group of Somali women, some of whom had previously given birth in European countries, the report says that in the UK maternity system they were "subjected to racist attitudes" whereas in countries such as Norway and the Netherlands they were treated "with more kindness, consideration and compassion."

Mothers from ethnic minority backgrounds may be more likely to suffer from mental health problems, with one study finding that Indian and Pakistani women were at greatest risk.[107]. A study of Black Caribbean women found, however, that their interactions with professionals in the perinatal period were "protocol driven and formulaic, affording little scope to discuss psychological distress, identify morbidity, or deliver interventions that might restore or maintain maternal mental health."[108]

Language is also an important factor in the experiences of minority ethnic women in maternity care. In 2022, 30.3% of all live births in England and Wales were to women born outside the UK, the majority of whom were non-EU nationals. The most common country of birth for non-UK mothers was India, followed by Pakistan, Romania and Poland respectively.[109]

Many of those women will not have English as a first language, meaning that interpreters are essential. Yet an investigation by the BBC found that a lack of interpreters in the NHS is leading to adverse outcomes in maternity. Interpreting issues, it found, "were a contributing factor in at least 80 babies dying or suffering serious brain injuries in England between 2018 and 2022." Some staff are using online translation tools to deliver serious news to non-English speaking patients.[110]

Giving oral evidence to the inquiry, Professor Doshani said that for some women, the use of interpreters from their own community could be problematic because of the lack of confidentiality. She also noted that some women from ethnic minority communities can't read, even in their mother tongue. The app she has developed, JanamApp, includes animated videos to reach those women. Speaking to service users, she also found that if they didn't understand a question they were asked

by a health professional, they would often say "yes", creating the impression that they were giving consent when they weren't.

Ms King-Stephens told the inquiry that many women from marginalised groups simply cannot afford to travel to the hospital or their GP practice, and therefore miss important antenatal appointments. In Walsall, the council and the local bus company have now provided free day savers so mothers can attend the appointments. Sometimes the NHS is not mindful of cultural practices, she added – offering appointments to Muslim women on a Friday, for example, when they might be at mosque. Similarly, Clotilde Abe, co-founder of Five X More, giving evidence in session 1, suggested that it was possible to reach some minority women through offering sessions after church services.

A number of submissions, including some from professionals, mentioned more explicit racism, with one Asian woman, for example, saying that she was treated with greater respect when her white husband was present. Another, who was very seriously ill after a complicated birth (and suffered permanent injuries) wrote of the on-call consultant:

"She came the next morning and spent the whole time talking to my sister (who is also brown skinned) who was sat on the chair next to me. She said I looked much better and didn't even realise that wasn't me."

In a written submission, Dr Aditi Sharma, who conducted research with South Asian women on birth trauma, said that many feel coerced and dehumanised in childbirth, with one saying that two white women giving birth at the same time "had a lot more support and staff were being very responsive to them." Similarly, some organisations representing Black mothers said that many were treated automatically as being of higher risk than white women, and therefore put on a more medicalised pathway.

There were examples too of medical professionals making inappropriate comments. One woman wrote: "I tore, and as I was being stitched up, the doctor said, 'I'll stitch you up so you'll never do this again.'" I thought the doctor told me this because I was young and my baby was of mixed heritage. I thought I probably deserved it."

Other marginalised groups

We have less information about the outcomes and experiences of women from other marginalised groups, such as lesbian women or women with neurodivergent conditions, though a large-scale Californian study found that same-sex couples had significantly higher risk of adverse outcomes such as postpartum haemorrhage.[111]

There is some research evidence that marginalised groups may experience poorer maternity care, supported by testimony heard by the inquiry. Same-sex couples, for example, can face prejudice from health professionals, including the assumption that a birthing mother must be heterosexual. They therefore find themselves having to "come out" repeatedly to health professionals throughout the pregnancy, birth and postnatal period.[112] One qualitative Swedish study found that LBTQ parents experienced "disrespectful treatment from healthcare professionals that violated their bodily integrity."[113]

Laura-Rose Thorogood, a woman in a same-sex relationship, told session 6 of the inquiry that when she introduced her wife to the consultant, the consultant's attitude "just switched", and from that point on the care was "unprofessional". This included "shouting at the midwife in front of a whole room of us because she couldn't work out where baby was facing, to giving me an internal and crudely yanking a massive clot out of me, without an apology or explanation." When the baby was born by forceps, the doctor "pulled the baby out and she was 'flung' on top of my lower stomach and landed like a sack of potatoes. My wife gagged, because as she did, blood flew up everywhere and went all up me and over my face."

Qualitative research on how autistic women experience pregnancy has found they have more physical difficulties, such as nausea and pain, during pregnancy than non-autistic participants. Maternity professionals did not have a good understanding of autism and the women did not always feel comfortable telling professionals about their autism diagnosis. They also needed professionals to communicate with them clearly and to make changes during appointments such as dimming lights to reduce sensory overload.[114] Because autistic women may appear calm even when in severe distress, caregivers do not always trust women's reports of being in pain.[115] As one woman quoted in a submission from the National Autistic Society said: "It can be difficult when people expect you to be performing your pain in a way they recognise at a time when you have nothing spare to spend on doing the right facial expressions!"

Some submissions from young mothers suggested that they were treated less sympathetically because of their age. Jayde Edwards, who became pregnant when she was 15, told session 7 of the inquiry that the first question her GP asked her was whether she had considered having an abortion: "When I said to her, 'No I'm keeping the baby', she made a referral to social services and didn't tell me why…if she had explained, 'Maybe you need a bit more support,' I would've said I have family around, I was attending a church at the time and I have a really strong support network."

Jayde drew the inquiry's attention to the fact that many people may be marginalised in more than one way, and that certain types of marginalisation go together: young mothers, for example, are 22% more likely to be living in poverty by the age of 30[116], while those who have been through the care system are three times more likely to become mothers by the age of 18.[117]

Exceptionally vulnerable women

There are some women who are so vulnerable their voices are rarely heard: women in prison, for example, refugees, women who have been through the care system, or women whose babies are taken into care. One woman described in her submission feeling that she was "tortured" by midwives withholding essential care from her while she was in labour, which she believes is because she had been a heroin addict, though clean by the time of giving birth. She was given opiates for pain relief, and the fact that her urine test then showed traces of opiate was used against her in court when a decision was made to take her baby away from her. She wrote of the aftermath of her traumatic birth: "I have urine infections constantly and need to always be near a toilet as I have to urinate frequently, but the mental scars are far worse. I was treated like an animal, a second-class citizen that didn't deserve to be treated with any form of care."

Naomi Delap, a director of the charity Birth Companions, which supports marginalised women in childbirth, told the inquiry that many women have overlapping vulnerabilities: they may be victims of domestic abuse, of child sexual abuse, of trafficking; these women are likely to be single mothers, and they may be in prison, or have had a baby taken into care. Birth Companions is able to advocate for these women, who often may not feel listened to, or and who often feel pressured into particular choices during labour. Women who have had previous trauma, she pointed out, are three times as likely to develop postnatal PTSD as other women. Survivors of sexual abuse, for example, may find vaginal examinations – a common way of establishing progress during labour – intensely traumatic. "If maternity staff are aware of this aspect of woman's history this is something that can be planned for," she said.

Improving care

The evidence presented to the inquiry demonstrated the variety of ways in which it is possible to feel marginalised during labour and childbirth. Every individual who gives birth has their own unique history and needs. It might be that their ethnicity puts them at greater risk of tearing, or that their trauma history makes them terrified of internal examinations, or that their autism makes them particularly sensitive to sensory input. As Jacob Stokoe, a trans man giving oral evidence in session 7, said: "It's about seeing the person in front of you and responding to them as they need."

Ms Delap emphasised the importance of continuity of care – which, she pointed out, "doesn't necessarily reside in continuity of carer." Instead, it could be that "everybody has an understanding of trauma, that everybody is compassionate and kind, that there is continuity of information-sharing so that people don't have to keep on reiterating their trauma, telling their stories over and over again to different people." It should, she added, "also include individualised approach, individualised care plans, meaningful consent."

If we are to offer good quality maternity care to everyone, then this focus on individuality, on care and on consent is essential.

Vision: what does 'good' look like in maternity?

Our inquiry has uncovered a pattern of poor maternity care across the country, resulting in many women being deeply traumatised. In many cases, the effects extend beyond the individual woman to her partner, her children, wider family and friends. Many women spoke of being unable to return to work and of having to spend years undergoing NHS treatment for both psychological and physical injuries. In some cases, the impact of traumatic birth was still felt decades later.

We believe that it doesn't have to be like that. Sometimes unavoidable emergencies happen during birth, and sometimes, unfortunately, mothers or babies are harmed. It is not always possible to prevent stillbirth, for example, and sometimes a woman will experience a severe obstetric tear as the baby is born.

But it is possible both to reduce the incidence of harm and to make sure that women and their partners are better supported when harm occurs.

The common theme running through the personal submissions was of women not being listened to when they thought that something was wrong, or when they asked for help. Red flags that indicated a difficulty in pregnancy or labour were often ignored. Women told us that they felt belittled or dismissed when they raised concerns. After birth, women wrote of being unable to access basic help on the postnatal ward, even if they were too ill or weak to lift their baby. Partners, too, wrote of being ignored by staff and left unaware of what was happening. Attempts by parents to gain answers after a difficult birth in which mistakes were made often result in efforts to cover up or minimise the harm caused.

We suggest that a good maternity service would include the following elements:

Antenatal education

All pregnant women should have the opportunity to access good quality antenatal education that explains, clearly and straightforwardly, what giving birth involves, what the risks are and the kinds of choices they might have to make during labour so that they can think them through beforehand. Women should also have access to a risk calculator that helps them understand their own individual risk profile and to make choices about their birth accordingly.

Listening to women

Too many of the stories we heard involved women not being listened to. If a woman is concerned about bleeding in pregnancy, or reduced fetal movements, or that her bump has stopped growing, for example, then these concerns should be taken seriously and investigated. If she asks for pain relief, then she should be offered it. There should not be a default assumption that women are being over-anxious or over-dramatic when they express concerns.

Sharing good practice and using evidence-based care

Women should be able to feel reassured that the care they receive is based on agreed standards and guidelines. Where a maternity unit has been successful in, for example, reducing stillbirth rates, staff in other maternity units should have the opportunity to learn from that. Training in known problem areas (for example, correctly reading a CTG trace) should be given regularly, so that staff skills are up-to-date.

Consent

Except in an emergency, no procedure should be carried out on a woman without her consent.

Safe working environment for staff

All maternity units should be fully staffed. Staff should not be subjected to bullying from other staff members. It should be taken as a given that obstetricians and midwives work as a team, with the same goals in mind. Instances of bullying or bad behaviour should be dealt with robustly.

Postnatal care

All women should receive good quality postnatal care. This means that, on the postnatal ward, they are given appropriate help to go to the toilet, if necessary, or to pick up their baby. Women who want to breastfeed should receive help from staff trained in breastfeeding support. No woman should be made to feel inadequate or a failure for not being able to breastfeed. Staff should be trained to identify signs of illness postpartum, such as sepsis or haemorrhage.

Transparency and accountability

If mistakes happen during a woman's care, then hospitals must be open and honest with her about the mistake, in line with the duty of candour requirement. Mistakes should be treated as an opportunity to learn and improve future practice.

Partners

If a woman chooses to have her partner with her during birth, then a staff member should be assigned to keep the partner informed about what is happening if a problem arises.

Racism

No woman or staff member should be subjected to racist attitudes or assumptions. Women whose first language is not English should be offered a good-quality interpreting service. Cultural differences should be understood and respected.

Trauma-informed care

Women who disclose that they have had a previous traumatic experience (including traumatic birth) should be offered trauma-informed care, including the opportunity to receive mental health support from a professional and the opportunity to discuss potential triggers, and how they can be avoided, with the obstetric team.

Mental health support

Women and partners should be offered routine screening to see if they display trauma symptoms after birth, and offered appropriate mental health help if necessary.

Conclusion

Some of the findings in this inquiry – in particular the scale of birth trauma and the devastating impact it has on women and their families – will be new to a lot of people. Yet there is much still to be explored, and we hope this inquiry will begin a national conversation on birth trauma. Despite being a relatively common experience, the very first time birth trauma was discussed in parliament was in October 2023. Now that the taboo has been broken, we hope there will be many more such debates and that birth trauma will be taken seriously. We call on the prime minister and the UK government to implement our recommendations in full.

APPENDIX 1

Birth Trauma Inquiry Witnesses

Evidence session 1: 5th February 2024

Ranee Thakar, President, Royal College of Obstetricians and Gynaecologists

Gill Walton, Chief Executive, Royal College of Midwives

Professor Susan Ayers, Professor of Maternal and Child Health, City University London

Maureen Treadwell, Co-founder, Birth Trauma Association

Rachael McGrath, Chair, Birth Trauma Association

Clotilde Abe, Co-Founder, Five X More

Evidence session 2: 12th February 2024

Emma Hurst MLC, Member of the Legislative Council of New South Wales

Dr Hazel Keedle, Researcher, BESt Study and New South Wales Birth Trauma Inquiry

Amy Dawes, CEO Australasian Birth Trauma Association

Professor Antje Horsch, University of Lausanne

Jan Willem De Leeuw, Consultant Obstetrician and Gynaecologist

Evidence session 3: 19th February 2024

Dr Nitish Raut, Gynaecologist, Stoke-on-Trent Hospital

Dr Posy Bidwell, Chair of the MASIC Foundation, Deputy Head of Midwifery, South Warwickshire Foundation Trust

Professor Michael Keighley, Founder, MASIC Foundation

Geeta Nayar, mother with lived experience

Jenny Tighe, mother with lived experience

Sarah Embleton, mother with lived experience

Evidence session 4: 26th February 2024

Dr (h.c.) Donna Ockenden, Chair, Independent Review into Maternity Services

Dr Rebecca Moore, Perinatal Psychiatrist

Honey Attridge, Peer Supporter for the CNWL Maternity Trauma and Loss Care Service

Neera Ridler-Mayor, mother with lived experience

Emily Barley, mother with lived experience

Natalie Tasker, mother with lived experience

Evidence session 5: 4th March 2024

Professor Pauline Slade, Professor in Clinical Psychology, University of Liverpool

Kate Lough, Chair, Pelvic Obstetric and Gynaecological Physiotherapy Group (POGP)

Suzanne White, Head of Medical Negligence, Leigh Day

Professor Robert Freeman, Consultant Gynaecologist, University of Plymouth

Heather Simmons, mother with lived experience

Neya Joshi, mother with lived experience

Evidence session 6: 11th March 2024

Dr Andrew Mayers, Psychologist, University of Bournemouth

Mark Williams, Founder, Fathers Reaching Out

Kieran Anders, Operations Manager, Dad Matters

Scott Mair, Director, Fatherhood Solutions

Lucy Allen-Goss, Academic and Writer

Laura-Rose Thorogood, Founder, LGBT+ Mummies

Evidence session 7: 18th March 2024

Professor Angie Doshani, Consultant Obstetrician and Gynaecologist

Illyin Morrison, Midwife and Birth Trauma Specialist

Carol King-Stephens, Midwife and Lead on Inequality for the West Midlands

Jayde Edwards, Project Manager at Mental Health Foundation for Young Mums Connect

Naomi Delap, Director, Birth Companions

Jacob Stokoe, Founder, Transparent Change

APPENDIX II

Summary of Recommendations

Chapter One:

1. Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services and provide mandatory training on trauma-informed care.
2. Make sure all NHS trusts offer antenatal classes to inform parents of what to expect from birth and to outline their options.
3. Make an awareness of the causes and impact of birth trauma a mandatory part of both midwifery and obstetrics training.

Chapter Two:

1. Make training in trauma-informed care a mandatory part of midwifery and obstetric education.
2. At the 34-week appointment, discuss with women their options during birth, including the risk factors relating to instrumental and caesarean birth.
3. Offer regular CPD training to maternity professionals on communicating risk.

Chapter Three:

1. Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.
2. Introduce mandatory data gathering, so we know exactly how many women experience OASI.
3. Maternity units to adopt the recommendations of the consensus statement on instrumental birth, to be published this year.
4. Government to provide funding to validate the UR-CHOICE pelvic floor risk disorders calculator so it can be used in clinical practice.
5. Maternity units to implement NHS England's Perinatal Pelvic Health service specification, which includes providing information for women in antenatal period, such as the importance of pelvic floor exercises; increased education for health professionals including GPs; and early access to care for symptoms of incontinence. Women with perineal injuries to be seen by specialists in pelvic health clinics.[118]

Chapter Four:

1. Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery.
2. Make a more focused effort to train and recruit perinatal mental health staff.
3. Introduce specialist training in birth trauma for CBT and EMDR therapists.
4. Introduce national oversight of maternal mental health services, with resources developed nationally instead of each service having to create their own.
5. NHS to commission research on birth debriefs, with the aim of creating a standard, evidence-based model that works and can be applied throughout the country.
6. NHS to commission an academic researcher to develop two standard screening questions about birth trauma that can be asked by the GP at the six-to-eight week postnatal check.

Chapter Five:

1. Government to commission research on the economic impact of birth trauma, including factors such as women delaying returning to work, the break-up of relationships and the costs of raising a disabled child.
2. Government to commission research on the costs to the NHS and social care of birth trauma, including the long-term cost of repairing birth injuries, providing mental health support and providing care for disabled children.
3. NHS to offer better support for maternity professionals, including opportunities to debrief and receive counselling after witnessing trauma.
4. Government to introduce more robust procedures for investigating bullying behaviour in NHS maternity care.

Chapter Six:

1. Offer mental health screening to partners after birth. This could be in the form of one or two questions from a health professional.
2. NHS England to develop guidance for keeping partners informed about an obstetric emergency (for example, assigning a health professional to update the partner on what is happening during and after the emergency).
3. Government and employers to consider offering extended parental leave in cases where a father or non-birthing mother has to support a new mother who is physically or mentally unwell.

Chapter Seven:

1. Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women. To address this NHS England should provide funding to each NHS Trust to maintain a pool of appropriately trained interpreters with expertise in maternity and to train NHS staff to work with interpreters.
2. Launch a national NHS-wide campaign to publicise the importance for Black and Asian women of taking Vitamin D during pregnancy.
3. Introduce specialist midwives for young parents who understand the intersection with other vulnerabilities, such as deprivation or care experience.
4. Provide training for maternity staff in trauma-informed care.

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To:
- ICB:
  - chief executives
  - chairs
  - chief nurses
  - medical directors
- Provider trust:
  - chief executives
  - chairs
  - chief nurses
  - medical directors

cc.
- LMNS chairs/leads
- Neonatal operational delivery network (ODN) leads
- Regional:
  - directors
  - chief nurses
  - medical directors
  - chief midwives
  - lead obstetricians

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

17 May 2024

Dear colleague,

Maternity and neonatal services - listening to women and families

The importance of listening to women, and taking appropriate action in response, has again been brought into sharp focus this week following publication of the report by the All-Party Parliamentary Group (APPG) on Birth Trauma.

We are grateful to the APPG on Birth Trauma for giving a voice to mothers and families who have experienced birth trauma. There is no single solution to reducing risks before, during and after birth, and the needs of each mother, baby and family affected by a traumatic birth will be different, and local services have important roles to play in preventing traumatic births, and better supporting those who experience them. We urge all Boards, and those that work in maternity and neonatal services to read the report and how its themes and recommendations inform existing local plans to implement the three year delivery plan for maternity and neonatal services.

The Priorities and operational planning guidance 2024/25 makes clear that the implementation of the Three year delivery plan for maternity and neonatal services continues to be a key priority for Integrated Care Boards (ICBs), Trusts and primary care. The vast majority of women, babies and families receive safe care, and the plan commits

the NHS to making maternity and neonatal care safer, more personalised, and more equitable, and prioritises listening to women and families to achieve this.

Trust boards and ICBs have a duty to ensure regular, robust oversight of maternity and neonatal services in line with the perinatal quality surveillance model. In particular, if not already done so, boards must review the commissioning and implementation of existing commitments for which you have received funding for implementation in 23/24, and which will help address recommendations in the All-Party Parliamentary Group (APPG) on Birth Trauma report:

- Perinatal pelvic health services, in line with the national service specification
- Maternal mental health services, in line with national guidance
- Availability of bereavement services 7 days a week
- LMNS equity and equality action plans, working across organisational boundaries

Since 2020 there has been a contractual requirement to offer women a maternal postnatal consultation with a GP, and in December 2023 we issued 'what good looks like' guidance in support of this. We therefore ask ICBs to review local delivery of this standard.

NHS England is providing an additional £3m of funding for maternity and neonatal voice partnerships (MNVPs) in 2025/26 and 2026/27, with a part-year effect of £1.2m in 2024/25. This funding is part of a £35m package of additional investment in maternity and neonatal services over three years that was announced in the Spring Budget. ICBs should already be providing appropriate levels of funding and resourcing to MNVPs, and therefore the additional funding recognises the central role MNVPs play in helping to improve care as outlined in Maternity and neonatal voices partnership guidance, and the need to strengthen the neonatal parental voice component. This letter confirms allocations for 2024/25 (Annex 1), which have been calculated on a per unit basis. The funding will be available for ICBs to draw down by June.

We look forward to continuing to work with you to improve maternity and neonatal care.

Yours sincerely,

Dame Ruth May
Chief Nursing Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Annexe: ICB allocations for MNVPs

Org Code	Org Name	No. of units	Allocation 2024/25
QOX	BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB	3	£23,077
QHG	BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB	3	£23,077
QHL	BIRMINGHAM AND SOLIHULL ICB	3	£23,077
QUA	BLACK COUNTRY ICB	4	£30,769
QUY	BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB	2	£15,385
QU9	BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST ICB	3	£23,077
QUE	CAMBRIDGESHIRE AND PETERBOROUGH ICB	3	£23,077
QYG	CHESHIRE AND MERSEYSIDE ICB	8	£61,538
QT6	CORNWALL AND THE ISLES OF SCILLY ICB	1	£7,692
QWU	COVENTRY AND WARWICKSHIRE ICB	3	£23,077
QJ2	DERBY AND DERBYSHIRE ICB	3	£23,077
QJK	DEVON ICB	4	£30,769
QVV	DORSET ICB	2	£15,385
QNQ	FRIMLEY INTEGRATED CARE ICB	2	£15,385
QR1	GLOUCESTERSHIRE ICB	1	£7,692
QOP	GREATER MANCHESTER INTEGRATED CARE ICB	8	£61,538
QRL	HAMPSHIRE AND THE ISLE OF WIGHT ICB	5	£38,462
QGH	HEREFORDSHIRE AND WORCESTERSHIRE ICB	2	£15,385
QM7	HERTFORDSHIRE AND WEST ESSEX ICB	3	£23,077
QOQ	HUMBER AND NORTH YORKSHIRE ICB	6	£46,154
QKS	KENT AND MEDWAY ICB	5	£38,462
QE1	LANCASHIRE AND SOUTH CUMBRIA ICB	5	£38,462
QK1	LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	2	£15,385
QJM	LINCOLNSHIRE ICB	2	£15,385
QH8	MID AND SOUTH ESSEX ICB	3	£23,077
QMM	NORFOLK AND WAVENEY ICB	3	£23,077
QMJ	NORTH CENTRAL LONDON ICB	5	£38,462
QHM	NORTH EAST AND NORTH CUMBRIA ICB	10	£76,923
QMF	NORTH EAST LONDON ICB	5	£38,462
QRV	NORTH WEST LONDON ICB	6	£46,154
QPM	NORTHAMPTONSHIRE ICB	2	£15,385
QT1	NOTTINGHAM AND NOTTINGHAMSHIRE ICB	3	£23,077
QOC	SHROPSHIRE, TELFORD AND WREKIN ICB	1	£7,692
QSL	SOMERSET ICB	2	£15,385
QKK	SOUTH EAST LONDON ICB	5	£38,462
QWE	SOUTH WEST LONDON ICB	5	£38,462
QF7	SOUTH YORKSHIRE ICB	5	£38,462
QNC	STAFFORDSHIRE AND STOKE ON TRENT ICB	1	£7,692
QJG	SUFFOLK AND NORTH EAST ESSEX ICB	3	£23,077
QXU	SURREY HEARTLANDS ICB	3	£23,077
QNX	SUSSEX ICB	5	£38,462
QWO	WEST YORKSHIRE ICB	6	£46,154
TOTAL		156	£1,200,000

Maternity & Newborn Safety Investigation Programme
Care Quality Commission
Second Floor
2 Redman Place
London
E20 1JQ

Bradford Teaching Hospitals NHS Foundation Trust
Bradford Royal Infirmary
Smith Lane
Bradford
BD9 6DA

07 June 2024

Dear Sara and Nada,

Escalation of a concern from MNSI investigation case number MI-036777

The Maternity and Newborn Safety Investigations (MNSI) programme began in October 2023 after formally being known as the Healthcare Safety Investigation Branch (HSIB). Our role is to undertake independent investigations into cases which meet our eligibility criteria.

Case MI-036777 was reviewed by the MNSI concern's panel on 6 June 2024. As part of this review the medical records and all documentation relating to this investigation obtained to date have been considered.

The concerns noted by the panel are in relation to the assessment and management of the Maternity Early Warning Score (MEWS). In particular, the panel asks whether the Trust is assured that if a mother's condition deteriorates, the team is able to detect this and react with effective escalation in a timely manner.

MNSI seeks the evidence for this assurance in relation to:

- The tools and technology in place to support recording of clinical observations and identification of deterioration in a mother's clinical condition
- The processes that support early escalation to the multidisciplinary team
- The skills and knowledge of all staff undertaking clinical observation to recognise abnormal readings and where to seek advice and support.

MNSI has previously raised concerns regarding the Trust's MEWS process within the maternity service; following safety investigations in August 2020 and February 2023.

The case numbers and details of the concerns and recommendation made are below:

Report 2002-1680 (August 2020)

Page 32:

Diastolic blood pressure is an important additional parameter used in the screening for and diagnosis of pre-eclampsia (NICE, 2008). This is not included in the Trust MEWS chart. The HSIB clinical panel considers that diastolic BP is a required part of maternal observations and should be included in a MEWS system.

Page 33:

The HSIB clinical panel considers that the Trust's MEWS system is not effective in supporting staff to escalate and manage an elevated MEWS score.

Recommendation: *The Trust to ensure that staff are supported to identify a mother with an elevated MEWS and to escalate for a timely medical review.*

Report MI-010714 (February 2023)

Page 48:

HSIB considers this can be more easily observed on a MEWS chart (RCP, 2017). The investigation learnt that locally observations are no longer plotted on a MEWS chart showing visual trends, following the introduction of the electronic patient record.

The investigation cannot find any evidence of documentation of 'HDU [high dependency] monitoring', which includes monitoring of fluid intake and output. This is not in line with local standards (Trust, 2017).

The investigation learnt that staff consider that the use of a handwritten paper HDU chart (used pre implementation of the electronic patient record) or MEWS chart may have helped see the trend of low BPs and high heart rates.

We want to make you aware of this to enable learning and safety improvements to begin, before completion of the final investigation report. We will include in our report any relevant changes or improvements you put in place in response to these concerns.

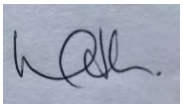
We request the following actions:

1. Please confirm receipt of this letter within 24 hours to MNSI: Helen Smith helen.smith@mnsi.org.uk , copying MNSIConcerns@mnsi.org.uk
2. Please respond within five working days by email to Helen Smith copying MNSIConcerns@mnsi.org.uk to confirm what immediate actions you have taken to address our concerns.
3. Please confirm that our concerns have been escalated within your trust governance structure.
4. Please confirm you have shared our concerns externally with the ICB.

5. In line with NHSE England's perinatal quality surveillance model principle 1 you should share this letter with your trust board as part of your perinatal quality surveillance dashboard.

If you have any questions, please contact Helen Smith, Head of Region or Cara Taylor, Team Leader who will be happy to discuss the concern's panel review and the associated concerns.

Yours sincerely



Helen Smith

cc.

MNSI Team Leader: Cara Taylor cara.taylor@mnsi.org.uk

Head of Region: Helen Smith helen.smith@mnsi.org.uk

MNSIConcerns@mnsi.org.uk.

Regional Chief Midwife: tracey.cooper22@nhs.net

Regional Chief Obstetrician: r.gosakan@nhs.net

CQC

Bradford Teaching Hospitals
NHS Foundation Trust

Women's Service
Clinical Business Unit

Women's CBU
Admin Corridor, Women's and Newborn Unit
Bradford Teaching Hospitals NHS Foundation Trust
Bradford Royal Infirmary
Duckworth Lane
Bradford BD9 6RJ

Tel: 01274 364500

Date: 14 June 2024
Our ref: SH/NS

PRIVATE & CONFIDENTIAL

Dear MNSI,

Following receipt of your escalation of emerging concerns letter, received 7 June 2024, we have considered the concerns raised and have provided a summary of any relevant changes or improvements already in place and any further actions or planned improvements.

The response also includes a number of appendices to provide further assurance of the processes in place and evidence to support how learning has been shared with the multidisciplinary team in response to the HSIB/MNSI cases referenced.

Escalation of a concern from MNSI investigation case number MI-036777

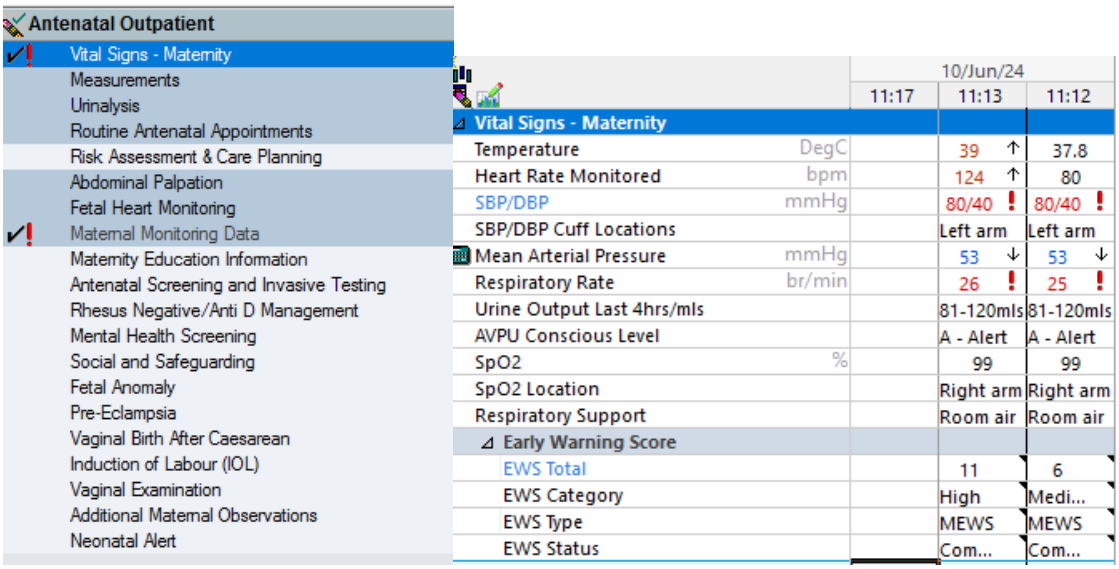
The concerns raised are in relation to the assessment and management of the Maternity Early Warning Score (MEWS). In particular, the panel asks whether the Trust is assured that if a mother's condition deteriorates, the team can detect this and react with effective escalation in a timely manner.

MNSI seeks the evidence for this assurance in relation to:

1. <u>The tools and technology in place to support recording of clinical observations and identification of deterioration in a mother's clinical condition</u>

The EPR system is used to record all patient observations.

The guidance and algorithm for MEWS can be found by clicking the EWS (blue text) within the vital signs box (see image below). Appendix 1 includes a copy of the guidance and algorithm which is available to staff. This guidance and algorithm are also available on the Trust intranet on the Women's services guidelines page.



Any observations entered into the vital signs iband appear on the vital sign chart and vital sign graph which is displayed on the maternity view page. The graph view enables staff to be able to view trends in recordings and any subtle changes over time as is there to replace the MEWS charts which were previously on paper (example image above).

Any severely abnormal parameter highlights within the system in red. Red exclamation marks appear within the iView band menu when a patient has a parameter which has highlighted in “red”. As soon as a patient scores medium or high (Amber or red), the ALERT message appears on the patient record with the associated escalation guidance (see examples above and below). This supports staff with the requirements for escalation.

Vital Signs

All Visits | Last 48 hours | Last 24 hours | Last 1 years

	18:00	17:00	16:00	15:00	14:00	13:00	12:00	11:00	10:00
Respirat... br/min	16	14	14	15	16	15	18	19	18
SpO2 %	99	97	98	99	97	98	98	98	98
Temp DegC	37.0	36.9	36.9	36.8	36.8	37.0	37.8	37.1	37.3
HR bpm	↑ 115	↑ 114	↑ 112	↑ 111	↑ 120	↑ 94	↑ 106	↑ 109	↑ 125
BP mmHg	125 / 67	127 / 75	122 / 75	136 / 76	125 / 67	118 / 78	134 / 80	123 / 81	124 / 66
Mean Art... mmHg	86	92	91	96	86	91	98	95	85
Conscious Level	Awake and R...	Awake and...	Awake and R...	Awake and R...	Awake and R...	Awake and R...	Awake and R...	Awake and R...	Awake and R...
Respiratory Su...	Room air	Room air	Room air	Room air	Room air	Room air	Room air	Room air	Room air
Urine Output L...	201-800mls	201-800mls	201-800mls	201-800mls	121-200mls	201-800mls	201-800mls	201-800mls	121-200mls
EWS Total	2	3	2	2	3	0	2	--	3
EWS Category	Green	Green	Green	Green	Green	Stable	Green	--	Green
EWS Type	MEOWS	MEOWS	MEOWS	MEOWS	MEOWS	MEOWS	MEOWS	--	MEOWS

MEWS RED ALERT - HIGH RISK

Name: ZZZTEST, ONE
Date: 10 June, 2024 11:14:18
MRN: 4172626
Age: 23 Years
Location: BRIM; Labour WD BRIM; Room 01

MEWS = 11

MEWS Score of 8 or more MEWS Score of 5-7 with Additional Concerns	
Level of concern	**High**
MEWS	8 or more Or 5-7 with Additional Concerns
Primary escalation & response (use SBAR Framework)	Immediate review by midwife/nurse in charge
	Immediate review by ST3+ or equivalent & consultant. Consder review by outreach team
Medical review timing	Immediate
Minimal vital signs redording until medical review/ongoing plan	Continuous Observations
Secondary contact	Clinical outreach team or equivalent

MEWS Criteria:
10 June, 2024 11:13:00 | Respiratory Rate = 26 **(2 point(s))**
10 June, 2024 11:13:00 | SpO2 = 99% **(0 point(s))**
10 June, 2024 11:13:00 | Temperature = 39 DegC **(3 point(s))**
10 June, 2024 11:13:00 | Heart Rate Monitored = 124 **(2 point(s))**
10 June, 2024 11:13:00 | Systolic Blood Pressure = 80 **(2 point(s))**
10 June, 2024 11:13:00 | Diastolic Blood Pressure = 40 **(2 point(s))**

(i.e screen shots are from test patient in the live system)

2. The processes that support early escalation to the multidisciplinary team

The system includes the supporting guidance (Appendix 1) for action and escalation in response to the MEWS. The red and amber alerts also support staff in what actions are required in response to abnormal observations as outlined above.

3. The skills and knowledge of all staff undertaking clinical observation to recognise abnormal readings and where to seek advice and support.

MEWS, recognition of the deteriorating patient and escalation is included within the annual Practical Obstetric Multi-Professional Training (PROMPT) within the scenarios for the practical skills simulation. The Trust achieved full compliance with the Maternity Incentive scheme year 5, including safety action 8; over 90% of all staff groups attended PROMPT by December 2023. The service is also on track to achieve year 6 of the maternity incentive scheme in all safety domains.

Professor Mel Pickup, Chief Executive Officer Sarah Jones, Chair

When working through scenarios within PROMPT and during ad hoc skills and drills in the clinical areas, the recognition of deterioration and escalation of this is a key learning outcome. Appendix 2-5 are the scenario plans to support where MEWS and recognition of deterioration and escalations has been incorporated. Appendix 6 demonstrates one of the in-situ skills and drills scenarios undertaken and the debrief learning and feedback.

A session regarding patient deterioration and MEWS was included in the Enhanced Maternity Care (EMC) session delivered to all staff groups during PROMPT in 2022 to 2023 (Appendix 7). This session also included documentation requirements for EMC within EPR and where to locate the tools and guidance for the management of sepsis within the EPR system.

A session within this year's PROMPT is specifically for MSWs and focuses on MEWS and scribing during clinical emergencies.

4. <u>Quality improvement work undertaken since 2020 to date in relation to MEWS including actions taken in response to MNSI incidents 2002-1680 and MI010714</u>

Regular audits have been undertaken since 2020 and actions taken in response to the findings of these audits. In addition, a staff sepsis survey was completed in 2022 which included exploration about risk assessment, escalation, documentation etc (Appendix 8).

In March 2022 Cerner electronic patient record (EPR) was launched. This aligned systems for all maternity patients. However, when the system was initially launched it did not accurately calculate a MEWS score but provided an early warning score (EWS) category of low, medium and high, if all the appropriate parameters were completed. Staff needed to refer to a paper chart for an accurate calculation of the score and enter this manually into the system. A risk assessment was completed and added to the maternity risk register (Appendix 9). On 21 August 2023 MEWS automation went live following system changes. This change was cascaded to staff via the Quality & Safety Bulletin (Appendix 10).
The most recent MEWS audits have taken place, November 2023 and May 2024 (Appendix 11 & 12). The last MEWS audit (Appendix 12) demonstrates an increase in MEWS compliance and there were no concerns identified in relation to escalating a MEWS above 5.

A MEWS questionnaire (Appendix 13) was sent out to staff in December 2023. This questionnaire gathered the following information:

- Staff role
- Area of work
- Do you find the vital signs iband within Cerner easy to use to obtain a MEWS?
- Are you familiar with the MEWS guidance algorithm, when to repeat observations and who to escalate to?
- Are you familiar with the special circumstances within Maternity that require increased MEWS surveillance?
- Do you know where to find the MEWS guidance algorithm within the Cerner vital signs iband?
- Do you feel there are any barriers to performing MEWS in line with the guidance or escalating a Medium or High MEWS?

If a negative response was provided to any of the questions further explanation was requested to explain the reason for this response.

In response to the questionnaire findings, in January 2024, a support video was cascaded to staff which included a demonstration of where and how observations are recorded within the records and how to find the guidance within the system.

Learning and information is shared with staff regularly via the weekly Quality & Safety Bulletin. Examples of these have been included in Appendix 14 -17. The audits and survey finding have also been shared with staff via newsletters and governance meetings.

5. Future planned improvements/Next Steps:

- The Trust is in early conversations with NHS England about trialling Martha's rule/worries and concerns work in a maternity setting. Thus, being the first Trust to do this nationally.
- Our current MEWS values are in line with regional maternal critical care guidance, and we are waiting for them to be superseded by national guidance. The service will be implementing the new national MEWS values following approval of the digital version. The anticipated approval date for this is in July 2024. It has been agreed already that BTHFT will be in the first group of Trusts to roll this out digitally.
- The Trust has also been approached regarding being the first Trust to contributing data to the DREAMeD study which is assessing the impact of implementation of national MEWS.
- Regular audits, at least 6-12 monthly will continue and any areas for improvement actioned.
- Staff training will continue at Trust induction and through the annual core mandatory training programme
- Any learning from incidents will be shared with individual staff, and the wider team via the safety bulletins and at the safety huddles

6. Trust Governance:

The MNSI letter of concern has been shared at the Trust Executive team meeting on 10 June 2024. The MNSI letter is included on the agenda for the Women's service Quality & Safety meeting on 18 June 2024. The MNSI letter will be discussed at the local perinatal quality surveillance meeting on 14 June 2024 which includes representation from the LMNS and ICB.
The MNSI letter will be included in the June Maternity and Neonatal Services Monthly update report, which will be presented to July Quality and Patient Safety Academy in lieu of Trust Board. For completeness, it will be included in the Maternity and Neonatal Assurance paper and presented to July Trust Board.

7. Appendices

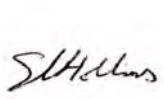
- Appendix 1 BTHFT MEWS Chart
- Appendix 2 Scenario 1- version 2 PROMPT VBAC & Uterine Rupture
- Appendix 3 Scenario 2 mMIST Cord Prolapse MAC
- Appendix 4 Scenario 2-mMIST Eclamptic Fit VB EDIT 6.10
- Appendix 5 2023 Scenario 1 - Low BMI PPH
- Appendix 6 mMist Anaphylaxis 02.01.23 and Shoulder dystocia 02.01.23
- Appendix 7 PROMPT EMC Training update May 23
- Appendix 8 Maternal Sepsis Survey 2022-summary
- Appendix 9 Risk assessment CERNER MEWS v3

- Appendix 10 Q&S Bulletin 18.08.23
- Appendix 11 MEWS Audit Report Nov 2023
- Appendix 12 MEWS Audit Report May 2024
- Appendix 13 Maternity Early Warning Score (MEWS) Questionnaire
- Appendix 14 Q&S Bulletin 04.08.23
- Appendix 15 Q&S Bulletin 27.11.23
- Appendix 16 Q&S Bulletin 22.12.23
- Appendix 17 Q &S Bulletin 17.05.24

We hope that this provides you with the assurance that improvement work has already been undertaken in relation to the recording and escalation of MEWS, including staff training and the regular assurance audits in place, specifically relating to MEWS.

Please do not hesitate to contact us if any additional information or clarification is required.

Yours Sincerely



Sara Hollins
Director of Midwifery

Nada Sabir
Clinical Director, Women's Clinical Service Unit

BO.7.24.7 - ENGAGEMENT STRATEGY ANNUAL REPORT

REFERENCES

Only PDFs are attached

- Bo.7.24.7 - Engagement Strategy Annual Update (presentation).pdf
- Bo.7.24.7 - Engagement Strategy annual update (cover) and patient experience report.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Engagement Strategy 2023-2028 and Patient Experience Annual Update.

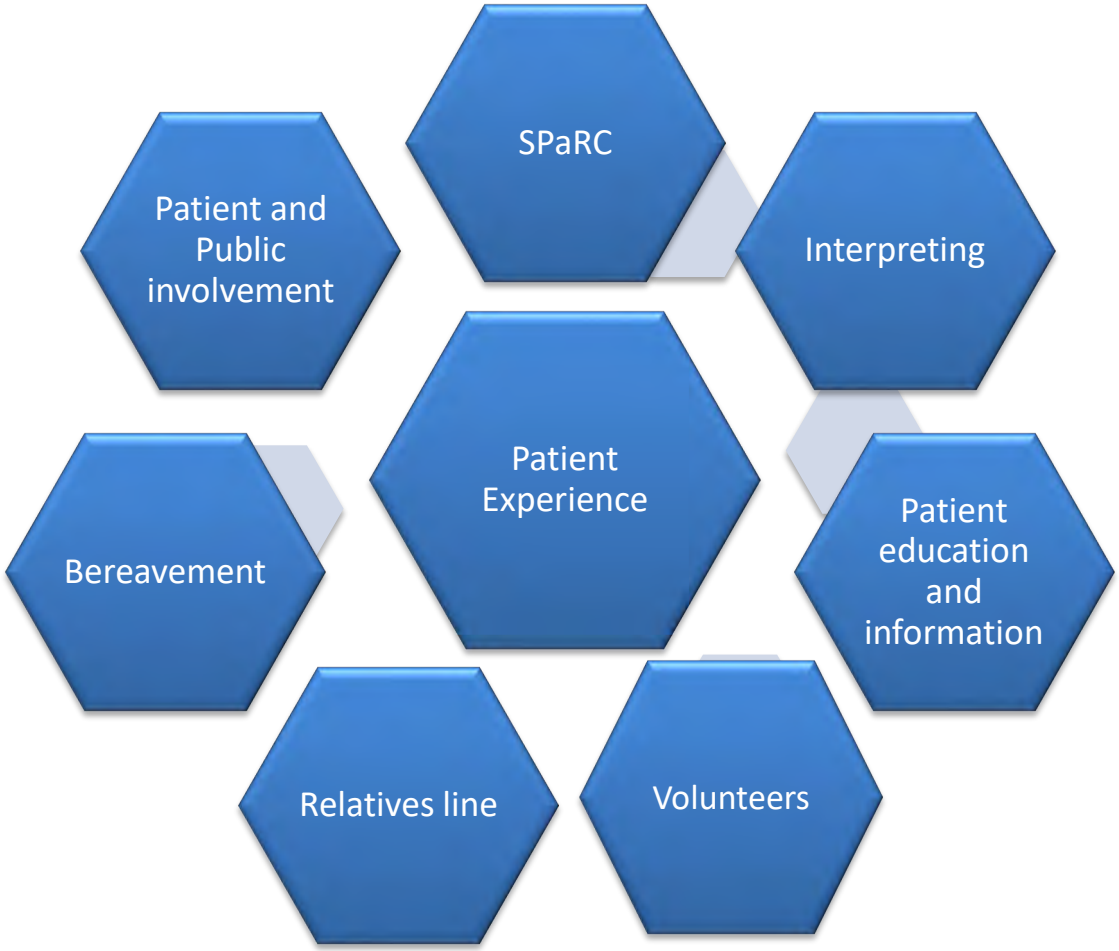
Ruth Tolley
Quality Lead for Patient Experience

Board of Directors – 11 July 2024

"Kindness at every step, no decision about you without you"

Teams.

Bradford Teaching Hospitals
NHS Foundation Trust



Model of feedback.

Bradford Teaching Hospitals
NHS Foundation Trust

Examples of Engagement and Involvement.

- Monthly Healthwatch meetings and project work.
- Community Engagement meetings.
- Formal engagement programs, PLACE and CQC surveys.
- Patient Stories.
- Patients representation at meetings and groups.
- Contribute to listen events.
- Work with the Trusts Membership Group.
- EDI2022, community engagement event with EDI team.
- Engage with formal bodies CQC, PHSO.
- Patient feedback via complaints, PALs compliments, NHS choices.
- Patient and public involvement team projects for example radiology.
- Service user feedback from diverse representation and actions evidenced back to the group as direct feedback. E.g. AED walk around.
- Co production of involvement work Hi-Vis group.

Citizen Voice Forum- joint work.

Bradford Teaching Hospitals NHS Foundation Trust

- Sets the strategic direction for citizen voice across Bradford District and Craven.
- Work with priority boards and decision-making groups in BDCHCP to obtain assurance that involvement duties are met, and that citizen voice is having impact.
- Oversee programmes to amplify citizen voice and deliver coproduction by activating the Citizen Voice Operational Group/Network.
- Receives strategic themes from involvement, experience, insight work across partnership.
- Strengthen our network of networks approach to map the activity that takes place and how we connect pieces of work and intelligence.
- Continue our work on actively involving and collaborating with the VCSE to collect insight gathered through existing networks.
- Strengthen our focus on using our community partnerships and other locality-based working to better understand our communities

Thank you

Questions?

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.7

PATIENT EXPERIENCE ANNUAL REPORT 2023/24

Presented by	Karen Bentley, Assistant Chief Nurse, Patient Experience Ruth Tolley, Quality Lead for Patient Experience	
Author	Karen Bentley, Assistant Chief Nurse, Patient Experience	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	Patient Experience Annual Report 2023/24 (Including PLACE and complaints)	
Key control	This paper is a key control for the strategic objective to provide outstanding care for patients.	
Action required	For assurance	
Previously discussed at/ informed by	Patients Experience Group (in part) Monthly PEG summary sent to QPSA	
Previously approved at:	**Academy/Group**	**Date**
	Quality and Patient Safety Academy QA.5.24.16	22.05.24

Key Options, Issues and Risks

Executive summary

This report provides an annual update on the work that has taken place in relation to Patient Experience and Engagement (PEE) and the work streams that feed into the Patient Experience Group (PEG).

. Analysis of the 2023/24 Patient Experience Annual report holds the following headlines:

- 87% of FFT responses received reported Good or Very Good feedback compared to 79% in previous years.
- Several Patient Engagement projects have taken place and resulted in changes to service following these.
- Partnership working and monthly Engagement meetings have enabled network of networks to flourish and key messages to be shared and responded to.
- PLACE results have seen deterioration in food scores, but improvement in environment and disability.
- Complaints has seen an increase of around 20% compared to the last financial year.
- PALs have seen a slight decrease compared to the same period the previous year.
- There have been 3 complaints graded as High during 2023/24.
- The Trust has received 6 new enquiries during 2023/24 from the PHSO. 2 of these were closed, 1 was partially upheld and 3 are still being investigated.
- Learning from complaints is a key priority and evidence of how this is captured and reported.
- National recognition and awards for the development of the SPaRC (formally chaplaincy) model and new ways of working, this includes the development of the SPaRC App and Ramadan allies.

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Recommendation

- Support is required from all areas to promote and endorse the Patient Experience and Engagement Strategy 2023-2028.
- Continue promoting the use of real time feedback via FFT to react and make timely improvements.
- Use of QI methodology for tests of change.
- National Survey (CQC) action plans to be monitored via the PE Group for improvement, led by the designated area lead once complete.
- Ongoing promotion and development of FFT data, evidence of "*You said we did".*
- Continue collaboration work with Bradford District and Craven Health Care Partnership to improve collective and consistent improvements.
- Benchmark against other Trusts that are doing well or significantly better in key Patient Experience (PE) areas.
- There is the requirement for a *tight grip* to remain on the handling and processing of complaints to enable KPIs to be met. These will be monitored via the Clinical Service Unit (CSU) at their performance meetings.
- PHSO standards to be implemented for early resolution.
- Learning from complaints to be strengthened and made transparent for the public.
- Compliments to be captured and celebrations and acknowledgement of these to be developed.
- Development of compliance repository for shared Trust wide learning.

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 (*)					

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

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

Risk Implications (see section 5 for details)	Yes	No
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: Caring
Care Quality Commission Fundamental Standard: Person Centred Care
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

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

1 PURPOSE/AIM

This report provides an Annual overview to the Quality and Patient Safety Academy/Board of Directors on some of the work that is being undertaken within Bradford Teaching Hospitals NHS Foundation Trust to improve Patient Experience and Engagement. The report includes the overall annual complaints data for 2023/24. The Patient Experience Team and the work streams that sit

within this portfolio of work are focussed on supporting the delivery of the Foundation Trust's mission; *to provide the highest quality healthcare at all times.*

From a governance perspective, work carried out within the Trust in relation to Patient Experience ordinarily is over seen by the Patients Experience Group, which is chaired by the Director of Nursing. A monthly update is provided to the Quality and Patient Safety Academy (QPSA) presenting the headlines and highlighting any risks to escalate. In addition, new activity is presented through Executive Management Team meetings for discussion, decisions and assurance.

In addition to providing this assurance to the Quality and Patient Safety Academy/Board of Directors, it is recognised that there is a need for effective dissemination down throughout the organisation to all areas within the Trust to ensure patients, friends and family are at the forefront of all that we do. There are plans to continue to invite one of our Patient and Public Voice Representative to future work stream meetings to increase our accountability, transparency and furthering our ethos of co-working.

This report provides an update on some of the key pieces of work being undertaken in relation to Patient Experience led by the team or as part of identified work streams. This includes:

- Patient Experience and Engagement Strategy.
- Friends and Family Test.
- National CQC Survey.
- Patient Experience Projects.
- Patient Led Assessment of the Care Environment (PLACE).
- Updates from work feeding into the Patient Experience Group.
- Patient and Public Involvement and Engagement updates.
- Complaints, Patient Advice and Liaison Service (PALS) and Compliments.

2 CURRENT POSITION

2.1 Patient Experience and Engagement Strategy.

During the first half of the financial year The Patient Experience Strategy was updated and replaced with the Patient Experience and Engagement Strategy 2023-2028. This strategy takes the work on "embedding kindness" to "kindness at every step, no decision about you without you". The aim of the strategy sets out how the Trust is committed to ensure it works towards including patients, families, and carers in decisions about the care that is being provided. The patient's voice

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is to be at the centre of all improvement work and there is a commitment to collaborate with partners like Healthwatch and colleagues in various agencies within the district to achieve this. The Trusts aim is to ensure that patient, family, and carer experience is at the heart of all the work carried out and recognise the importance of community engagement and working.

The strategy sets out 6 aims and a framework for improvement of how the work is to be achieved by:

- Ask and capture.
- Listen and understand.
- Act to improve.
- Measure and share.

All of which will support a culture of improving experience. The strategy has been developed with assistance from the community in the development of this. Within the organisation there has been a shift to make patient experience a standing agenda item on additional meetings to highlight the general overall importance and links to patient safety.

The strategy has been launched at several forums including:

- Quality and patient safety forum.
- Community engagement meeting.
- District wide Citizen Forum.
- EDI 2022 community event.
- Healthwatch.
- Nursing and Midwifery Excellence event.
- A stall at the Annual General Meeting, ward walks and public events.

Work is planned to continue embedding the strategy and cross pollinating with other Trust strategies to ensure patient experience and involvement are at the centre of all that we do. The strategy is also being produced in Easy read format.

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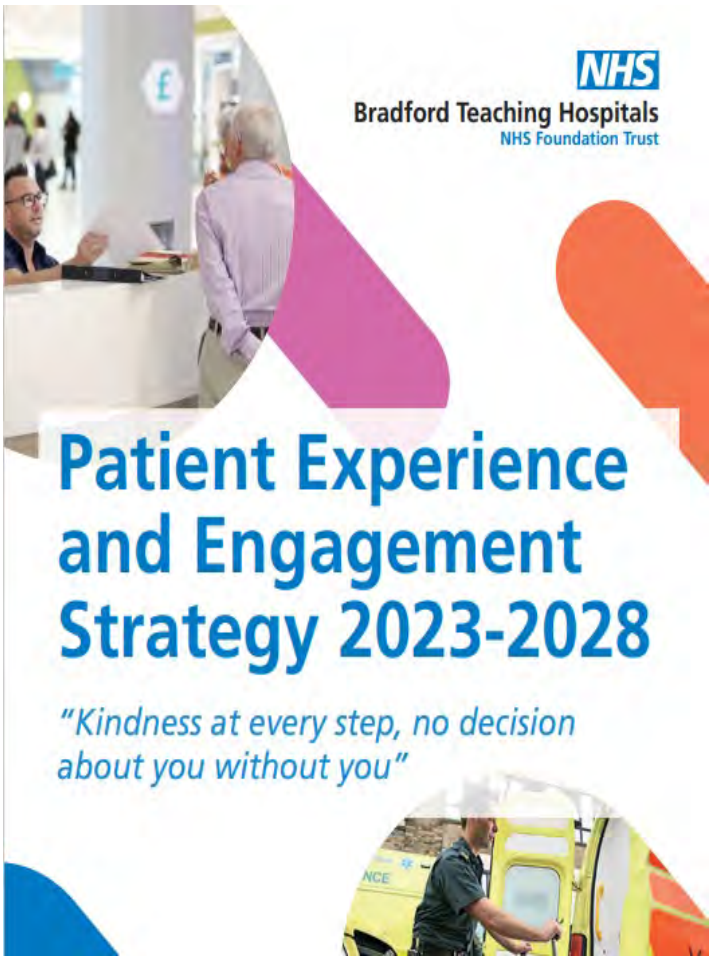

Image of the Patient Experience and Engagement Strategy.

2.2 Friends and Family Test

During 2023/24 the Trust has commissioned a new contractor to analyse all the FFT data. This company HealthCare Communications collects the data in several different ways:

- Text following outpatient visits, Admissions and AED visits.
- Via scanning of QR codes.
- Via iPad in clinical areas.
- Paper format (including accessible and child friendly formats).

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

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	Very Good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Grand Total
A&E Feedback	6,619	2,632	965	847	1,987	77	13,127
Inpatient Feedback	17,598	2,738	550	332	609	103	21,930
Outpatient Feedback	19,434	2,885	542	296	372	97	23,626
Maternity Feedback	1,169	99	18	11	34	2	1,333
Totals	**44,820**	**8,354**	**2,075**	**1,486**	**3,002**	**279**	**60,016**
Percentage	**74.68%**	**13.92%**	**3.46%**	**2.48%**	**5.00%**	**0.46%**	

Figure 1 – Friends and Family Test Responses 2023/24

The overall Trust position for 2023/24 is an increased score of 88.6% of patients scoring the Trust as 'very good' or 'good' in comparison to the previous year of 78.9%.

Figure 2 demonstrates an analysis of words from the comments received for all the inpatient feedback and figure 3 highlights the themes.

Figure 2 represents the words pulled from overall annual inpatient FFT feedback responses.

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Figure 3 represents the themes pulled from the total annual inpatient feedback responses.

Now areas have access to real time feedback development work is taking place with dashboards to enable areas to visit and review as part of ongoing audit work.

2.3 National CQC Survey updates

During 2023/24, the Trust received the results of the following surveys:

- National In-Patient Survey 2022.
- Maternity Survey 2022

All results are reported via the PE Group and developments and action plans are monitored for assurance. A paper and presentation of the full results are presented to the QPSA.

2.3.1 National In-Patient Survey 2023

The National Inpatient Survey programme covers 133 NHS Trusts. This programme ran from January 2023 to April 2023 and covered patients who were discharged from Inpatient stays in Bradford Teaching Hospitals in November 2022. This survey offered a new mixed method of survey, offering both paper and SMS. The survey offered 48 questions, 10 demographic questions and 3 free text questions.

The best scoring questions on the survey related to:

- Hospital staff explaining reason for changing wards during the night (above average)
- How did you feel about the length of time you were on the waiting list. (above average)
- Were you ever prevented from sleeping at night by hospital lighting.
- To what extent did hospital staff involve family and carers into hospital when planning for you to leave.
- During your time in hospital, did you get enough to drink.

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The above results as positive and reflect some of the patient experience projects that have taken place in terms of discharge planning and providing patient information.

Respondents and response rate:

- 1,250 invited to take part.
- 342 patients responded to the survey.
- An overall response rate of 28%.
- 84% of responses noted to have long term conditions, were following urgent/acute admissions.
- 79% of respondents were over the age of 51.

Compared to the previous year's Inpatient survey results (2022):

- Statistically significant increase on 0 questions.
- No statistically significant change in 39.
- Statistically significant decrease in 4 questions.

Key areas for improvement are:

- Discharge advice and planning.
- Communication.
- Pain, privacy and dignity and staffing.
- Help with meals and feeding, help to wash and dress.

Each of the above areas form part of the improvement plan discussed and steered at a steering group and updated as provided to PEG.

2.3.2 Maternity Survey 2023

The CQC National Maternity Survey was sent to all women in England who gave birth in February 2023. Trusts were compared and benchmarked against 54 questions covering the pregnancy journey from antenatal booking to discharge from community postnatal care. This survey offered a new mixed method of survey, offering both paper and SMS.

The best scoring questions on the survey related to:

- Midwives advising about mental health in the postnatal period.
- Information about infant feeding choices in the antenatal period.
- There were no delays in discharge from hospital following the birth.
- Midwives and Doctors were aware of past medical history during both the antenatal and intrapartum period.

Respondents and response rate:

- 922 invited to take part.

- 324 patients responded to the survey.
- An overall response rate of 36%. Whilst this is below the national average this is a 5% increase from the 2022 survey.

Analysis of the results:
Compared to the previous year's CQC Maternity Survey (2022):

- Statistically significant increase on 3 questions.
- No statistically significant change in 46
- Statistically significant decrease in 0 questions.

Key areas for improvement are:

- Access for partners.
- Access to midwifery support immediately following the birth.
- Advice at the start of labour.
- Being asked about mental health antenatally.

An improvement plan has been co-produced with the Maternity Voices Partnership to include the service user voice. There are actions for each area which are discussed, and the plan updated at the monthly Unit manager meetings.

2.4 Patient Experience work

Several projects have taken place during 2023/24 which have been led by the patient and public involvement team to consider ways to improve patient's experience. These include:

- Imaging walk-in service.
- Outstanding Theatres service.
- Visiting review.

Visiting Hours Survey.

The Assistant Chief Nurse provided a further revision to the visiting guidance in December 2023 considering the feedback following an engagement piece of work with staff, patients and relatives and the Trust agreed to extend visiting to 2-730pm as a direct result. It was clear from the work carried out the value and importance visiting family can provide and enhance patient experience and patient safety. The Trust extended visiting to support celebration events including Christmas and during Ramadan to enable families to visit more flexibly.
External review of visiting at BTHFT provided high levels of assurance when independently reviewed by Audit Yorkshire. Visiting continues to be reviewed in line with national CQC guidance (9A) and community engagement and involvement.

Patient Stories.

These continue to be produced and presented at Board. In addition, they are shared wider where consent is obtained for wider learning and available on the Trust website. Stories are obtained from a diverse background of patients to enable us to represent stories from all the communities we serve.

2.5 Patient Led Assessment of The Care Environment. (PLACE)

Details of the PLACE programme can be found in appendix 1.

2.6 Veterans work and accreditation.

Bradford Teaching Hospitals are a formally accredited as a Veteran Aware Trust, which recognises the commitment to the Armed Forces community.

Accreditation was carried out by the Veterans Covenant Healthcare Alliance (VCHA), which is a group of NHS healthcare providers in England.

The VCHA'S aim is to develop, share and drive the implementation of best practice that will improve Armed Forces Veterans care, while at the same time raising standards for everyone based on the principles of the Armed Forces Covenant.

The accreditation, from the VCHA acknowledges the Trusts commitments to several key pledges, including:

- Ensuring that the Armed Forces community is never disadvantaged compared to other patients, in line with the NHS's commitment to the Armed Forces Covenant.
- Training relevant staff on Veteran specific culture or needs.
- Making veterans, reservists and service families aware of appropriate charities or NHS services beneficial to them, such as mental health services or support with financial and/or benefit claims.
- Supporting the Armed Forces as an employer.

The Trust provides hospital services across Bradford and the surrounding areas, serving a population of around 500,000 people and provides specialist services for some 1.1 million.

A key part of the Trust's veteran Aware plan is to recruit veterans as volunteers within the Trust, to meet and greet patients from the Armed Forces community and provide advice and support if required. it is estimated that more than 9,000 people are from the Armed community in the Bradford area. There has continued to be an active working group, which meets monthly to continue to steer this work and also extends to spouses, partners and children/dependants. Work from this group has evolved development of flagging on IPM on admission to enable the Trust to report the number of veterans who have attended hospital, and this work is now being developed further to support further work by providing visits from ex service personnel soon and looking to recruit veteran volunteers. The annual veteran's celebration day is currently being planned for June 2024 to celebrate and raise awareness around this important work.

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2.7 Spiritual, Pastoral and Religious Care (SPaRC)- Formally Chaplaincy.

The model has been well received by staff and patients and is utilised by both alike. During 2023 the team carried out over 23,000 visits and figure 4 below represents this.

Month	Patient Visits
Apr-23	1,834
May-23	1,701
Jun-23	1,810
Jul-23	1,925
Aug-23	2,339
Sep-23	2,218
Oct-23	1,617
Nov-23	1,830
Dec-23	1,938
Jan-24	2,109
Feb-24	1,801
Mar-24	2,393
	Total 23,515

Figure 4– SPaRC Visits for patients and visitors during 2023.

The SPaRC team have a team of volunteers named End of Life Companions (ELC). The primary role is to assist the palliative care team with patients who are at the end of life and have no family or carers that are available to reach them at their last stages in life. The role of the ELC is to accompany patients to be with them during this time.

Several new projects have taken place during 2023, one which includes *Front Door* support. The SPaRC team have teamed up with the Accident and Emergency Department to support patients and triage in this busy and unpredictable environment. The SPaRC team member and volunteers support the department three times a week and this is facilitated by a SPaRC core team member.

The SPaRC team have been delivering tailor made cultural competency training to various departments across the Trust upon request. The SPaRC team play an active role in delivering training to newly appointed Health Care Assistants monthly.

There has been external recognition and enquiries about SPaRC *Fast Packs* first developed in 2022. These include pop up prayer facility packs that have helped managers support their colleagues during the Ramadan period. A bigger and more organised campaign commenced for the Holy month of Ramadan that started mid-March 2023.

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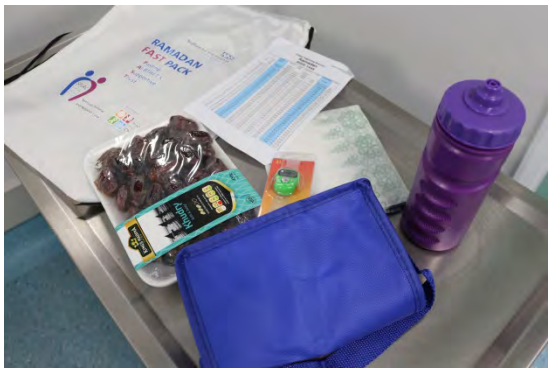

Images show a Ramadan fast pack and contents.

This rewarding and exciting work has led to national and local nominations for awards as follows:

- Bradford District and Craven health and Partnership Awards (Celebrate as One). **Team of the Year** (delivering frontline service) Ramadan Allies, October 2023.
- Health Service Journal (wellbeing category) **Winner** for Ramadan Allies work, November 2023.
- Nursing Times **Finalist** for Ramadan Allies work, November 2023.

Image of SPaRC team receiving the Celebrate as One, Team of the Year award.

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2.8 Partnership Working and Engagement.

The patient and public involvement team have worked with several groups around improving accessibility. *Walk arounds* with members of the HI Vis group has enabled feedback from members of the community who have accessed BTHFT to provide feedback from a partially sighted and deaf perspective, which have led to amendments in signage and several other accessibility changes. Other partnership working is the ongoing relationship with the EDI team to ensure full consideration is given for people with additional needs which includes language support, learning disabilities and protected characteristics. Feedback from this group has provided a level of assurance that we are engaging and listening and keen to make change. Reinviting groups back into the Trust to review the progress enables service users to see what improvements we have made.

2.9 Community Engagement.

The Patient Experience Team continues to work with partners in the district to improve patient experience and engagement. Meetings have been set up across the district to facilitate and share work in this area. The Trust is a member of the Citizen Engagement Forum, which has membership from across the Bradford District and Craven Health Care Partnership. The group has been established to operate as a network of networks and plans to bring people and communities together to host several events with the relevant parties for communities to access relevant information.

Regular meetings and joint work take place with local Healthwatch. This ensures that teams are sighted on any areas of concern raised by the public at the earliest opportunity and provides the opportunity for the teams to invite relevant staff to answer to areas of concern raised. BTHFT have been active members in the *Listening in* events which have been held at various locations throughout the district and provided the opportunity for community members to have access to different staff members from statutory and voluntary organisation to enable their voices and concerns to be heard. The programme for 2024 plans to repeat these listening events following the previous year's success, with the aim this year of the programme being based on themes. The first theme of the programme will be *Children and young people.*

The success of the Trust Community Engagement meeting has continued with an open forum to enable different community service and teams (both statutory and voluntary) to request and share concerns internally at BTHFT and listen regarding new and planned projects.

2.10 Interpreting Services

During 2023/24 the interpreting service became part of the wider Patient Experience Team. This has brought several benefits and opportunities to work closely on joint projects to enhance patient experience. An example of this joint work is when the bereavement team arrange hospital funerals and when English is not the first language an interpreter is now arranged for the family.

Our interpreting services team supported people on no fewer than **51,008** occasions, and in over 50 different languages. It meets the needs of non-English speakers and British Sign Language

users, primarily through face-to-face interpreting. We also provide support using telephone and video, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through our team. The top 10 languages requested are show in table 2 below.

Urdu/Punjabi	24781
Czech/Slovak	6320
Arabic	3290
Polish	3194
Bengali	3137
Hungarian	1260
Kurdish	1085
Pushto	1017
Farsi	760
BSL	725

Table 2 shows the top 10 languages requested through interpreting services.

Interpreters are used to communicate with patients about their medical history, to obtain information from them about their current problem, to discuss diagnosis and treatment options, to obtain consent for any treatment or procedure and delivering bad news.

To further support inclusivity the patient experience team were proud to announce a partnership with CardMedic, the latest innovation adopted at the Trust as part of the “Clinical Insite” membership of the NHS Clinical Entrepreneur Programme.

CardMedic is a language translation App available on Trust iPads, clinical desktops and available for clinical BTHFT staff to download onto Trust mobiles. It is an A-Z collection of digital flashcards, written by clinical experts, simply and succinctly. It replicates conversations around common healthcare topics with simple questions and explanations to guide the interaction between patient and carer.

CardMedic is designed to supplement existing interpreting service, provide help with translation where it wouldn’t be convenient or appropriate to call for an interpreter. Or where an interpreter is unavailable.

This App is proving great benefit to patients and staff to facilitate communication in a variety of accessible formats. Content can be translated into 49 different languages and each translation has been human reviewed for accuracy. Some cards have sign language videos, and many have an *Easy Read* format intended for use with patients who have learning difficulties or cognitive impairments such as dementia. A SOP was produced to support the use and application.

2.11 Bereavement

The Bereavement team continue to support families after the death of their loved ones with high volumes of calls and face to face meetings being responded to. The team work closely alongside

the mortuary team and the medical examiner's office to provide holistic care to the deceased person and their family/carers.

Improvements to Bereavement Services during 2023/24 include:

- Publications for next of kin – work with internal Communications team to add relatives search requests along with a local newspaper advert.
- New process for Funeral Directors requesting cremation forms –Mortuary agreed that FDs would call them direct and send these requests through via email. This free's up the phone line for relatives to make contact.
- Review process for *Free from infection* – new process has been proposed and is awaiting final signoff.
- Review of full hospital funeral process including finances responsibility, property from house searches and *Tell us Once* responsibilities. This will enable a full review and update to the Bereavement policy in 2024.
- Website content internal/external both live and updated.
- Revamp of the Bereavement booklet in March 2024 – new booklet now in circulation to ward areas.
- Working closely with the Interpreter's team to communicate with parents when arranging baby funerals – working together ensures bereaved parents feel comfortable and fully understand all the information during the very sensitive conversations discussing funeral arrangements.
- Working with other Patient Experience services to present at HCA inductions to educate new members of staff on Bereavement services.
- Patient Property Disposal Review – working with AED to donate to need. Bereaved relatives are given the option to 'donate to need' any deceased items that they don't want to collect. If the item is in a good condition this is taken to AED so they can hand out as part of the Dignity project.
- Revised internal property process – electronic internal database to log all property that comes to bereavement. All property logged and signed into the bereavement office. Reiterated bereavement will not take property without a property list.
- Collection of unwanted glasses from families and is then donated to the charity Lions.
- Active involvement in the national end of life care audit to promote feedback and support changes for improvements.
- Bradford District and Craven health and Partnership Awards (Celebrate as One). **Finalist**, highly recommended for the work in Bereavement services.

2.12 Patient Information

There has been a vast improvement in relation to how patient information is accessed and stored on the Trust intranet with the development of a A-Z library and webpage to store all information in one place. There is ongoing work required to look at process for production and update of internal information during the next financial year.

There continues to be ongoing work with the *Working Academy* and the VRI to develop education videos.

The Patient Experience Team were pleased to commission Eido leaflets. This is an externally produced library of patient information available via Trust clinical desktops for internal print to provide for patients. All leaflets produced are written by nationally practicing clinicians and support written information for medical procedures. The library is endorsed by national medical *Royal Colleges* and is reviewed by members of the *Plain English Campaign*.
The library is available in various additional formats to enable the Trust to fulfil their obligations under government non-discriminatory standards and legislation such as the Accessible Information Standard.

The Eido leaflets are available in multiple different languages, *Easy Read* and large print.

2.13 AccessAble

AccessAble and Bradford Teaching NHS Foundation Trust have been in partnership since 2017. This partnership aims to provide detailed accessibility information to patients, visitors, and staff, ensuring that everyone can navigate the Trust's premises with ease and confidence. AccessAble, renowned for its comprehensive accessibility guides, continues to collaborate with the Trust to conduct thorough visits of its sites, assessing facilities such as entrances, parking, toilets, and consultation rooms. The information gathered is integrated into AccessAble's digital platform, empowering individuals with disabilities to plan their visits in advance. AccessAble also provide guidance reports to promote changes to ensure an environment where all individuals, regardless of their mobility or sensory needs, can access healthcare services without barriers.

The Trust is about to embark on a new project to send an AccessAble surveyor to carry out a 360-degree scan of Bradford Royal Infirmary. The scan will include the entrance/s to the hospital and the areas of circulation up to the doors to wards, departments, and services. Then create a digital twin model of the hospital from the scan to aid wayfinding, adding links to all relevant Detailed Access Gides and plotting any routes.

The past 12 months AccessAble have:

- Completed a number of teams engagement meetings to provide Patient Experience Group with updates and to promote the access guides.
- Attended in-person the Community Engagement Event (EDI 2022 joint project), to promote the guides and understand better, the needs of the community and how the guides can impact them daily.
- Sent two trained AccessAble surveyor to visit and update guides that had changed.

This is a valuable tool for BTHFT and usage as follows demonstrates this:

- **May 2023 - April 2024**. **Users 42,915**
- **Views 52,128**

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- **5.5%** of the users are finding the guides via links embedded into the Bradford Teaching NHS Foundation Trust website.

3.0 Complaints

3.1 Complaints

The Patient Experience team receive complaints, PALS and compliments into the organisation and support the CSUs in responding to concerns. Table 3 below presents complaints per Clinical Service Unit (CSU) received during 2023/24.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Diagnostics and Corporate Operational Services	17	26	20	21	84
Planned Services	45	42	46	57	190
Unplanned Services	51	45	55	62	213
Central	3	1	2	2	8
Total	116	114	123	142	495

Table 3 Complaints per quarter and Clinical Service Unit received during 2023/24.

The number of complaints as shown in table 3 has increased overall during 2023/24 from 411 in 2022/23 to 495 this financial year. Figure 5 below makes comparisons of this data.

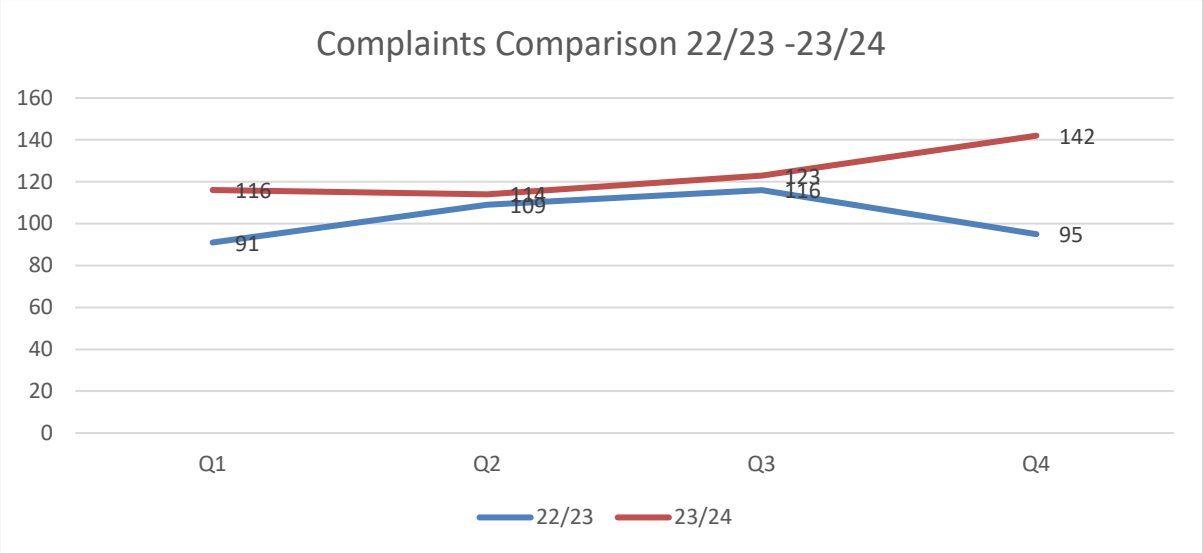

Figure 5 Complaints comparison between 2022/23-2023-24.

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Complaints are monitored weekly via QUOC and quarterly through the CLIP reports presented through the Quality and Governance Team to the Quality and Patient Safety Academy. Complaints are now resolved through face-to-face meetings with complainants. Arranging to meet with complainants has led to a timelier investigation/response.
Analysis of the actual complaints received allows the team to track that numbers received are within the calculated normal limits. Figure 6 below tracks the annual trend.

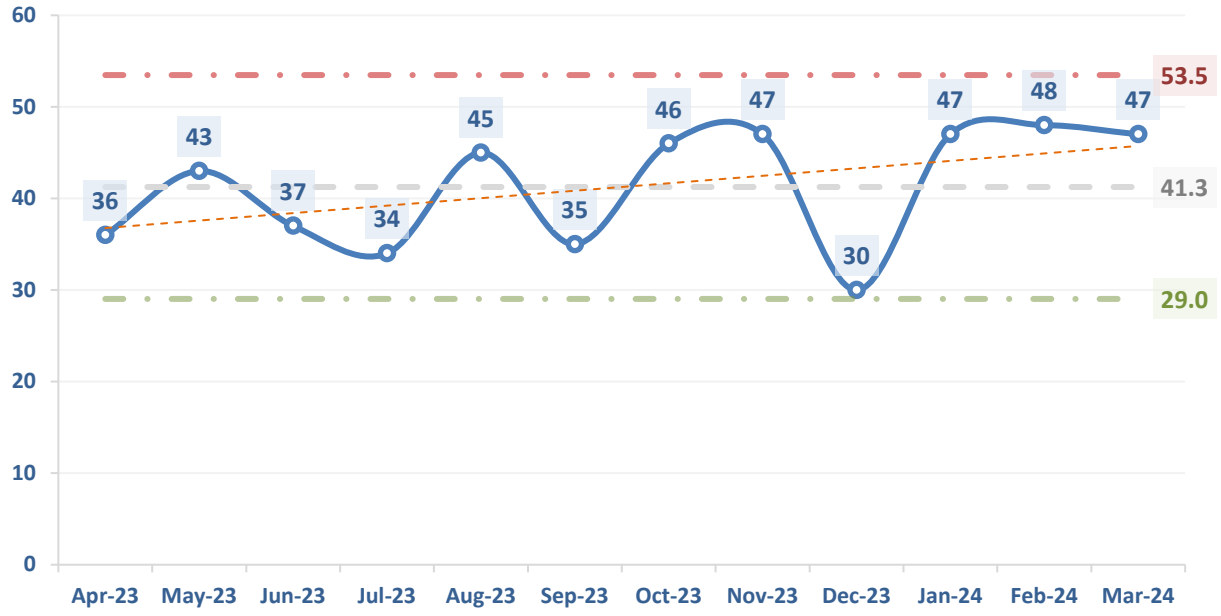

Figure 6 Annual complaints against the actual upper and lower control limits against the calculated fields based on the actuals.

- The red and green lines show the upper and lower control limits (these are calculated fields based on the actuals)
- The blue lines are the actuals e.g., the number of complaints
- The grey line is the average of the actuals.
- The orange dotted line is the trend (again, based on the actuals)

Appendix 2 provides complaints data analysis of areas trends and themes.

During the past year, several complaints were responded to beyond 6 months from receipt, which is the national recommendations maximum timescale and Trust policy. Table 4 highlights the number of breaches of complaints that are over 6 months in relation to the total open complaints reported that month. The Trust has seen a slight rise in the number of six-month breaches and as a direct result, work has taken place within the CSUs to address this and future new developments of the complaints process and policy to fall in line with the new PHSO standards should help with the introduction of early resolution and meetings with family to resolve complaints earlier.

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.7

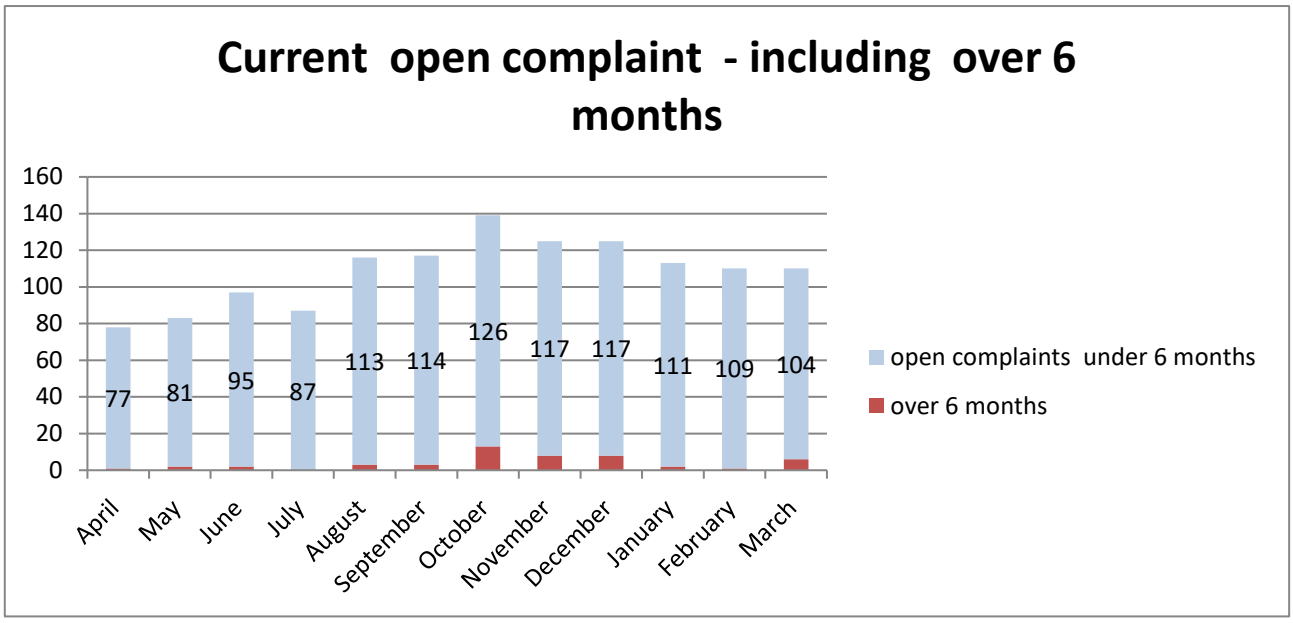

Table 4 Current open complaints including those over 6 months from receipt.

There were three complaints graded as *High* during 2023/24 by the CSUs. There continues to be on-going collaborative work and scrutiny between the Quality and Governance and complaints team, any moderate and above are discussed in detail at QUOC and the Safety Event Group (SEG) for assurance regarding risks. Table 4 provides a summary of the Trusts position over the past year.

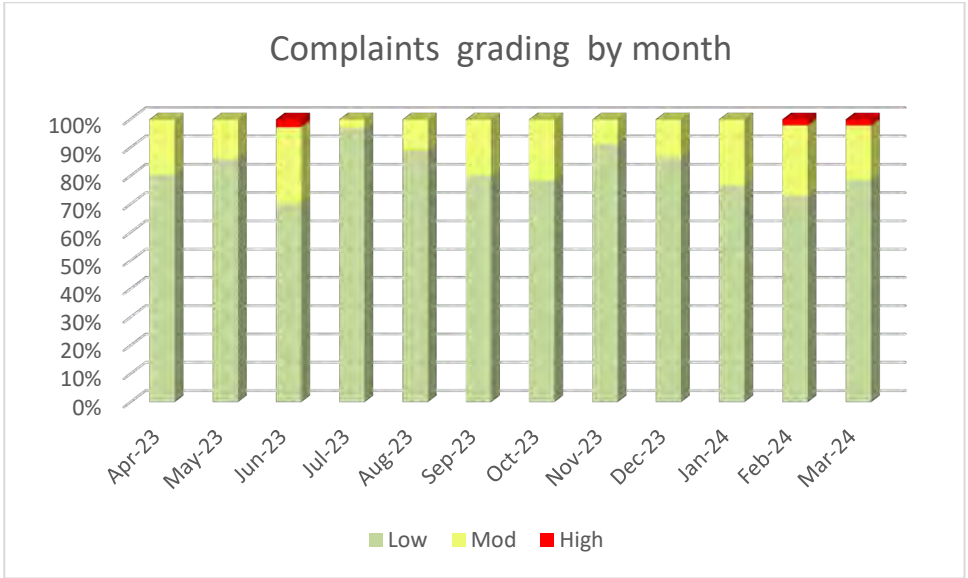

Table 4 Grading of all complaints received during 202/24.

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.7

3.2 Parliamentary and Health Service Ombudsman (PHSO)

The Parliamentary and Health Service Ombudsmen (PHSO) is an independent body that investigates complaints about the NHS and other public organisations. Once a complainant has exhausted local resolution with the Trust, they are entitled to take their case to the PHSO for consideration. During 2023/24 the Trust were informed that the PHSO were investigating 6 of the cases where the Trust had stated they had reached local resolution with the complainant. Of these 6 cases 2 were closed with no further action, 1 was investigated and was partially upheld and 3 are still open with the PHSO awaiting their decision. During 2023/24 the Trust received 8 outcomes (this includes the 3 mentioned above) a further 4 were decided that there was no further action and 1 was partially upheld. Full details of the latter can be found in appendix 3.

Full details of any partially or fully upheld complaints are shared with the CQC and NHS England for full transparency. A summary and status of the PHSO cases are also presented to the Trusts Moving to Outstanding meeting.

During 2023 the PHSO released a set of new standards. This followed a period of review where BTHFT had been a pilot site. New training delivered by the PHSO is now available to staff, many of whom have already completed this and the Team is working towards amending our policy to reflect these new standards and promote early resolution with complainants and their families.

3.3 PALS (Patient Advocacy and Liaison Service)

The total number of Patient Advice and Liaison Service (PALS) issues continues to remain high albeit there has been a slight reduction in the total number received. Table 5 and Figure 7 provides comparisons to this data.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Diagnostics and Corporate Operational Services	110	102	107	117	436
Planned Services	233	207	155	196	791
Unplanned Services	168	155	152	162	637
Central	67	61	51	54	233
Total 23/24	578	525	465	529	2097
Total 22/23	504	507	555	615	2181

Table 5 Number of PALs contacts per year comparison.

Meeting Title	Board of Directors		
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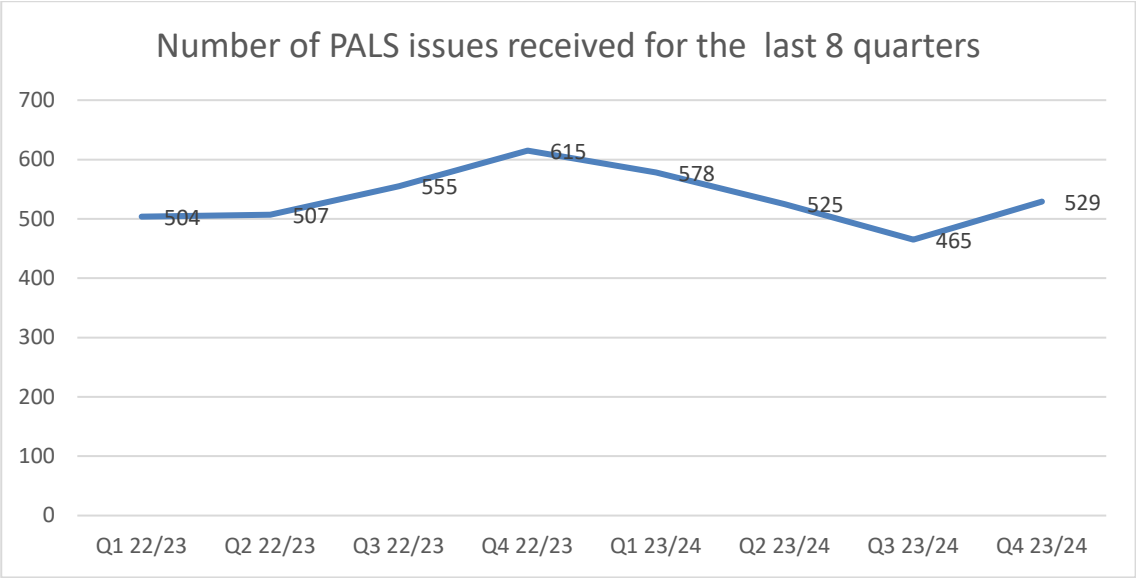

Figure 7 Comparisons of PALs data between years.

These numbers demonstrate the high volume of activity that the Patient Experience Team are dealing with; in many cases they are resolving at first contact and preventing issues being progressed to formal complaints. PALS issues are dealt with quickly to prevent escalation. At the time of writing this report of the 2,097 only 1 Pals issues remain open. Further work is planned during the next financial year to look further at learning from PALs themes and triangulate with other data. Details data analysis of PALs can be found in appendix 4.

3.4 Compliments

Compliments are simple ways for people to show their appreciation and kindness. At the Trust there are many ways that staff receives compliments, via thank you letters, emails, via X and cards. Table 6 provides the compliments data.

	Q1	Q2	Q3	Q4	Total
2022/23	227	215	194	246	882
2023/24	359	334	361	266	1320

Table 6 Compliments data.

During the past year whilst carrying out several patient experience initiatives throughout the Trust, areas, teams have been encouraged to log these compliments on Datix/IRIS in the same way that a complaint or PALS are logged. There is much work to be done to capture and celebrate this success and plans to strengthen and expand our kindness pledge. It is important that learning occurs in relation to what is perceived to be done well to build on this further and this is something the team

are looking to build on. Compliments are now collected as part of the ward accreditation assessments that are taking place. Data analysis of themes from compliments can be found in appendix 5.

Below are a few statements extracted from some of the many compliments received to demonstrate the impact staffs have had on Patient Experience and their family members.

A massive thank you to everyone at the Endoscopy unit, for the way I was treated on 4th May
From reception on level 2, to all the administration, the actual gastroscopy, recovery and discharge
I am not my most mobile after 2 fractures in my back, yet everyone went above and beyond the call of duty to ensure that I did not struggle.
Keep up the good work!

Vascular Surgery
A week after a Transient Ischaemic Attack my 85-year-old husband was admitted to BRI for surgery on a blockage in his neck. The surgeon and team were outstanding; a visiting district nurse said afterwards that she'd never seen such a neat wound, which is testimony to the high standard of skill exercised. He has now made a good recovery; we are grateful for the meticulous care given to him. This is a real tribute in difficult times - we can't value our NHS staff enough. Thank you so much.

My daughter who is 22 and awaiting autism diagnosis and struggles with anxiety had urgent tonsillectomy 16/5/23.

I was worried how she would cope but didn't need to.
The staff on ENT Day unit are angels, she was treated professionally and with dignity and respect, nurses, porters, were a credit to the NHS.

Special mention to her recovery nurse and anaesthetist. Their professional, kind and caring manner made the experience in theatre so easy for her, thanks also to her surgeon who performed an amazing and skilled procedure.

II would like to thank the staff on women health for their welcoming approach and my excellent treatment today. They made me feel valued and at ease.

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Finally, figure 9 provides the annual overall position to demonstrate the month by month complaints, PALs and compliments as received during 2023/24.

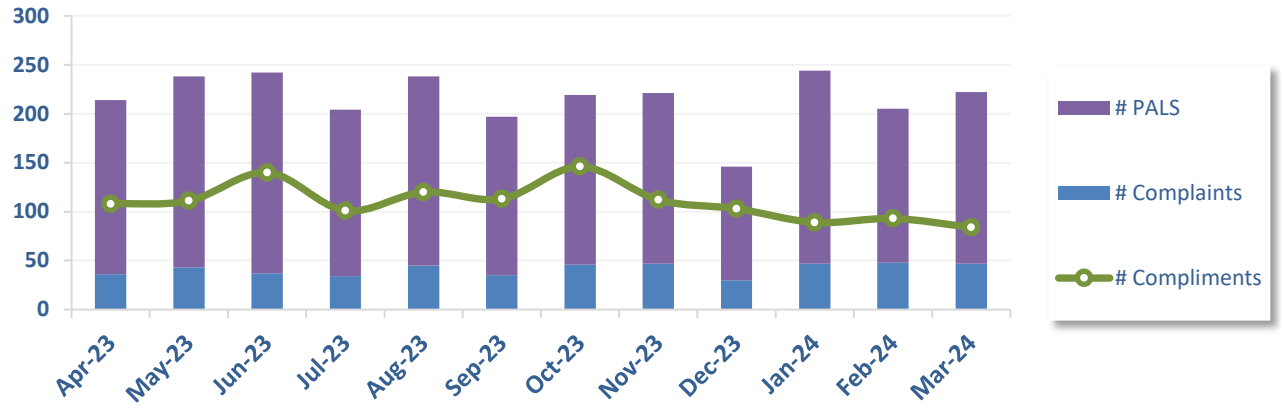

Figure 9 Annual summaries of complaints, PALs and compliments received within the Trust.

3.5 Learning from Complaints

Over the past year the CSUs and the Patient Experience Team has been collating information regarding the potential learning from complaints. Revision of CSU checklist now captures the learning and actions, and these are recorded on trackers and within the IRIS system.

During Q2 Audit Yorkshire conducted an independent review of complaints handling at BTHFT. Whilst the Trust received *High* and *Significant* levels of assurance in the overall report it was recommended that a central repository of learning is obtained with a view to this being centrally visible to all CSUs for ongoing shared learning. The Trust is due to use a new programme to log and monitor complaints and there are plans for this to form part of this new tool. Dates for agreed actions from learning and improvement will also be included as part of this work to enable this to be kept on track.

In the coming months this will be analysed, discussed, and shared to create Quality Improvement Projects. The aim is for the learning to be shared Trust wide to demonstrate we are listening and learning to improve. Additionally, potential patient stories and examples are being shared with the Patient and Public Involvement Team to triangulate learning and work collaboratively.

Tabletop learning from complaints session has taken place where complex complaints were shared for learning. This was carried out across roles and specialities. More meetings and combined CSU events have included patient experience on their agendas which has led to opportunities to demonstrate shared learning from complaints and other patient engagement feedback.

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The complaints steering group, which reports into the Patient Experience Group monitors partial and upheld PHSO complaints and the Action Plan produced to support the learning from these to hold the responsible CSUs to account. Data is provided highlighting themes and trends. This gives staff an opportunity to ask questions and reflect.

Learning from complaints has been demonstrated in several other forums which have included patients' stories that have been presented to Board, these have then been widely shared across the organisation and on the Trust intranet. A direct example of this is the joint work around kindness and civility and the importance in the workplace.

Finally, some examples of learning from complaints include:

- Implementation of property checklist for property and medication instigated following complaints to bereavement.
- Information leaflet produced about the requirement of use of stirrups during hysterectomy procedures to inform patients.
- Education team to include skin staining in their training in cannulation and use of iron infusions.
- Regular bi-monthly meetings now agreed between maternity and bereavement to improve and avoid unnecessary delays when arranging funerals for stillbirths.
- Built a kitchen area in AED to support food and drink distribution for patients and installed vending machines.
- Development of a quiet room in AED for patients with additional needs and a dementia friendly cubicle.

3 PROPOSAL

The Patients Experience Team and Chief Nurse Office will continue to develop work to enhance patient and relatives encounters with the Trust and ongoing community engagement. During 2024/25 work will focus on implementing the Patient Engagement and Engagement Strategy and the commitment to further involve the work carried out the local communities.

Quality Improvement work will continue via the Patient Experience Teams work, working collectively with staff in individual areas following recommendations from the CQC National surveys will help direct these areas for improvement.

Valuable patient and public collaboration work will continue within the Trust, with Healthwatch and with partners at a district level to ensure peoples voices are heard and influence Patient Experience projects for the months ahead.

The overall complaints process and numbers will continue to have ongoing oversight from the central team, to enable challenge, monitoring and tracking to agreed timescales. The team will look to implement several of the PHSO recommendations which includes early resolution. The Central team will continue to provide support and training and assist with training and complex cases where required. To deliver on this the team will:

- Hold weekly “Grip and Control” complaints meeting between Central and CSU leads to track status of complaints and provide timelines for completion.
- Monthly complaints meetings with DDN and Chief Nursing office.
- Lower the threshold for senior escalation where complaints are not progressing.
- Delivery of complaints training to all staff who is investigators to improve quality.
- Utilise the PHSO training available to all staff and implement the standards into policy.
- Buddying and mentorship provided for authors of complaints responses.
- Process reviewed and guidance strengthened for complaints procedure to align to new PHSO standards in relation to PSIRF and reporting of incidents.
- Weekly position reported to Chief Nurse.
- Capture learning and action on the review check list and create a central repository with timescales for completion.

Finally, the teams will look at ways of celebrating success and compliments received to ensure teams and individuals are recognised for the kindness and compassion they share daily.

4 RISK ASSESSMENT

No new risks have been identified. AIS and patient information currently sit on the risk register; a monthly group meets to work at reducing this risk which has resulted in a reduction in the risk level. There have been significant improvements noted on patient information being provided in an inclusive different formats and languages.

5 RECOMMENDATIONS

- Support is required from all areas to promote and endorse the Patient Experience and Engagement Strategy 2023-2028.
- Work towards the agreed Patient Experience priorities agreed as part of the Quality Account.
- Continue with coproduction and engagement work and continue collating this information in our engagement log for learning and revisiting.
- Recruit more patient/community representatives from a diverse demographic to sit and advise on workstreams and groups within the Trust.
- Continue promoting the use of real time feedback via FFT to react and make timely improvements.
- Use of QI methodology for tests of change.
- National Survey (CQC) action plans to be monitored via the PE Group for improvement, led by the designated area lead once complete.
- Ongoing promotion and development of FFT data, evidence of “*You said we did".*
- Continue collaboration work with Bradford district and Craven health Care Partnership to improve collective and consistent improvements.
- Benchmark against other Trusts that are doing well or significantly better in key PE areas.

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- There is the requirement for a *tight grip* to remain on the handling and processing of complaints to enable KPIs to be met. These will be monitored via the CSU at their performance meetings.
- PHSO standards to be implemented for early resolution.
- Learning from complaints to be strengthened and made transparent for the public.
- Compliments to be captured and celebrations and acknowledgement of these to be developed.
- Development of compliance repository for shared Trust-wide learning.

6	Appendices

Appendix 1 PLACE results (2.5)
Appendix 2 Complaints Data (3.1)
Appendix 3 Parliamentary and Health Service Ombudsman (PHSO) cases (3.2)
Appendix 4 PALs Data (3.3)
Appendix 5 Compliments Data (3.4)

6	Appendices

Appendix 1 PLACE results.

Patient Led Assessments of the Care Environment (PLACE) is a voluntary self-assessment of the care environment, which contributes to health delivered in the NHS and Independent/ Private Healthcare sector in England. PLACE aims to promote the principles established by the NHS Constitution, that focus on the areas that matters to patients, families and carers; committing to ensure that services are provided in a clean and safe environment that is fit for purpose. The findings and scores are used by the CQC to form part of their assessment of the services that we provide. PLACE is about being open and honest, making a point-in-time assessment, against set criteria. Un-announced assessments for PLACE were carried out in both clinical and non-clinical areas of all Trust sites, September through to December 2023. The inspections were undertaken by teams of public volunteers (Assessors) facilitated by Trust staff members (Facilitators). The assessments are not reflective of the whole Trust but provide a framework for assessing quality against common

guidelines and standards in order to quantify our facility's cleanliness, food and hydration provision, the extent to which the provision of care with dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

The areas assessed are categorised under the following Domains:

- Cleanliness.
- Combined Food Score.
- Organisational Food.
- Ward Food.
- Privacy, Dignity and Wellbeing (how the environment supports the delivery of care with regards to the patient's privacy dignity and wellbeing).
- Condition, Appearance and Maintenance of healthcare premises.
- Dementia (whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria).
- Disability (the extent to which premises can meet the needs of people with disability against a specified range of criteria).

Unannounced inspections were carried out at Bradford Royal Infirmary, St Luke's Hospital and the Community Hospital sites. Assessments included wards, outpatient areas, Accident and Emergency Department (AED), communal and external areas.

The number of areas to be assessed is clearly defined in the guidance and on all sites; the assessments met or exceeded these requirements. The PLACE scores are weighted in several ways to take account of a range of variables (such as the size of the site defined by the number of beds).

The guidance aims to make scoring consistent and as objective as possible; however, there are subjective elements to the process which cannot be entirely eliminated (such as food tasting).

PLACE assessments are intended to provide motivation and direction for improvement by providing a clear message - directly from patients - about how our environments and the services we provide might be enhanced. Results are published to help drive improvements locally and nationally. The assessment focuses exclusively on the environment in which care is delivered and does not cover clinical care provision.

The PLACE data (collated and distributed by NHS Digital) has been scrutinised and developed into several informative charts.

Domain	2023 score	2022 score	% Difference

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Cleanliness Score %	97%	98%	-1%
Combined Food Score %	83%	Not comparable	
Organisational Food Score %	67%	89%	-22%
Ward Food Score %	86%	96%	-10%
Privacy, Dignity and Wellbeing Score %	82%	86%	-4%
Condition, Appearance and Maintenance Score %	97%	95%	2%
Dementia Score %	81%	84%	-3%
Disability Score %	83%	82%	1%

Table 1 PLACE scores 2023.

The above scores (table 1) highlights, the scores obtained for each domain in both 2022 and 2023. To note, the Combined Food Score is new for 2023 and therefore cannot be compared to previous years data.

It is disappointing to see significant deterioration in food and drink scores. Estates and Facilities colleagues are currently carrying out several transformation improvements including digital ordering of food, serving analysis and variety of options for Halal meals, not always a curry option.

The improvements in the condition and appearance and disability scores are pleasing, particularly as a few projects have taken place to improve the environment and have included walk arounds from people with different disabilities to enable constructive feedback and improvements to be made.

There is a PLACE steering group held quarterly which meets to update improvements and actions made and track progress. Updates are provided to the Patient Experience Group at regular intervals and feedback is provided directly to our patient assessors who support this program.

Appendix 2 Complaints Data.

Of the 495 complaints received, Figure 1 demonstrates the position of the areas who received the most.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Accident and Emergency	9	13	17	24	63
Acute Medical	1	6	3	7	17
Audiology	0	0	0	1	1
Breast Surgery	1	0	0	3	4
Imaging	3	4	4	5	16
Cardiology	3	2	2	5	12
Central Patient Booking Service	0	0	0	1	1

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Chief Nurse	1	1	0	1	3
Dermatology	0	1	2	2	5
Diabetes and Endocrinology Administration	0	0	1	1	2
Elderly	7	3	4	6	20
ENT	5	7	5	6	23
Estates	1	0	2	1	4
finance	0	1	0	0	1
Gastroenterology	4	7	2	2	15
General Medicine	2	0	1	0	3
Gynaecology	10	6	10	3	29
Haematology and Oncology	4	10	3	5	22
HIV Service	0	1	0	0	1
Intensive Care	4	1	3	1	9
Maternity Services	13	9	8	11	41
mortuary	0	0	0	1	1
Nucleus Theatres and Theatre		1	2		3
Ophthalmology	1	1	1	2	5
Oral and Maxillofacial	3	1	1	2	7
Orthotics			1		1
Orthopaedic General	11	10	11	7	39
Paediatric	4	7	7	5	23
Pain Management	1	0	0	0	1
Pathology	0	2	1	0	3
Phlebotomy	0	1	0	0	1
research	1	0	0	0	1
Therapies	2	0	3	2	7
Plastic Surgery	2	0	2	4	8
Renal	3	6	1		10
Respiratory Medicine General	3	0	7	3	13
Rheumatology	0	1	0	0	1
Stroke & Neurology Services	7	1	6	6	20
Surgical	7	7	6	16	36
Urology	3	2	2	6	13
Vascular Surgery	0	2	5	3	10
Total	116	114	123	142	495

Figure 1 Complaints annually by speciality 2023-24.

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Accident and Emergency Department (AED) remain the area that received the highest number overall (N=63) annually. However, this has decreased from previous financial year. Table 1 provides the supporting data.

AED	Q1	Q2	Q3	Q4	Total
2022/23	16	20	15	17	68
2023/24	9	13	17	24	63

Table 1 Provides the AED data of complaints in years and quarters.

Following a deep dive into the themes of the AED attendances the following areas were identified as common themes within the complaints:

- Appropriateness of treatment (which included concerns like xrays not carried out, patient felt lack of examination).
- Staff attitude - Unprofessional.
- Missed Diagnosis.

Listening and learning from these complaints has resulted in the following measures taking place in AED:

- Display boards in waiting room with waiting times.
- Member of staff from the complaints team based in AED to pick up any issues at the time and keep patient informed of delays.
- Recruited staff to assist in refreshments 24/7 where waits are unavoidable
- Work withhin the Trust and Patient Experience around civility and kindness towards patients and staff.
- Newsletter produced highlight the impact of patients story/complaint produced for AED staff to communicate learning.
- Training planned to improve preventing complaints including the importance of proving goods customer service.

It is disappointing to see that unprofessional/rude staff is highlighted within the top themes. A large amount of work has taken place in relation to embedding kindness and civility and ensuring Trust values are recognised as form part of staff reviews including appraisals. This work is set to continue and be strengthened during 2023/24 with the planned customer service training.

Maternity was the second highest speciality that received complaints during 2023/24, with an increase in complaints of 46% through this financial year. A deep was presented to PEG for assurance that no reoccurring themes or trends had been missed and that learning could be evidenced. Table 2 provides the maternity data.

Maternity Services	Q1	Q2	Q3	Q4	Total
2022/23	9	7	8	4	28

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2023/24	13	9	8	11	41

Table 2 Maternity complaints data comparison per year.

Figure28 reports the top overall themes of complaints during 2023/24. It should be noted that complaints usually contain more than one theme. Triangulation against other sources of data i.e. patient feedback surveys and risk incidents are monitored within the CSU and at performance meetings.
Reporting of themes is monitored at the Patients Experience Group meeting via the CSU reporting, along with actions being taken to address issues identified. Reports on complaint themes have also been supplied for departmental quality improvement initiatives, such as “deep dives” and ‘time-out’ sessions to review services.

Care and treatment continue to be the highest category of complaints (N=199). This category includes an array of clinical concerns that have been raised as part of the complaints process; these include things like delay in or alleged or reported failure in:

- Not following care plans.
- Delay in monitoring observations.
- Lack of examination.

	23/24 Q1	23/24 Q2	23/24 Q3	Total
Admission	1	4	2	7
Access to NHS services	0	2	0	2
Appointment	9	12	10	31
Attitude & behaviour	21	25	16	62
Care and treatment issues	72	63	64	199
Communication	14	15	14	43
Delay in diagnosis	9	18	15	42
Discharge	10	4	5	19
Discrimination	3	0	0	3
Environment issues	0	1	1	2
Equipment issues	1	0	1	2
Fall, slip or trip on same level	3	1	0	4
Fall from height	4	2	0	6
Food quality issues	1	1	1	3
Infection control	0	1	0	1
Information security breach	3	1	1	5
Medication	6	4	5	15
Medical records issues	2	2	0	4
Nutrition	0	1	0	1
Patient procedure issues	8	9	7	24
Support Needs	0	1	1	2

Transportation issues	0	0	1	1
Ulcers	0	0	1	1
Total	167	167	145	479

Figure 2 Care and treatment themes.

During quarter 4 of the reporting period the Trust moved from reporting via the Datix system to IRIS. With this came the opportunity to develop and change some of the themes to make them more meaningful. Ten primary reporting subjects have been agreed initially with the ability for these primary subjects to be filtered down further to enable more detail analysis of data in the future. Figure 3 provides the new agreed primary subjects.

Primary Subjects
Clinical Care - (doctor led)
Patient Care - (nurse led / ward decisions)
Communication & information
Values & Behaviours
Appointments & waiting times
Admission, discharge and transfer
Environment & Equipment
Falls
Property
other

Figure 3 New primary subjects agreed for reporting on IRIS.

Due to IRIS being implemented during quarter 4 there is a mix of the new primary subjects, but some were still reported under the previous subjects (for example care and treatment) due to a both systems being used during this period. Figure 4 reports this data, which will be more meaningful in future reports when further analysis and more data is available.

Primary Subjects	23/24 Q4
Admission & Discharge	12
Appointments & Waiting times	16
Values & Behaviours	26
Care and treatment issues	14
Clinical Care (Dr Led)	56
Communication	22

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Environment & Equipment	6
Patient Care led	13
Property	2
Total	167

Figure 4 Q4 Complaints themes including the new primary subjects agreed for reporting on IRIS.

When complaints are received and reviewed, they are recorded and graded on the Trust Datix or more recently (Q4) IRIS system.

Appendix 3 Parliamentary and Health Service Ombudsman (PHSO) cases.

Table 1 below provides the details of these cases as they are not always received and resolved in the same financial year.

Reference.	Care Group.	Date complaint received in Trust.	Date PHSO received complaint.	Outcome.	Date outcome received.
22513	Unplanned	Dec 19	Mat 22	Partly upheld – action plan shared	Nov 23
25044	Unplanned	Nov 20	Aug 22	PHSO decided not to investigate - case Closed	July 23
27229	Unplanned	July 21	Sept 22	PHSO - decided to close case - no further action	Aug 23
25574	Planned	July 19	Sept 20	Asked the Trust to complete further work – closed	April 23
26475	Planned	May 21	Jan 23	PHSO - decided not to investigate - closed case	May 23
28639	Planned	Dec-21	April-23	PHSO - Closed the case	Feb 23
33248	Unplanned	April 23	Oct 23	Refered back to the Trust - closed	Oct 23
28974	Planned	Jan 22	July 23	Partly upheld	May 24
27970	Planned	Oct21	May 23	Sent info to PHSO - PHSO currently investigating	Ongoing
27889	Planned	Oct 21	Nov 23	Sent info to PHSO - PHSO currently investigating	Ongoing

32191	Planned		Dec 23	Sent info to PHSO - PHSO currently investigating	Ongoing
20060	Womens and Children	April 19	Dec 22	Sent info to PHSO - PHSO currently investigating	On going

Table 1 PHSO case received during 2023/24.

Appendix 4 PALs Data.

AED received the highest number of PALs contacts (N=181). Within these AED PALs the top subcategory of concerns were raised in relation to care and treatment issues.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Accident and Emergency	56	41	33	51	181
Acute Medical	18	19	16	20	73
Adult OP	0	1	1	0	2
Anaesthetics	2	1	0	1	4
Audiology	12	8	6	7	33
Blood Transfusion	1		0	0	1
Breast Surgery	2	1	3	1	7
Bowel cancer	2	0	0	0	2
Imaging	28	31	32	27	118
Cardiology	18	23	22	20	83
Central Patient Booking Service	10	6	13	13	42
Chief Nurse	47	36	30	25	138
Chief Medical Officer	0	1	0	0	1
Dermatology	13	13	13	14	53
Diabetes and Endocrinology Administration	6	3	7	4	20
Education	0	3	2	1	6
emergency planning	0	0	0	1	1
Elderly	17	16	20	16	69
Endoscopy	0	5	0	1	6
ENT	33	28	21	21	103
Estates & Facilities	16	19	11	25	71

Meeting Title	Board of Directors		
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finance	1	2	4	4	11
Gastroenterology	14	9	3	19	45
General Medicine	0	2	1	1	4
Gynaecology	37	30	26	32	125
Haematology and Oncology	21	10	19	19	69
HIV Service	0	0	0	0	0
Intensive Care	5	4	4	0	13
informatics	0	1	0	0	1
Maternity Services	21	12	22	10	65
medical records	5	9	8	7	29
Medical illustration	0	1	1	0	2
Multi Agency Integrated Discharge Team	0	2	1	0	3
mortuary	0	0	0	0	0
Nucleus Theatres and Theatre	0	1	0	0	1
Ophthalmology	7	5	10	10	32
Oral and Maxillofacial	15	10	6	11	42
Orthotics	2	2	4	3	11
Orthopaedic General	28	23	20	34	105
Paediatric	9	20	15	18	62
Pain Management	6	2	1	3	12
Palliative	1	0	0	0	1
Pathology	2	3	1	0	6
Plastic Surgery	9	7	6	2	24
Pre op	1	0	1	1	3
Phlebotomy	4	1	0	1	6
Pharmacy	3	0	2	4	9
research	0	0	0	0	0
Therapies	11	18	6	8	43
Renal	3	5	4	2	14
Respiratory Medicine General	11	8	3	12	34
Rheumatology	6	6	3	3	18
Sleep studies	1	0	0	2	3
Stroke & Neurology Services	7	15	16	18	56
Surgical	34	42	29	37	142
Switchboard	1	0	0	2	3
Urology	21	11	12	16	60
Vascular Surgery	9	9	7	2	27
Virtual Services Project	2	0	0	0	2
Total	578	525	465	529	2097

Figure 1 Breakdown of the PALS issues, by speciality.

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The data reported for the Chief Nurse team appears to be high, however this category is often used for many general enquiries such as how to request access to medical records, visiting queries or general enquiries to reception areas which many patients report concerns including parking permits, lost property etc. themes for these will be developed further following the change to IRIS.

Meeting Title	Board of Directors		
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Analysis of the themes of the annual PALS sees *Care and Treatment* as the highest value (23%). For the first 3 quarters. Figure 2 holds the themes from PALs data.

	23/24 Q1	23/24 Q2	23/24 Q3	Total
Admission	1	1	0	2
Access to NHS services	5	7	8	20
Appointment	147	130	93	370
Attitude & behaviour	46	45	33	124
Care and treatment issues	128	119	124	371
Communication	101	92	90	283
Delay in diagnosis	17	35	20	72
Discharge	13	20	14	47
Discrimination	1	0	1	2
Environment issues	22	21	16	59
Equipment issues	5	3	3	11
Fall, slip or trip on same level	2	1	0	3
Fall from height	0	1	0	1
Food quality issues	1	0	1	2
Infection control	1	0	0	1
Information security breach	5	6	1	12
Medication	16	5	11	32
Medical records issues	37	24	26	87
Nutrition	1	0	0	1
Patient procedure issues	31	23	22	76
Service provision issues	1	0	1	2
Support Needs	3	1	4	8
Theft, loss or damage of personal property	17	12	8	37
Transfer	0	1	0	1
Transportation issues	2	1	2	5
Visiting issues	5	3	1	9
Total	608	551	479	1638

Figure 2 Themes of PALs 2023/24.

Again, due to IRIS being implemented during quarter 4 there is a mix of the new primary subjects, and older categories when looking at PALs themes due to both systems being used during Q4 to capture the data. Figure 3 reports this mix but does highlight a number of PALs concerns being raised due to communication concerns.

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Primary Subjects	23/24 Q4
Admission & Discharge	22
Appointments & Waiting times	136
Values & Behaviours	36
Care and treatment issues	42
Clinical Care (Dr Led)	68
Communication	153
Environment & Equipment	30
Patient Care led	18
Property	9
Other	30
Total	544

Figure 3 Themes of PALs Q4 2023/24.

Appendix 5 Compliments Data.

Figure 1 highlights the compliments received by speciality.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24	Total

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.7

Accident and Emergency	12	15	14	12	53
Acute Elderly and Downstream Stroke -	1	3	0	0	4
Acute Elderly Rehabilitation Inpatients	2	1	1	2	6
Acute Medical Admissions	5	4	1	5	15
Acute Medicine-Shielding	5	10	8	1	24
Acute Oncology Service	0	1	0	0	1
Acute surgical admissions	4	7	4	5	20
Anaesthetics	0	9	1	0	10
Audiology	0	0	2	7	9
Bereavement Services	0	1	1	3	5
Pathology - Blood Sciences/Biochemistry	0	1	0	0	1
Breast Imaging	11	9	9	18	47
Breast Surgery	2	2	0	1	5
Cardiology	4	2	10	0	16
Catering Services	1	0	0	0	1
Chief Nurse	1	2	0	3	6
Child Development	2	1	0	0	3
Clinical Haematology	5	1	0	0	6
Clinical Psychology	2	5	2	3	12
Coronary Care	3	12	1	0	16
Acute Elderly	0	1	2	0	3
Dermatology	8	9	1	2	20
Diabetes and Endocrinology	0	0	23	0	23
Dietetics and Nutrition	0	0	1	1	2
Downstream Acute Surgery	28	18	22	12	80
Elderly Care Assessment	12	4	9	11	36
Elderly Medicine	4	14	15	4	37
Endoscopy	25	1	4	7	37
ENT Day Case	17	11	19	5	52
ENT Inpatients	16	10	5	7	38
ENT Outpatients	5	6	2	4	17
Estates	0	1	0	0	1
Gastroenterology Inpatients	24	28	12	29	93
Gastroenterology Outpatients	3	0	3	1	7
Gynaecology	4	3	2	2	11
Haematology and Oncology Day Case	8	2	2	0	12
Infectious Diseases	0	0	0	1	1
Intensive Care	34	25	25	21	105
Intermediate Care WWP	1	1	1	0	3
Maternity Services	5	5	8	5	23
Maxillofacial Inpatients	1	0	0	1	2
Medical Day case	0	0	0	10	10
Medical Examiner Office	4	5	9	5	23
Medical Physics	0	0	1	0	1

Meeting Title	Board of Directors		
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Medically Optimised for Discharge	0	0	3	9	12
Mortuary	1	0	0	0	1
Neonatology	6	25	9	15	55
Neurophysiology	0	0	1	1	2
Occupational Therapy	1	0	0	0	1
Oncology Inpatients	0	1	2	0	3
Ophthalmology Day Case	2	3	2	0	7
Oral and Maxillofacial Surgery Outpatients	2	2	0	0	4
Orthodontics	4	2	0	2	8
Orthopaedic General	16	8	2	0	26
Orthotics	0	0	1	0	1
Paediatric Medicine	3	5	1	2	11
Pain Management	0	0	2	0	2
Palliative Care	1	1	0	0	2
Patient Experience	1	14	12	10	37
Pharmacy	0	0	0	2	2
Phlebotomy	2	1	0	1	4
Physiotherapy	0	0	5	0	5
Plastic Surgery Outpatients	0	1	0	0	1
Portering General	0	1	0	0	1
Pre-Op Assessment	1	0	0	0	1
General Surgery Progressive Care	14	8	11	0	33
Quality Improvement	0	0	1	0	1
Renal Medicine	1	0	1	3	5
Respiratory Medicine General (	0	0	8	0	8
Rheumatology	1	0	0	0	1
Quality Governance	1	0	1	0	2
Specialist Imaging - including MRI and CT	5	2	1	2	10
Stroke Services	4	3	0	2	9
Surgical Outpatients	2	1	2	8	13
Ultrasound	0	1	0	0	1
Ultra Green Surgical -	4	4	5	0	13
Ultra Green Day Case -	0	10	62	4	76
Ultra Green Surgical Inpatient -	22	7	4	9	42
Urology	2	2	0	5	9
Vascular Surgery	3	1	3	2	9
Virtual Services Project	0	0	1	0	1
Voluntary Services	0	0	0	1	1
WWPDTC - Nursing	1	1	0	0	2
Risk Registers Only - Planned Care Group-wide	0	0	1	0	1
Total	359	334	361	266	1320

Figure 1 Compliments by speciality.

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.7

BO.7.24.8 - INFECTION PREVENT AND CONTROL ANNUAL REPORT 2023/24

REFERENCES

Only PDFs are attached

Bo.7.24.8 - Infection Prevention and Control Quarterly report Q4 2023-24 (presentation).pdf

Bo.7.24.8 - Infection Prevention and Control Report Q4 2023-24 (cover).pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors

11 July 2024

Infection Prevention and Control Quarter 1 Progress Report Jan-March 2024.

Muhammad Yaseen

Nurse Consultant/Director of Infection Prevention and Control

Together, putting patients first

Learning

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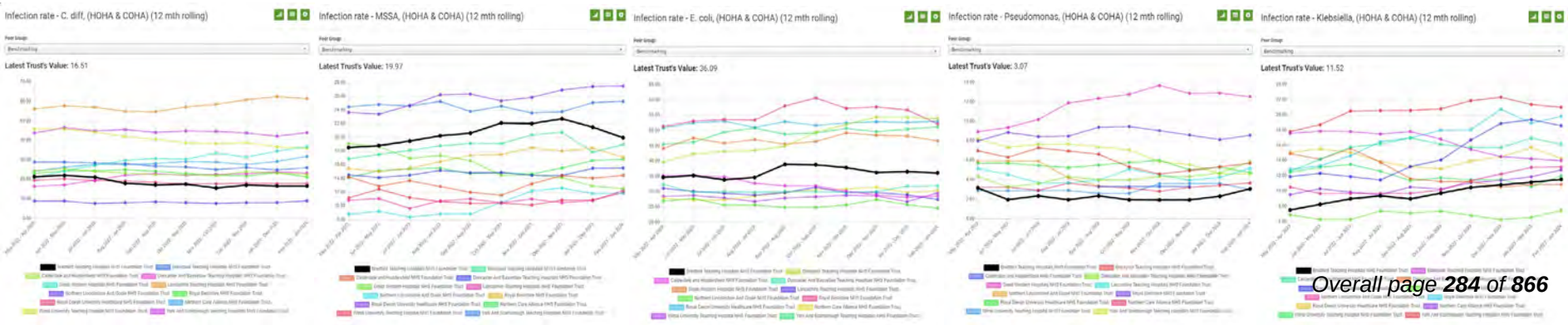
Standard Indicator Set: Clinical Quality	Trust Performance			Benchmarking			
Indicator	Current	Previous	Change	Peer	National	Position	Module Link
Infection rate - C. diff, (HOHA & COHA) (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (Apr 2024)	16.51 (Feb 2023 - Jan 2024)	16.52 (Jan 2023 - Dec 2023)	-0.01 ↓	-	26.61		
Infection rate - MRSA, (HOHA & COHA) (12 mth rolling) PHE MRSA Infection Rates, HES Inpatients (Apr 2024)	1.54 (Feb 2023 - Jan 2024)	1.54 (Jan 2023 - Dec 2023)	No Change	-	1.17		
Infection rate - MSSA, (HOHA & COHA) (12 mth rolling) PHE MSSA Infection Rates, HES Inpatients (Apr 2024)	19.97 (Feb 2023 - Jan 2024)	21.52 (Jan 2023 - Dec 2023)	-1.55 ↓	-	14.36		
Infection rate - E. coli, (HOHA & COHA) (12 mth rolling) PHE E. coli Infection Rates, HES Inpatients (Apr 2024)	36.09 (Feb 2023 - Jan 2024)	36.51 (Jan 2023 - Dec 2023)	-0.42 ↓	-	36.39		
Infection rate - Pseudomonas, (HOHA & COHA) (12 mth rolling) PHE Pseudomonas Infection Rates, HES Inpatients (Apr 2024)	3.07 (Feb 2023 - Jan 2024)	2.31 (Jan 2023 - Dec 2023)	0.76 ↑	-	6.48		
Infection rate - Klebsiella, (HOHA & COHA) (12 mth rolling) PHE Klebsiella Infection Rates, HES Inpatients (Apr 2024)	11.52 (Feb 2023 - Jan 2024)	11.14 (Jan 2023 - Dec 2023)	0.38 ↑	-	15.04		



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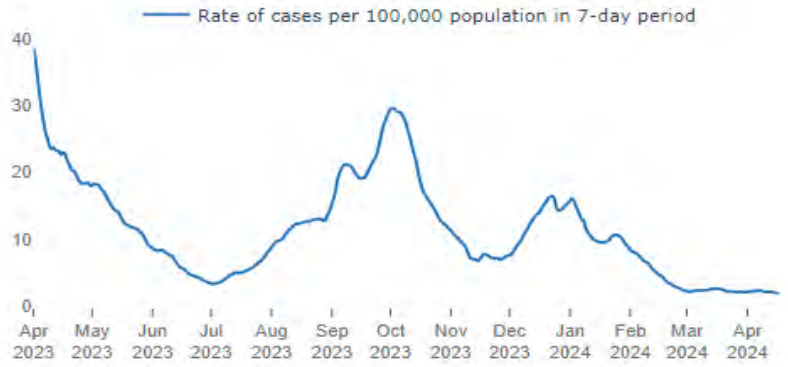
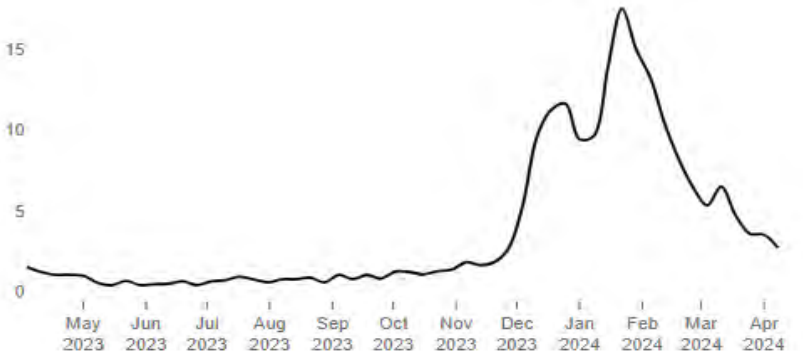
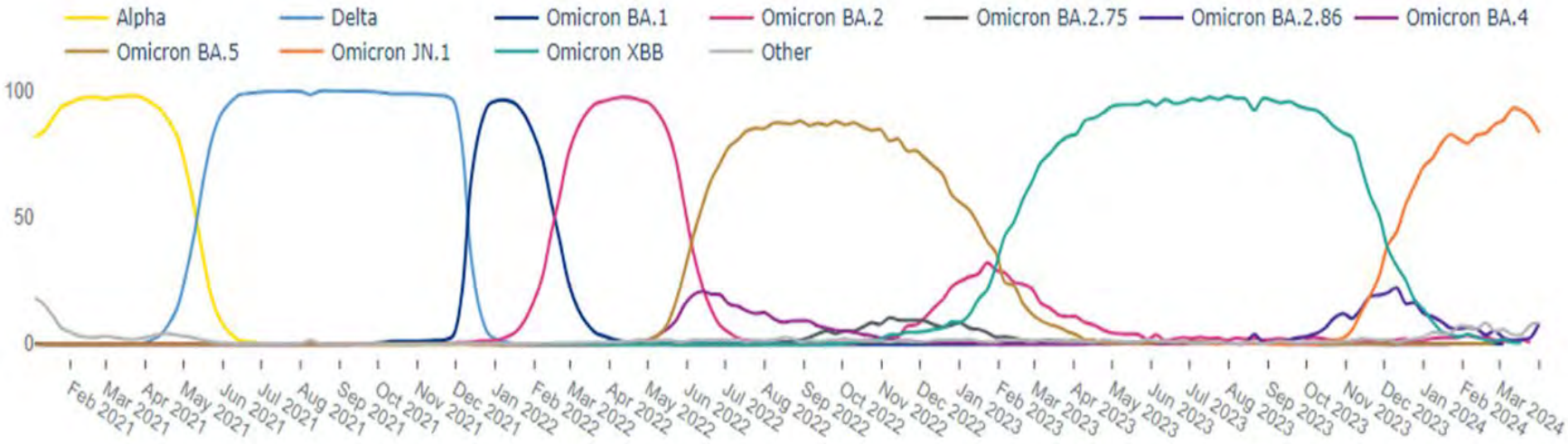
COVID-19 cases England



Influenza cases England





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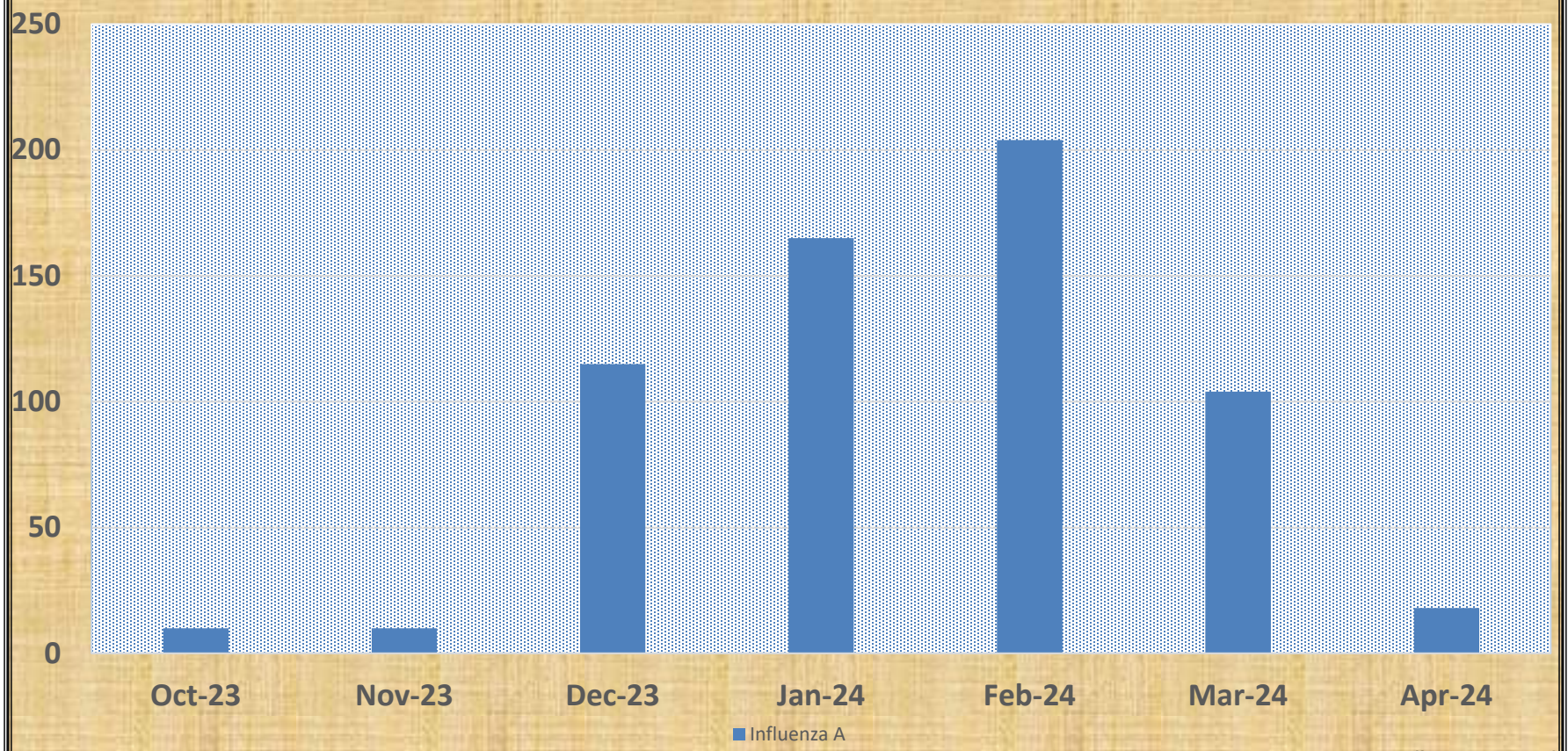
Influenza identified cases at BTHFT



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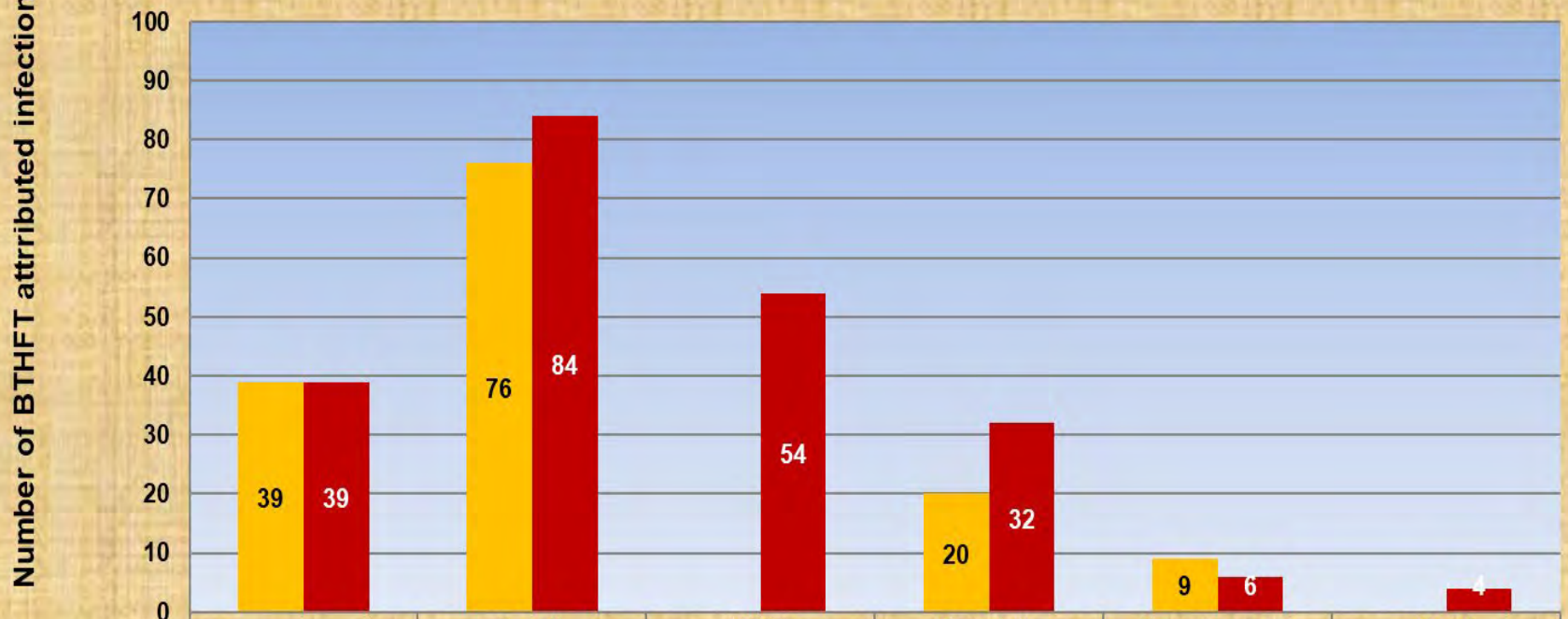
Mandatory Organisms Reporting for BTHFT



	C. diff infection	E. coli Bacteraemia	MSSA Bacteraemia	Klebsiella Bacteraemia	Pseudomonas Bacteraemia	Mrs A Bacteraemia
Target for 2023/24	39	76		20	9	
Actual 2023/24	39	84	54	32	6	4

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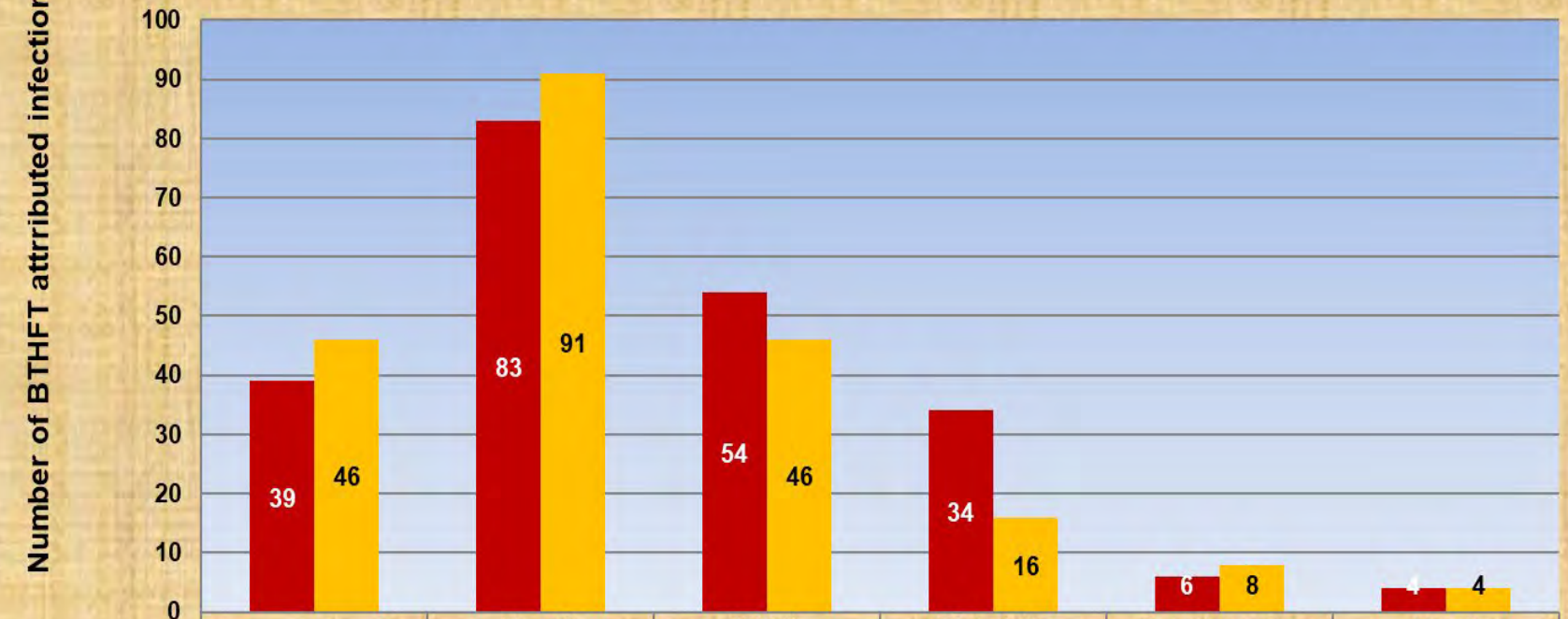
Mandatory Organisms Reporting for BTHFT 2022-23 vs 2023-24



	C. diff infection	E. coli Bacteraemia	MSSA Bacteraemia	Klebsiella Bacteraemia	Pseudomonas Bacteraemia	Mrs A Bacteraemia
Actual 2023/24	39	83	54	34	6	4
Actual 2022/23	46	91	46	16	8	4

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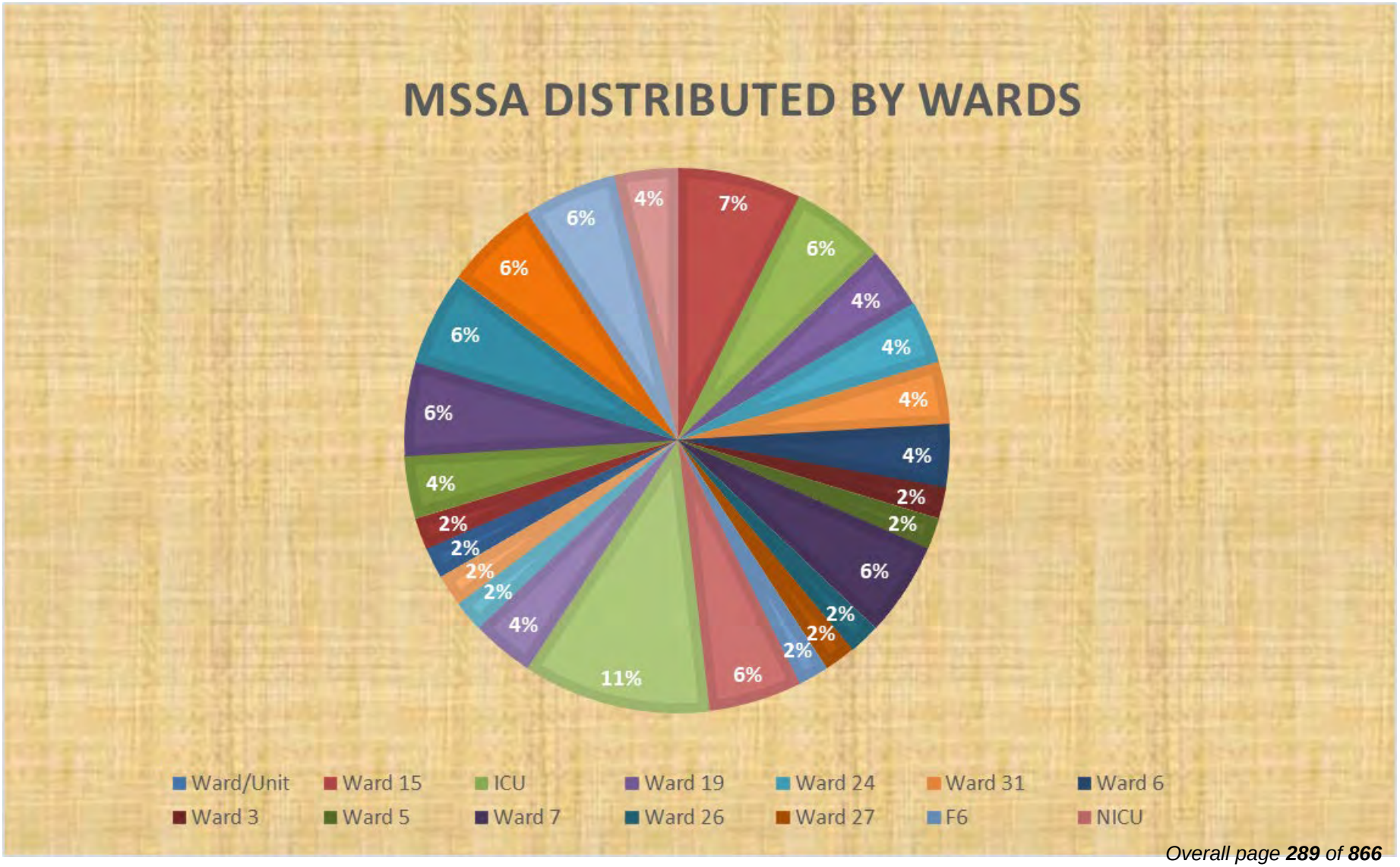

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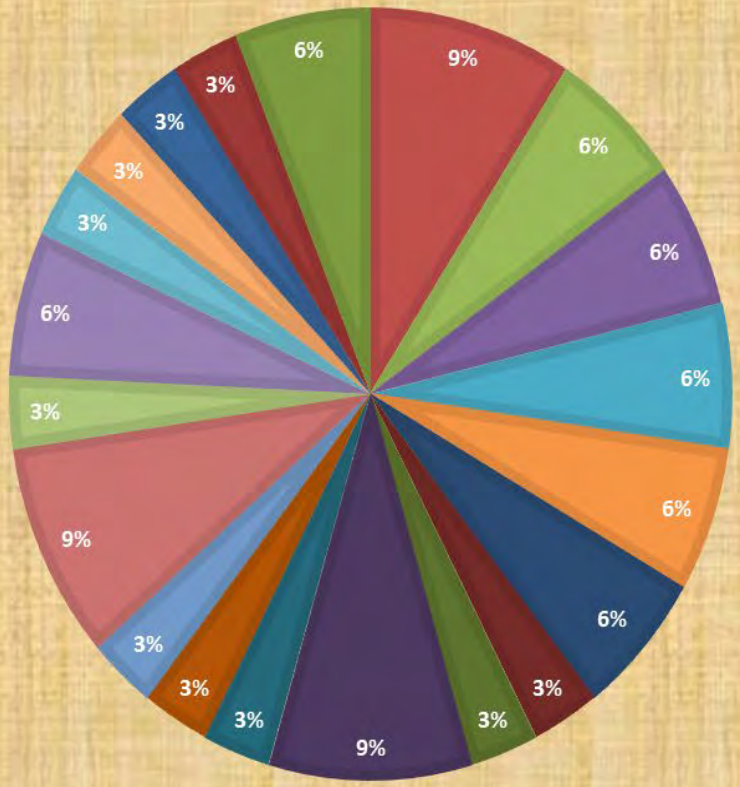
KLEBSIALLA SPP. BACTERAEMIA DISTRIBUTED BY WARDS



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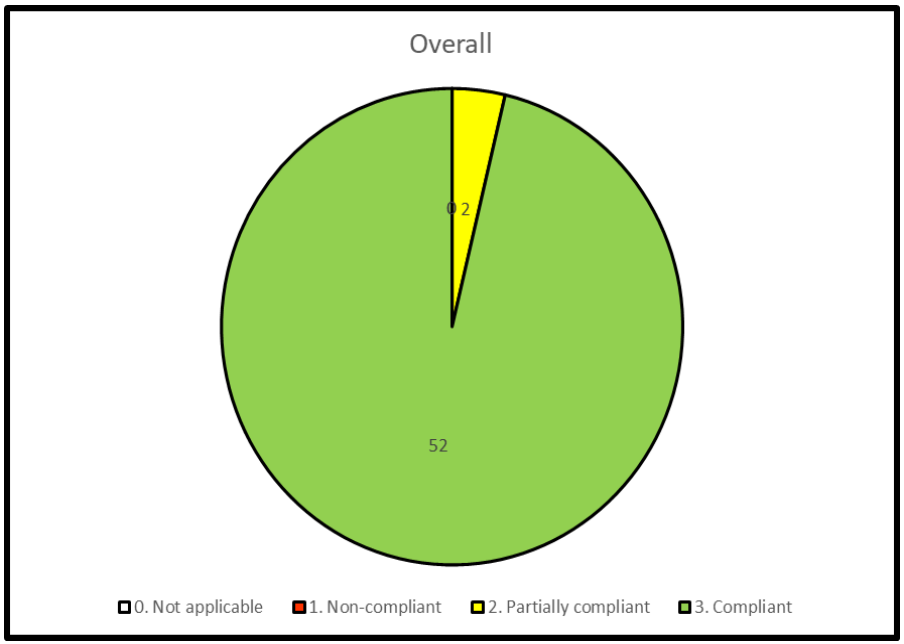
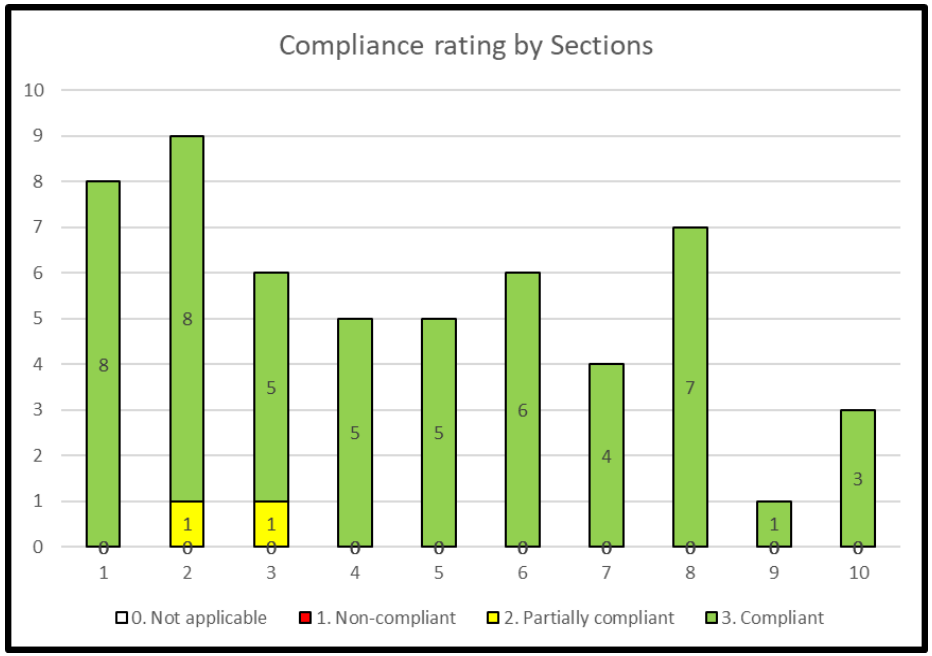
IPC Board Assurance Framework





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Trust attributed E. coli Bacteraemia at BTHFT

Bacteraemia Reduction Measures

- A comprehensive improvement plan updated regularly
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Preparing for ANTT accreditation (Silver)
- Updated SOP for Central Venous Access devices (CVAD)
- Hand hygiene improvement campaign using Semmelweis hand scanners
- Support Gloves off Campaign
- Hydration improvement project
- Audits of Octenisan compliance (IRIS on non-compliance)
- Addition of a tool to ask patients about Octenisan bath

CDI Reduction Measures

- CDI Improvement plan in place with regular updates
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Multidisciplinary team meeting in case of increase in the cases
- Ad hoc and regular environmental audits
- Commode audits with IRIS on non-compliance
- Dedicated antimicrobial Stewardship pharmacist
- Data collection on compliance to Start Smart and Focus

Mitigating Actions to assure Compliance to IPC BAF (IPC Annual Work Plan)

- Water Safety plan is almost ready. To be approved by Water Safety Group.
- Plan for more side rooms with negative pressure in Ward 1.
- A risk assessment followed by business case for another pharmacist with AMS responsibilities.

Thank you

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.8

INFECTION PREVENTION AND CONTROL (IPC) REPORT: JANUARY – MARCH 2024 (QUARTER 4, 2023/24)

Presented by	Professor Karen Dawber, Chief Nurse Muhammad Yaseen, Director Infection Prevention and Control	
Author	Muhammad Yaseen, Director Infection Prevention and Control	
Lead Director	Karen Dawber, Chief Nurse / Executive Lead Infection Prevention and Control	
Purpose of the paper	This report summarises progress against the infection prevention and control work plan for 2023/24 and sets out the Trust's infection control activities and performance between January and March 2024. This is the Q4 report for 2023/24 and provides the fourth of 4 reports which comprises the annual report. To provide assurance on compliance with: • NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. • Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code).	
Key control	This paper is a key control for the Board Assurance Framework	
Action required	For assurance	
Previously discussed at/ informed by	Infection Prevention and Control Committee	
Previously approved at:	Infection Prevention and Control Committee	Date: 30/04/2024
	Quality and Patient Safety Academy QA.5.24.14	22.05.24

Key Options, Issues and Risks

This is the quarterly infection prevention and control report which is required by the Quality and Patient Safety Academy/Board of Directors to demonstrate progress against the annual infection prevention programme and in achieving compliance with:

- The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the Q4 report for 2023/24 and provides the fourth of 4 reports which comprises the annual report.

Analysis

The report presents assurances for progress against the annual infection prevention work programme. The report also highlights and provides an escalation summary of key risks in systems and processes which impact on the prevention of healthcare associated infections.

Recommendation

Meeting Title	Board of Directors		
Date	11.07.24	Agenda item	Bo.7.24.8

The report provides assurance to the Quality and Patient Safety Academy/Board of Directors by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the actions arising from the recommendations identified are appropriate.
The Quality and Patient Safety Academy/Board of Directors is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

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)

Meeting Title	**Board of Directors**		
Date	**11.07.24**	**Agenda item**	**Bo.7.24.8**

☐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): NICE [QS61] Infection prevention and control	

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	11.07.24	Agenda item	Bo.7.24.8

INFECTION PREVENTION AND CONTROL REPORT: JANUARY - MARCH 2024 (QUARTER (Q) 4)

1 PURPOSE/ AIM

1.1 The purpose of this report is to demonstrate progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted. The Committee is asked to note the report in relation to:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

2 BACKGROUND/CONTEXT

2.1 Section 21 of the Health and Social Care Act (H&SCA) 2008 contains statutory guidance about compliance with the registration requirement relating to infection prevention (regulation 12(2)(h) and 21(b) (Regulated Activities) Regulations 2014. It should also be noted that Regulation 15 is also relevant.

2.2 Care Quality Commissions (CQCs) guidance about compliance with the above regulations includes a reference to the 'premises and equipment' regulation (regulation 15) as CQC considers this code to be relevant for the purposes of meeting that regulation.

2.3 The 'Code of Practice' on the prevention of infections under The Health and Social Care Act 2008 sets out the 10 criteria. Criterion 1 requires that systems to manage and monitor the prevention and control of infection and require the Director of Infection Prevention and Control (DIPC) to provide oversight and assurance on infection prevention (including cleanliness) directly to the Trust Board and produce an annual report. This report therefore provides assurance to meet the requirements set out above.

3 PROPOSAL

3.1 This report will confirm continued assurance systems for compliance against the statutory requirements which will support assurance with corporate strategic objective 1 - To provide outstanding care for our patients.

3.2 This is the Q4 report for 2023/24 and provides the fourth of 4 reports which comprises the annual report.

Meeting Title	Board of Directors		
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4 BENCHMARKING IMPLICATIONS

4.1 The latest information available on Healthcare Evaluation DATA (HED) in relation to infection rates is included in the section below. It shows the Trusts position for MRSA and MSSA bacteraemia, Clostridioides difficile (CDI), Klebsiella Spp, Pseudomonas aeruginosa and E. coli, in relation to the national distribution for each of these infections as of March 2024. The arrows in the graph below indicate the position of BTHFT in relation to National and Regional data.

Standard Indicator Set: Clinical Quality	Trust Performance			Benchmarking			
Indicator	Current	Previous	Change	Peer	National	Position	Module Link
Infection rate - C. diff, (HOHA & COHA) (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (Apr 2024)	16.51 (Feb 2023 - Jan 2024)	16.52 (Jan 2023 - Dec 2023)	-0.01 ↓	-	26.61		
Infection rate - MRSA, (HOHA & COHA) (12 mth rolling) PHE MRSA Infection Rates, HES Inpatients (Apr 2024)	1.54 (Feb 2023 - Jan 2024)	1.54 (Jan 2023 - Dec 2023)	No Change	-	1.17		
Infection rate - MSSA, (HOHA & COHA) (12 mth rolling) PHE MSSA Infection Rates, HES Inpatients (Apr 2024)	19.97 (Feb 2023 - Jan 2024)	21.52 (Jan 2023 - Dec 2023)	-1.55 ↓	-	14.36		
Infection rate - E. coli, (HOHA & COHA) (12 mth rolling) PHE E. coli Infection Rates, HES Inpatients (Apr 2024)	36.09 (Feb 2023 - Jan 2024)	36.51 (Jan 2023 - Dec 2023)	-0.42 ↓	-	36.39		
Infection rate - Pseudomonas, (HOHA & COHA) (12 mth rolling) PHE Pseudomonas Infection Rates, HES Inpatients (Apr 2024)	3.07 (Feb 2023 - Jan 2024)	2.31 (Jan 2023 - Dec 2023)	0.76 ↑	-	6.48		
Infection rate - Klebsiella, (HOHA & COHA) (12 mth rolling) PHE Klebsiella Infection Rates, HES Inpatients (Apr 2024)	11.52 (Feb 2023 - Jan 2024)	11.14 (Jan 2023 - Dec 2023)	0.38 ↑	-	15.04		

5 RISK ASSESSMENT

5.1 The paper provides assurance for compliance with:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health and Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

5.2 Gaps in compliance during January - March 2024 that have been identified are highlighted below and within the main report (Appendix 1).

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6	RECOMMENDATIONS

6.1 The report provides assurance to the Quality Academy by monitoring the activity of infection prevention and control annual work programme is requested to confirm the actions arising from the recommendations identified are appropriate.

6.2 The Academy is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

7	Appendices

Appendix 1: Infection Prevention and Control: Main Report

1. Introduction

1.1 The following report demonstrates progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted.

2. Strategic Context

2.1 This report summarises progress against the work plan for 2023/24 and sets out the Trust's infection control activities and performance. This is the Q4 report for 2023/24 which comprises the annual report.

2.2 The infection prevention programme of work continues to be delivered. The progress is monitored through the Infection Prevention and Control Committee (IPCC), which meets 6 times a year and has been chaired by the Director Infection Prevention and Control. Reports are submitted at each committee on progress against the annual plan and key performance objectives.

3. Healthcare Associated Infections

The NHS Standard Contract 2023/24 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. Trusts are required under the NHS Standard Contract 2023/23 to minimise rates of both Clostridioides difficile (C. difficile) and Gram-negative bloodstream Infections so that they are no higher than threshold levels set by NHS England and Improvement. The following table sets out the threshold levels for each trust.

- The classification of healthcare acquired infection cases is split into defined groups:
    - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥3 days after admission (where day of admission is day 1).
    - Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).
    - Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.

- During August 2020 the Public Health England (PHE) Data Capture System (DCS) started to report cases of MSSA, E.Coli, Pseudomonas sp. and Klebsiella sp. bacteraemias in a similar way to CDI. The classification of cases is split into the defined groups:
    - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥3 days after admission (where day of admission is day 1).
    - Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).
    - Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.
- Therefore, the surveillance reporting of HCAIs for all reportable organisms has aligned with the same categories as CDI.
- Consequently, there has been transference in numbers of cases that are trust assigned, particularly as healthcare associated cases will include those with recent (last four weeks) hospitalisation. The SPC charts presented in this report reflect this change to indicate the re-assignment.
- Since January 2024, as a result of Patients Safety Incident Reporting Framework (PSIRF), the individual PIRs are not carried out as a routine, however, a quick review is carried out to identify any urgent issues.

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Trust Target for 2023/24

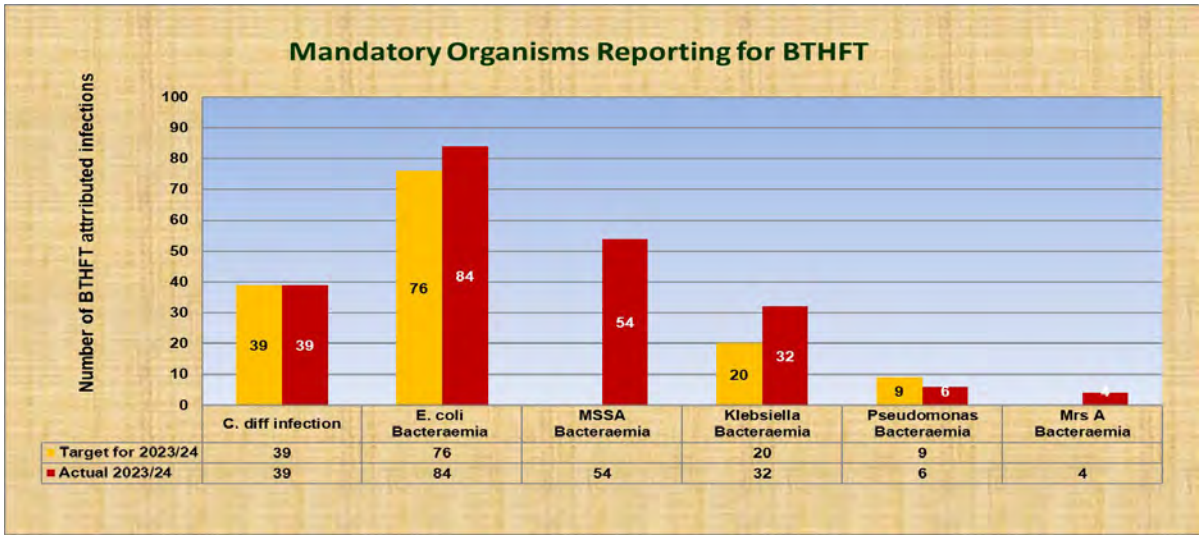

Figure 1

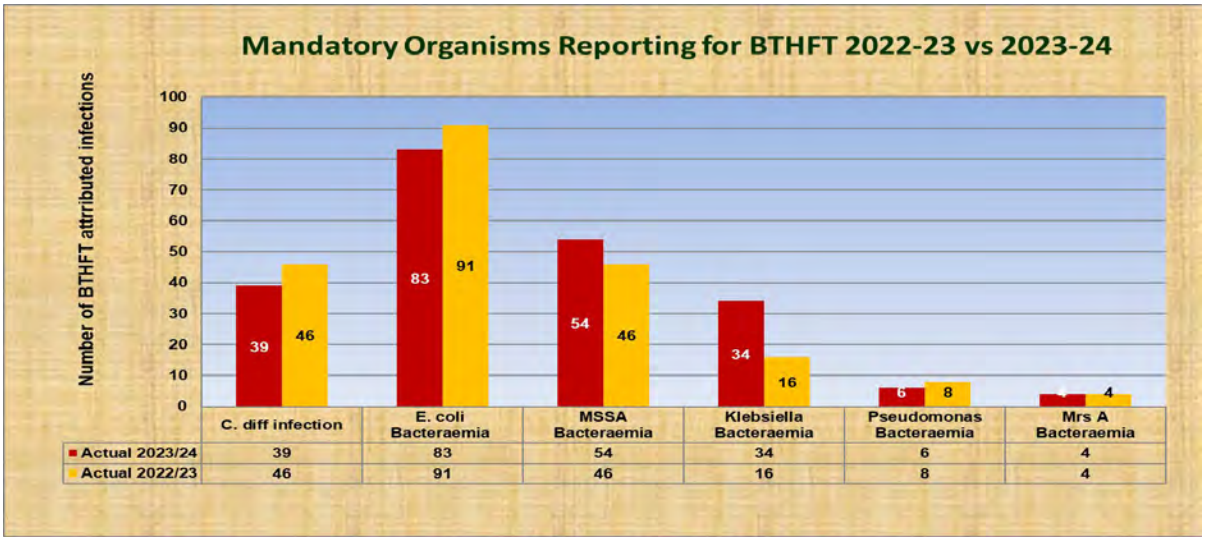

Figure 2

3.1 MRSA bacteraemia

The Trust has reported 4 cases of MRSA bacteraemia during 2023/24. Figure 3 statistical process (SPC) chart highlights the Trust allocated cases from April 2021 to March 2024.

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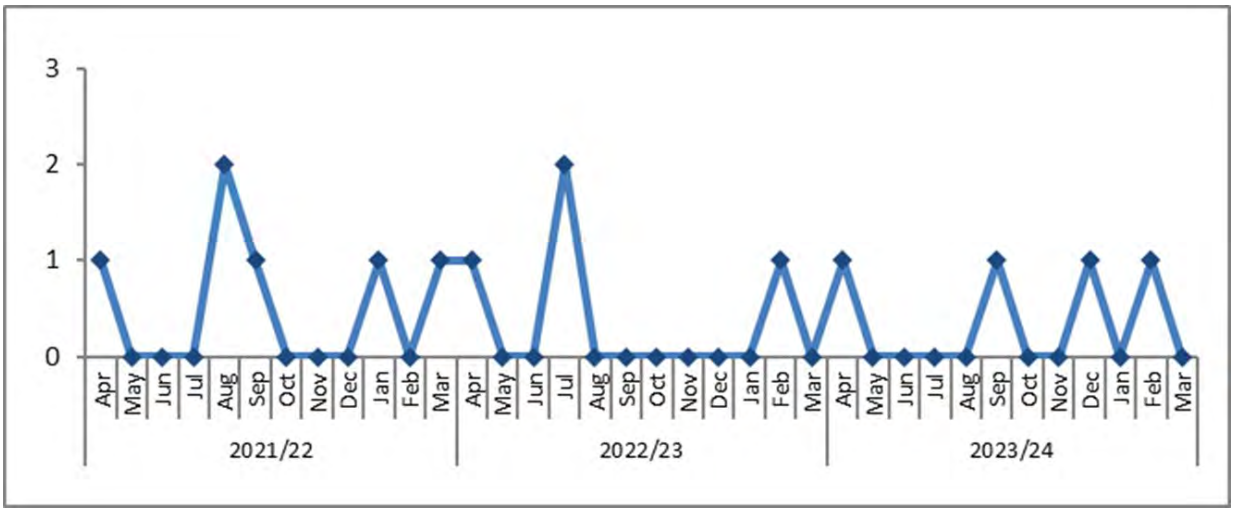

Figure 3

3.2 MSSA Bacteraemia

- The Trust has reported 54 hospital attributed MSSA bloodstream infections from April 2023 to 31st March 2024. There is no National objective for MSSA.
- Figure 4 statistical process (SPC) chart shows Trust allocated cases from April 2021 to March 2024.

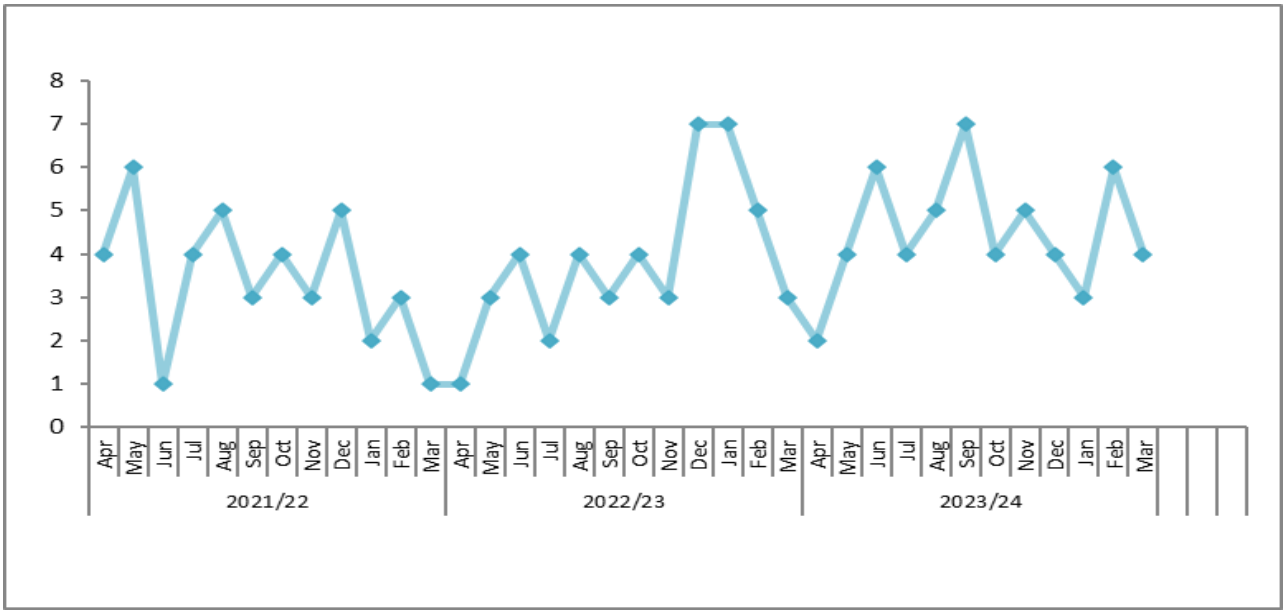

Figure 4

3.3 E. coli Bacteraemia

- Figure 5 SPC chart highlights the Trust attributed *E.coli* BSI cases per month from April 2021 to March 2024.

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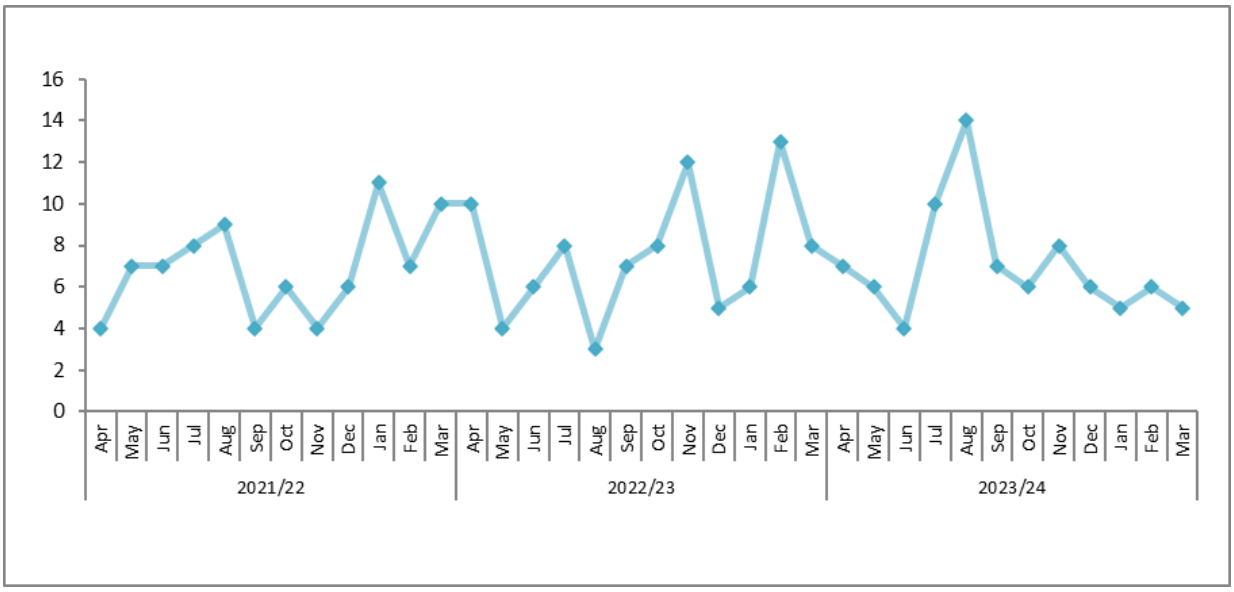

Figure 5

- There have been 84 cases of E.Coli bacteraemias attributed to the Trust from April 2023 to 31st March 2024 against an annual trajectory of 76.
- The majority of patients appeared to be admitted unwell and developed E.Coli sepsis as part of their ongoing clinical condition.

3.4 Klebsiella Bacteraemia

- Figure 6 SPC chart highlights the Trust attributed *Klebsiella Spp.* BSI cases per month from April 2021 to March 2024.
- There have been 32 cases of Klebsiella Spp. bacteraemias attributed to the Trust from April 2023 to 31st March 2024 against an annual trajectory of 20.

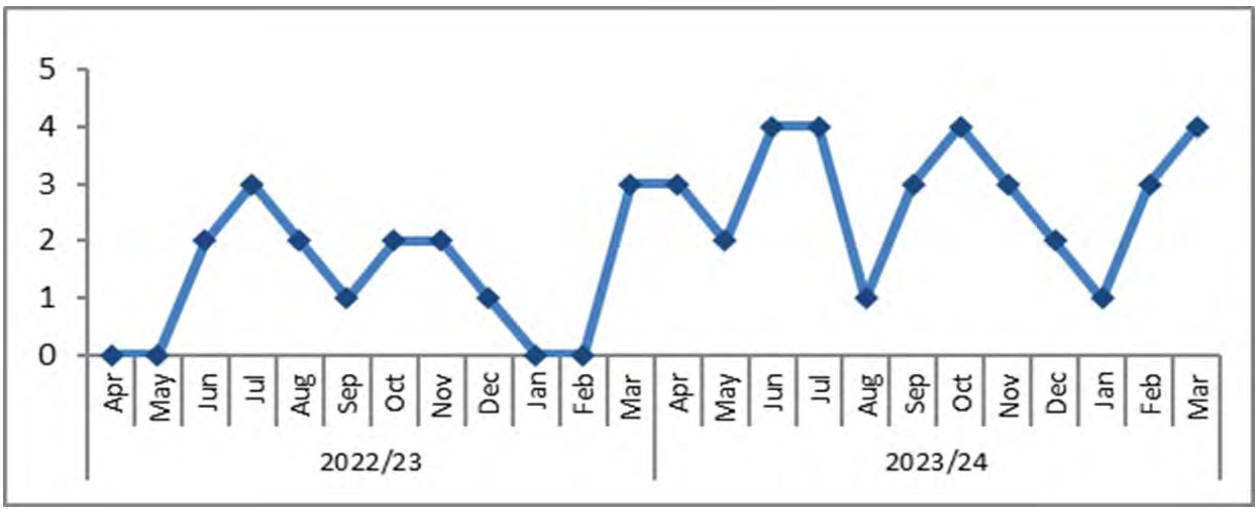

Figure 6

3.5 Pseudomonas aeruginosa Bacteraemia

- Figure 7 SPC chart highlights the Trust attributed *Pseudomonas* aeruginosa BSI cases per month from April 2021 to March 2024.
- There have been 6 cases of Pseudomonas aeruginosa bacteraemias attributed to the Trust from April 2023 to 31st March 2024 against an annual trajectory of 9.

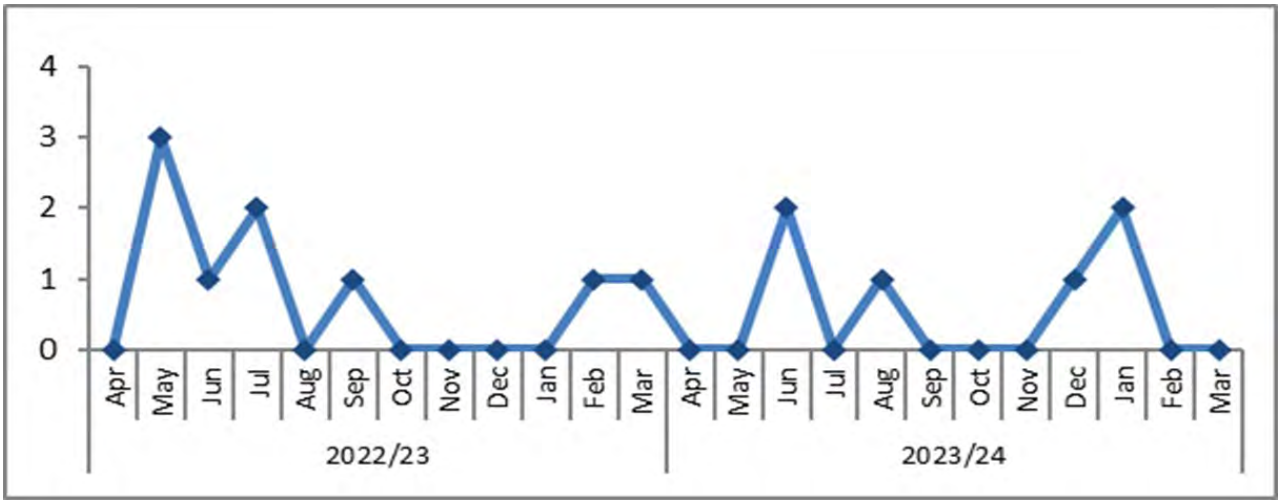

Figure 7

Bacteraemia Reduction Measures

- A comprehensive improvement plan updated regularly (Appendix 2)
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Preparing for ANTT accreditation (Silver)
- Updated SOP for Central Venous Access devices (CVAD)
- Hand hygiene improvement campaign using Semmelweis hand scanners
- Support Gloves off Campaign
- Hydration improvement project
- Audits of Octenisan compliance (IRIS on non-compliance)
- Addition of a tool to ask patients about Octenisan bath

3.6 Clostridioides difficile infection (CDI)

- Figure 8 statistical process (SPC) chart shows Trust allocated cases.
- There have been 39 cases of CDI attributed to the Trust from April 2023 to 31st March 2024 against an annual trajectory of 39.

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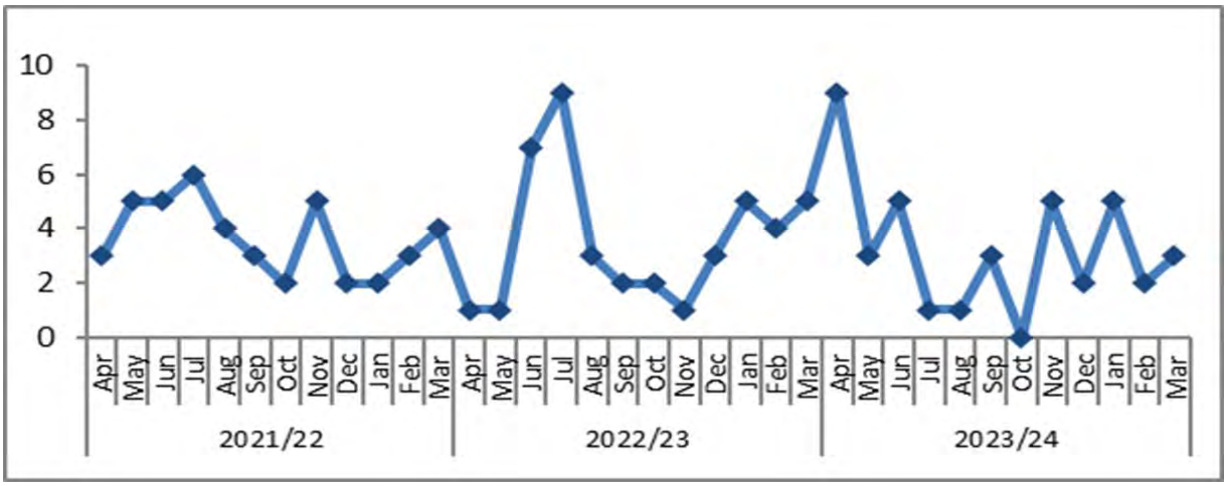

Figure 8

- Each CDI case is sent to a UKHSA (previously PHE) reference laboratory for typing; 25 subtypes of Clostridioides *difficile* have been reported during 2023/23 at BTHFT. Where there are any similar typing results, a search is undertaken to identify any potential risks for cross transmission (for example, the same ward either at the same time or at different times). No evidence of cross transmission has been identified.
- Cleaning and decontamination, including hydrogen peroxide vapour (HPV) fogging for any side-room following the discharge or transfer of a patient with CDI has continued and clinical wards and departments have maintained their audit programme for hand hygiene and PPE compliance.

CDI Reduction Measures

- CDI Improvement plan in place with regular updates. (Appendix 3)
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Multidisciplinary team meeting in case of increase in the cases
- Adhoc and regular environmental audits
- Commode audits with IRIS on non-compliance
- Dedicated antimicrobial Stewardship pharmacist
- Data collection on compliance to Start Smart and Focus

4. Winter Pressures

The winter pressures have caused many challenges in terms of appropriate placement of infectious patients. The peak of Influenza cases was seen in February 2024 as shown in figure 9.

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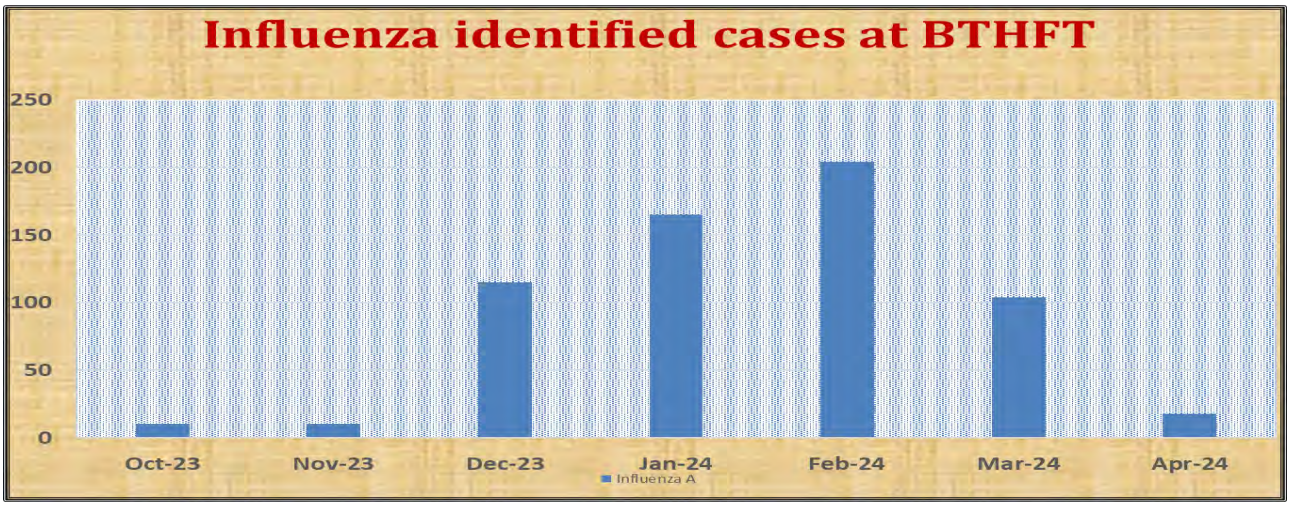

Figure 9

5. Infection Prevention and Control Board Assurance Framework (IPC-BAF)

The IPC-BAF consists of 54 total standards. Complete details of the trust compliance can be seen in Appendix 4 of this report. The trust is fully compliant to 52 of the standards. Only two elements are partially compliant. Following mitigating action have been taken:

- Water Safety plan is almost ready which will be approved by Water Safety Group in ten next meeting.
- Plan for more siderooms with negative pressure in Ward 1.
- A risk assessment followed by business case for another pharmacist with AMS responsibilities

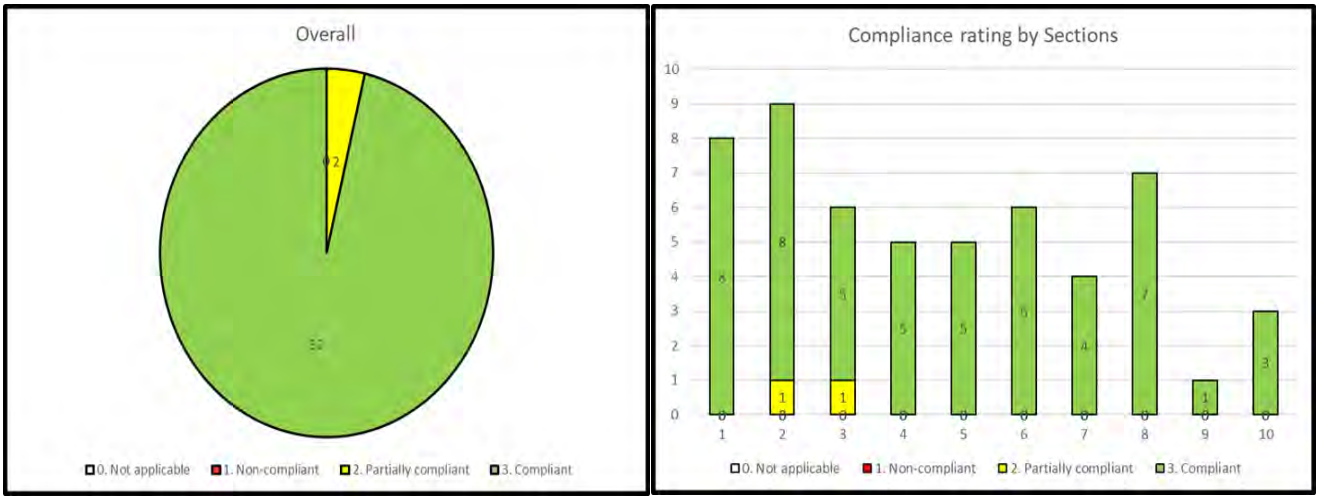

Figure 10

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Appendix 2: Improvement plan to reduce the incidence of *Clostridioides difficile* infection (CDI) (Updated March 2024)

Rationale: This improvement plan has been developed following an increase in patients being diagnosed with *Clostridioides difficile* resulting in the Trust being above trajectory in quarter 1 2023 / 23 a total of 18 patients have been diagnosed with *Clostridioides difficile;* have been reported against a trajectory of 43 for the year (10 per quarter).

Status:	
O	Open/Ongoing
OC	Open and to be completed
C	Closed
OD	Overdue

Control Objective	1	Reduce the incidence of *Clostridioides difficile* infection (CDI)

No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
1	**Understand key themes/ learning points and areas for improvement from C Difficile immediate review tool**	Review Immediate review tools returned from the clinical areas as part of the Patient Safety Incident Framework (PSIRF) and share learning points and key findings with Clinical Business Units	IPC Lead Nurse	Ongoing	O		Learning points shared with CBU's once identified
2	**Determine whether our commodes across the trust are clean and fit for use**	IPCNs to continue performing unannounced commode checks to ascertain practice and provide additional support i.e. commode training to areas which have not acceptable standard Consider introduction of golden commode award for areas that have achieved standard on 3 consecutive monthly checks	IPCT	31.03.2025	O		Commode checking rota and golden commode certificates being developed. golden commodes being purchased.

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Control Objective	1	Reduce the incidence of *Clostridioides difficile* infection (CDI)

No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
3	**Inconsistent timings in staff obtaining samples from patients experiencing loose stools**	1.1 Clarify standards required when stool samples must be obtained – Develop poster to support ward teams	IPC Team	30.9.22	**C**	1.12.2023	The posters have been distributed; supported with verbal update at time of delivery. Awaiting confirmation for EPR team if Push report or alert messaging is feasible
		1.2 Develop a 'push report' to alert staff to stool sample compliance. Increase awareness to all staff of the correct time to take samples using different communication strategies.	EPR Team	30.11.22	**OC**		
4	**Delays in isolating patients with unexplained diarrhoea, those diagnosed with CDI and CD toxin gene positive results due to competing requirements for single rooms**	2.1 Strengthen communications and escalation processes when isolation is delayed – delays are escalated to Clinical Site Team and reported at daily site Ops meetings/action log and notified to IPC Team.	Ward Managers/ Matrons/ Clinical Site Team	30.9.22	**C**	10.11.2023	Escalation process is being followed and Datix completed where applicable. Sideroom priority posters have been reprinted and currently being provided to the clinical areas
		2.2 Provide refreshed Sideroom priority Poster	IPC Team	30.11.22	**C**	31.01.2024	Sideroom priority posters have been reprinted and currently being provided to the clinical areas
		2.3 Inform developments in CapMan to ensure that sideroom usage (based on priority criteria available) is reflected in long term solutions	IPC Lead Nurse/EPR Team	31.12.2023	OC		Feasibility escalated to Dr Southern and EPR team
5	**There are discrepancies with ward based hand hygiene and PPE audits and IPC spot-checks – an**	3.1 Increase / raise awareness of hand hygiene requirements for all health care professionals and	IPC Team	30.11.22	C	30.11.2023	Posters have been delivered to clinical areas. Awareness raising on concourse

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Control Objective	1	Reduce the incidence of *Clostridioides difficile* infection (CDI)

No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
	over use of gloves has been observed	staff at the point of patient care – Reintroduce "The Gloves are off" campaign and hand hygiene promotion					held on 24.11.2023 . clinical areas also provided with order codes for end of bed gel holders
6	**Ensure MDT Review completed of CDI PIRs including compliance with antibiotic protocols**	4.1 Ensure there is a Medical review of CDI PIRs is completed; Antibiotic Pharmacist review and comments and forwarded completed document to PIR review panel.	DADNs	30.8.22	C	13.09.2023	PIR process embedded and all cases reviewed by ABP and lessons learnt shared through IPCC and Governance meetings.
7	**Intelligence is needed to understand the Trust use of Cephalosporins (e.g. Co-amoxiclav) and compliance with protocols**	5.1 Antibiotic Pharmacist to share data to IPCC on antibiotic usage and compliance with antibiotic protocols – Any high risk prescribing to be escalated to Clinical Teams and DIPC. 5.2 Lessons learnt from CDI PIRs where antibiotic prescribing concerns highlighted to be shared with CSU Governance meetings, the relevant clinical team and Drugs & Therapeutics meetings.	Antibiotic Pharmacist	30.9.22	C		Antimicrobial pharmacist provides report to IPCC Reporting and feedback process is in place
8	**Evidence identified of need for Infection clean programme for those wards with identified CDI cases during June/July**	6.1 Agreed programme of cleaning/decontamination (including HPV/UV light of ancillary areas and siderooms) for all wards where a case of CDI was reported – priority given to those wards with >1 cases	Facilities Manager/Ward Matrons	30.9.22	C	13.09.2023	Agreed programme completed for wards 6,15,18 22, 26 and continues for any ward area where > 1 case identified
9	**Infection clean standards may not always be achieved**	7.1 Review the current standard and develop a sign off procedure for	Facilities Manager/Ward Managers/ Matrons	30.8.22	C	30.09.2023	Areas concerned were recleaned followed by ATP testing prior to and HPV decontanimation

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Control Objective	1	Reduce the incidence of *Clostridioides difficile* infection (CDI)

No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
	prior to an HPV cycle due to competing demands/ communication issues	with Facilities Team to ensure that the environment and any equipment is visibly clean prior to commencing the HPV and that this is consistent trust wide. 7.2 Ensure bedspace checklist is completed as per cleaning policy					
10	**Evidence of the need to improve understanding of how to clean a commode and improve compliance for cleaning**	8.1 How to clean a commode poster to be re-issued to all wards; commode cleaning training to be provided to wards identified with concerns.	IPC Team/Ward Managers	30.9.22	C	31.01.23	Posters have been delivered to the wards and departments
		8.2 Focus on commode cleaning during August/September: Commode cleaning checks to be included in the ward managers daily checklist and all nursing staff to watch to “how to clean a commode” video.	Ward Managers/ Matrons	30.9.22	C	30.11.22	Assurance received from matrons at local IPC meeting that staff have reviewed the video
		8.3 IPC Team/Matrons to undertake spot-checks of commode cleaning and escalate to DADNs and areas of concern	IPC Team/Matrons	30.8.22	C	30.09.2023	Spot-checks completed and escalation to Local IPC meeting via Datix
11	**Need to understand any lessons learnt, key themes and areas for improvement from Post infection reviews**	9.1 Review of all completed CDI PIRs during June/July 2023 and share any lessons learnt/key themes via IPCC and CSU Governance meetings.	DADNs/ DIPC/Lead Nurse IPC	18.9.22	C	10.11.2023	Lessons learnt shared at local IPC meetings.
1	**It is not known if patients are consistently being offered hand hygiene at essential moments during**	10.1 Ascertain current practice and report to IPCC with recommendations for improvement.	IPCN Team	30.1.23	OC		Patient hand hygiene audit of 10 clinical areas completed

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Control Objective	1	Reduce the incidence of *Clostridioides difficile* infection (CDI)

No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
	the day (especially after using the toilet)	IPC to repeat previous QI project regarding the importance of patients' hand hygiene - before meals and after using the toilet.					
13	**How can we determine if our mattresses across the trust are clean and fit for use**	11. Ensure mattress ingress and damage checks are part of (1) ward accreditation audit (2) Matron/IPC audits (3) annual mattress audit reinstated	IPCN Team/Matrons/ Chief Nurse Team	30.11.22	C	30.10.2023	Audit question added to the matron and IPC audit; assurance audit and IPC unannounced ward audit

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Appendix 3: MRSA & MSSA Bacteraemia Improvement plan 2021/22/2024 (Updated March 2024)

Status:	
O	Open
OC	Open and to be completed
C	Closed
OD	Overdue

Control Objective	1	Reduction in MRSA / MSSA Bacteraemia

No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
1	Commission new incubators for BTHFT laboratory to ensure timely incubation of blood cultures	JVC across site manager	01.08.2023	01.12.2024	O		Commissioning process commenced; progress monitored at Senior laboratory meetings
2	Octenisan antimicrobial body wash to be prescribed for all acute inpatients at the time of admission	DIPC	1.3.2023	01.12.2023	OC		SOP, patient information leaflet and screensaver developed and previously circulated. EPR team have created a new SOP. A task alert on EPR for the nursing staff to activate the decolonisation care plan. The IPC team are monitoring compliance on a weekly basis Datix completed for areas of non-compliance and escalation to Local IPC care group meetings
3	Upload peripheral line screensaver to computer network across all hospital's sites o Circulate peripheral line newsletter o Finalise Biopatch poster and launch in conjunction with tool box sessions to areas using the product	Lead IPCN	1.4.2024	01.07.2024	O		Draft screensaver created in by IPCT; medical illustration to finalise prior to upload to the computer network. Biopatch poster drafted by manufacturer; await final

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Control Objective	1	Reduction in MRSA / MSSA Bacteraemia

No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
							version following feedback by IPCT.
	All patients admitted to the trust must have an IPC risk assessment correctly completed in EPR for their current admission with non-compliance being reported via the Clinical Datix reporting system	Matron/IPCT	27/03/2021	01.10.2023	C	14.6.2023	Non-compliance continues to be reported via Datix SOP in EPR developed, staff training in progress on SDEC using PDSA cycle. Point prevalence audit completed and will be repeated again following training followed by wider roll out to clinical areas
	All admission wards to use the MRSA screening Protocol	Matron/IPCT	27/03/2021	01.10.2023	C	14.6.2023	
4	All new inpatients with MRSA will receive a IPC review (Monday-Friday)	Lead IPCN	15/03/2021	01.10.2023	C	14.6.2023	Daily reviews continue to support clinical teams checking compliance with o VIPS /Clips o Decolonisation suppression treatment commenced and prescribed according to protocol o
5	Antibiotic prescriptions within EPR are in line with prescribing policy or agreed variation with ID or Consultant Microbiologist	Antimicrobial Pharmacist	22/03/2021		C	1.4.2023	Audit compliance will be reported to Drug and therapeutic committee and IPCC
6	All patients admitted to the trust must have an IPC risk assessment correctly completed in EPR for their current admission with non-compliance being reported via the Clinical Datix reporting system	Matron/IPCT	27/03/2021	01.10.2023	C	14.6.2023	o Body was continues for duration of stay if greater than 5 days o Referral to TV team if required

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Control Objective	1	Reduction in MRSA / MSSA Bacteraemia

No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
							o Urinary catheter care Datix completed for non-compliance
7	All clinical areas must be o supplied o Use peripheral cannula packs for insertion of cannula and FREPP available for skin cleansing	Head of Procurement / Director of Pharmacy	27/04/2021	1/07/2023	C	01.05.2023	Frepp discontinued by manufacturer but substituted by Cloraprep containing 4% CHG 70%IPA
8	Blood cultures must be taken using o closed system SAFETY Blood collection set o aseptic technique	Education Team	22/03/2021	1/07/2021	C	14.06.2023	Staff members are taught using safety blood collection sets and ANTT
9	Concentrate initial ANTT refresher training in areas with high patients acuity i.e. ward 29, ward 22, ICU, ward 6 & AED	IPCT	22/03/2021	1/09/2021	C	14.06.2023	93 ANTT assessors in place and trained. Focus training completed on ICU, NICU, The meadows, ward 26 Training and assessment being led by the Education team supported practice educators supported by IPC team
10	Peripheral cannula\CVC to be reviewed by clinical team o 3 times daily o VIPS\CLIPS assessment will be recorded on the patients EPR VIPS/CLIPS care plan within EPR	Matron	27/04/2021	01/11/2023	C	31.10.2023	Discussed at local care group IPC meetings and will be supported by IPC team to ensure VIPs recorded at least daily and then focus on achieving 3 times daily . IPC continue to monitor VIP scores during matron/IPC assurance audits. Wards continue to audit insertion and ongoing care of cannula's monthly.

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Control Objective	1	Reduction in MRSA / MSSA Bacteraemia

No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
11	Explore feasibility of creating MRSA care plan in EPR	IPCT	20/04/2021	01/12/2023	C	31.10.2023	Awaiting confirmation from CHFT IPC team as joint agreement required. No replies from CHFT and not able to proceed
12	All peripheral cannula to be removed within 72 hours of insertion or 96 hours if venous access is limited and VIPS recorded as Zero	IPCT/ matron	27/04/2021	01/12/2023	C	31.10.2023	Audit compliance against Vascular access device policy. VIP audits restart March 22 and audit results reviewed at local IPC meetings. Wards continue to audit insertion and ongoing care of cannulas monthly. IPC/Matron audit 6 monthly auditing VIPS/CLIPS.
13	Remove peripheral cannula within 24 hours of cannula being inserted in emergency situations where aseptic technique cannot be assured	IPCT	22/03/2021	01/07/22	C	01/07/2023	VIP audits restarted March 22 and audit results discussed at care group IPC meetings
14	Relaunch the 'Gloves are off Campaign' to support hand hygiene compliance and reduce unnecessary glove use	IPCT	27/04/2021	1/10/2021	C	05.05.2023	Relaunched on 05.05.2023, stall on concourse with good staff engagement; tool box exercises delivered to clinical areas with revised posters and inclusion in 'Let's talk'
15	Restart matron IPC audit programme; results and actions to monitored by the individual care groups at local IPC meeting and included in report to IPCC	Matron/ ADNs	27/04/2021	1/8/2023	C	1.5.2023	Audit has resumed, action plan created for areas of non-compliance and monitored at local IPC meeting. Summary included in care group report to IPCC

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Appendix 4: Infection Prevention and Control Board Assurance Framework (Updated April 2024)

Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Responsibility	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	There is an Infection Prevention and Control Committee with terms of reference. The committee is chaired by the DIPC and meets quarterly. The committee reports to the Quality and Patients Safety Academy quarterly with an annual report to the trust Board. The Infection Prevention and Control policy clearly defines the lines of accountability to the IPC team				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	There is comprehensive system of data collection and reporting of mandatory organisms data on mandatory organisms.				3. Compliant

1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Datix submitted for any hospital onset bacteraemia/CDI cases so that each care group can track HCAI PIR and log PIRs as evidence with Datix. Post Infection Reviews (PIRs) are completed at PIR Review panel and level of harm agreed with feedback to Datix				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	The implementation of the NIPCM is still not mandatory as a national requirement and a group at national level is still working on the final implementation plan. However, the trust has it's own trust IPC policies and protocols. The NIPCM is uploaded into the trust intranet page and available for the staff to view.				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	The quarterly report for hospital onset bacteraemia caused by mandatory infectious agents and CDI cases is presented in the Infection Control Committee and an annual report is presented to the trust board.				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Clinical audits are carried out to monitor compliance to IPC policies and protocols				3. Compliant

1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Training programme currently covers mandatory infection control and complies with National Core Skills Framework. Record of Mandatory training held centrally. The report for compliance to mandatory training is presented to the IPCC committee				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Risk assessments completed By IPC/Risk& Governance Leads with support from Clinical MDT. Risk assessments shared for comments and approval through Silver and Gold CRG systems.				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						

2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Audit frequency is based on the functional risk category as defined in the National cleaning standards. All rectifications are undertaken within the agreed timescales and are recorded centrally Star ratings displayed and updated following audit Quarterly summary report sent to IPC Committee outlining any areas of concern Trust Cleaning Policy reflects the national cleanliness standards and has links to a suite of documents including SOP's, commitment to cleanliness charters, cleaning responsibility/frequency of cleaning framework, Cleaning Schedules etc. All functional areas have been reassessed (2023) with IPC and assigned to one of the 6 Functional Risk Categories				3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE inspections are undertaken annually, and all areas inspected in line with the definitions specified in PLACE guidance. Reports are produced once results reviewed and action plans produced, which are presented to the board (NOTE- Check with George Reynolds and Karen Bentley who lead this)				3. Compliant

2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	The responsibilities framework identifies roles and responsibilities for cleaning in line with National Standards In addition, commitment to cleanliness charters are available for each area on the ward. These are also contained on the intranet and links are within the policy. These clearly define which items are cleaned, how often and by whom.				3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	2.4.1 A schedule is kept by the authorising person (AP Vent) of all the ventilation verifications undertaken annually. The reports are also reviewed by the AE Vent (Authorising Engineer). The findings on the action plan are acted upon where feasible to do so, a program of refurbishment and upgrades is also available seeking funding. 2.4.2 the water safety plan (WSP) is in development, the current water safety procedures are in use until the WSP is finalised, which compliments the water safety policy.	Ongoing work with the development of the WSP with support of the AE Water. Not all areas are compliant to ventilation standards.	Current WS procedures in place. Water safety plan will be approved in the January water Swafety6 Group meeting. Risk assessment has been carried out for areas with sub-optimal ventilation. Patients with airborne isolation are prioritised in negative pressure rooms.	Deputy Director of Estates/Water Safety Management Group	2. Partially compliant

2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	There is a programme of PPMs which are administered via our Planet FM system and undertaken by a combination of our own trade teams and external providers where required. IPC are consulted and involved as part of the Estates Project Management Quality Manual (PMQM) on new builds or refurbishment projects. IPC are also consulted, when required, during maintenance works especially when in augmented care areas.				3. Compliant

2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen is delivered to the sites by an external contractor. This is packed to ward based standards agreed with each ward and department. Stock levels are monitored and audited to ensure suitable number of items and fit for purpose Standards are reviewed annually. Linen is delivered in cages which are covered to each ward/ department and then decanted to the areas linen cupboard. A contingency stock is kept covered in the clean linen gantry. Dirty linen is bagged and put in cages in the linen and waste rooms. Red alginate bags are used for infected linen				3. Compliant

2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	There is a waste policy in place that reflects HTM 07:01. In addition there is a matching set of standard operating procedures Bins are available at ward level, to clearly segregate all waste types in line with guidance. Colour coded bags are used, and bins are clearly labelled. Clinical waste is tagged with numbered tags to identify which area this has come from Central waste rooms are available throughout the site, and these contain waste bins separate for each waste types. Once full bins are moved to appropriate external storage holds prior to being removed by contractors Clinical waste operates a bin swap, and domestic waste are emptied on site There is an external chilled hold for anatomical waste, which is logged in line with HTM:07:01 and the human tissue act. Waste transfer notes and consignment notes are kept and logged to provide a full audit trail regarding disposal of waste. a new e-learning package has been developed to support correct segregation of waste				3. Compliant

2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Surgical instruments processing service is provided by third party- (B Braun Sterilog). Compliance assurance audits are carried out regularly and reports provided to the trust. Endoscopes are processed in-house and processes are monitored regularly with annual review of flexible endoscope decontamination facilities.				3. Compliant

2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	The Trust has in place a food hygiene policy and a ward kitchen code of practice, which are readily available on the Trusts internet pages. The food hygiene policy has a training matrix within it and defines what training is required at each level. Both documents have clear guidance available regarding food brought in. This includes labelling, dating and storage. All fridges are monitored twice daily by Ward Hospitality assistants where they are based. and action taken if these fall outside of set temperatures. This is covered within the policy and code of practice	At ward level, training doesn't extend to all food handlers, eg members of the nursing team Areas where no ward hospitality assistant is, clinical staff check temperatures.	Full guidance in place. Posters available. Checking of high risk items, monitoring the fridge etc all under control of trained staff. Education are working to review training for all levels Hygiene audits review and monitor temperature sheets		3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	An antimicrobial stewardship strategy is now in place which outlines the arrangements for AMS in the Trust.	Currently no formal lead nominated	Responsibilities lie with a group rather than resting with an individual		3. Compliant

3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	The antimicrobial stewardship report that summarises performance is submitted at the IPCC meetings and subsequently is included in the IPC report presented to the QPS academy and the Trust Board.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The Chief Nurse has additional responsibility as a Trust IPC Executive Lead who presents the IPC report that includes AMS activities				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	Antimicrobial consumption data is available via PHE fingertips. A quarterly report is circulated by the regional Antimicrobial Prescribing and Medicines Optimisation lead (APMO) , which summarises antimicrobial usage and performance against the requirements of the NHS Standard Contract. The antimicrobial stewardship report (submitted at the IPCC meetings) summarises performance The antimicrobial strategy includes monitoring arrangements				3. Compliant

3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Latest APMO report gives reassurance that BTHFT is demonstrating good practice				3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	The data on antimicrobial usage is collected and reported regularly to the IPCC	Although there is a dedicated pharmacist for AMS activities but Current staffing (pharmacy) is making audit data collection challenging	A business case is being developed for another pharmacist with AMS responsibilities	Director of Pharmacy, Lead pharmacist antimicrobial therapy	2. Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						

4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	All patients/ service user information is developed taking into consideration diverse population of Bradford and is approved from with EDI and is approved from Communication and with Patients approval group (CPAG).				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Patient information leaflets are available on the Trust external webpage including: Reducing risk of Infection, MRSA and Clostridium difficile. Information available on the website. Easy read versions have been commissioned from Bradford Talking Media. Hands ,Face, Space posters and banners in place. Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted including use of posters. Translation service is also available for diverse patient population.	Some information needs to be updated line with the national guidance especially in line with de escalation of COVID-19 preventive measures.	The information has been updated and visitors policy revised.		3. Compliant

4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Patient information is in line with IPC and AMR policies and principles including isolation information for isolated patients.				3. Compliant

4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	The visiting policy includes comprehensive information on roles and responsibilities of carers and visitors.				3. Compliant

4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Information on infectious status of patients is shared with other organisations through discharge letters, EPR and GP letters. Urinary catheter passport is used for catheterised patients.				3. Compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Automated electronic flagging in place on EPR for patients infected or colonised with common infectious agents including PTB, MRSA, CPE, C. diff infection etc. at previous admission. This enables effective communication by clinical teams and Command centre staff on patient transfer. Screening questions part of assessment on EPR. Admission assessment template in EPR Screening questions part of pre-op assessment and attendance at OPD				3. Compliant

5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patients infectious status is regularly reviewed by the IPC and command centre teams based on the microbiology results. Medical input is also sought for patients needing clinical review. Additionally, side-room priority boards are in place in wards to support continuous assessment in clinical areas.				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Information on infectious status of patients is shared with other organisations through transfer/discharge letters. Additionally information can be accessed by some organisations via EPR.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage in place at hospital entrances and information available on Trust website				3. Compliant

5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	All infectious cases meeting the definition criteria for outbreaks are investigated and outbreaks are reported through electronic portal. Information on all outbreaks is shared in Infection prevention and control committee (IPCC) as well as included in the quarterly reports to Patients Safety Group as well as Quality and Patients Safety Academy.				3. Compliant
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	All new hirees receive IPC training on induction that includes basic IPC principles including standard and transmission based precautions and Aseptic Non-touch technique (ANTT).				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IPC training level 2 is mandatory for all healthcare workers.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Compliance to IPC training is monitored and reported regularly to the IPCC.				3. Compliant

6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Compliance to IPC training is monitored and reported regularly to the IPCC.				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	All clinical staff are fit tested and records are maintained in ESR.				3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	In addition to mandatory IPC level 2, bespoke training and competency plan is implemented by education department.				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						

7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Automated electronic flagging in place on EPR for all patients with infectious status at previous admission. This enables effective communication by clinical teams and Command centre staff on patient transfer. Screening questions part of assessment on EPR. Admission assessment template in EPR Screening questions part of pre-op assessment and attendance at OPD				3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Source Isolation policy includes information on appropriate isolation precautions for infectious patients. The policy includes a Sideroom Priority System that enables command centre and clinical teams to priorities sideroom usage. In case unavailability of siderooms, patients with same infectious agent are cohorted. Such incidences are recorded via datix. Winter surge plan is created before the winter season and implemented during the season.				3. Compliant

7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Signage is displayed with colour coding for patients requiring TBPs. PPE posters available on entry to all inpatient wards.				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Command centre staff have been instructed to avoid transfer of infectious patients to other wards/clinical areas unless clinical necessary to receive appropriate clinical care.				3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	All individual involved in testing for infectious illness are trained and competent. SOPs in place for training and competency management.				3. Compliant

8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	All positive cultures are monitored by the IPC and clinical teams via ICNet, EPR. Sepsis pathway has been implemented for early identification and management of sepsis. All patients with respiratory symptoms are tested for identification of respiratory pathogens.				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Microbiology lab services are jointly managed in collaboration with Airedale and any new guidance is reviewed jointly.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	All trust policies and protocols for testing potentials infectious patients are in line with the national guidance and updated accordingly. Information on infectious status of patients is shared with other organisations through discharge letters. Additionally information can be accessed by some organisations via EPR.				3. Compliant

8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	All trust policies and protocols for testing potentials infectious patients are in line with the national guidance and updated accordingly.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	There is agreed SOP for Laboratory action in the event of an outbreak which includes testing for high consequence diseases e.g. VHF, MERS-CoV etc.	Laboratory action in the event of an outbreak.docx is out of date and requires review.	The SOP is in the review process	DIPC/Medical Director /ID Microbiology team/Gen Manager for Pathology	3. Compliant

8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	IPS_Path_MP_29 Specimen Transport IPS_Path_RAF_039 Pathology vehicle goods and sample transportation IPS_Path_RAF_016 Transport Of Samples Using The Pod Airtube System. IPS_Path_QD_03 Pathology Handbook				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Outbreak protocols in place. Outbreaks reported a to Quality & Patient Safety Academy and lessons learnt shared. Outbreak reports shared at IPCC and action plans monitored through Care Group IPCC meetings.				3. Compliant

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Risk assessment process in place for vulnerable groups of staff including guidance for managers and risk assessment checklist and template. Documents are regularly updated in line with national guidance. OH support available to staff/managers that have concerns about their vulnerabilities including signposting to psychological support. [local and national]				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	All staff members with an evidence of exposure to an infectious agent without appropriate PPE are referred to occupational health for further follow up				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	All staff undergo preemployment health checks via occupational health				3. Compliant

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BO.7.24.9 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY

REFERENCES

Only PDFs are attached

- Bo.7.24.9 - People Academy Chair's Report - 22 May 24.pdf
- Bo.7.24.9 - People Academy Chair's Report - 3 July 2024.pdf

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Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 22 May 2024

Key escalation and discussion points from the meeting
Alert:
Annual Statement of Fire Safety 2023 – the Deputy Director of Estates and Facilities and the Fire Safety Manager attended to provide assurance that risks arising from fire are managed safely. There is a programme of activity to replace the existing fire alarm systems, upgrade the emergency lighting system and improve fire and smoke compartmentation and fire-stopping. There were five fires in 2023, up from two in 2022. Four of these were smoking/lighter related and 1 related to a charger. The Trust is working with the Fire Service on actions to take to prevent smoking related fires when there is a Trust-wide no smoking policy, and a task and finish group has been created to help address this. The Chief Nurse highlighted the issue of verbal abuse from individuals who Trust staff approach when seen smoking on Trust premises.
Advise:
Equality update Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) – the Equality, Diversity and Inclusion (EDI) team presented the Trust's 23/24 WRES and WDES data, showing improvements in ethnic minority staff represented in overall workforce to 40.5%, and in senior leaders to 18.7%, albeit under-represented at bands 8a+. Ethnic minority applicants are now more likely to be appointed from shortlisting, and are less likely to enter the disciplinary process and experience bullying, harassment and discrimination. More ethnic minority staff believe the Trust provides equal opportunities in career progression and promotion. There is still work to do on ethnic minority representation at senior levels, improving the staff experience and embedding the EDI strategy. For disabled staff, there is an increase in overall representation to 4.9%, a slight reduction in appointment from shortlisting, a reduction in disabled staff experiencing bullying and harassment (but a slight reduction in those reporting it) and other improvements such as feeling valued, provision of reasonable adjustments and overall engagement. Work planned includes improving disability declarations, recruitment processes, provision of reasonable adjustments and the staff experience. The 24/25 action plans are being finalised for approval and the Academy will be regularly updated. **Freedom to Speak Up (FTSU) –** the Trust's FTSU Guardian shared the Annual report 23/24. There were 101 concerns raised, the most reported since records began. The Trust has an anonymous route for raising concerns via the FTSU app which has been further developed to allow for feedback to be shared with the anonymous person who raised the concern – less than 25% of concerns were raised anonymously. The highest category of concerns relates to inappropriate attitudes and behaviours and the highest

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number of concerns are raised by the Nursing and Midwifery teams, mirroring the national trend. The majority of concerns are resolved by leadership teams, some are referred on for Human Resources (HR) advice and support but few result in HR investigations. The Trust saw improvements across the Staff Survey People Promise elements of raising concerns.

Assure:

The Thrive Hive – the Organisational Development team attended the Academy to share their plans to create a sense of belonging through this new initiative that will positively impact the staff experience of coming to work, engagement, productivity, job satisfaction and wellbeing. They are creating a colleague led interactive calendar of events via the existing Thrive portal to cover a diverse set of activities such as music, dance, sport, fitness, gardening, hobbies, arts and crafts. They will measure the initiative's success by attendance and engagement, focus groups and the staff survey results.

Dashboard – sickness absence has started to reduce again, from 5.88% in March to 5.63% in April. Monthly turnover has also reduced, from 9.81% in March to 9.77% in April.

Report completed by:

Karen Walker
Academy Chair and Non-Executive Director

22 May 2024

Meeting Title	Board of Directors		
Date	11 July 24	Agenda item	Bo.7.24.9

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 03 July 24

Key escalation and discussion points from the meeting
Alert:
Industrial action – the Junior Doctors took strike action from 27 June to 2 July, with 76% of the Trust's Junior Doctors participating. The public are becoming immune to the strikes and the messages nudging them towards other healthcare routes, with Monday seeing a record 507 attendances in A&E. The Trust, though, has learned from the strikes over the last year and is much better at mitigating the effects. **Closing the Gap** – the Academy received an update on how the programme was mitigating impacts on the Trust's people, including the expected reactions to change, the value of listening and understanding, and that the values were built into the programme. We Care covers communications and transparency, workload and quality and patient care. We Are One Team covers engagement and involvement, and morale. We Value People covers training and development, fairness, and continuous education. The Academy were assured that the people impacts of the programme were understood and being mitigated and invited further regular updates to the Academy throughout the programme.
Advise:
Nursing and Midwifery Staffing – there is a reduction in the number of vacancies, an improvement in recruitment and a reduction in agency use. There are gaps in Healthcare Support Worker staffing, being addressed through the monthly recruitment bootcamps albeit this is not moving as quickly as the Trust would like. Harms data is consistent even though recruitment is up and red flags are down, and the consistency links to the issue of lack of time. The Trust is conducting a review of how it supports its nursing and midwifery staff to develop the right skills and ensuring it has the right people, with the right skills, in the right place. The Partnership Lead asked that the Trust survey its international nurses and the Academy was updated on the international nurse listening events they've been doing over the last couple of weeks. The key themes are a more cohesive approach to living in the UK and in Bradford (a Yorkshire slang glossary would be helpful), understanding what isn't taught in the UK or their native country that they should/need to know, and progression. There are several quick actions, such as buddies and the recruitment of a potential relocation officer that would help. The biannual establishment review has taken place and 9 areas asked for a staffing uplift. Two of these have been progressed and the others need more information before a decision is made. The Emergency team needs a review. The Trust uses the Safer Nursing Care tool to guide the required staffing numbers based on acuity and it was explained that whilst the tool is useful, local context is also needed. On harms, the output is measured but it's often the process that falls down, therefore the Trust is reviewing processes to reduce harms. A previous question on ICU recruitment and retention was addressed.

Meeting Title	Board of Directors		
Date	11 July 24	Agenda item	Bo.7.24.9

Attrition in the ICU (Intensive Care Unit) impacts the number of bed closures, and the department has lost 20 nurses over the last few years due to the burnout from Covid, an ageing workforce, and challenging patient behaviour. There has been a significant amount of work done to overcome the challenges, with 5 Staff nurses awaiting start dates, and current vacancies standing at 3 wte (whole time equivalent).

Assure:

Dashboard – the Academy celebrated the improvement in the number of bullying and harassment cases. Sickness absence has reduced to 5.36% and continues to fall, and turnover is the lowest in 2 years at 8.99%, a fall from 11% in April 23.

NHS Staff Survey Results Action Plan – the Academy reviewed the final 2023 results action plan, covering 17 actions across 6 key areas. The plan highlights the ask for customer service type training to help people reduce negative experiences, increased support for managers, reward and recognition, having a voice, Thrive Live and the need for healthy foods around the clock. The Partnership Lead asked that the scope for personal development plans be considered, and it was confirmed that personal development was on the Organisational Development team's agenda.

Karen Walker
People Academy Chair and Non-Executive Director

03 July 24

WORKFORCE REPORT

REFERENCES

Only PDFs are attached

Bo.7.24.9 - Workforce Report - April 2024.pdf

Introduction

The last Workforce report was presented to the People Academy in January 2024. This report picks up key workforce themes and trends since then and is presented in the format previously used to report to Workforce Committee.

This report will continue to be presented to the People Academy on a quarterly basis as agreed in July 2021.

Trust Data as at 31st March 2024

	DIVISION						
	Unplanned Services	**Planned Services**	**Diagnostic & Corporate Operational Services**	**Corporate Services**	**Estates & Facilities**	**Research**	**Whole Trust**
Staff in Post (Headcount)	2,112	2,141	1,409	793	596	255	7,306
Staff in Post (FTE)	1,856.67	1,923.56	1,250.53	718.45	484.82	224.18	6,458.21
Establishment	2142.88	2136.59	1371.27	772.21	616.61	205.34	7244.90
Agency Usage (FTE)	15.58	42.04	33.49	0	29.81	0	120.92
Bank Usage (FTE)	313.13	190.89	109.16	14.23	122.17	1.43	751.01
Turnover	10.12%	9.66%	9.62%	11.65%	8.47%	6.67%	9.81%
Leavers within 12 months/Joiners	36/324	38/304	21/218	14/76	5/104	0/0	114/1026
Monthly Sickness %**	6.14%	6.10%	6.47%	3.86%	7.12%	2.33%	5.88%
YTD Sickness %**	6.06%	5.90%	6.14%	4.05%	7.09%	2.58%	5.77%
Jnr Dr Sickness (Monthly) %	3.71%	2.77%	2.13%	3.23%	0.00%	0.00%	3.21%
Jnr Dr Sickness (YTD) %	3.91%	2.97%	2.48%	3.04%	0.00%	0.00%	3.31%

	STAFF GROUP								
	Add Prof Scientific & Technic	**Additional Clinical Services**	**Admin & Clerical**	**Allied Health Professionals**	**Estates and Ancillary**	**Healthcare Scientists**	**Medical & Dental**	**Nursing & Midwifery Registered**	**Whole Trust**
Staff in Post (Headcount)	171	1,315	1,660	503	564	118	968	2,007	7,306
Staff in Post (FTE)	145.82	1,149.14	1,474.89	443.27	449.65	107.96	906.52	1,780.96	6,458.21
Establishment	147.25	1305.98	1600.91	502.68	605.06	100.09	967.95	2014.98	7244.90
Agency Usage (FTE)	16.56	0	4.20	33.02	25.61	1.91	12.56	27.06	120.92
Bank Usage (FTE)	7.73	329.71	25.54	36.28	126.54	0.14	47.73	177.34	751.01
Turnover	12.08%	10.26%	11.10%	8.94%	8.39%	7.55%	5.42%	10.03%	9.81%
Leavers within 12 months/Joiners	0/13	41/393	28/204	5/64	5/95	0/15	2/19	33/222	114/1026
Monthly Sickness %**	4.13%	8.46%	5.42%	5.94%	8.06%	3.76%	2.32%	6.16%	5.88%
YTD Sickness %**	3.96%	8.39%	5.41%	4.53%	8.07%	4.74%	2.52%	6.05%	5.77%

*** ODP's/Theatre Nurses are split out into the relevant staff groups for the staff in post figures but not for the Establishment figures.**
**** The above Sickness figures are an indicative figure as at the end of March 24**
***** Includes usage for centralised budget code for COVID-19**

NOTE - Establishment, agency and bank usage data is supplied by Finance. The Establishment figures for Research staff are included within the overall Research Division, however where staff are line managed in Clinical Divisions the rest of the figures include them under the relevant Division. Therefore, there is a mismatch between the Establishment data and the rest of the data for Research staff only.

Staff in post at the start and end of each month

Month	1/6/22	30/6/22	1/7/22	31/7/22	1/8/22	31/8/22	1/9/22	30/9/22	1/10/22	31/10/22	1/11/22	30/11/22
Headcount	6515	6508	6503	6489	6486	6525	6514	6603	6588	6655	6657	6662
Month	**1/12/22**	**31/12/22**	**1/1/23**	**31/1/23**	**1/2/23**	**28/2/23**	**1/3/23**	**31/3/23**	**1/4/23**	**30/4/23**	**1/5/23**	**31/5/23**
Headcount	6659	6674	6663	6717	6713	6778	6765	6779	6737	6776	6768	6799
Month	**1/6/23**	**30/6/23**	**1/7/23**	**31/7/23**	**1/8/23**	**31/8/23**	**1/9/23**	**30/9/23**	**1/10/23**	**31/10/23**	1/11/23	30/11/23
Headcount	6787	6814	6801	6827	6815	6868	6853	6,960	6,996	7,078	7,070	7,143
Month	**1/12/23**	**31/12/23**	**1/1/24**	**31/1/24**	**1/2/24**	**29/2/24**	**1/3/24**	**31/3/24**				
Headcount	7,148	7,152	7,148	7,236	7,240	7,298	7,292	7,306				

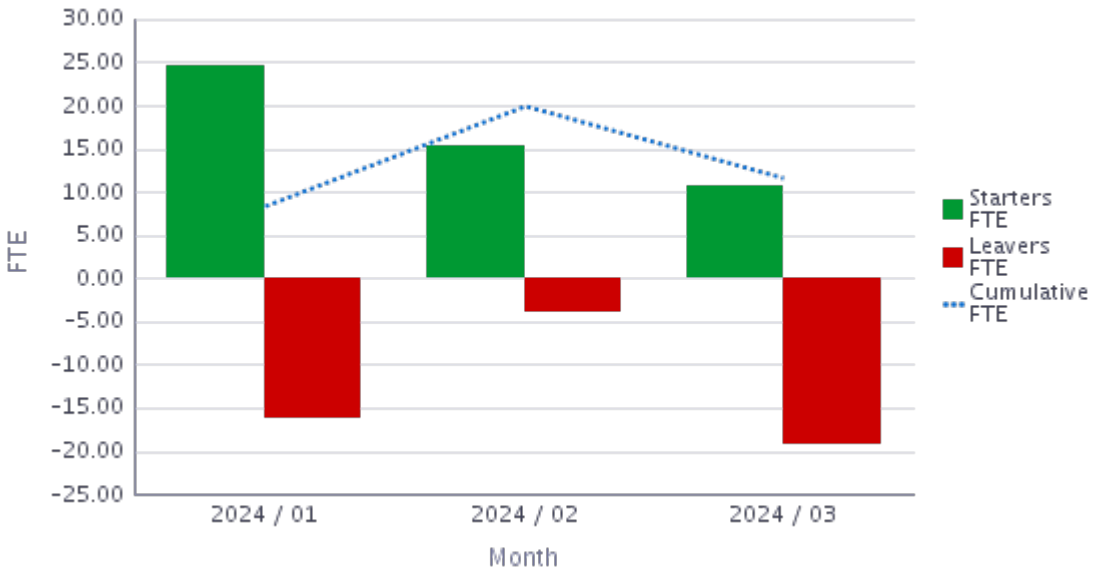
Staff in Post

Since the last report staff in post FTE has increased from 6,321.86 in December 2023 to 6,458.21 in March 2024 representing an overall increase across all staff groups of 136.35 FTE.

The largest increase in FTE over the period was in the Nursing & Midwifery Registered Staff Group (51.61 FTE) followed by the Additional Clinical Services Staff Group (40.60 FTE). The increase in the Nursing & Midwifery Registered staff group is linked to Newly Qualified Nurses joining aswell as Nurses recruited as part of international recruitment. Some overseas Nurses are still awaiting their NMC Registration so are included in the Additional Clinical Service Staff Group.

The only staff group that has shown a reduction is Medical & Dental which has reduced by 2.18 FTE over the period.

The table below shows the position with respect of qualified nursing / midwifery starters and leavers which demonstrates the position over the last three months. The cumulative position for the 3 months is +11.59 FTE with 50.68 FTE registered nurses / midwives joining the Trust and 39.09 FTE leaving.



e-Job Planning and e-Rostering

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

increased by 7.8% for registered and decreased by -.9% for unregistered. Out of the 2890 filled registered shifts, 487 were filled by registered Theatre staff.

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

This data highlights the percentage of signed off job plans within the electronic system. Medics (consultants/specialist doctors), Allied Health Professionals and Nurses (Clinical Nurse Specialists) are all required to have a signed off job plan. There are currently 882 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 352 Medics, 350 AHPs and 180 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. Currently there are 121 Job plans signed off for Medics with 13 awaiting 1st Sign off, 21 awaiting the 2nd sign off and 178 in review. Despite the drop in job plans required (due to SAS Dr's being removed – please see below) 1st and 2nd Sign off job plans have increased.

Previous reports have included SAS Dr's but from December we have excluded these so that only consultants are recorded for Medics hence the dip in total job plans and Medics numbers.

Turnover

Turnover has shown a slight increase to 9.81% in March 2024 from 9.73% in December 2023. Turnover has reduced slightly across all staff groups apart from Additional Clinical Services, Allied Health Professionals Medical & Dental where it has increased slightly.

Nursing and Midwifery

Background

Data from the Model Hospital Portal can be used to Benchmark against peer organisations, locally and nationally. Our Nursing and Midwifery Vacancy Rate as reported via Model Hospital has reduced to 12.6% (January 2024) compared to a median of 10% with peers. We have moved from the 4th quartile into the 3rd quartile. We expect this position to continue to improve as our vacancy gap closes.

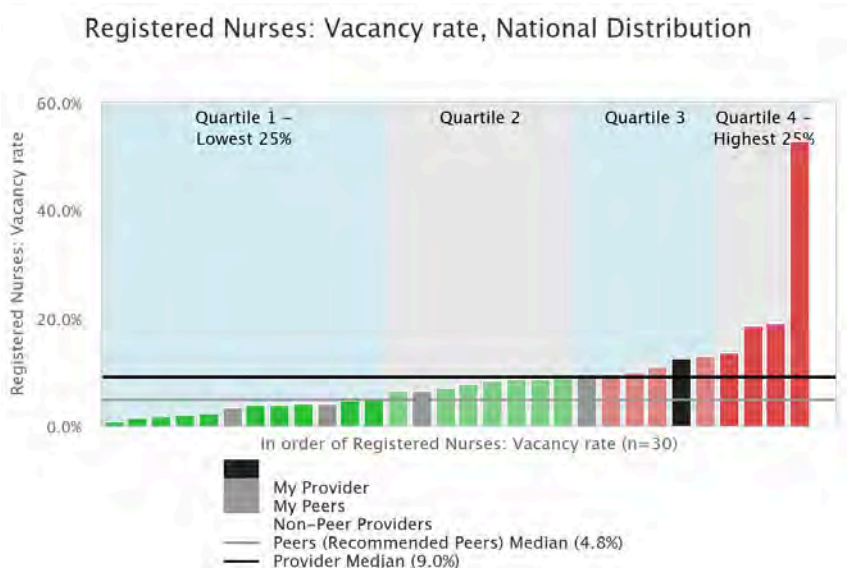


Figure 1

Registered Nurse Vacancy position

Figure 2

Although we have a higher number of vacancies than other organisations, our registered nurse turnover rate has reduced over the last 12 months (Figure 3).

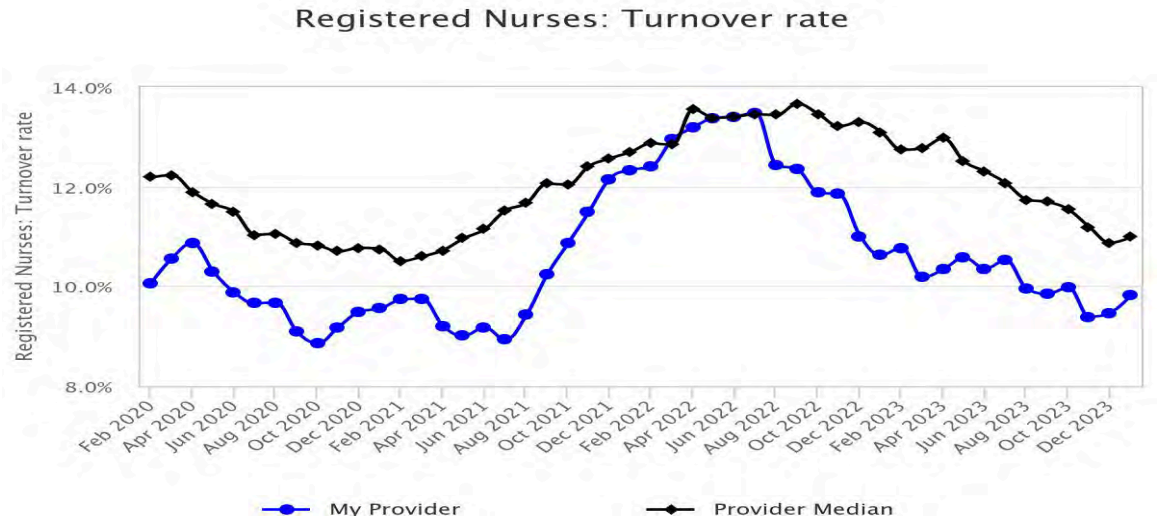


Figure 3

Risks and Recruitment

In view of the vacancy position Nursing and Midwifery staffing was on the Chief Nurse Risk Register (Risk ID 3732) as 5x4 (13th April 2023), however this has been reduced to 4x4 (31 October 2023). Our Nurse and midwifery Staffing Fill Rates at a ward level continue to improve and are consistently above 80% for Registrants and 95% for Healthcare Support workers.

From our monthly finance data, we are reporting 70 vacant Band 5 nursing posts and 149 Band 2 Healthcare Assistant posts. Our aim was to reduce our registrant vacancy position to 10% by March 2023 and less than 4.7% for Healthcare Assistants by July 2024.

Band 5 Recruitment Events

We held a recruitment event focused around Newly Qualified Nurses in March 2024 and have offered posts to 59 candidates. Intensive Care, Childrens, Midwifery and our Neonatal Intensive Care Unit ran their own recruitment drive. We are expecting approximately 100 newly qualified staff to start with BTHFT over the next 6 months.

We will be working with Human Resources to support the onboarding process to maximise retention of those waiting to start in the organisation.

Recruitment of Internationally Educated Nurses and Midwives

Since April 2023 150 internationally educated nurses have joined BTHFT and we have received NHS England's Pastoral Care Award in recognition of the support we have shown.

We have not planned any additional recruitment; however we will still continue to support the SIFE process. The SIFE process enables internationally registered nurses who have been unable to register with the CQC due to their English Language score. If they have worked in healthcare roles for 12 months, we can support them to obtain NMC registration via our OCSE bootcamp.

Band 2 Recruitment

We currently have 140 Band 2 Healthcare Assistant vacancies within the organisation. The leavers rate for healthcare assistants is an average of 60 per year or 6 per month. In July 2023, we moved to a monthly recruitment process, to support our New to Care programme. The New to Care Programme was developed to encourage the recruitment of trainee Health Care Assistants with minimal qualifications or experience of care. This is part of our ongoing commitment to "Grow your own" workforce.

We expect to see the number of HCA vacancies reduce as the table below sets out attendance on the new starter HCA bootcamp.

2023	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Substantive	9	12	10	26	18	No	26	29	23	153
Bank only	6	9	20	13	14	BC	3	0	4	69
Total	15	21	30	39	32	0	29	29	27	222

Although we have vacancies, our turnover rate remains stable (Figure 4).

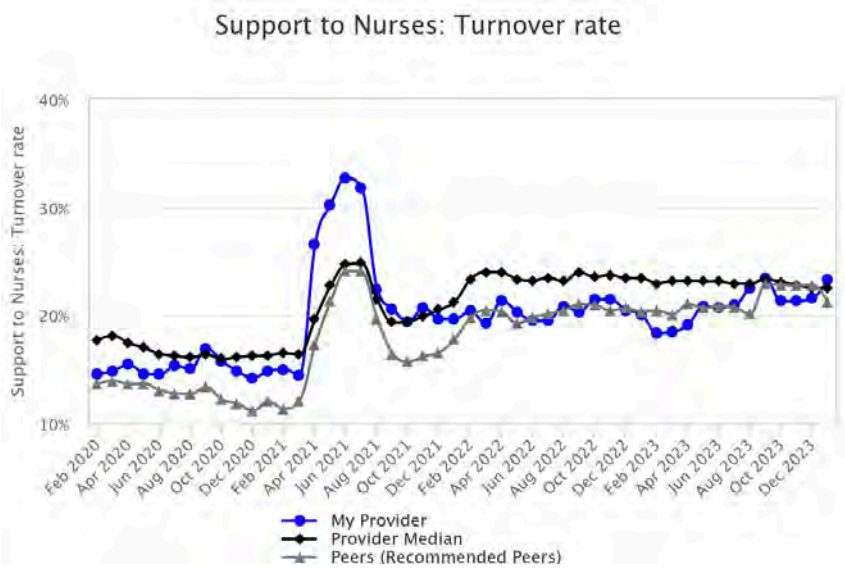


Figure 4

In addition to the work outlined above, several other initiatives are ongoing to improve our vacancy position and reduce our reliance upon bank and agency. These include;

- **Endoscopy**. Planning is underway to review the workforce requirements for a new Endoscopy Unit at Bradford Royal Infirmary planned to open in 2025. The staffing requirements estimated to be an additional 12 registrants.

- **Trainee Nursing Associates:** We will review this process with an expectation that we will have a cohort of 30 Trainee Nursing Associates to start in October 2024.

- **Engagement events Universities:** We are now engaged with our community mental health partners and University of Bradford to develop a career pathway for Dual Qualified Registrants, (Adult/Child and Mental Health) and new approaches and collaboration to support post registration employment. We expect to appoint 4 staff in 2024 and develop the pathway to increase this to 10 in 2025 if successful.

Midwifery

Midwifery recruitment will continue to be coordinated via the LMNS process (Local Maternity and Neonatal Services) for Newly qualified midwives. This process is hosted by Leeds Teaching Hospitals NHS Trust, open days start in February with the aim of graduates starting in October 2024. There is also a plan for a rolling midwifery advert to attract experienced midwives to join or return to BTHFT. The current vacancy rate for safe staffing is -26.28 WTE and -45.26 WTE Midwifery Continuity of Carer (MCoC) teams. There is no further international recruitment planned for 2024. The university of Bradford have offered Midwifery training places to up to 5 registered nurses. Their salary during the training will be supported by NHS England.

Retention

The retention of staff is a key objective of the NHS People Promise and an important step in providing safe staffing. We continue to be engaged in a number of initiatives to improve recruitment including;

- Embedding the Professional Nurse Advocate role and Legacy mentor.
- Learning from exit interviews and career conversations.
- Recognition of staff via Daisy and NHS England's Chief Nurse Awards.
- Support to move staff from Bank to substantive contracts.

Allied Health Professionals

The overall vacancy position for AHP's in March 2024 was reported at 8%, however there are considerable variations within the specialist groups.

Physiotherapy are reporting 4.3% vacancy position or 5.21 Whole Time Equivalents (WTE).

Occupational Therapy vacancies have reduced from 12% to 4% with 2 WTE posts available.

Speech & Language Therapy vacancies (within Therapies) were reported as 17%, or 2.4 WTE posts.

Dietetics vacancies are reported at 10%, or 7.2 WTE, we expect this position to improve as approval has been given to recruit new graduates as they qualify. This practice has been successful and well managed to prevent overspend.

Operating Department Practitioners
The recruitment of OPD's continues to be challenging with the expansion of surgical services across WYAAT. We are reporting a 25% vacancy rate or 12 WTE. Work is ongoing to strengthen our commitment to growing our own workforce with 19 apprentice ODP's on the programme. Our aim is to reduce our vacancy position to <5% by 2026.

Orthoptics is in a good position with no vacancies.

Radiographers
The current international recruitment initiative has finished with 6 recruits out of an initial target number of 8 having joined the Trust from Kerala and the Philippines. There are no significant vacancies for Radiographers in the modalities except for Sonography (Vacancy rate 12%) where a plan was approved some months ago to manage the waiting list – this involves recruitment as well as upskilling staff, increasing retention.

The general risk regarding recruitment (for all staff groups) is covered in the Board Assurance Framework and AHP workforce issues are addressed collaboratively with the Lead AHP and AHP services. Often this involves work within the Trust such as with Education, or with external stakeholders such as education providers, the AHP Faculty, the WY AHP Council. Strong relationships exist between AHP leadership teams in BTHFT, its neighbouring Trusts and those throughout the WY ICS. Issues and risks are discussed within these external partnerships.

Overall, the staffing and workforce situation for the AHPs is stable and well managed. Risks in some clinical pathways have been identified and plans are in place. Over the next 12 months plans to develop an AHP workforce dashboard will start. The aim of the dashboard is to provide visibility of AHP data, which will allow vacancy gaps to be monitored, recruitment prioritised and support capacity and demand planning.

<u>Healthcare Scientists</u>

Audiology
Several staff on are maternity leave but have been able to recruit to 2 x Band 5 fixed term posts.
Have 2 specialist Audiologists that will retire in the next 12 months, but it's likely to be difficult to recruit given lack of experienced Band 6/7 staff nationally.
In the process of recruiting another Band 4 apprentice and have put in an expression of interest for 2 STP posts (HCS 3 Year M level training) for 2024/25.
Have secured some project funding to develop a Band 5 development programme/resources
Sickness rate presently 4.99%

Cardiac and Respiratory Scientists
Unable to recruit to experienced Band 6, band 7 and band 8a posts. Have recruited new graduates however this has had major impact on training and mentorship which in view of lack dedicated training facilitator has caused issues, with associated increase in work related stress.
Continue to make use of HEE funding support for trainees at Level 2 and Level 7.
In the absence of dedicated CPD funding or additional support from HEE, funding from income streams being utilised to support the development of staff in an effort to 'grow our own' and increase retention.
Sickness absence over the last quarter 8.38%

Medical Illustration
There are no vacant healthcare scientist positions. A previous B5 has progressed in a 'grow our own' B6 position resulting in successful retention of qualified staff member'.
Sickness position is currently difficult with 50% WTE staffing in HCS Clinical Photography role (2 staff long term sick, & short term sickness at 6.79% overall for team)

Other Clinical Professions

Optometry
This team of 10 plus a Head Optometrist (5.05 WTE) is fully recruited. Recruitment is OK at this band (staff are B7) but very few applicants have previous hospital experience. One person is starting maternity leave in February but cover for the role is not possible due to the specialist nature of the clinics and the fixed term. Sickness is 5.67% mainly due to 2 x long-term sick.

Clinical Health Psychology
Remain committed to diversifying the workforce but were not successful in a bid for NHSE money to support this. Have recruited a Consultant Clinical Psychologist to head the Paediatric Psychology team (the only Consultant Clinical Psychologist of Pakistani origin in West Yorkshire). Retention rates are good, currently there are 2 vacancies (although nationally recruitment of psychological therapists is a challenge). The workforce has increased following successful development of new posts to work into Sickle Cell and Audiology.

Pharmacy

The Outstanding Pharmacy Services (OPS) Programme is now underway with work stream leads identified, work stream charters finalised and work programmes started. The Wellbeing Workstream is in full flow and has had a number of successes.

Staff Survey

Thanks to the support of OPS and a team of designated staff survey leads (DSSL)s, 79% of Pharmacy and Medicines Optimisation colleagues completed the annual staff survey. This is an increase of 29% on last year's results representing the largest increase in responses of any service and placing the service in the top three of respondents.

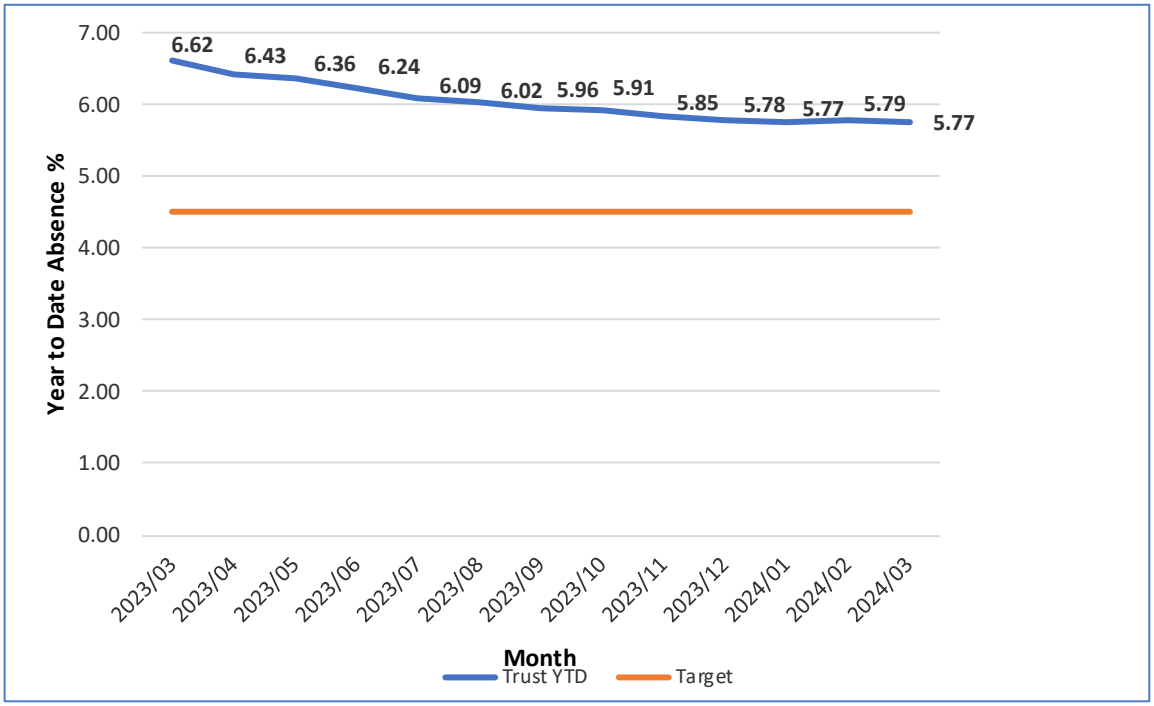
The various teams within the service have had sight of their sections staff survey results and are working through action plans to celebrate successes and to plan improvements where needed.

Wellbeing events continued to be undertaken with the current focus on the second annual Eid and Easter pharmacy recipe book.

Civility Training

Civility training has been offered to all colleagues with almost half the department taking part. Feedback on the training is now being gathered to plan next steps.

Absence Timeline – Year to Date Absence % Rate – Table 1



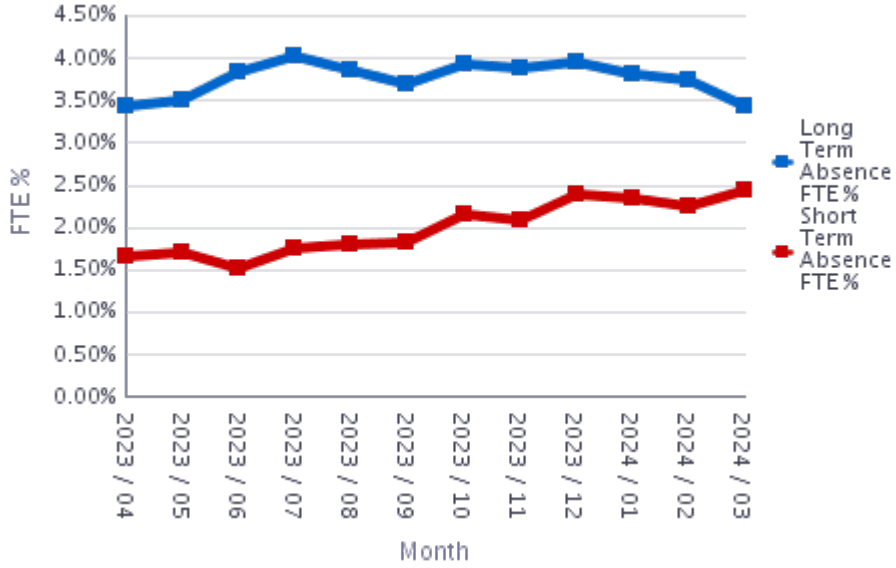
The year to date absence percentage rate in March 2024 is 5.77%. The absence rate has remained stable since December 23. At this time last year the year to date absence rate was 6.62%. The graph above also shows Year to Date sickness absence (%) up to March 2024.

Top 5 Absence Reasons by FTE Lost – Table 2

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	24.6
S98 Other known causes – not elsewhere classified	15.1
S12 Other musculoskeletal problems	8.0
S13 Cold, Cough, Flu - influenza	7.8
S25 Gastrointestinal Problems	7.0

Anxiety / stress / depression are the most common reasons for absence. This is followed by other known causes.

Absence Long Term / Short Term – Table 3



This table shows the long-term and short-term sickness trend. Long-term sickness has shown a consistent slight reduction since December. Short-term sickness reduced slightly in January and February but has risen slightly in March.

Organisational Development (OD) Update

Leadership & Development

Leadership Pathways

We have delivered 11 cohorts of face-to-face Leadership Pathways to 94 leaders since the commencement of the 2023 development year. One cohort of Progressing Leaders is due to conclude on the 26 March 2024. On completion we will have delivered 12 cohorts to staff.

The tables below show the cohorts delivered in 2023/24 and the 2024/25 delivery plan. A refreshed content plan has been devised and will be implemented as capacity allows. It is key to note that the first three pathways are all fully booked, with considerable waitlists. Room and facilitator availability remain the biggest risks and challenge to delivery.

2023/24 Delivery

Pathway	Cohorts delivered	Completions	Booked on future cohorts	Total
Aspiring Leaders	4	48	Year Complete	48
Developing Leaders	4	40	Year Complete	40
Progressing Leaders	3	26	11 (final cohort in progress)	37
Total	11	114		125

2024/25 Planned Delivery

Pathway	Cohorts Planned	Places Reserved	Places Available	Potential Total
Aspiring Leaders	6 x 12 per Cohort	72	0	72
Developing Leaders	6 x 12 per Cohort	72	0	72
Progressing Leaders	4 x 12 per Cohort	48	0	48
Advancing Leaders*	1 x 12 per Cohort	6	6	12
Total	18	178	38	216

Advancing Leaders

EMT approved piloting two cohorts of the recently developed Advancing Leaders Pathway. This pathway is a dynamic, modular, learning and development programme, aimed at senior leaders (bands 8a and above). The programme will last 12months and in addition to taught development, will also include Action Learning sets, a Psychometric Assessment; Lumina Leader including a 360-feedback assessment, a Quality Improvement (QI) project and Reach in, Reach out mentoring opportunities.

Uptake of Advancing Leaders has been slow, with 6 staff fully completing the enrolment process. We currently have 13 names (12 required per cohort) for the first cohort and work is underway to complete enrolment to achieve the aspiration of delivering the first cohort in April 2024.

Development Masterclasses

Commencing April 2024 are half day Development Masterclasses. The purpose of these sessions is to act as standalone development opportunities that cover gaps in our delivery offer. These will enhance development at individual and team level in specific areas.
We have working titles currently in development covering:

- Courageous conversations
- The Art of Delegation & time Management
- The Art of Facilitation
- Presentation Skills

As this element of the offer develops, we will update accordingly.

Management Development Sessions

In Future updates we will be reporting on the delivery and attendance numbers of the Management Development Sessions. Most subject matter experts are representatives from across the Trust, with OD contributing, supporting the coordination and communication of the sessions to staff.

Session Title	Sessions Delivered	Completions	Sessions Remaining
Equality, Diversity & Inclusion for Managers	4	29	4
Introduction to Finance	3	17	4
Managing Health, Wellbeing & Attendance	4	48	1
Recruitment & Selection Training	8	88	4
Time2Thrive Appraisal Training (OD)	8	75	1
Wellbeing Conversation Training (OD)	5	9	2
Total	32	266	16

There may be ambiguity in final numbers due to the closing down process of sessions. This is simply a handrail to demonstrate the development being offered.

Manager as Coach

The Manager as Coach programme will be offered as a standalone programme for managers following on from 'Everyday Coaching Skills' and offered to delegates of the Progressing Leaders Programme.
The programme will consist of modules that introduce managers to coaching techniques and allows real practice of these techniques using real examples brought by delegates. Delegates will be encouraged to practice these techniques in between modules to aid in their development of a coaching approach. The programme launch has been pushed back from April to later in 2024 due to current OD team capacity.

Psychometric Update – Lumina

Lumina Select; a recruitment psychometric tool which is designed to increase awareness for both the recruiter and the candidate so they can both get a better sense of the qualities needed for a particular role within the culture of an organisation. This tool was used to

support the recent Director of Strategy and Transformation interviews. Our next step is to evaluate with all stakeholders.

Lumina Leader 360; a Leadership psychometric tool with 360 feedback which increases self-awareness, decision making capability and confidence to lead others in times of increased competition and ambiguity. This tool including debrief and follow up coaching sessions have been embedded into the new Advancing Leaders Pathway.

Lumina Spark; a personalised psychometric assessment that aids increased self-awareness. One day workshops are being piloted with two senior leadership teams. The aim is to increase self-knowledge and awareness, value diversity and appreciate other ways of being, build rapport, creating a connection and adapting styles to match other preferences and use this to empower and inspire a high performing team.

Action Learning Sets Facilitators

We now have 10 trained Action Learning Sets (ALS) facilitators within the trust, follow-up sessions with the provider are planned for this month, we will then be meeting as an informal task and finish group to discuss how we can embed this concept further within the trust beyond embedding it as part of the Advancing Leaders Pathway.

We also have 6 of that cohort moving their development forward to become ILM accredited facilitators in 2025. These facilitators will be key to supporting Advancing Leaders and teams within the trust.

Appraisals

As of 29 Feb 24, the annual appraisal rate is 76.38%

An internal audit of appraisals was conducted in January, the aim being to establish progress with improving the quality and consistency of appraisals following the 2022 external audit by Audit Yorkshire.

The 2024 Internal Audit selected a larger sample of staff members from non-clinical staff groups. Job roles varied across a range of departments, and people from different responsibility levels were included.
79 records requested, 13 were not made available for review.

Appraisal forms were audited against 5 criteria:

- Is the correct paperwork being used?
- Has an appraisal been carried out in the last 12 months?
- Are all sections complete?
- Have objectives been set?
- Has a conversation around EDI & Wellbeing taken place?

The data showed that:

- 52 appraisals were carried out using the correct paperwork.
- 14 of the appraisals were conducted on incorrect paperwork.

- 11 used out-dated versions of the appraisal paperwork.
- 2 appraisals were not completed on any appraisal paperwork but used a personal objectives form.
- 1 appraisal was on the shorter wellbeing conversation paperwork which was used at the height of Covid-19 Pandemic.
- All 66 records showed an appraisal had been carried out in the last 12 months.
- 60 appraisals had all sections completed on the form.
- 58 had objectives set for the next 12 months however these were varied from being strictly about the job role, to educational and personal objectives. Role objectives appeared to vary in quality, with some being generic (such as meeting set operational targets) to taking on learning opportunities and mentoring initiatives.
- 2 had no objectives set as they had "no development needs".
- 10 appraisals were not signed off by both the manager or staff member.
- 52 recorded having a conversation around EDI & Wellbeing.

As a result of our findings the following actions were put in place:

- Contact identified areas to high light the importance of using the correct forms. (attending the Time2Thrive training session was recommended)
- Reminder to all staff to sign appraisal paperwork –in training, comms & Thrive.
- Facilitator to reiterate the importance of clear, measurable objectives.

Wellbeing

Health and Wellbeing (HWB) Group

The group has set up a Wellbeing Facebook page. We urge teams & departments who have Facebook pages to like the page. We are exploring production of leaflets with wellbeing offers on to distribute and put on notice boards around the Trust.

We have been analysing the NHS staff survey data received around wellbeing and pulling through the common themes where support may need to be focused moving forward; one such area is around staff being able to eat nutritious and affordable food whilst they are working. As a Trust we have scored lower than the national average, this is a priority area which we will be focusing on.

Financial Wellbeing

Our financial wellbeing offer continues to be reviewed and updated with all available support on Thrive and communicated out via Thrive bulletin, let's talk and social media.

Reward and Recognition

Team of the Month
Nominations:

January: 1 (carried over to February)
February: 4
March (1-6th): 2

Employee of the Month
Nominations:

January: 0
February: 5
March (1-6th): 0

The nomination forms for staff awards have now been moved to Microsoft Forms. The backlog on Employee and Team of the Month presentations has now been resolved with Mel's PA's arranging our winner presentations.

Greatix

Submissions received:

January: 86
February: 123
March (1-6): 29

Greatix is fully migrated to an automated system using JotForm. We have been monitoring the workflow of the form for several months now and everything appears to be working smoothly. The free subscription we are using on JotForm does have some limitations (160 submissions per month), options for increasing this limit are being explored.

Voice and Listening

The National Quarterly Pulse survey

The quarterly People Pulse survey ran from 1-31January 2024. 85 responses were received which is a significant reduction from the last Pulse Survey which took place in July 2023 where 270 responses were received.

As in previous quarters, work to highlight the importance of completing the survey was communicated through screen savers, and invitations were sent out directly to new starters, bank staff, General Managers and Staff Engagers. Promotion also took place in the Thrive Bulletin, Let's Talk and Twitter.

The response rate represents a very small proportion of our workforce (1.3%) and therefore the statistical significance of them is limited.

The Pulse survey commenced 2 April 2024 and is open currently for the first quarter of this financial year. Further work will be carried out to focus on increasing response rates in order for the data to be utilised in as a representative sample of the staff across the Trust.

NHS Staff Survey 2023

Staff Survey Heatmap results have been distributed across the Trust to Senior Leadership Teams along with a link to a 'Staff Survey Toolkit' to help teams create local action plans. Meetings have taken place with leaders in some areas of the Trust to assist with interpretation of results and to discuss the availability of additional more in-depth reporting using the SOLARIS staff survey dashboard.

The OD team are linking in with HR BPs to discuss how we can monitor local action plans.

Regular Designated Staff Survey Lead (DSSL) meetings are still taking place to discuss Staff Survey next steps and there has been some excellent work from DSSLs in their local areas around action planning and engagement with colleagues.

Results show that BTHFT has increased on all People Promise theme scores from 2022 to 2023 – we will be able to benchmark against local and national Trusts on Thursday 7th March when all results are published nationally.

We have received BTHFT's benchmark report and are currently writing a paper for ETM and the People Academy sharing staff survey headlines.

This week we received staff survey 'free text comments' – these will be themed, and a summary will be shared when completed.

PSIRF & Just Culture Update

A collaboration between OD, Staff Psychology and Patient safety specialist continues to work towards aligning work to embed our safety culture, in line with the NHS Patient Safety Strategy supported by a Just Culture in which staff are psychologically supported and feel empowered to support teams. This is done with the recognition that if they are supported psychologically, they feel safer and are more likely to say when things go wrong.

This work contributes to the recommendations to promote good mental health in NHS workforce found in the NHS Health and Wellbeing framework and specifically the following recommendations:

- Provision of confidential and timely psychological support with clear pathways
- Working conditions support good Mental Health
- There are a number of preventative interventions in place to support staff
- There are procedures in place to support staff following traumatic events

A member of the OD team attended the recent patient safety review training and will undertake the Mersey Care / Northumbria University Restorative Just and Learning four day programme in June in support of this work and the organisational approach to a Just and Learning Culture.

Culture

Workplace Civility development session (all staff)

'Civility in the Workplace' Training has launched with sessions taking place monthly. There is a dedicated OD practitioner and EDI manager supporting this. A pilot took place with Outstanding Pharmacy Services where the training has received full attendance and fantastic feedback. 65 members of Pharmacy Services attended the 4 pilot sessions.

The training is a two hour session in which videos created (Found on Thrive) are used to aid discussion around Civility and introduces delegates to the options they have to address

incivility in the workplace. Delegates are also given further information about the Civility Toolkit, Our People Charter, Staff Advocates, Internal Mediation, civility posters and wellbeing information.

The table below shows attendees at the 2 sessions delivered so far:

Organisation	Total
389120250 Flexible Workforce Team	1
389122290 PGME - Junior Doctor's Income	2
389M21008 Ward 9	1
389M23510 - Centralised Staff - Obstetrics	1
389M24357-EPR - Phase 1	1
389M24464-Human Resources Management	1
389M24465 Medical Workforce	7
389M24467 Recruitment	8
Total	**22**

There are currently 20 individuals booked onto sessions that are yet to take place.

Equality, Diversity and Inclusion

- **EDI Training**

The half day EDI training course for managers continues to be delivered - positive feedback is being received on the quality and contents of the training. The newly developed videos on Civility in the workplace have also been weaved into the half day training. Feedback is suggesting that managers are finding the training helpful and overall empowering them to deal with issues of EDI in an effective and timely manner.

- **Respect Civility & Resolution**

Our 5 newly trained staff advocates are already starting to pick up cases and provide valuable support to staff across the Trust and the EDI team are in the process of developing refreshed comms to re-launch the service in conjunction with the ratification of the Respect, Civility & Resolution policy which is expected to be finalised in May 2024. The re-launch will also work to promote the ongoing Workplace Civility training (which is in high demand and receiving some fantastic feedback), along with the established Workplace Mediation Service, the Civility Toolkit, Our People Charter and our three thriving Staff Equality Networks.

The proposed 'Respect, Civility & Resolution' policy is currently reaching the end of an extensive consultation process including members of the HR management team and staff side representatives and is hoped to be approved by JNCC and ready to launch in May 2024. Once approved there will be a clear implementation plan which will be agreed to ensure the policy is shared widely through global comms/ CSU and Department meetings and accompanied by an on-line toolkit and training which is to be developed for managers in informal resolution (e.g. facilitated conversations).

- **Equality Delivery System 2022**

The EDS2022 is a framework that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS whilst meeting the requirements of the Equality Act 2010.

A range of colleagues from across the Trust were involve in collating and showcasing a range of evidence and insights to demonstrate the Trusts progress against the 3 Domains:

- Commissioned or Provider Services
- Workforce health and well-being
- Inclusive Leadership

A staff engagement and community engagement event took place in Q4 where the evidence was presented on all 3 domains and feedback gathered from stakeholders. The Trust was rated 'Achieving' on all 3 domains and some useful feedback was gathered which will help feed into both our WRES/ WDES action plans (as we refresh them over the coming months) and also the work of the Patient Experience team. The EDS2022 report is published on the Trust website and the Head of EDI is planned to meet with regional partners, including the ICB to discuss plans and our approach for 2024 review.

- **Staff Equality Networks**

Our staff equality networks continue to be instrumental in arranging a range of events on the main concourse and getting involved in a range of activity with the aim of raising the profile of race, disability and LGBT+ equality.

In partnership with the Equality and Diversity Unit, the networks are currently in the process of developing our comms and engagement to celebrate National Day for Staff Networks (8th May) and Equality, Diversity & Human Rights week (13th to 17th May).

Recommendation

The People Academy is asked to note the contents of this report.

Glossary - Appendix 1

Indicator	Description	Source
Staff in post WTE	The number of whole time equivalent staff in post at that point in time.	HR Department via ESR (Electronic staff record).
Mandatory Training	The proportion of staff who have undertaken the statutory and mandatory training for the rolling year. The threshold is now 100%.	HR Department – via ESR
Appraisals	The proportion of staff who have undertaken an annual appraisal. The threshold is equal to or greater than 75% of staff.	HR Department – via ESR
Sickness	The proportion of staff that are absent due to sickness. The threshold is less than or equal to 4.50%.	HR Department – via ESR
Friends and Family Test	% of patients who complete a friends and family questionnaire following an inpatient admission.	Picker Services
Staff Group	Staff are coded to one of a national set of Staff Groups as follows: **Add Prof Scientific and Technic** – Pharmacists, Psychologists, Counsellors, Chaplains **Additional Clinical Services** – All clinical staff who don't need to be Professionally registered i.e. Bands 1-4 **Administrative and Clerical** – All Admin staff inc Managers who aren't Clinical **Allied Health Professionals** – OT, Physio, Dieticians, Radiographers **Estates and Ancillary** – Estates Officers, Porters, Cleaners, Catering **Healthcare Scientists** – Audiologists, Clinical Scientists, Physiologists **Medical and Dental** – All Medical & Dental Staff **Nursing and Midwifery Registered** – All Registered Nurses and Midwives.	HR Department – via ESR
Workforce Planning	NQB (2013) *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability.* https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf	NHS England

MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT

REFERENCES

Only PDFs are attached

Bo.7.24.9 - Medical Appraisal and Revalidation Annual Report 2023-24.pdf

Meeting Title	People Academy		
Date	3rd July 2024	Agenda item	PA.7(1)24.13

ANNUAL REPORT
ON MEDICAL APPRAISAL AND REVALIDATION 2023/24

Presented by	John Bolton, Deputy Chief Medical Officer & Medical Director (Ops)/Consultant Urological Surgeon	
Author	Dr Remi Akerele, Associate Medical Director for Professional Medical Standards Noorzana Azam, Revalidation and Appraisal Officer	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	To provide assurance on the position of Medical Appraisal and compliance with the Responsible Officer Regulations.	
Key control		
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

All doctors in the United Kingdom have been subject to Medical Revalidation since 2012 as a means of regulation as well as to ensure continual improvements in both patient safety and quality of care. Medical Revalidation confirms the continuation of a doctor's licence to practice by the GMC, but also serves to provide greater assurance to patients and public with respect to medical systems.

All Acute Trusts have therefore been required to submit an Annual Organisation Audit (AOA) to NHS England since 2012 as a means of providing assurance that the Trust/Organisation is compliant with Responsible Officer Regulations.

Mandatory AOA submission was temporarily suspended nationwide between 2020 and 2023 in view of the unprecedented pressures experienced by many Trusts as a result of the Covid-19 pandemic. Board Reports and Statements of Compliance have continued to be submitted as per NHSE guidance since this time. It is likely that reporting will remain in the format of the Board Report and Statement of Compliance for the foreseeable future.

This report provides assurance in relation to the Trust's compliance for 2023/24 with regards to Responsible Officer Regulations.

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Analysis

At 31st March 2024 514 doctors had a prescribed connection with the Trust. This was comprised of:

- 349 Consultant staff
- 39 Specialty doctor grades
- 126 Doctors with temporary or short-term contracts

Despite the persistence of multiple challenges following the Covid-19 pandemic, our appraisal completion rate has seen a sustained improvement with a return to pre-pandemic levels of compliance last year.

Challenges have included high levels of sickness, changes in the employment preferences of Junior Doctors impacting on the number of doctors with short term contracts (with well-recognised challenges relating to rates of appraisal in this group of doctors) as well as the impact of Industrial Action in 2023-2024.

Understandably, similar challenges have been seen in relation to the revalidation process which formally restarted following the pandemic on 1st April 2021.

For the appraisal year 2023-24:

- 498 doctors (96.89%) received an Outcome Measure 1 (Completed appraisal).
- 16 doctors (3.11%) were allocated an Outcome Measure 2 (Approved Missed appraisal). This includes doctors on long-term sick leave, maternity leave, recent retirements and new connections at 31st March.
- 2,024 who have not been in post for a sufficient duration to have undertaken the appraisal process.
- There were no Outcome Measure 3 appraisals (Unapproved Missed) for this period.

Recommendation

This report outlines the Trust's performance for 2023/24 and provides assurance in relation to its compliance with Responsible Officer Regulations.

Submission of an Annual Organisational Audit to NHS England was stood down by NHS England in 2020 in recognition of the sustained pressures experienced by individual Trusts as a result of the pandemic. Acute Trusts (including Bradford Teaching Hospitals) have continued to submit an annual Board Report and Statement of Compliance to NHSE in accordance with national guidance.

Comparative data for the purpose of benchmarking Acute Hospitals have not been released by NHSE since 2020.

It is likely that reporting will continue in the format of the annual Board Report and Statement of Compliance for the foreseeable future.

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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?	☐	☐	☒

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

Regulation, Legislation and Compliance relevance
NHS 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: Fit & Proper Staff
NHS Improvement Effective Use of Resources: People
Other (please state):

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

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ANNUAL REPORT ON MEDICAL APPRAISAL AND REVALIDATION 2021/22

1 PURPOSE/ AIM

All doctors in the United Kingdom have been subject to Medical Revalidation since 2012 as a means of regulation as well as to ensure continual improvements in both patient safety and quality of care. Medical Revalidation confirms the continuation of a doctor's licence to practice by the GMC, but also serves to provide greater assurance to patients and public with respect to medical systems.

Between 2012 and 2020, all Acute Trusts were required to submit an Annual Organisation Audit (AOA) to NHS England as a means of providing assurance that the Trust/Organisation remained compliant with Responsible Officer Regulations.
Mandatory AOA submission was stood down nationwide in 2020 in view of the unprecedented pressures experienced by many Trusts as a result of the Covid-19 pandemic. Since this time, Annual Board Reports and Statements of Compliance have continued to be submitted to NHSE as per guidance.

The change in the nature of reporting since has meant that there have been no comparative data to allow benchmarking against other Acute Trusts in England since this time. It is likely that the format of the annual Board Report and Statement of Compliance will continue for the foreseeable future.

This report continues to provide assurance in relation to the Trust's compliance for the period 2023/2024 with regards to Responsible Officer Regulations and will form the basis for BTHFTs Annual Board Report and Statement of Compliance for 2024.

2 BACKGROUND/CONTEXT

At 31st March 2024, 514 doctors had a prescribed connection with the Trust. This was comprised of:

- 349 Consultant staff
- 39 Specialty doctor grades
- 126 Doctors with temporary or short-term contracts

Despite the persistence of multiple challenges since the re-instatement of the appraisal process following the Covid-19 pandemic, our appraisal completion rate has seen sustained improvement with a return to pre-pandemic levels of compliance in 2022-23. This has been continued in 2023-2024. Challenges have included high levels of sickness, changes in the employment preferences of Junior Doctors impacting on the number of doctors with short term contracts (with well-recognised challenges relating to rates of appraisal in this group of doctors) as well as the impact of Industrial Action in 2023-2024.

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For the appraisal year 2023-2024:

- 498 doctors (96.89%) received an Outcome Measure 1 (Completed appraisal)
- 16 doctors (3.11%) were allocated an Outcome Measure 2 (Approved Missed appraisal). This includes doctors on long-term sick leave, maternity leave, recent retirements and new connections at 31/03/24 who have not been in post for a sufficient duration to have undertaken the appraisal process.
- There were no Outcome Measure 3 appraisals (Unapproved Missed) for this period.

There were 83 revalidation recommendations for the period 2023-24. This included 5 recommendations to defer revalidation based on insufficient evidence.

3 PROPOSAL

In keeping with the NHSE and GMC decision to halt the appraisal process at the onset of the Covid-19 pandemic, submission of the Annual Organisation Audit was stood down in 2020. Annual Board Reports and Statements of Compliance have continued to be submitted to NHSE since this time.

It is likely that submission will continue in the format of the Annual Board Report and Statement of Compliance for the foreseeable future.

An action plan to ensure compliance with the Responsible Officer Regulations has been completed.

4 BENCHMARKING IMPLICATIONS

514 doctors had a prescribed connection to the Trust on 31st March 2024.
As above, submission of the Annual Organisation Audit to NHSE was stood down in 2020 in recognition of sustained covid-related pressures in many Trusts nation-wide.
BTHFT has continued to submit Annual Board Reports and Statements of Compliance to the NHSE as per guidance.
Comparative data for local/regional Trusts has not been generated/circulated since 2020 by the NHSE.

5 RISK ASSESSMENT

There are no risks associated with this paper.

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6 RECOMMENDATIONS

This report outlines the Trust's performance for 2023/24 and provides continued assurance in relation to its compliance with Responsible Officer Regulations.

We are unable to compare the Trust performance with peers due to the change in reporting to the NHSE following the outset of the pandemic in 2020. This is reflective of the NHSE/GMC's initial instruction to temporarily halt the appraisal and revalidation process for the same period, combined with the recognition that Covid-related pressures and other challenges have been sustained in a significant number of Acute Hospital Trusts since this time.

7 APPENDICES

1. Executive Summary

In keeping with Responsible Officer Regulations, the Trust has had a statutory duty to support the Responsible Officer in discharging their duties since 2012. *(The Medical Profession (Responsible Officer) Regulations, 2010 as amended in 2013 and The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012).* It is expected that the Board will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals within the organisation.
- Checking there are effective systems in place for monitoring the conduct and the performance of their doctors.
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that the medical practitioners have qualifications and experience appropriate to the work performed.

Dr Raymond Smith, Chief Medical Officer has held the role of Responsible Officer (RO) for BTHFT since 1st January 2021. The responsibility for the day-to-day support and monitoring of compliance against the legislation and continued progress against identified actions lies with the HR Department to facilitate consistency with HR practice across all staff groups.

On 31st March 2024, 514 doctors had a prescribed GMC connection with the Trust. Of these, 349 were Consultant staff, 39 were Specialty Doctor grades and 126 were Doctors with temporary or short-term contracts.

On 31st March 2024, 498 (96.89%) doctors had received an Outcome Measure 1 (Completed appraisal), and 16 (3.11%) doctors were allocated an Outcome Measure 2 (Approved Missed). This includes doctors on extended sick leave, maternity leave, recent retirements and doctors with a very recent connection to BTHFT such that they would not have been in post long enough to have undergone the appraisal process. Reflected in this cohort of doctors receiving an Outcome Measure 2 is a higher proportion of recently connected bank and locum doctors as compared to pre-pandemic figures suggesting a sustained change in employment preferences/patterns by Junior Doctors since the advent of the Covid-19 pandemic.

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There were no Outcome Measure 3 (Unapproved Missed Appraisal) for the period 2023-2024.

Mandatory AOA reporting was stood down at the start of theCovid-19 pandemic. BTHFT submitted an AOA for the period 2019 to 2020 on a voluntary basis to NHS England and NHS Improvement. In keeping with guidance, BTHFT has continued to submit Annual Board Reports and Statements of Compliance to the NHSE since this time.
Due to the change in the nature of reporting nationwide, the NHSE has not generated data to allow benchmarking between Acute Trusts since 2019. It is thought that reporting will continue in its current format for the foreseeable future.

The Annual Board Report is designed to guide organisations by setting out the key requirements for compliance with regulations and key national guidance. It provides a format to review these requirements and allows the designated body to demonstrate compliance as well as continued quality improvement over time. In addition, it will provide the necessary assurance to the higher-level responsible officer and may contribute to evidence for CQC inspections.

2. Purpose of the Paper

The purpose of this paper is to provide the People Academy with an annual update in relation to compliance with Responsible Officer Regulations. This is combined with an update on completed Medical Appraisals and Revalidations and to explain the rationale for submission of the Annual Board Report and Statement of Compliance.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way in which doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Prior to the Covid-19 pandemic, AOAs from all designated bodies were collated to provide an overarching status report of the responsible officer function across England. The AOA has been superseded by the Annual Board Report and Statement of Compliance submitted to NHSE by all Designated Bodies.

Since 2012 the Trust has been required to provide assurance that the organisation is compliant. Dr Raymond Smith, Chief Medical Officer took over the role of Responsible Officer (RO) for BTHFT in January 2021 following completion of the required training.

All organisations have a statutory requirement to support the Responsible Officer in discharging their duties and as such the Executive Team has oversight of the compliance status providing assurance through to the Quality and Safety Committee via the Trust Governance structure.

3.1 Definitions

A glossary of terms is provided in Appendix B.

In response to feedback from designated bodies, the categories for reporting of appraisal outcomes have been simplified to:

• Category 1: A single figure of completed medical appraisals.
• Category 2: No change (‘approved missed’ e.g. maternity, sickness).
• Category 3: No change (‘unapproved missed’).

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4. Governance Arrangements

The Responsible Officer is supported by the Associate Medical Director for Professional Medical Standards and the Medical Appraisal and Revalidation Officer.

There are robust mechanisms in place to facilitate effective communication between the RO, the Associate Medical Director for Professional Medical Standards, and the Divisional Clinical Directors to ensure relevant information and required actions are shared and acted upon. Following the introduction of new operational management structures in September 2022 into 3 service areas, Medical Directors of Clinical Business Units have been replaced by Clinical Directors of Clinical Service Units.

The Electronic Staff Database (ESR) in conjunction with regular downloads from the GMC Database is used to ensure that the baseline data identifying all doctors with a prescribed connection to the Trust is maintained and up to date. The list of doctors who hold an honorary contract with the Trust is also checked regularly to ensure accuracy.

Completed appraisal information is provided through our appraisal platform – PReP hosted by Premier IT. Premier IT also hosts MSF360clinical which is our electronic revalidation management system (RMS).

Since 2017 the Trust has met the criteria to be exempt from providing quarterly returns and was asked to provide the NHS England with the necessary assurance via the North Regional Office quarterly by a brief email.

The criteria for exemption are below:

1) The DB has achieved > 90% appraisal uptake in the previous year as stated in the AOA/Board Report and Statement of Compliance.
2) The DB has < 1% non-managed incomplete or missed appraisal (those recorded as a “3” on section 2.1 on the AOA).
3) The DB engages with the RO and appraisal networks.
4) No concerns have been evidenced from an independent verification visit or any other source.

5. Medical Appraisal

The Associate Medical Director for Professional Medical Standards monitors the annual participation in appraisal and provides support, advice and guidance to both appraisee and appraiser where required.

Performance Data

Table 1 below illustrates the data for the period 1st April 2023 to 31st March 2024.

Overall, we achieved a completed appraisal rate (Category 1) 96.89%.

3.11% of doctors were allocated a Category 2 appraisal (Approved Missed). This includes doctors on extended sick leave, maternity leave, recent retirements and doctors with a very recent connection to BTHFT such that they would not have been in post long enough to have undergone the appraisal process.

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Reflected in this cohort of doctors receiving an Outcome Measure 2 is a higher proportion of recently connected bank and locum doctors as compared to pre-pandemic figures suggesting a sustained change in employment preferences/patterns by Junior Doctors following the Covid-19 pandemic.

There were no Outcome Measure 3 (Unapproved Missed Appraisal) for the period 2023-2024.

Table 1

	Medical Staff Group	Number of prescribed connections	Appraisal Outcome			Total
			Completed Appraisal Outcome 1	Approved incomplete or missed appraisal Outcome 2	Unapproved incomplete or missed appraisal Outcome 3	
2.1.1	Consultants	349	348	1	0	349
2.1.2	Staff Grades/Associate Specialists	39	38	1	0	39
2.1.3	Doctors on performers list	0	0	0	0	0
2.1.4	Doctors with practising privileges	0	0	0	0	0
2.1.5	Temporary, short-term contracts	126	112	14	0	126
2.1.6	Other doctors with prescribed connection to this designated body	0	0	0	0	0
2.1.7	Total	514	498	16	0	514

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Table 2 indicates the same appraisal performance information for 2023/24 by Clinical Service Unit.

Table 2

	Unplanned Services	Planned Services	Core Central	Total
Number of prescribed connections	153	201	160	514
Completed appraisals Category 1	148	198	152	498
Approved incomplete or missed appraisal Category 2	5	3	8	16
Unapproved incomplete or missed appraisal Category 3	0	0	0	0

5.1. Timescales

Current rules for appraisal state that appraisals should be completed annually between 9 and 12 months of an agreed appraisal date and before the end of the doctor's planned appraisal month. Historically the window was 9-15 months. Reporting has also been simplified within the NHSE Board Report and Statement of Compliance document to reflect the overall number of completed appraisals (Category 1).

BTHFT achieved an overall appraisal completion rate (Category 1) of 96.89% for the period 2023-24. This is despite sustained, multifactorial pressures throughout the Trust since we exited the pandemic and includes the significant impact of Industrial Action by multiple medical and non-medical unions on non-essential activity including appraisal meetings.

There were 16 (3.11%) Missed Approved appraisals (Category 2). This group includes doctors on sick leave, maternity leave, recent retirements and very recent connections to BTHFT who have not been in post for a long enough period to undergo the appraisal process.

There were no Missed Unapproved appraisals (Category 3) for the period 2023-24.
(Full definitions contained in Glossary Appendix B).

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6. Revalidation Recommendations

Table 3: Revalidation Performance

	Submitted on time	Late Submission
Recommendations/Submissions made	83	0
Deferrals made	5	0

A total of 83 revalidation submissions were made for the period 2023 to 2024. Of these, 78 were positive recommendations for revalidation and 5 were recommendations for deferral. Where deferral recommendations were submitted, this was on the basis of insufficient evidence to support a positive recommendation. In most cases this related to incomplete colleague and patient feedback. It should be stressed that deferral should not be viewed as a negative process and does not indicate a lack of engagement in the process.
There were no deferrals based on a doctor being subject to on-going processes.

7. Medical Appraisers

As to be expected, there is a continual cycle of appraiser recruitment and retirement. The Trust currently has 84 trained medical appraisers having trained and recruited 12 new appraisers in 2022-23. This brings our overall appraiser:appraisee ratio to 1:6.1. Despite significant appraiser recruitment, a combination of retirements, changes in job plans and an overall increase in the number of connections to the Trust means that on-going programme of recruitment will be necessary in order to achieve the NHSE recommended Appraiser:Appraisee ratio of 1:4 in the future.

Local Appraiser Network Meetings take place bi-annually as an opportunity to disseminate information relating to changes in process/NHSE guidance, to troubleshoot, and also as an opportunity for appraisers to network.

8. Quality Assurance

Appraisal and Revalidation Committee meetings are also held bi-annually chaired by the Associate Medical Director for Professional Medical Standards. The key objectives of the group are:

- To review the appraisal system and the performance of appraisers to ensure that these conditions are met, and improvements are made where possible.
- To provide quality assurance of the appraisal process, including an assurance review of medical appraisers. This is an on-going review of the appraisal outputs for all medical appraisers to ensure that they are appropriately supported in calibrating their appraisal work, their development needs are being addressed and appraisals are being performed to the required standard.
- To make recommendations to the Responsible Officer on the appraisal system and the performance of appraisers.

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- To plan training and support for appraisers.
- To consider the appraisal process from the perspective of the appraisee to improve the quality of appraisal.

The group will provide a report to the People Academy that in turn reports to the Board of Directors. The Appraisal and Revalidation Group will report any immediate concerns directly to the RO whenever necessary.

The Associate Medical Director for Professional Medical Standards formally assesses each appraisee portfolio, via the Appraisal Management System including appraisal outputs at the point of revalidation, thus every appraisee's documentation is quality assessed once during every revalidation cycle.

The most recent Internal Audit of the Trust's appraisal and revalidation process was completed in August 2022 by Audit Yorkshire. The overall assurance provided was "significant". The audit concluded that there were satisfactory controls in place to ensure that the doctors at the Trust received an extensive and thorough appraisal. Appraisals were appropriate and robust enough to enable the Responsible Officer to provide a recommendation on revalidation to the GMC. The audit identified 3 minor and 1 moderate recommendations all of which have now been addressed/actioned.

The last satisfaction survey using Survey Monkey was conducted during 2017/18 to assess the level of satisfaction with the Trust's appraisal process. 192 surveys were completed, and the results were very positive, with 99% of staff rating the process as good or very good. 76% of those who responded said that the appraisal process helped them reflect on their practice. A further satisfaction survey will be planned in due course.

As per NHSE guidance, an audit of the quality of our Appraisal Output documentation is undertaken on an annual basis. In December 2023, the Appraisal Audit Group comprising the Responsible Officer/Chief Medical Officer, the Associate Medical Director for Professional Medical Standards and three volunteer appraisers reviewed a sample of the appraisals completed during 2023. The audit focused on the overall quality of our appraisal outputs (Output Forms) for the period using a template based on the NHSE Appraisal Summary and PDP Audit Tool template (ASPAT). A report highlighting themes for learning and improvement for appraisers has been shared with the Appraisal and Revalidation Committee. Learning from the audit has been disseminated to all appraisers. The forms reviewed within the audit supported the fact that effective appraisal discussions are taking place, in turn providing robust assurance towards the revalidation process. Potential areas for improvement have been highlighted to all appraisers.

9. Access, Security and Confidentiality

No security issues have been identified during this period.

10. Clinical Governance

A new Clinical Governance Framework was implemented within the Trust in 2014/15. Governance arrangements at specialty level will allow doctors to access relevant information in relation to their specialty and individual practice.

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All doctors should be able to obtain the supporting information they require for their annual appraisal through the new Trust Incident Reporting System – IRIS and via other corporate processes such as compliments, complaints and claims. As IRIS is a new system, access to reports by our Appraisal and Revalidation Officer is currently limited but this is in the process of being addressed and is currently on the Risk Register for the Trust. The Appraisal and Revalidation Officer aims to provides each doctor with a report detailing any incident, claims and complaint recorded for them on the outgoing DATIX system/in-coming IRIS system in the previous 12 months for inclusion and discussion at their appraisal. Appraisers and Appraisees have been made aware of the current issue with generating reports whilst resolution is awaited.

11. Recruitment and Engagement Background Checks

Pre- and post-employment checks that are undertaken in BTHFT comply with the NHS Employment Checks Standards.

These standards simplify the legislative requirements for NHS organisations, outline the procedures that NHS Trusts should follow and give advice for good practice. The standard checks are:

- Verification of identity
- Verification of right to work in the UK
- DBS Check
- Employment history and reference checks
- Occupational health checks
- Registration and Qualification checks and monitoring of professional registration

Recruitment and engagement checks for doctors, including trainees, are managed through the Human Resources Department. An internal recruitment audit was undertaken in 2022 which provided High Assurance. This covered a random sample across all staff groups.
The review confirmed that there are policies and procedures in place to enable a rigorous and fair recruitment process. The policies and procedures for the recruitment and employment of staff at the Foundation Trust have been disseminated to and understood by all managers involved in the recruitment process.

The processes relating to the engagement of medical locums was audited in 2017 by Audit Yorkshire. The audit concluded that significant assurance was provided in all areas apart from the Trust's local induction arrangements which only provided limited assurance. An action plan has been in place to address this since this time. As above, an internal recruitment audit covering a random sample across all staff groups was completed in 2022 which provided High Assurance.

12. Monitoring Performance

The Disciplinary, Capability, Ill Health and Appeals Policy and Procedure for Doctors and Dentists was revised and re-issued in January 2023

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13. Responding to Concerns and Remediation

In line with all staff, concerns about an individual doctor's practice may be raised through the Trust Raising Concerns at Work Policy or via the Trusts 'Disciplinary, Capability, Ill Health and Appeals Policy & Procedures if the behaviour of the doctor causes or has the potential to cause harm to a patient or other members of the public, staff or organisation. In addition, a concern will be raised if a doctor develops a pattern of making or repeating mistakes. In most cases minor concerns can be addressed through the normal continuing professional development or supervisory processes.

The Trust Remediation Policy for Doctors and Dentists has been updated and re-issued in May 2024 following a Trust Governance audit of Policy Documents. The updated document is accessible to all staff via the Intranet.

There were no doctors investigated under Maintaining High Professional Standards for Medical and Dental Staff for the period 2023-2024. The Board of Directors is notified if any doctor with a prescribed connection to the Trust is excluded from practice. Monthly updates are then provided to the Board for the duration of the exclusions.

14. Risks and Issues

The Chief Medical Officer, Associate Medical Director for Professional Medical Standards, and Appraisal and Revalidation Officer meet on a monthly basis to review individual portfolios prior to revalidations and to highlight any issues. Any urgent concerns are reported to the RO directly when necessary.

Terms of Reference are agreed for the Appraisal and Revalidation Committee which meets on a bi-annual basis.

The Trust Performance Management Framework and the Divisional Governance processes monitor appraisal rates enabling issues to be identified early and appropriate corrective action to be taken and escalated if required.

15. Corrective Actions, Improvement Plan, Next steps

Progress against the Action Plan (Appendix A) developed following the 2017 Annual Organisational Audit submission continues to be monitored through the Appraisal and Revalidation Group. All actions are complete.
The Appraisal and Revalidation Policy has been updated to reflect the new NHS England guidance.

16. Recommendations

The Committee is asked to note:

- The Trust is compliant with the requirements of the Responsible Officer Regulations.
- The Annual Organisational Audit (AOA) has not been submitted to NHSE since 2020/2021 following the outset of the pandemic and as per national guidance
- The suspension to mandatory reporting has meant that the NHSE has not generated comparative data for benchmarking against other Acute Trusts since 2019

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- A Board Report and Statement of Compliance has continued to be submitted annually as per guidance
- It is likely that reporting will remain based on the Board Report and Statement of Compliance for the foreseeable future

Appendices

Appendix A: Review of the Requirement of Responsible Officer Legislation and Associated Actions Required

Appendix B : Glossary of Terms.

Appendix A - Review of the Requirements of Responsible Officer Legislation and Associated Actions Required

(Items that are shaded grey are recommended and not mandatory)

	The Designated Body and the Responsible Officer	Compliant Yes/No	Action Required	Lead	Timescale	RAG Rating
Section 1						
1.4	A responsible officer has been nominated or appointed a responsible officer in compliance with the Responsible Officer Regulations. The responsible officer is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.	Yes	Additional management resource required to design, implement and manage process to ensure RO can fulfil their legal requirement. **Comment**: The Medical Director, Dr Raymond Smith took over as responsible officer in January 2021. An Associate Medical Director for Professional Medical Standards – Dr Remi Akerele has been formally appointed. A Medical Appraisal and Revalidation Officer, Miss Noorzana Azam has also been appointed, who will work within the HR Department as part of the Medical Workforce Team.	Responsible Officer	Completed	
1.5	Where a conflict of interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative been appointed?	N/A	Reciprocal arrangements made with neighbouring RO.	Responsible Officer	Completed	

1.6	In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.	Yes		Responsible Officer	Completed	
1.7	The responsible officer is appropriately trained and remains up to date and fit to practise in the role of Responsible officer.	Yes		Responsible Officer	2020	
1.8	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.	Yes				
1.9	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.	Yes				
1.10	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.	Yes				
1.11	The governance systems (including clinical governance where appropriate) are subject to external or independent review.	Yes				

1.12	The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment)	Yes	Internal Audit completed by Audit Yorkshire. This provided significant assurance. Local Annual Appraisal Output Audit as per NHSE guidance held in December 2023 Peer Review	Audit Yorkshire Responsible Officer	August 2022 December 2023 June 2017	
Section 2	Appraisal					
2.2	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded	Yes	Continual review	Appraisal and Revalidation Officer	Last update 31st March 2024	
2.3	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)	Yes	Policy updated April 2023	Associate Medical Director for Professional Medical Standards Appraisal and Revalidation Officer	April 2023	
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.	Yes	Audit Group's findings reported included in annual report	Associate Medical Director for Professional Medical Standards	June 2024	

2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.	Yes	Doctors are provided with reports detailing their complaints, claims and incidents. Continual review by Appraisal and Revalidation Officer. Review during annual audit	Appraisal and Revalidation Officer	December 2023	
2.6	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection	Yes	12 new appraisers trained during 2022 - 23 bringing our overall appraiser total to 91 Rolling program of update training for established appraisers	Training provided by external company Virtual meetings	January 2023 December 2022 to February 2023	
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.	Yes	Four Appraiser Network Meetings are held each year. Attendance recorded	Associate Medical Director for Professional Medical Standards	Last update June 2024	
Section 3	Monitoring Performance and Responding to Concerns					
3.1	There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection.	Yes				
3.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise Concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).	Yes				

3.3	The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.	No	The Board of Directors is notified if any doctor with a prescribed connection to the Trust is suspended from practice. Monthly updates are then provided to the Board for the duration of the suspension.	Chief Medical Officer		
3.4	The designated body has arrangements in place to access sufficient trained case investigators and case managers.	Yes	Case Investigator training delivered at BTHFT in October 2023.	Training provided by NCAS	October 2023	
Section 4	Recruitment and Engagement					
4.1	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).	Yes	Locums employed directly by the Trust are subject to the same level of checks as non-locum staff. New Direct Engagement process commenced 1st April 2016.			

Appendix B

Glossary of Terms

Appraisal
Medical appraisal is the annual process of self-review supported by information that is set out by the GMC with evidence gathered from the full scope of a doctor's work. It includes reflection on achievements, challenges and lessons learnt in addition to proactively identifying learning needs and producing a Personal Development Plan (PDP).

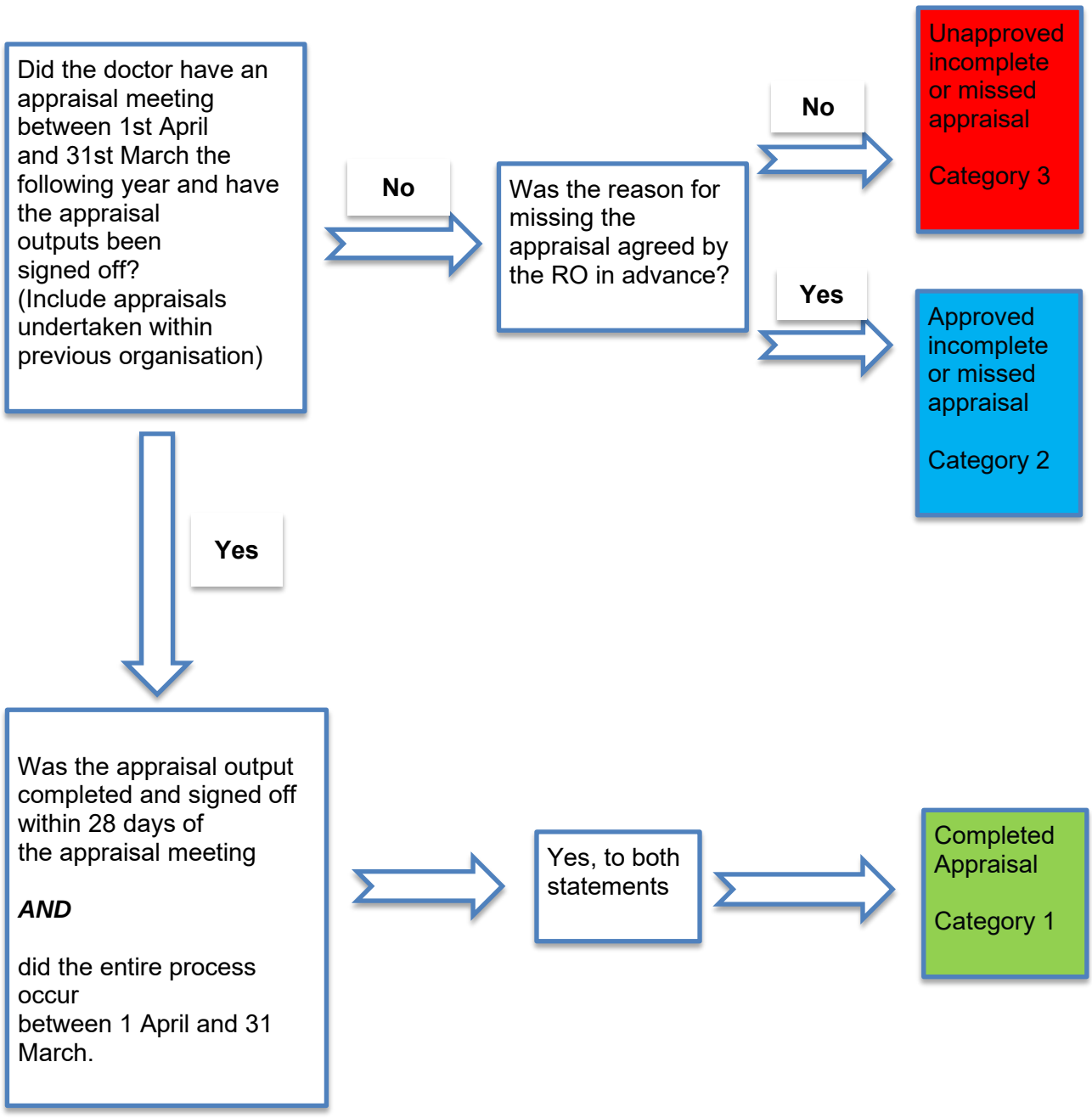
Appraisal Categories

Measure 1 Completed Annual Medical Appraisal.
A completed annual medical appraisal is one where the appraisal meeting has taken place ideally in the three months preceding the agreed appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context.

Measure 2: Approved incomplete or missed appraisal:
An *approved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*.

Measure 3: Unapproved incomplete or missed appraisal:
An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of *Category 1 completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.

Appraisal Categories:



Designated body
Licensed doctors have a connection with one organisation that supports their regular appraisal and revalidation process. This organisation is referred to as the 'Designated Body'. All Designated Bodies have a duty to support the RO by providing adequate resources. There is a clear set of rules that determines which is a doctor's designated body.

Prescribed connection
A prescribed connection is the name given to the link between the doctor and the RO. Having a prescribed connection ensures that the doctor will be supported with revalidation and that they can be assured that they are working within an environment conducive to continuously improving the services it offers to patients.

Responsible Officer
The RO has a statutory role in medical regulation. The RO must be a senior, licensed doctor, formally appointed by the Board of Directors who is responsible for ensuring there are systems in place to enable doctors to be appraised annually and where there are concerns about a doctor's fitness to practice, they are appropriately investigated and managed, liaising with the General Medical Council (GMC) where necessary.

The RO is responsible for considering the evidence presented through the Trust's appraisal process and using this to make a recommendation to the GMC in relation to each doctor's revalidation. The GMC will then make the final decision. The RO can recommend one of the 3 options listed below:

- A recommendation that the doctor is up to date and fit to practise and should be revalidated
- A deferral as more time or more information is required in order to make an accurate recommendation
- A recommendation that the individual has not engaged with the appraisal process or any other system that would support their revalidation

Revalidation
Doctors are required by law to hold a license if they wish to be a medical practitioner. Revalidation is the process by which all doctors renew their license. Every doctor must be able to demonstrate to the GMC that they have kept up with current medical practice and are fit to practise. All licensed doctors must be revalidated every 5 years as a condition of their license.

REFERENCES

Only PDFs are attached

Bo.7.24.9 - Annual Fire Report 2023 V2.pdf

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ANNUAL FIRE SAFETY REPORT AND DECLARATION OF FIRE SAFETY (1.01.23 to 31.12.23)

Presented by	Chris Davies, Deputy Director of Facilities & Estates	
Author	Darren Mitchell, Fire Safety Manager.	
Lead Director	Chris Davies, Deputy Director of Facilities & Estates	
Purpose of the paper	For assurance	
Key control	To provide outstanding care for patients.	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**
	Health & Safety Committee (virtually)	19.04.24
	People Academy	28.05.24

Key Options, Issues and Risks

The attached Annual Fire Report is presented as part of the organisational assurance process to demonstrate compliance with mandatory requirements of *Firecode HTM 05-01: Managing Healthcare Fire Safety* and the *Regulatory Reform (Fire Safety) Order 2005 [RRO].*

Analysis

This report provides assurance that risks arising from fire are being effectively managed.

This report confirms the Trust's continued commitment to effectively managing fire safety, and this is demonstrated through the following:

1. Completion of an 'Annual Statement of Fire Safety' to provide assurance that risks arising from fire are effectively managed. (Declaration of Fire Safety - Appendix 1).
2. The Fire Safety Policy and the Fire Procedures define roles and responsibilities and latest legislation, standards and industry best practice. (These documents are in date until July 2025).
3. An ongoing programme of audits, reviews and risk assessments ensures the Trust complies with all regulatory requirements.
4. An ongoing programme of investment exists to improve fire safety detection and prevention across Trust premises.
5. During 2023 there were 5 fires, which is an increase of 3 compared to last year.
6. The roles, responsibilities and management arrangements associated with fire safety management are currently being reviewed to ensure they are fit for purpose.

Recommendation

The Trust Board are asked to:

a) Note the contents of this report and acknowledge the work being undertaken to deliver a robust system of fire safety management across the Trust's estate.

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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)						

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: Safe
Care Quality Commission Fundamental Standard: Safety
NHS Improvement Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities
Other (please state):

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

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Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☒	☐	☐	☐	☐

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ANNUAL FIRE SAFETY REPORT AND DECLARATION OF FIRE SAFETY (1.1.23 to 31.12.23)

1.0 Introduction

1.1 This Annual Fire Safety Report is prepared to demonstrate compliance with the mandatory requirements of *Firecode – HTM 05-01: Managing Healthcare Fire Safety* and implications associated with the *Regulatory Reform (Fire Safety) Order 2005 [RRO].*

1.2 An Annual Statement of Fire Safety 2023 was completed to provide assurance that risks arising from fire are effectively managed in line with the RRO. As the organisation is a Foundation Trust, the requirement to complete an Annual Statement of Fire Safety is not mandatory, however, the Board previously agreed to continue the process as it is considered best practice. Based on assurances given by the Deputy Director of Estates & Facilities, the Chief Executive has signed the Annual Statement of Fire Safety for 2023. (Appendix 1).

1.3 The Trust Board will note that the Trust Fire Safety Policy defines roles and responsibilities in line with requirements of HTM 05-01. The Fire Safety Policy makes specific reference to the Fire Strategy & Procedures document, which should be read in conjunction with the Policy. The Policy and Procedures have been reviewed and updated and are due to expire in July 2025.

2.0 Fire Safety Legislation and NHS Requirements

2.1 The Trust's Fire Safety Manager has an ongoing programme of audits and risk assessments, to ensure the Trust complies with all regulatory requirements. This includes measures taken to reduce false alarms and unwanted fire signals (the Fire & Rescue Service defines an unwanted fire signal as being when a false alarm results in attendance by the fire service).

2.2 A prioritised programme of investment has been allocated during the year to:

- Replace existing fire alarm systems with single replacement with a projected sum of £2million per year on a rolling 3-5 year program allocated.
- Update existing emergency lighting system, this is to be factored in to backlog maintenance program and areas will be picked up when refurbished.
- Improve fire and smoke compartmentation and fire-stopping with on-going surveys being undertaken to find scope of works required.

3.0 General Standards

The Trust's Fire Safety Manager draws attention specifically to the following matters: -

3.1 <u>Fires.</u>

During 2023 there were five fires reported.

3.1.1 In February there was an incident in A&E Male WC. The fire was started by a patient/visitor deliberately starting a fire in the WC. The fire was started by toilet roll being ignited. The fire and smoke were contained within the room and smoke detector activated alerting Switchboard, they bleeped the Fire Response Team who attended

promptly and found that the fire had burnt out, silenced & reset the alarm and locked off the room to allow it to be refurbished the following day. No injuries occurred.

3.1.2. In March there was an incident on Ward 7 on the Bradford Royal Infirmary (BRI) site. A patient lit a cigarette whilst on oxygen. Unfortunately, due to the saturated oxygen levels the patient received slight burns to face. The fire was extinguished by staff and the Fire Response Team were called and attended.

The patient received superficial burns that were dealt with by staff on the Ward, all smoking materials were removed from room.

3.1.3. In June a patient set fire to paper magazines at the side of her bed using a cigarette lighter, there was fire damage involving a drip stand, mobile phone and charging cables and light smoke pollution to the room and bedding.

A member of staff smelt smoke as she was passing room 142/013. She entered the room to investigate the smell of smoke, at the same time the fire alarm sounded across the ward.

The Nurse alerted other staff by shouting ‘fire’, at the same time evacuated the patient from the room.

Two staff members of staff responded and successfully extinguished the fire using 2 foam extinguishers. Staff reported flames were reaching approximately 3ft to 4ft high. No injuries were reported.

3.1.4. In August a buffing machine battery charger was both left plugged into the mains power socket and turned on, although not connected into a machine. The actual charger was sat on the floor in a pool of water, which caused the charger to short out producing large volumes of smoke.

The room filled with smoke which then leaked under the door to the catering area. Smoke was discovered in the area by a member of staff who activated the Manual Call Point to raise the alarm.

After receiving a bleep call, the ‘Fire Response Team’ attended the incident and immediately raised the alarm to actual fire. The Fire Service was contacted, and 3 fire engines and a command car attended. The Fire service used positive pressure fans to blow the large amount of smoke out of the building via the catering gantry loading bay.
No injuries reported during incident.

3.1.5 In October a patient who was under 24/7 bed watch on Ward 27 started to become agitated, he held a lighter in his hand, was shouting and trying to get off the bed.

A security guard was positioned on the corridor at the door entrance. He noticed the patient was agitated and had a cigarette lighter, so immediately went to get assistance from ward staff.

Upon returning to the room, they found the mattress and bedding on fire, ignited by the lighter. Both members of staff extinguished the fire.

The patient was found to be holding a molten plastic pen which had been ignited by the fire, he was making stabbing motions with the pen towards both members of staff. At this point both the nurse and the security guard received slight burns.

4 out of the 5 fires was smoking related, 1 patient smoking in bed and 3 due to a person being in possession of a lighter, it is recommended that a full review is undertaken of arrangements for smoking, as the present stance on no smoking in buildings and grounds is very difficult to manage and police. The Trust is being questioned by West Yorkshire Fire & Rescue Service on what actions it is taking to prevent fires being started by smoking if we have a policy banning smoking. This is not easy to tackle and requires careful consideration by a specific task & finish group. The Trust needs to ensure that it creates a safe environment that reduces the risk of staff patients and visitors smoking in illicit areas due to the no smoking arrangements.

3.2 Fire Risk Assessments.

The Fire Team continued to conduct a system wide review of the Fire Risk Assessment (FRA) process in 2023 which included revisiting and refreshing all FRA's throughout the Trust. A total of 161 fire risk assessment reviews were undertaken across the Trust in line with current legislation. We, as a Trust, are now fully compliant with all our fire risk assessments.

Fire risk assessments have been carried out by the Trust's Fire Safety Manager, with support from external independent specialist advisors from Fire Safety Solutions. A full program of reviews is now in process and will continue annually.

3.3 Waste.

3.3.1 The Fire Safety Manager continues to liaise with Facilities Managers and the Environmental & Sustainability Manager to reduce risks associated with waste storage. Departments are reminded of their responsibilities to keep corridors and means of egress clear and free of combustible materials, including waste. This is generally working well, with clear corridors in most areas.

3.3.2 To reduce the risk of waste being a health as well as a fire/arson hazard, the Trust has locked waste rooms across the site, waste is moved from these to external compounds following a regular schedule and removed daily from site by specialist contractors.

3.3.3 A review of all waste compounds across the sites has been carried out by the Fire Safety Manager and the Waste Manager. Actions have been identified to improve the storage of waste on site to reduce the risk of arson and also to reduce the risk of any impact should a fire occur in a waste compound.

3.4 Fire Detection.

3.4.1 The planned testing programme of fire detection systems continues to be implemented on a regular basis throughout the Trust's buildings. Staff are aware of the testing of alarms at a set time.

3.4.2 Contracts for both fire alarm testing and maintenance have been undertaken by Lanterns Fire Ltd.

3.4.3 A significant rolling investment program is underway to upgrade all the fire alarm systems across the Trust and replacing with a new 'GENT' Fire Alarm system. The existing Autronica and Kentec fire alarm systems installed across the Trust's estate are no longer manufactured and are being maintained from an existing stock of spare parts. As part of the fire alarm upgrade, the evacuation strategy will also be reviewed.

3.5 External Escape Routes

3.5.1 The external iron fire escapes from C and D blocks at St Luke's Hospital which carry listed status are a cause for concern. The metal is significantly rusted, reducing the strength of the stairs, platforms and bridges. Temporary strengthening by means of scaffolding and boarding has been installed to ensure the safe use of the exits until a long-term acceptable design solution has been agreed. This is under discussion with Bradford Council's Conservation Department to agree a satisfactory solution and has been identified on the Estates Backlog Maintenance Programme of works.

4.0 Training

4.1 Compliance

The Trust has a target of 90% of staff to be trained in Fire Safety, we are presently at 91% trained. This is a slight improvement compared to the same time the previous year. Difficulties getting shift-working staff to scheduled training sessions have been addressed by the flexibility of the Fire Safety Trainer in delivering training programmes out of hours.

A new fire safety training package has been produced and we are now back with face-to-face training sessions, these have all been booked in for following 12 months. Feedback from staff regarding the new training has been positive.

4.2 Effectiveness.

The Fire Safety Manager continues to monitor the effectiveness of fire safety training, liaising with the Education & Training teams to rationalise and improve the uptake of training. One cannot overstate the importance of effective training, both to prevent fires and to react correctly if a fire does occur. Training includes initial induction training, followed at set intervals by mandatory training designed specifically for staff with either patient-contact or no patient-contact. Patient-contact does not necessarily mean clinical: it includes porters, cleaners, housekeepers and any persons who work regularly in a patient area.

4.3 Development.

4.3.1 The Fire Safety Manager has implemented a Fire Response Team at both BRI & SLH to attend all fire calls, consisting of staff from the Command Centre, Porters, Security and Estates. The main purpose is to ensure prompt attendance to all fire calls and to ensure quick response if there is an actual fire and Fire Service are required. The Fire Response Team also ascertain quickly if the fire call is in fact an unwanted fire signal (false alarm) and thus reducing disruption to services.

4.3.2 The Fire Safety Team are regularly reviewing the training that is delivered to identify opportunities for improvement, especially extra training for Fire Wardens.

5.0 False Alarms & Unwanted Fire Signals (UFS)

5.1 Analysis of false alarms for 2023, compared with the previous year, is shown below:

2022		
BRI	SLH	Total
117	10	127
2023		
BRI	SLH	Total
94	10	104

Underlying causes are attributed to fire alarms being triggered as a result of:

- Smoking.
- Staff cooking, namely toast.
- Patients activating manual call points (red boxes).
- Faulty detectors mainly due to the age of the device or water ingress.
- Contractors not asking for alarms to be isolated and dust setting them off.
- Unknown causes due to age of existing fire alarm systems.

5.2 Break down of false alarm calls in each quarter for 2023;

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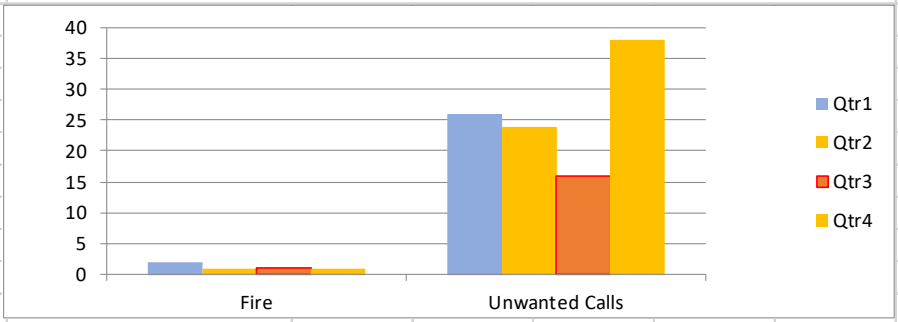
FIRES & UNWANTED CALLS 2023



Type	Qtr1	Qtr2	Qtr3	Qtr4	Total
Fire	2	1	1	1	5
Unwanted Calls	26	24	16	38	104

FIRE CAUSES

CAUSES	Qtr1	Qtr2	Qtr3	Qtr4	Total
Arson	1	1	0	1	3
Electrical (Mains)	0	0	0	0	0
Electrical (Cooking)	0	0	0	0	0
Smoking Related	1	0	0	0	1
Equipment Failure	0	0	1	0	0
Totals	**2**	**1**	**1**	**1**	**5**

UNWANTED CALL CAUSES

CAUSES	Qtr1	Qtr2	Qtr3	Qtr4	Total
Unknown	3	7	3	7	20
Good Intent	0	0	0	0	0
Dust/Water	1	0	0	0	1
Cooking	0	4	1	9	14
Smoking	4	5	4	6	19
Steam/Water Leak	5	4	4	6	19
Aerosol	0	0	0	0	0
Covered Detector	0	0	0	0	0
Contractors	4	4	1	4	13
Faulty Electrical Equipment	0	0	1	0	1
Broken Manual Call Point	9	0	2	6	17
System Fault	0	0	0	0	0
Totals	**26**	**24**	**16**	**38**	**104**

INCIDENT OUTCOMES

	Qtr1	Qtr2	Qtr3	Qtr4	Total
No Injury	0	0	0	0	0
Injury	0	0	0	1	1
Fatality	0	0	0	0	0
Disruption to Services	26	25	17	38	106
Damage	2	0	0	0	2
Totals	**28**	**25**	**17**	**39**	**109**

5.3 Staff training, emergency procedures and upgrading the fire alarm systems (subject to funding approval) contribute to keeping false alarms at an acceptable level. The number of Fire Service turnouts to Trust sites is commendably low, but our goal is always to reduce UFS further.

5.4 The West Yorkshire Fire & Rescue Service charges £350.00 + VAT per vehicle for each attendance of a false alarm call. The pre-determined attendance is two vehicles for an alarm without a confirmed fire (UFS). After ensuring the safety of persons in the area, the main priority of our local Fire Response Team is to locate the reason for the alarm and turn back the fire service if not required. If the fire service can be turned back before they arrive on site, the Trust will not be charged. During 2023 the Trust was charged for one attendance to SLH for out of hours lift release of a member of public.

6.0 New Projects & Developments

6.1 There was a continuation of development projects which commenced in 2023; BRI to Ward 1, Radiology, Dialyses Unit, Temple Bank House, with New Endoscopy Unit being commenced January 2024. SLH to Day Care Unit, Service Duct, Block C & D Heritage external link structure.

6.2 Project Managers continue to ensure that fire safety implications are considered and addressed by seeking specialist advice from the Fire Safety Manager during planned upgrades or new development work.

6.3 The Fire Safety Manager continues to liaise with colleagues in the National Association of Healthcare Fire Officers (NAHFO) and the Institute of Healthcare Engineering and Estates Management (IHEEM), as well as other professional bodies, to update and share industry knowledge and best practice.

7.0 Fire Safety in Community Hospitals

7.1 There has been significant involvement in those community hospitals which contain Trust patients and staff. These include:

- Skipton General Hospital
- Eccleshill Community Hospital
- Westbourne Green Community Hospital
- Westwood Park Community Hospital
- Other community properties, such as the Horton Park Medical Practice, where the Trust has a staff presence.

7.2 Skipton General Hospital has a Renal Unit operated by Trust staff. The property is managed by NHS Property Services and is a multi-tenant site, with a wide variety of building users (NHS, council and charities) various working hours and patterns, and no site manager or coordinator. The Fire Managers from three separate organisations are working together to ensure safety and effective action in the event of a fire alarm.

7.3 Westbourne Green & Westwood Park Community Hospitals. Trust staff at these premises liaise regularly with the Fire Safety Managers. Both sites have had fire evacuation training and fire risk assessments.

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8.0 Management Review

The Fire Safety Manager has been in position just over three years. This has provided an opportunity for roles, responsibilities and management arrangements associated with fire safety management to be reviewed to ensure they are fit for purpose and provide the organisation with appropriate levels of assurance regarding fire safety across a significant and aged estate. Further appointments have been made to strengthen the Fire Safety Team, namely a part time Fire Safety Advisor and full time Fire Safety Trainer to assist the Fire Safety Manager.

9.0 Recommendation

The Executive Team is asked to:

a) Note the contents of this report and acknowledge the work being undertaken to deliver a robust system of the fire safety management across the Trust.

b) Recommend that this report be tabled at Trust Board as part of the assurance process demonstrating effective fire safety management.

Date: 31.01.2024
Ref: DM

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Appendix 1

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Annual Statement of Fire Safety 2023

NHS organisation: Bradford Teaching Hospitals NHS Foundation Trust

I confirm that for the period 1 January 2023 to 31 December 2023, all premises which the organisation owns, occupies or manages have had fire risk assessments undertaken in compliance with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):

1	There are no significant risks arising from the fire risk assessments.	✓
2	The organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment.	✓
3	The organisation has identified significant risks, but does not have a programme of work to mitigate those significant risks.	✓
	Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.	✓
4	During the period covered by this statement, the organisation has not been subject to any enforcement action by the fire and rescue authority.	✓
	Please outline details of enforcement action in Annex A Part 1.	
5	The organisation has not got any ongoing enforcement action pre-dating this Statement. Please outline details of ongoing enforcement action in Annex A Part 2.	✓
6	The organisation achieves compliance with the Department of Health's fire safety policy by the application of Firecode or some other suitable method.	✓

Chief Executive Officer: Mel Pickup

Fire Safety Manager: Darren Mitchell

Contact details:
E-mail:darren.mitchell@bthft.nhs.uk
Telephone:01274 364229
Mobile: 07973 375892

Signature of Chief Executive

Date: 05.02.24

Completed statement to be retained for future audit.

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ANNEX A

Part 1 – Outline any enforcement action taken during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.

None

Part 2 – Outline any enforcement action ongoing or unresolved from previous years including the original date, and the action the organisation has taken so far. Include any proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.

None

BO.7.24.10 - FREEDOM TO SPEAK UP ANNUAL REPORT

REFERENCES

Only PDFs are attached

- Bo.7.24.10 - FTSU Annual report 2023-24 cover and Appendices 1 to 3.pdf
- Bo.7.24.10 - FTSU Appendix 4 - Ethnicity Word Doc (002).pdf
- Bo.7.24.10 - FTSU Appendix 4 - Job Role Word.pdf
- Bo.7.24.10 - FTSU Appendix 4 - Staff group.pdf
- Bo.7.24.10 - FTSU Appendix 5 - Feedback.pdf
- Bo.7.24.10 - FTSU Appendix 6 - FTSU Board Development action plan.March 2024 update.pdf

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FREEDOM TO SPEAK UP (FTSU) ANNUAL REPORT 2023-24

Presented by	Dr LeeAnne Elliott, Consultant Paediatric Radiologist/Deputy FTSU Guardian Sue Franklin, Associate Chief Nurse, Freedom To Speak Up Guardian	
Author	Sue Franklin, Associate Chief Nurse, Freedom To Speak Up Guardian	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide assurance in relation to the conduct and outcome management of the FTSU arrangements in the Trust	
Key control	A key control for the strategic objectives to provide outstanding care for patients and to being in the 20% of NHS employers.	
Action required	For assurance	
Previously discussed at/ informed by	None	
Previously approved at:		**Date**
	People Academy	22.05.24
	Quality and Patient Safety Academy	02.07.24

Key Options, Issues and Risks

This paper provides the Annual report 2023-24 update for the People Academy, the Quality and Patient Safety Academy and the Board of Directors on FTSU at Bradford Teaching Hospitals (BTHFT).

Analysis

This paper describes the number of concerns that have been raised during 2023-24 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern (Appendix 1).

It shows a trend line of the number of concerns raised here at BTHFT (Appendix 2).

In addition, the report includes the FTSU figures of Quarter (Q) 4 2023-24 at BTHFT.

It includes the 2023 NHS staff survey results for raising concerns for BTHFT (Appendix 3) and includes the breakdown of the data into ethnicity, job role and staff group (Appendix 4).

This paper also provides an update on feedback received from staff in infographic form (Appendix 5).

It includes the action plan from the Board development session held in June 2023, updated in March 2024 (Appendix 6).

Recommendation

For the Board/Academy to note the contents of the report and the FTSU concerns that have been raised at BTHFT during 2023-24.

For the Board/Academy to note Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) Q4 data headlines.

For the Board/Academy to note the feedback from staff who have spoken up.

For the Board/Academy to note the work of the FTSU Guardian and FTSU Ambassadors at BTHFT.

For the Board/Academy to encourage all grades of staff to complete the eLearning FTSU training.

For the Board/Academy to note the staff survey results and to share the results to encourage staff to make speaking up business as usual.

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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)
☒	☒	☐	☐

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1 PURPOSE/ AIM

1.1 This paper provides assurance to the Board/Academy in relation to the conduct and outcome management of the FTSU arrangements in the Trust by:

- Providing an update, using the National Guardian's Office (NGO) template, on FTSU and the progress in 2023-24.
- Reporting on the number of FTSU concerns that have been raised in Q4 at BTHFT in 2023-24 (Appendix 1).
- Representing the number of concerns raised per Quarter and year as a line graph of data plotted over time. (Appendix 2).
- The NHS Staff survey 2024 results – Raising concerns (Appendix 3).
- The breakdown of the staff survey by ethnicity, staff group and job role (Appendix 4).
- Providing feedback received from staff who have raised a concern in 2023/24 (Appendix 5).
- Providing the latest update to the FTSU action plan developed following the Board development session held in June 2023 (Appendix 6).

2 BACKGROUND/CONTEXT

2.1 Freedom to Speak Up is vital in healthcare. When workers feel psychologically safe, they will speak up to avoid harm, bring great ideas and be able to express their concerns. The National Guardian's office (NGO) believes a good speaking up culture makes for a safer workplace, for workers, patients and service users. Here at BTHFT we are working to make speaking up business as usual across the Trust. The FTSU team are helping to promote and support workers to speak up and to effect culture change to make speaking up business as usual.

2.2 Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust.

2.3 The FTSU Guardian has a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patients' safety and/or the way that the concern has been handled. The Guardian's role is to listen to and empower staff to speak up and support the organisation to a healthy speaking up culture. Besides raising awareness and working to remove barriers to speaking up the guidance from the NGO is that we must input data quarterly; keep up to date with FTSU knowledge by attending the Guardian network meetings and keeping on top of annual refresher courses.

2.4 The FTSU Guardian is Sue Franklin, Associate Chief Nurse for Quality Improvement. The deputy FTSU Guardian is Dr LeeAnne Elliott, Consultant Paediatric Radiologist.

2.5 Karen Dawber, Chief Nurse, is the Executive Lead for FTSU and the Non-Executive Director lead is Karen Walker.

2.6 There are 11 FTSU Ambassadors who have completed the training provided by the NGO. These are:

- Sarah Freeman – Director of Nursing.
- Amandeep Singh – Partnership Lead.
- Rupert Allen – Principal Dietitian.
- Anthony Doggett – Business Support Lead.
- Simon Kirk – General Manager.
- Faye Alexander – Education Manager.
- June Thomas – Midwife.
- Nazia Amir – Personal Assistant.
- Helen Fearnley – Lead Tissue Viability Advanced Practitioner.
- Rebecca Carter – Education Lead.
- Emma Fleary – Specialist midwife for pastoral care and preceptorship.

2.7 We have recently lost the two student midwives as part of the FTSU team due to personal issues within the university and their training. We are planning to recruit for more FTSU ambassadors and will target students as well as other staff groups.

2.8 BTHFT's FTSU policy was reviewed and updated in Jan 2024. This went through the Academy on a previous FTSU Board report (Q2) and is now in the Trust format on the intranet.

2.9 The FTSU group meets every four to six weeks. This meeting is to update the FTSU group on any updates from the National Guardian's Office (NGO) and to discuss and monitor any ongoing FTSU concerns and issues. The NGO directs how we listen to concerns and document those concerns. Any new data is discussed at these meetings too.

2.10 The FTSU group have a Human Resources (HR) link who they liaise with as/when necessary to discuss any concerns that need HR support or guidance.

2.11 Following any case review published by the NGO, the FTSU group discuss the review and check each recommendation to ascertain which ones are relevant to BTHFT. These recommendations are actioned to ensure we meet the expected standards.

2.12 The FTSU Guardian attends the FTSU regional network; North East, Yorkshire and Humber monthly meeting, where there is attendance from the NGO. She has close working links with the Equality, Diversity and inclusion team and the Organisational development team and is on the Civility programme Board here at BTHFT. She is a mentor for new FTSU Guardians led by the national team. She has regular buddy meetings with the FTSU Guardian at Calderdale NHS Trust.

2.13 The NGO requests regular updates and currently requests quarterly reports (in a standard template) on the concerns raised from each NHS Trust. We have complied with this submission.

2.14 The NGO, in collaboration with Health Education England, have three modules for FTSU on the eLearning platform.

- **Speak Up** – is for all workers and covers what speaking up is and why it matters.

- **Listen Up** – for managers, focuses on listening and understanding the barriers to speaking up.
- **Follow up** – is for senior leaders throughout health care, including Executive and non-executive directors, lay members and governor – its aim is to provide an opportunity for them to pause and reflect on the influence they and their fellow leaders have in shaping the speak up culture in our organisation.

The National Guardian, Dr Jayne Chidgey-Clark has asked that all senior leaders commit to undertake this training and make a Speak Up Pledge to show how they will Speak Up, Listen Up and Follow Up and role model these behaviours in our organisation.

2.15 Once a FTSU concern is closed we ask for feedback, whether they would speak up again and whether they have suffered any detriment for speaking up. The feedback is displayed in an infographic in Appendix 5.

2.16 The 2023 staff survey results have four questions relevant to speaking up, the results are in Appendix 3. The staff survey is further broken down by ethnicity, job role and staff group, (Appendix 4). This data will be reviewed at the next FTSU meeting to agree how we use the data to focus our work over the next twelve months.

2.17 The NGO state that the staff survey breakdown for this area is complex, with several factors influencing the cases raised with Guardians. It is essential to approach this information with curiosity and a commitment to deep understanding, rather than jumping to easy conclusions, as part of the continuous work to improve the speak up culture.

2.18 In February 2024, the report 'Too hot to handle: why concerns about racism are not heard or acted upon' - https://www.brap.org.uk/post/toohottohandle was published and shared from the NGO. Dr Jayne Chidgey-Clark said:
Conversations about racism are interlinked with Freedom to Speak Up because at the centre of this report remains the barrier for these workers, that speaking up is not worth it, because nothing changes, and the potential repercussions are not worth the risk.
This report includes the recommendation for better use of Freedom to Speak Up guardians, who as part of their role have a focus on encouraging their organisations to remove the barriers which workers face in speaking up – particularly Black and minoritized workers. But Freedom to Speak Up guardians can only be effective in their role if they are supported by the curiosity of their leadership. This requires a desire from leaders to listen to understand, and an appetite to take appropriate action." This report is part of the Equality, Diversity and Inclusion council.

2.19 Next year's mandatory annual refresher training for Freedom to Speak Up guardians is focusing on equity, diversity, inclusion and belonging to give all guardians an understanding of discrimination. This training will be a mandatory part of guardians' Foundation training going forward. The FTSU Guardian is a member of the Equality, Diversity and Inclusion council.

2.20 The NGO recently asked for Guardians to contact them to 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 met with the NGO, and they have developed 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.

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3 PROPOSAL

3.1 The FTSU team at BTHFT are working hard to truly make speaking up business as usual but the National Guardian states that the system as a whole needs to firmly commit to living up to the values of supporting and listening to workers. FTSU is an additional route for workers to speak up to, but they cannot improve the speaking up culture on their own.

3.2 The FTSU Board action plan (Appendix 6) was updated in March 2024 and reflects the Board's commitment to making speaking up business as usual and sets out the work for the coming year for FTSU.

3.3 The NGO have a Speak up month in October every year which we partake in. In October 2023, the topic was 'overcoming the barriers preventing people from speaking up'. The FTSU team took part in this event throughout October within the Trust. They have been visits to staff meetings, induction sessions for new staff and the team were in the main concourse throughout October. The stands in the concourse linked in well with other important events like Black history month, staff networks and Thrive.

3.4 The FTSU team are working hard to ensure staff feel safe to speak up but need the support of leaders throughout the organisation to make speaking up just what we do here at BTFHT, The National Guardian states that FTSU Guardians do not work in isolation. All leaders are responsible for setting the tone when it comes to fostering a healthy speak up, listen up, follow up culture.

4 BENCHMARKING IMPLICATIONS

4.1 Alongside the data headlines for each quarter, the NGO publish on their webpages the data submitted by all the Trusts in England. This enables each organisation to benchmark against similar types and sizes of organisations. This data is varied, but on average at BTHFT (classified as a medium sized Trust in the NGO data set) the data is consistent with other medium sized Trusts. There are however some examples of 'medium sized Trusts' reporting a lot more concerns than BTHFT.

4.2 In addition the annual NHS staff survey on safety culture about raising concerns provides an opportunity to monitor how BTHFT is performing in relation to other organisations classified as the best, average and worst performing. The latest NHS staff survey results are in Appendix 3.

4.3 The staff survey results by ethnicity, job role and staff group for the four speak up questions are part of the benchmarking work that the FTSU team and leaders of those areas can use to truly make speaking up business as usual.

4.4 The FTSU Guardian and Exec lead for FTSU have just agreed the specification for a review of the FTSU service by Audit Yorkshire. The internal audit report will be shared in a future FTSU Board paper once completed.

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5 RISK ASSESSMENT

5.1 The FTSU Guardian has 12 hours protected time within their substantive role to perform their FTSU duties. The deputy and FTSU Ambassadors currently have no protected time within their substantive roles.

5.2 The FTSU team, following the board development plan for FTSU are planning to develop the FTSU team further and appoint more Guardians/Ambassadors across the Trust.

5.3 It was highlighted in a previous internal audit report that if there was to be a sudden influx of concerns, we would need to address the resource requirements; this could be a potential weakness in the system. As the number of FTSU concerns are rising every year we are going to be reviewing the staffing requirement for this.

6 RECOMMENDATIONS

6.1 To note the number of FTSU concerns that have been raised during Q4 and the whole of 2023-24 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern.

6.2 To support the work of the FTSU group to continue with raising awareness of FTSU for staff and education for Guardians.

6.3 To continue with quarterly reports to the Board/Academy to update on progress with FTSU at BTHFT.

6.4 To support the staff across the organisation to complete FTSU training on the eLearning platform, including the Executive and Non-Executive team.

6.5 To continue supporting the FTSU team to deliver the two elements of their role. One part is the reactive – listening to workers, thanking them and supporting them so that their voices can be heard, and actions taken. The other part is the proactive element – supporting the organisation to learn from the opportunities which speaking up brings.

6.6 To note the staff survey results and share with staff teams the four questions related to staff speaking up and being listened to and it then being actioned.

7 Appendices

Appendix 1 – BTHFT Q4 data and 2023/24 data.

Appendix 2 – Run charts of number of concerns.

Appendix 3 – Staff survey results 2023 for the 4 Speakup questions and sub score.

Appendix 4 – Staff survey breakdown by ethnicity, Job role and staff group.

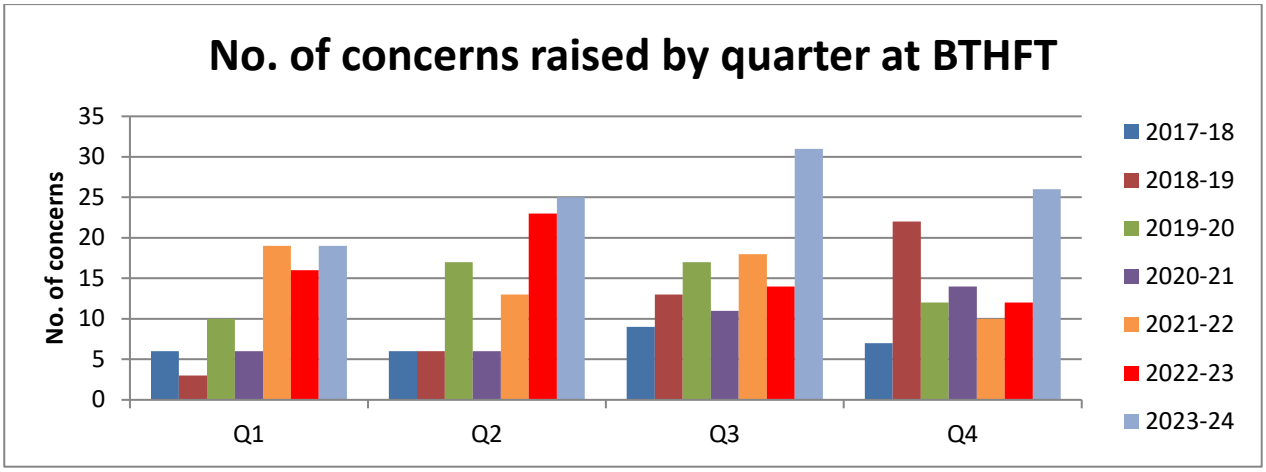
Appendix 5 – Feedback received in Q3.

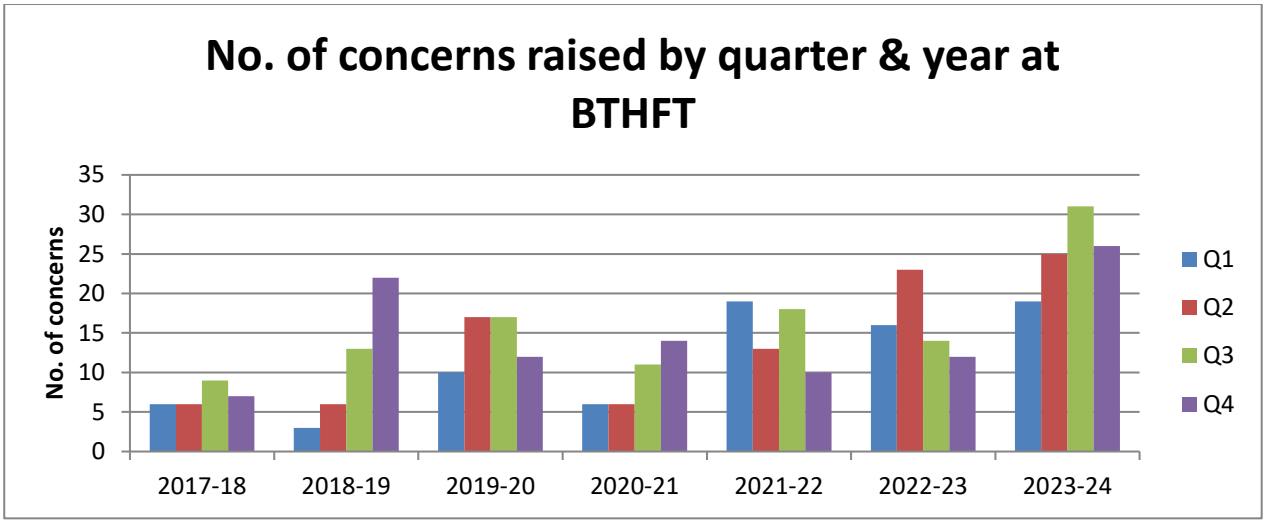
Appendix 6 – Board development action plan update March 2024.

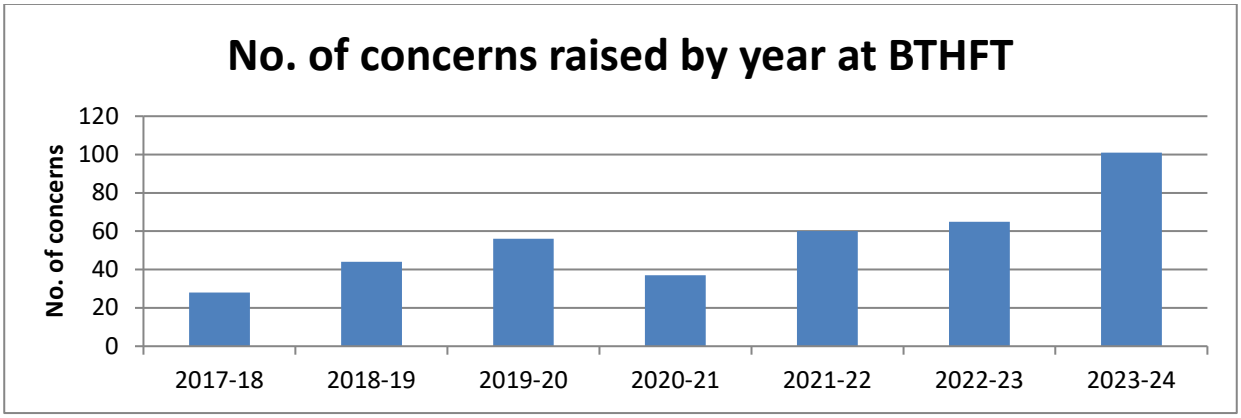
Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.10

7 Appendices

Appendix 1 – FTSU Concerns raised at BTHFT by Quarter and by Year.







Meeting Title	Board of Directors		
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7.1 These graphs show the number of concerns raised since the start of FTSU at BTHFT by quarter and by full year. It is displayed alongside the previous year's data to facilitate comparison. It shows an increase in concerns since the start of FTSU (except 2020-21 likely due to the pandemic).

7.2 In 2023/24 there were 101 concerns raised to the FTSU team.

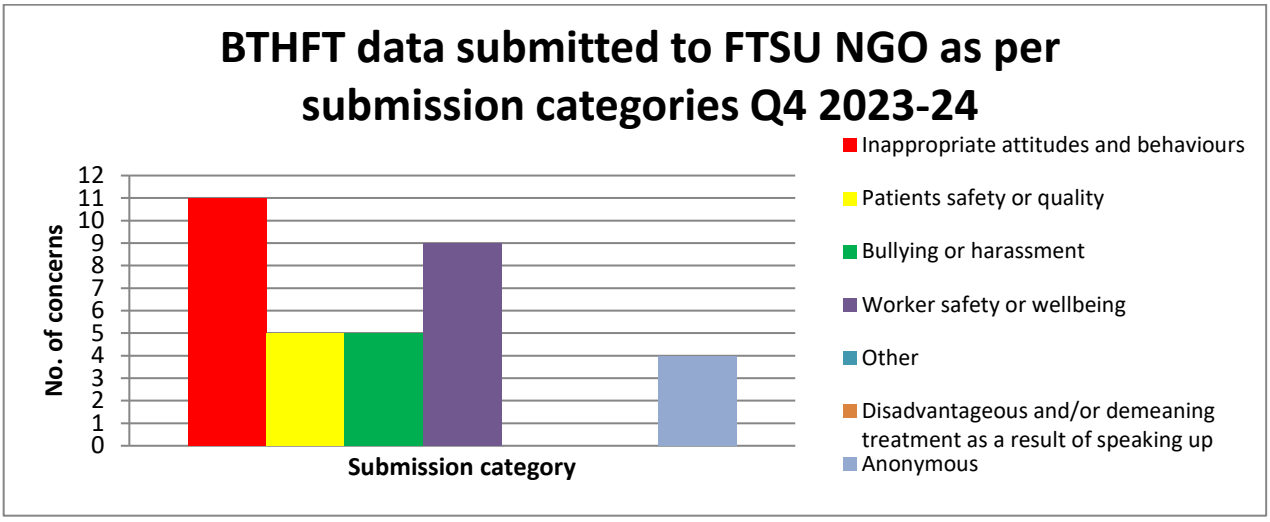
7.3 In Q4 there were 26 concerns raised to the FTSU team. There were 4 concerns that were raised anonymously and 9 concerns this quarter were raised via the FTSU App.

7.4 There is a new function on the App that we have started to use in Q1 2024/25 where we can now communicate via a unique log number which enables them to communicate further with us and we can feedback to them too. The NGO advocate that staff should be able to raise concerns anonymously if necessary.

7.5 **Concerns raised by category** (Using the NGO's submission categories)

The graph below shows the concern categories for Q4 2023-24*

*** A FTSU concern may have more than one category.**



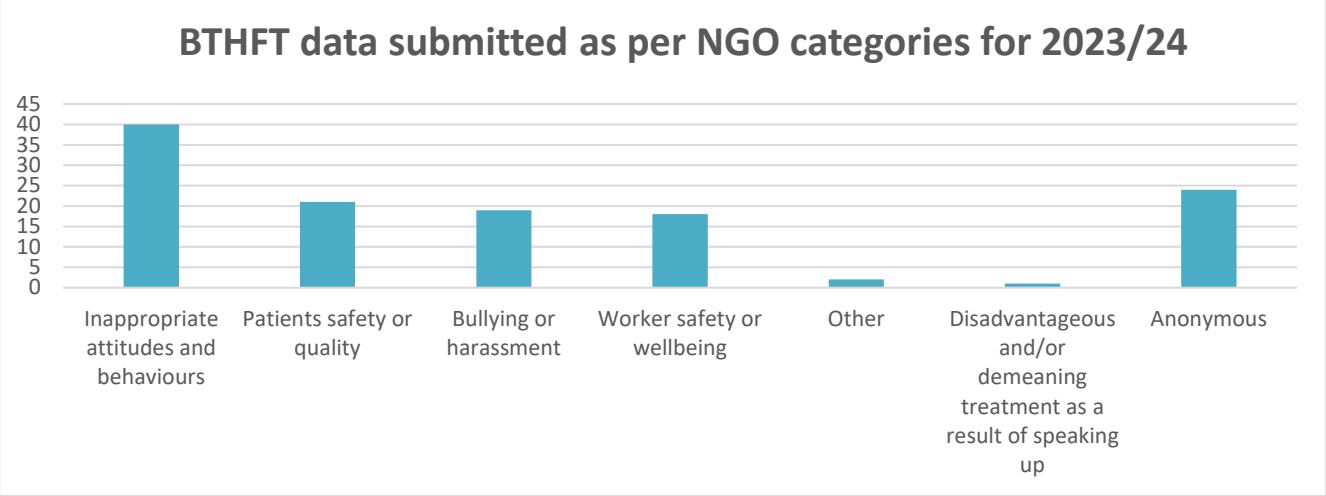
7.6 In Q4, of the 26 concerns raised,

- **5 had an element of patient safety/quality** - (Any case that may indicate a risk or adverse impact on patient safety or the quality of care). One of these concerns was from a Junior Dr and the Chief medical officer supported this concern, this is now sorted. Two of the other areas, the Chief nurse team were supporting the staff with, and this work is ongoing.
- **5 had an element of bullying and/or harassment** - (This can be a current or past matter and may identify risks or be about actual events)
- **11 had an element of inappropriate attitudes and/or behaviours** - (Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute Bullying or harassment)
- **9 had an element of worker safety or wellbeing –** (Any case that may indicate a risk of adverse impact on worker safety or wellbeing)
- No one this quarter has reported any disadvantageous and/or demeaning treatment as a result of speaking up (Detriment).

- 4 people reported their FTSU concerns anonymously to us.

7.7 The graph below shows the concern categories for 2023-24*

* A FTSU concern may have more than one category.



7.8 The graph above shows the number of concerns by category that have been raised in 2023/24. The highest number of cases are raised are with an element of other inappropriate attitudes or behaviours. These are any concerns that may indicate a risk or other inappropriate attitudes or behaviours that do not constitute bullying or harassment. They can be a current or past matter and may identify risk or be about actual events.

7.9 The table below shows the main people who gave support or advice to resolve the concern. *

Who referred to for support to resolve the concern	Number of concerns
HR for support/advice or ongoing help	19
HR investigations	9
Leadership teams	47
Counter fraud	1

*Does not include all concerns as some were dealt with via other routes.

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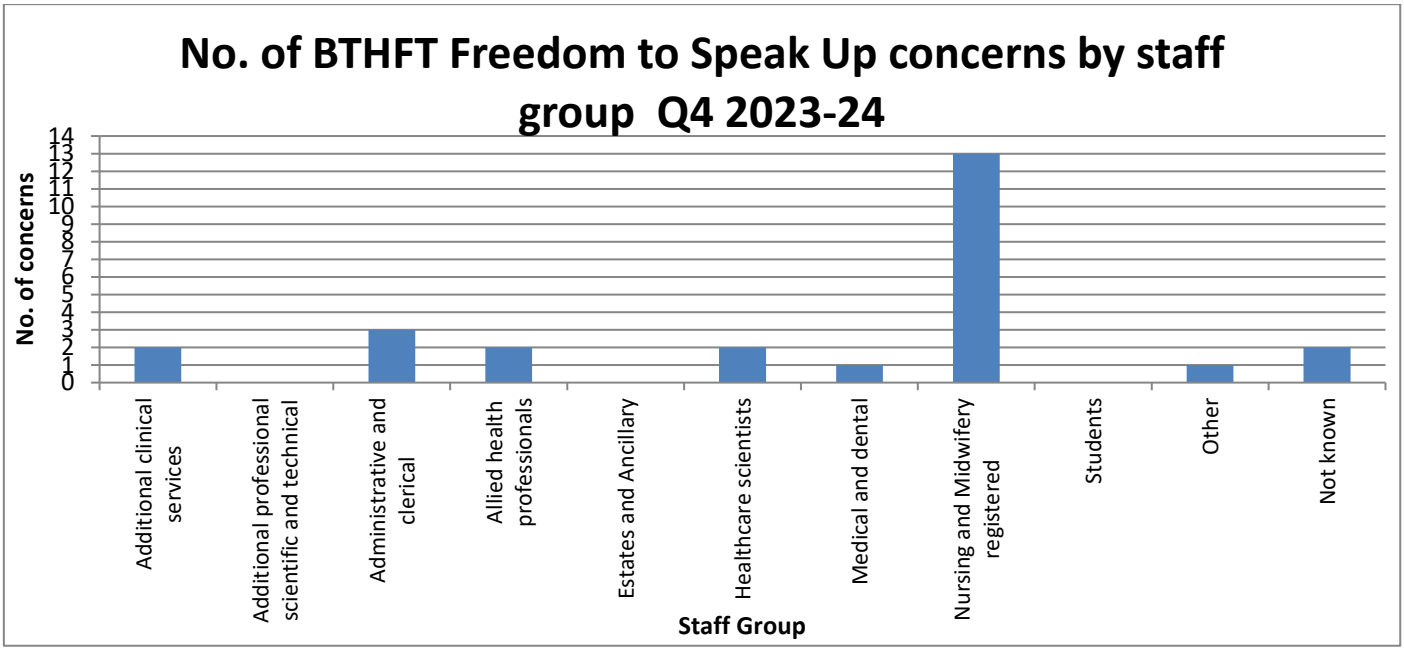
7.10 Number of Concerns by staff group for Q4 (Using the NGO's grouping)

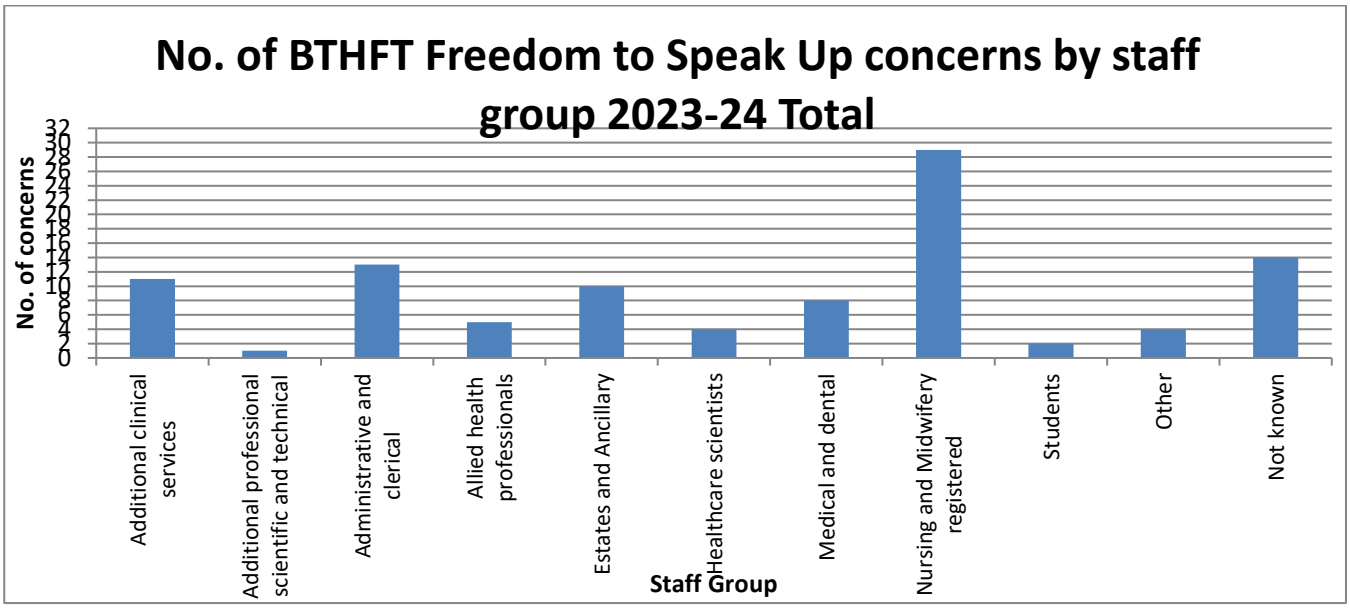


7.11 The above table shows the staff groups who have raised concerns in Q4.

- 13 concerns were raised by either a registered nurse or midwife.
- 1 concern was raised by medical or dental staff.
- 2 concerns were raised by AHP's.
- 2 concerns were raised by additional clinical service staff.
- 3 were raised from Admin and clerical staff,
- 2 concerns were raised by healthcare scientists.
- 3 of the concerns raised it was not possible to determine which staff group they were from as they did not stipulate or were anonymous.

7.12 The Graph below shows the numbers of concerns reported by staff groups 2023/24.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.10



7.13 The data over the 12 months shows that we have more staff from a nursing and/or midwifery background reporting concerns to the FTSU team. Nurses and midwives accounted for the bigger portion (29%) of cases raised. This is mirrored in the national data too for all FTSU Guardians where 29% of workers who spoke up were registered nurses or midwives.

7.14 The pie chart below shows the FTSU concerns by staff group for 2023-24.

This data is utilised to identify areas where promotion/education around FTSU may be required.

Meeting Title	Board of Directors		
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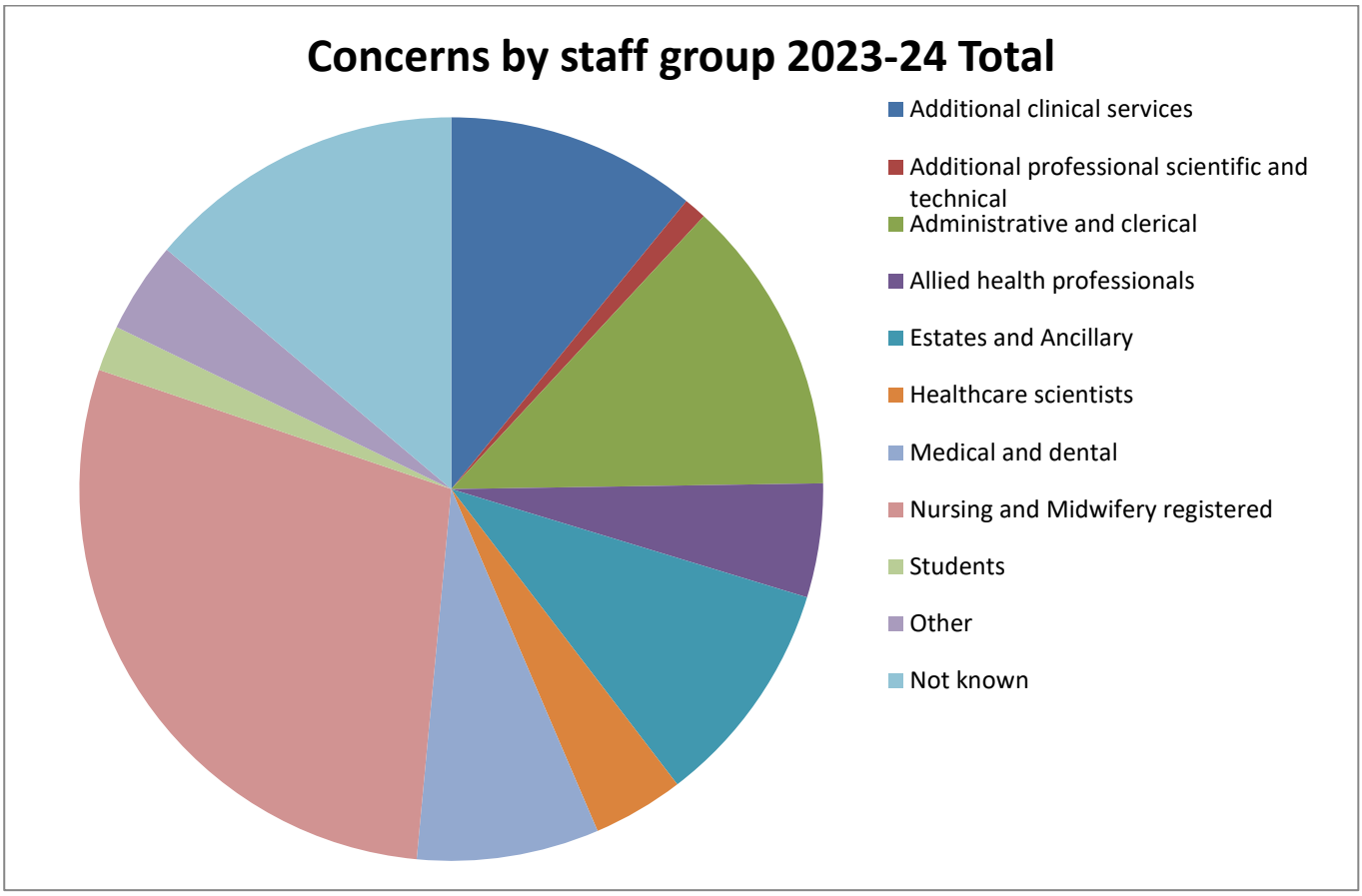

7.15 Workers from a range of professional groups spoke up to the FTSU team. Nurses and midwives accounted for the bigger portion (29%) of cases raised. This is mirrored in the national data too for all FTSU Guardians where 29% of workers who spoke up were registered nurses or midwives. The graph also shows a wide spread of staff from different roles who have raised concerns to the FTSU team.

Meeting Title	Board of Directors		
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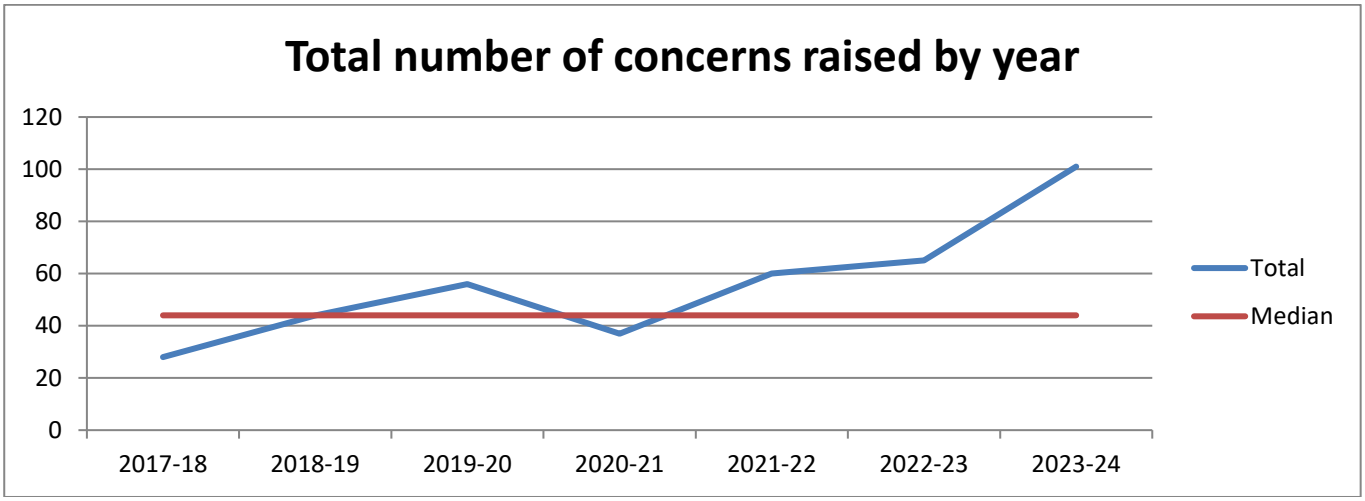
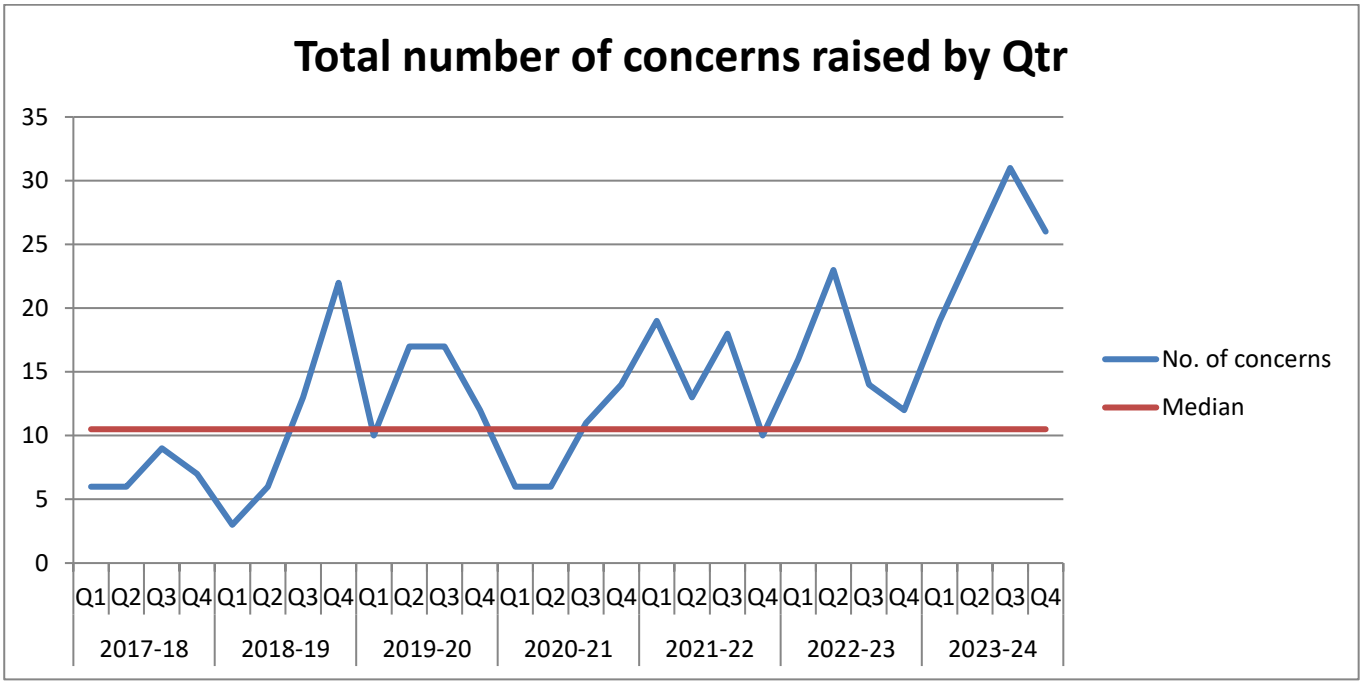
8.0 Appendix 2 – Run charts of the Total number of FTSU concerns raised by quarter and year.





8.1 These two charts show the number of FTSU concerns raised over time at BTHFT. In Q4 there were 26 concerns raised to the FTSU team, this is second highest number of concerns raised in any quarter since FTSU started here at BTHFT.

8.2 In 2023/24 we had the highest number of concerns raised to us, 101 in total. The number of staff raising a concern to the FTSU team has increased in 2023/24.

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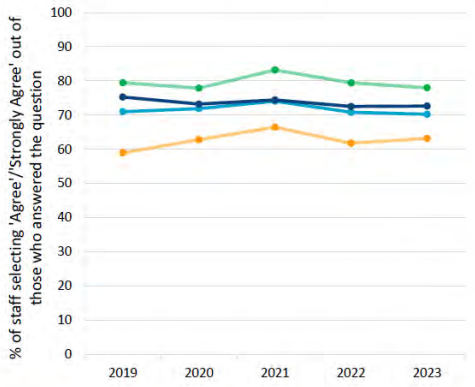
Appendix 3 – Staff survey results for BTHFT 2023 – we all have a voice

People Promise elements and theme results – We each have a voice that counts: Raising concerns

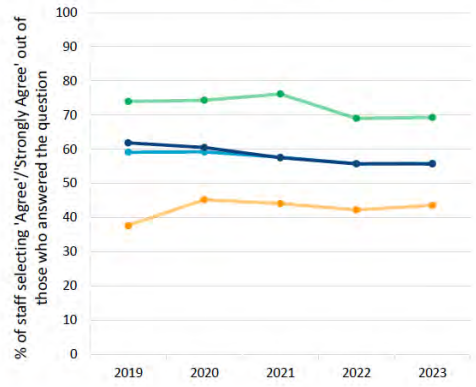
Survey Coordination Centre NHS

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2019	2020	2021	2022	2023
Your org	75.27%	73.22%	74.44%	72.53%	72.64%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	2229	2720	2944	2335	2851

Q20b I am confident that my organisation would address my concern.



	2019	2020	2021	2022	2023
Your org	61.88%	60.54%	57.54%	55.76%	55.73%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	2229	2718	2936	2327	2842

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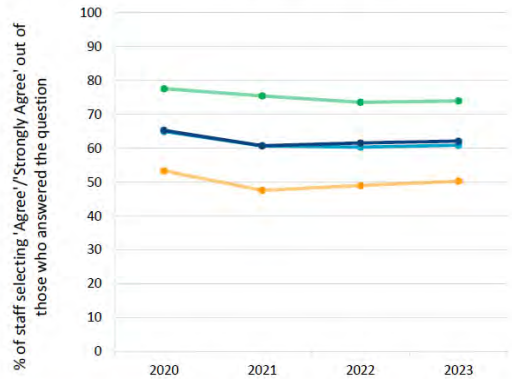
People Promise elements and theme results – We each have a voice that counts: Raising concerns

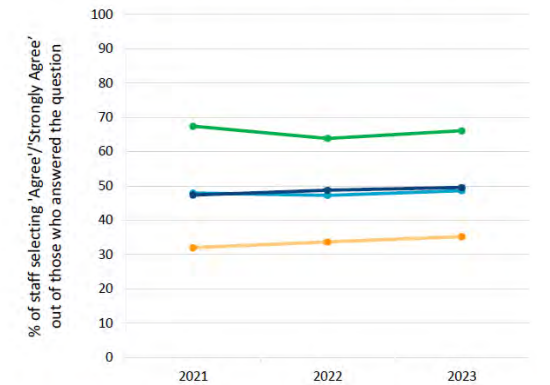
Survey Coordination Centre NHS

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023
Your org	65.32%	60.77%	61.57%	62.13%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	2715	2937	2333	2860

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023
Your org	47.36%	48.77%	49.58%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	2935	2328	2863

Bradford Teaching Hospitals NHS Foundation Trust Benchmark report 53

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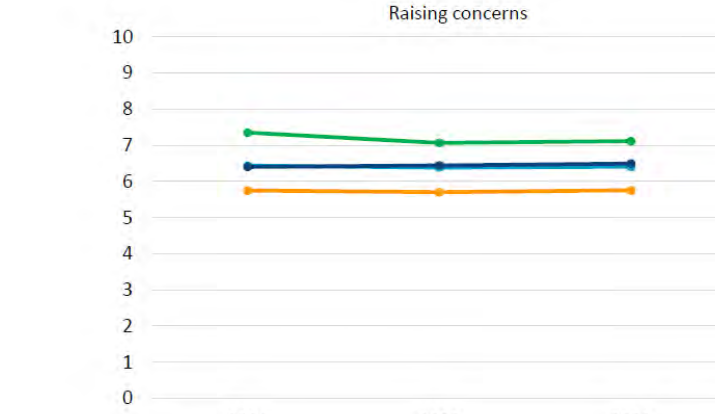
Staff survey Contd.

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



	2021	2022	2023
Your org	6.40	6.45	6.50
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	2935	2320	2842

Appendix 4 – Staff survey results by ethnicity, staff group and job role (Also as attachments)

Job Role Word Doc.docx

Ethnicity Word Doc.docx

Staff Group Word Doc.docx

Appendix 5 – Feedback infographic (Also as attachment)

Feedback from staff chart.docx

Appendix 6 – Board development action plan update (Also as attachment)

Appendix%206%20-%20FTSU%20Board%

Ethnicity	Any other Asian background		Bangladeshi		Indian		Pakistani		African		Caribbean		Any other Mixed / Multiple ethnic background	
Year	2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	75.9%	2.0%	68.2%	-6.8%	72.0%	10.7%	66.2%	0.1%	84.2%	19.7%	69.2%	6.7%	63.6%	-18.2%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	64.9%	5.1%	50.0%	-12.5%	61.3%	11.8%	55.2%	-0.6%	68.4%	12.2%	70.8%	44.2%	59.1%	13.6%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	63.4%	2.6%	54.5%	4.5%	67.1%	6.0%	55.0%	-4.9%	57.9%	-6.6%	61.5%	14.5%	50.0%	4.5%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	57.4%	2.9%	50.0%	6.3%	56.6%	8.4%	49.3%	-2.4%	55.3%	0.4%	53.8%	36.2%	34.8%	7.5%

Ethnicity	White and Asian		White and Black Caribbean		Any other ethnic background		Not available		Any other White background		English / Welsh / Scottish / Northern Irish / British		Irish	
Year	2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	61.9%	-9.5%	58.8%	-11.8%	70.3%	5.6%	55.3%	-23.3%	60.8%	-4.5%	73.7%	-0.4%	81.3%	2.7%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	61.9%	-9.5%	70.6%	14.3%	64.9%	19.4%	42.1%	-17.4%	46.8%	-7.6%	54.4%	-1.8%	56.3%	-15.2%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	47.6%	-9.5%	70.6%	5.9%	64.9%	6.5%	40.0%	-14.8%	59.7%	1.8%	63.5%	0.5%	75.0%	5.8%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	36.4%	-6.5%	70.6%	11.8%	66.7%	15.2%	25.7%	-24.3%	41.6%	-2.6%	49.2%	0.2%	56.3%	17.8%

Data Suppressed (less than 10 respondents):

Chinese; Any other Black / African / Caribbean background; White and Black African; Arab; Gypsy or Irish Traveller

Job Role	Pharmacist		Applied Psychologist - Clinical		Technician		Manager		Healthcare Science Assistant		Trainee Practitioner		Health Care Support Worker	
Year	2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	64.5%	6.8%	55.0%	-23.6%	75.0%	12.1%	63.0%	1.8%	58.8%	-21.2%	68.8%	-14.6%	76.7%	3.3%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	32.3%	5.3%	35.0%	-22.1%	57.7%	10.6%	51.0%	-3.6%	64.7%	-2.0%	50.0%	-8.3%	65.5%	-4.5%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	41.9%	3.5%	55.0%	-9.3%	71.2%	5.4%	62.0%	-0.1%	58.8%	-14.5%	56.3%	6.3%	73.3%	13.3%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	25.8%	2.7%	30.0%	-12.9%	48.0%	9.8%	56.0%	5.7%	58.8%	12.2%	31.3%	-18.8%	70.0%	20.0%

Job Role	Healthcare Assistant		Assistant		Maternity Support Worker		Nursing Associate		Officer		Clerical Worker		Researcher	
Year	2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	73.3%	0.5%	68.4%	9.7%	66.7%	6.7%	72.7%	2.7%	68.8%	-2.6%	63.9%	0.4%	53.5%	-6.5%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	63.1%	-0.1%	63.9%	12.2%	52.9%	2.9%	50.0%	20.0%	62.6%	3.1%	55.3%	-1.5%	46.5%	-3.5%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	59.7%	-0.2%	68.8%	13.0%	61.1%	11.1%	54.5%	-5.5%	59.2%	-5.2%	56.9%	5.0%	65.9%	-4.5%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	53.1%	1.6%	57.3%	4.8%	55.6%	-4.4%	36.4%	16.4%	52.6%	0.0%	49.1%	2.4%	56.8%	4.5%

Job Role	Senior Manager		Analyst		Personal Assistant		Medical Secretary		Secretary		Physiotherapist		Dietitian	
Year	2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	77.6%	-3.8%	50.0%	-7.9%	68.8%	-4.6%	58.4%	1.1%	68.8%	-4.6%	85.5%	4.1%	80.0%	2.2%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	75.9%	8.4%	50.0%	-7.9%	75.0%	-5.0%	44.9%	1.7%	56.3%	-10.4%	55.9%	6.6%	50.0%	-9.3%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	79.7%	2.4%	43.8%	-21.3%	88.2%	14.9%	53.8%	-4.8%	56.3%	-15.2%	65.2%	0.9%	73.9%	-7.6%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	67.2%	5.9%	43.8%	-16.3%	76.5%	3.1%	37.8%	-4.9%	46.7%	-30.3%	47.8%	3.5%	43.5%	-12.1%

Job Role	Occupational Therapist		Radiographer - Diagnostic		Support Worker		Healthcare Scientist		Healthcare Science Practitioner		Specialist Healthcare Science Practitioner		Specialty Registrar	
Year	2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score	Base	Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	93.8%	11.4%	77.8%	-2.2%	63.0%	-10.5%	75.0%	-8.3%	70.6%	-12.7%	63.2%	-19.2%	69.2%	-4.5%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	56.3%	-6.3%	53.3%	3.3%	57.4%	-17.1%	50.0%	0.0%	52.9%	-8.2%	57.9%	-12.7%	46.2%	-11.7%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	62.5%	3.7%	56.5%	-3.5%	55.3%	-10.1%	56.3%	-2.1%	58.8%	-2.3%	57.9%	-18.6%	50.0%	-13.2%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	43.8%	-15.1%	41.3%	-0.8%	55.3%	-9.5%	56.3%	14.6%	47.1%	2.6%	57.9%	5.0%	42.3%	0.2%

Job Role	Consultant		Specialist Nurse Practitioner		Nurse Manager		Midwife		Modern Matron		Staff Nurse	
Year	2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	75.4%	-2.8%	76.4%	-10.2%	90.0%	-2.7%	79.4%	4.7%	100.0%	5.3%	77.7%	8.3%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	50.6%	-0.9%	45.9%	-10.9%	74.4%	-11.0%	52.9%	1.0%	84.2%	5.3%	59.2%	11.4%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	67.4%	-6.6%	59.6%	-2.8%	80.0%	-2.9%	61.8%	7.3%	73.7%	0.0%	64.1%	13.0%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	44.0%	-1.6%	42.0%	-6.8%	67.5%	-5.7%	48.5%	4.2%	68.4%	5.3%	48.8%	2.6%

Staff Group	Add Prof Scientific and Technic		Additional Clinical Services		Administrative and Clerical		Allied Health Professionals		Estates and Ancillary		Healthcare Scientists		Medical and Dental		Nursing and Midwifery Registered	
Year	2023		2023		2023		2023		2023		2023		2023		2023	
Question	Score		Score		Score		Score		Score		Score		Score		Score	
20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	67.0%	5.3%	72.3%	-1.1%	64.9%	-0.6%	80.0%	0.2%	60.3%	3.2%	73.4%	-9.3%	73.5%	-1.8%	80.3%	1.0%
20b I am confident that my organisation would address my concern (Agree/Strongly agree).	45.0%	5.0%	59.9%	-1.0%	56.5%	-0.2%	54.7%	4.1%	57.4%	3.1%	59.4%	-2.7%	49.6%	-3.4%	55.4%	-0.8%
25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	58.7%	5.2%	61.6%	0.3%	60.8%	-1.7%	64.2%	-2.3%	58.5%	5.3%	60.9%	-2.9%	65.3%	-5.5%	63.4%	4.0%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	38.5%	6.4%	52.3%	2.9%	52.6%	0.5%	44.1%	-1.4%	52.6%	3.0%	56.3%	9.7%	44.9%	-0.6%	48.8%	-0.6%


Feedback from staff who have raised concerns
Very kind, supportive and helpful during the process
Thank goodness someone listened
They were friendly
I feel easy and comfy to speak to FTSU
Being able to speak to someone who listened was so good
I got reassurance from FTSU that I hadn't had before
The reassurance I got from the FTSU Guardian has been amazing, thanks for all your help
Yes, all is ok now
The FTSU Guardian made me feel listened to and respected
When you have been a victim of bullying you lose faith in yourself, the system you work for, however knowing that there is a support group of people who are there to listen and guide you gives you the confidence to speak up and make a stand
Being listened to was so reassuring for me, I will certainly come to FTSU again if needed

FTSU Action Plan – Following on from Board Self-Assessment in June 2023	Date initiated	15/06/2023
	Date of update	March 2024

Accountability		Responsibility	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Karen Dawber - Chief Nurse	People Academy Executive team meeting	Sue Franklin – FTSU Guardian and Associate Chief Nurse	FTSU Operational Meeting

Aim	Objective Ref		Expected Outcome	Assurance Mechanism	Review date
For the Board to be assured that they are proactively overseeing the role of FTSU at BTHFT and a commitment that speaking up must come from the Board in order to develop a speaking up culture across the organisation.	1	All staff feel safe and can confidently share their voice and speak up and are supported to do this.	Improved scoring in the staff satisfaction survey in regard to the questions relating to FTSU.	Board of Directors and People Academy	June 2024
	2	Regular update to the Board that include outcomes and examples so that lessons are learned and care improves as a result.	Examples of learning included in regular Board updates.	Board of Directors and People Academy	June 2024

Communications plan				
What?	**Who?**	**By whom?**	**How?**	**How frequently?**
Action Plan Support	Deputy FTSU Guardian	**LeeAnne Elliott**	Via FTSU Operational Group	6 weekly
Action Plan Oversight	Chief Nurse	**Karen Dawber**	People Academy by way of the quarterly reports	Quarterly
Action Plan Management	FTSU Guardian - Associate Chief Nurse Quality	**Sue Franklin**	Via FTSU Operational Group	6 weekly

1

	Improvement			

Change team members			
Name	**Job title**	**Contact details**	**Initial**
Sue Franklin	FTSU Guardian, Associate Chief Nurse		SF
LeeAnne Elliott	Consultant Radiologist		LE
Karen Dawber	Chief Nurse		KD
Karen Walker	Non-Executive Director		KW
Cat Shutt	Head of Organisational Development		CS

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

Objective	1	Principle 1 – Valuing speaking up - For a speaking up culture to develop across the organisation, a commitment to speaking up must come from the top

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1.1	The Executive lead should be accountable for the: • Fair and inclusive recruitment of the FTSU team. • Capacity of the Guardian and ring fenced time – Checks and balances to show that this is sufficient and effective for all aspects of the Guardian job description.	KD	03/10/23	April 2024	**O**		Time has been reviewed and the Guardians time will be increased once the PPE hub closes in April 2024.	
1.2	The Non-Executive Director responsible for FTSU should be able to: • Ensure that there is sufficient Board support for speaking up and wider cultural transformation. • Challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking up culture.	KW	03/10/23	Originally April 2024, revised to September 2024	**OC**		Chairing the People Academy – Opportunity to challenge further. Quarterly meetings with the Chair and CEO To be part of inward Board development	

Objective	2	Role-model speaking up and set a healthy Freedom to Speak Up culture

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
2.1	The person responsible for Organisation Development can evidence that they have a crucial role in promoting a speaking up culture and behaviours – especially in ensuring that this permeates throughout the organisation, eg building widespread cultural change.	CS	03/10/23	September 2024	OC		Ongoing Civility work led by the OD team. FTSU Guardian is a member of the Civility Programme Board.	

Objective	2	Role-model speaking up and set a healthy Freedom to Speak Up culture						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
							New People Officer commences April 2024	
2.2	The Executive lead can evidence that the leaders in this organisation role model behaviour that leads to a healthy speaking-up culture.	KD	03/10/23	Revised to September 2024	**OC**		Presented to the Council of Governors in March 2024	
2.3	The Executive lead for FTSU is assured that all staff are completing the FTSU eLearning modules, Speak up, listen up and follow up.	KD	03/10/23	Ongoing	**O**		Jan/Feb 2024 – Started to include FTSU training in the investigation recommendations Training access shared at inductions and presentations by the FTSU team. Is not mandated	

Objective	3	Make sure workers know how to speak up and feel safe and encouraged to do so						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
3.1	That staff know how to access the FTSU policy on the intranet and are aware of how they can raise concerns.	KD	03/10/23	December 2024	**O**	December 2024	New policy on staff intranet and shared at induction and presentations and promotional work.	Policy Ratified and uploaded
3.2	The FTSU team need to regularly communicate and promote FTSU throughout the Trust.	SF/LE	03/10/23	October 2024 and ongoing	**O**	October 2024 and ongoing	Regular promotional calendar dates throughout the year. Speak up month every October.	Lets talk, global emails, posters etc.
3.3	Plan the communication strategy for FTSU alongside the Communication team to ensure that we are reaching the whole workforce.	SF/LE	03/10/23	April 2024	**O**	March 2024	Regular Let's Talk articles published across the Trust. Screen saver booked on	

Objective	2	Role-model speaking up and set a healthy Freedom to Speak Up culture						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
							different months throughout the year.	

Objective	4	When someone speaks up, thank them, listen and follow up						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
4.1	Ensure that there is support for managers and leaders to handle speaking-up concerns by training on listening and providing emotional and psychological support.	KD/CS	03/10/23	April 2024	**O**		Civility toolkit launched for staff. Development leadership courses for staff available. Partially completed, will work with new Chief People officer to further develop	
4.2	Create support material for managers to help them create healthy, business as usual, speaking up cultures.	SF/CS /LE	03/10/23	April 2024	**C**	February 2024	Civility toolkit launched for staff.	

Objective	5	Use speaking up as an opportunity to learn and improve

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
5.1	The FTSU Guardian and Executive lead must identify patterns, trends and potential areas of concern. By using other data and information to show 'hotspots' and to identify what aspects of patient safety and quality, worker wellbeing and culture need attention.	KD/SF	03/10/23	May 2024	O		Graphs and trend data reported through to the People Academy on a Quarterly basis. Q4 23/24 data presented in May will show full year impact including more detailed trend data and EDI data.	

Objective	6	Support guardians to fulfil their role in a way that meets workers' needs and NGO's requirements

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
6.1	The Executive lead must ensure that the FTSU Guardian and team have enough time in their role to fulfil all aspects of the role that meets the NGO standards.	KD	03/10/23	April 2024 then ongoing	**O**		Plan to increase the number of FTSU Ambassadors and FTSU Guardians.	
6.2	The Executive lead will work with other senior leaders to ensure speak up cases are progressed in a timely manner.	KD	03/10/23	December 2024	**C**	December 2024	FTSU guardian has regular one to ones with the Executive lead where any delays are highlighted. Close working with HR director to ensure progress in line with any Trust processes	

Objective	7	Identify and tackle barriers to speaking up

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
7.1	The Guardian and FTSU team must have strong connections with the staff networks to be able to make a difference to staff speaking up.	SF	03/10/23	October 2023	**C**		The FTSU Guardian is a member of the Equality, Diversity and Inclusion Council and meets with the EDI leads regularly.	
7.2	The Non-Executive lead for FTSU should have sight of any grievances that involve allegations of detriment through speaking up.	KW	03/10/23	October 2023	**C**		The Non-Executive Director is informed of any allegations of detriment.	

Objective	**8**	**Continually improve our speaking up culture**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
8.1	The FTSU improvement strategy should set out clearly how speaking up fits in with the organisation's overall strategy and how it supports the delivery of related strategies.	KD/SF	03/10/23	April 2024	**O**		PSIRF – Proactive highlights from FTSU. Agenda item at QUoC. Insight data from the CLIP report and links with the Patient Safety Specialists.	
8.2	We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up.	KD	03/10/23	October 2023	**C**	October 2023	We review the concerns post closure and gain their views on the process and level of confidence.	

BO.7.24.11 - NURSING & MIDWIFERY STAFFING ESTABLISHMENT REVIEW

REFERENCES

Only PDFs are attached

- Bo.7.24.11 - Appendix 1 Nursing and Midwifery Staffing Establishment Review Presentation June 2024 PA.pdf
- Bo.7.24.11 - Nursing and Midwifery Staffing Establishment Review (cover).pdf
- Bo.7.24.11 - Appendix 2 Nursing and Midwifery Staffing Establishment Review.Report.Bi-annual mat staffing paper April 2024.pdf
- Bo.7.24.11 - Appendix 3 Nursing and Midwifery Staffing Establishment Review Red Flag Report 1 September 2023 to 29 February 2024.pdf
- Bo.7.24.11 - Appendix 4 Principles and documents supporting Safer Staffing Review.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Appendix 1

Strategic Nurse and Midwifery Staffing Review

Karen Dawber
Chief Nurse
June 2024

Introduction

Bradford Teaching Hospitals
NHS Foundation Trust

The establishment review paper focused on 2 areas:

1. Acuity, dependency and risk.
2. Business case development.

The slides describes the detail where there has been a request for change in nursing establishments and the recommended action of the Chief Nurse.

The areas identifying a requirement to produce a business case will do this in line with the Trust process outside of the establishment review.

Principles

Bradford Teaching Hospitals
NHS Foundation Trust

- All areas have been reviewed in line with national quality board standards, however only the areas where a change has been recommended are included.

- The principle of 1 Band 7 with 0.5% WTE supervisory time and 2 band 6 registered nurses remains in place for in-patient wards.

- The headroom applied to nursing establishments is 21.5% for all areas and 24.3% for Maternity.

- Confirm and Challenge meetings in place to support effective rostering and optimise staff availability.

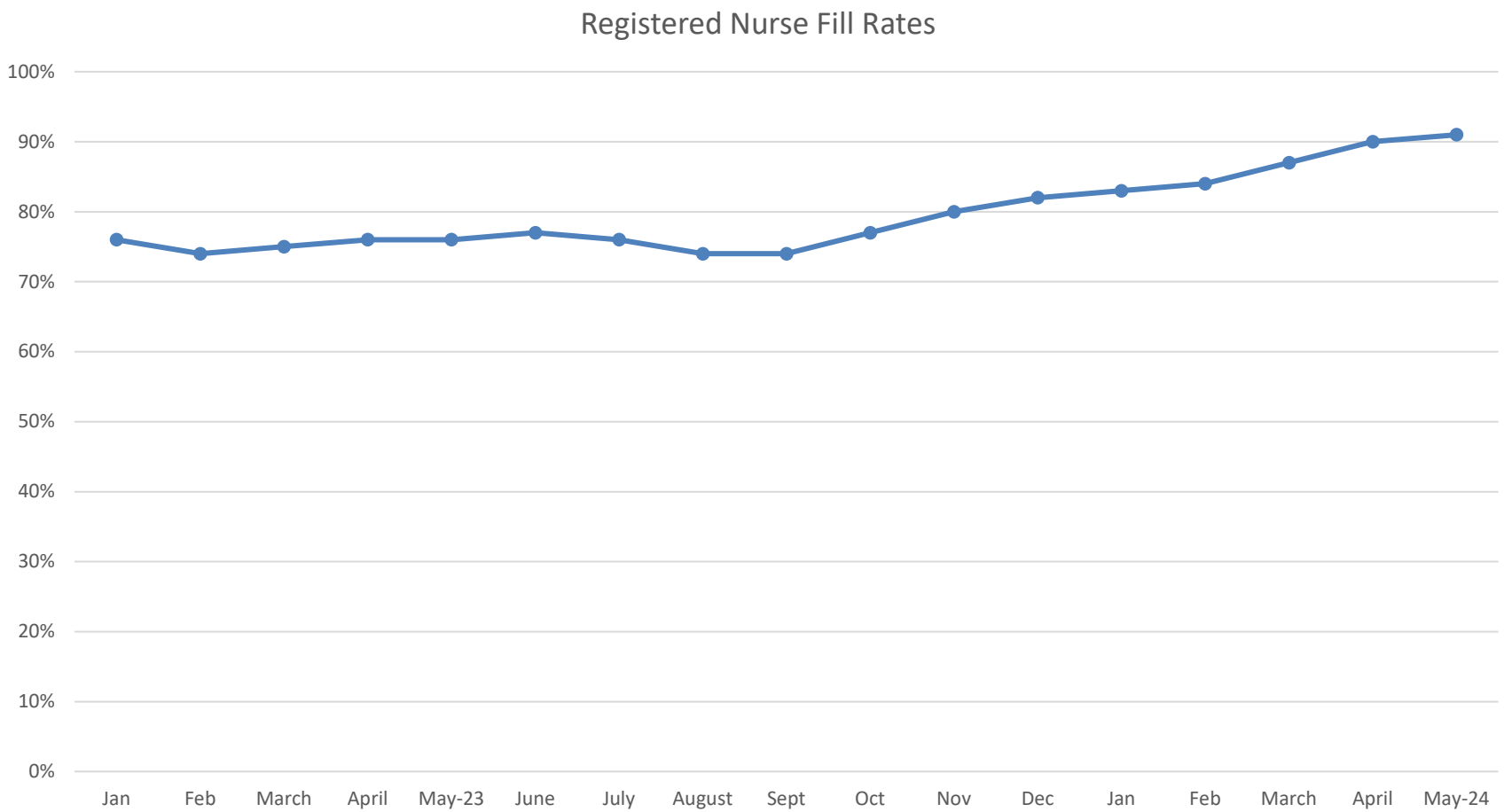
Principles

Bradford Teaching Hospitals
NHS Foundation Trust

- Processes are in place to monitor workforce and patient safety metrics to identify any specific areas of risk.
- Processes are in place to proactively manage staffing, escalate concerns and mitigate risks via Matrons, Command Centres and on call teams.
- Where workforce gaps are identified in the current establishment recruitment will be prioritised for those areas.
- To continue to monitor and report shift fill rates and impact on patient care and delivery.
- All areas remain under review but where specific requests have not been recommended through this review there will be enhanced focus and oversight.

Registered Nurse Shift Fill Rates

Bradford Teaching Hospitals
NHS Foundation Trust



Safer Staffing Principles

- Professional Judgement (PJ)
- Outcomes (OC)
- Evidence Based Tools. (EBT, eg SNCT, Birthrate Plus)

Figure 1: Principles of safe staffing

Safer Nursing Care Tool

Bradford Teaching Hospitals NHS Foundation Trust

Evidence based tools are available for:

- Adult Inpatient Wards in Acute Hospitals.
- Adult Acute Assessment Units.
- Children and Young People's Inpatient Wards in Acute Hospitals.
- Emergency Department Safer Nursing Care Tool.

The tools were updated 2024 to include two additional categories:

1C: Patients requiring continuous observations (Enhanced care).

1D: Patients requiring continuous observation by two members of staff.

Plan:

- All areas will receive training on the updated tools during the summer.
- The tool will be deployed in Autumn (with clinical oversight of accuracy and recording).
- Results will be reviewed alongside PJ and OC and recommendation put forward as part of the next 6 monthly review.

Acute Dialysis Unit

Bradford Teaching Hospitals
NHS Foundation Trust

The Acute Dialysis Unit, establishment is 9.25 WTE,

1 Band 7.

6.79 Band 5.

1.45 Healthcare Assistants.

Request to uplift 2 Band 5 posts to 2 Band 6 posts to allow a Senior nurse (band 6 or above) to be available on all shifts. (PJ)

Cost of uplift £14,729.

Outcome:

No change to establishment recommended at this time.

Plan:

- To continue to review in line with safe staffing principles and the leadership of the Band 7.

Ward 23

Bradford Teaching Hospitals
NHS Foundation Trust

Ward leadership team have reported increase in patient dependency, (PJ) and increase in PALs and complaints noted. (O).

Immediate action to support ward area by Chief Nurse, Director and Deputy Director of Nursing and Matron in place. Advice from subject matter experts as needed, and Quality Summit meetings established with oversight of improvement plan.

Request to increase HCA assistant numbers by 6.84 WTE,
Cost of increase: £264,556

Outcome:
No change to establishment recommended at this time.

Plan:
- To continue to review Ward 23's staffing model in response to patient acuity.
- To undertake SNCT to determine optimal nurse staffing levels.
- To reduce HCA, vacancy gap, currently 2.0 WTE.
- To continue Quality Summit and provide senior support to the Ward Leadership team.
- To continue to monitor Red Flag data.

Ward 27

Bradford Teaching Hospitals
NHS Foundation Trust

In response to patient dependency and care needs (PJ) the Ward Leadership team have recommended the following changes:

- A reduction of Registered Nurses by 8.0 WTE.
- An increase in Nursing Associate 2.76 WTE.
- The appointment of Rehabilitation Support workers, Senior HCA and Trainee Nursing Associates.

Cost of skill mix change £-29,511.

Outcome:

Establishment change recommended.

Plan

- To monitor impact of skill mix review, via outcome measures, staff deployment metrics and SNCT.

Ward 28

Bradford Teaching Hospitals
NHS Foundation Trust

The Ward leadership team and Matron have reported an increase in patient dependency, acuity, and patients at risk of falls (PJ) (O).

The Ward is working with the Trust's Falls lead, to reduce the risk, however additional HCA's have been used to provide enhanced care.

Request to increase HCA assistant numbers by 1 per shift.

Outcome:

No establishment change recommended at this time.

Plan:

- To prioritise HCA recruitment to reduce vacancy gap, currently 7.3 WTE.
- To use the updated SNCT to determine optimal nurse staffing levels and need for enhanced care.
- Continue collaboration with Trust Fall's lead.
- To continue to monitor Red Flag data and harms data, (falls, pressure ulcers, infections).

AMU Ward 1

Bradford Teaching Hospitals
NHS Foundation Trust

As patient length of stay has increased within AMU, the Ward Leadership team have requested an increase in the number of HCA's to support the delivery of care. The request is for an additional HCA on each shift, increasing from 3 to 4 HCA's.

Cost of uplift: £173,466

Outcome:

No establishment change recommended at this time.

Plan:

- To use the updated SNCT for Acute Assessment areas to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag data and harms data, (falls, pressure ulcers, infections).

AMU Ward 4

Bradford Teaching Hospitals
NHS Foundation Trust

The Ward leadership team have identified an increase in patient dependency and acuity (PJ). AMU has 24 beds, as the three surge beds opened in October 2022 are still in use.

Request to increase from 4+3 (plus a registered nurse twilight shift) to 5+4 (Day and Night). An increase of RN and HCA's.

Cost of Uplift £454,197

Outcome:

No establishment change recommended at this time.

Plan:

- To use the updated SNCT for Acute Assessment Units to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag data and harms data, (falls, pressure ulcers, infections).
- To consider closing the 3 additional surge beds.

Ward 6

Bradford Teaching Hospitals
NHS Foundation Trust

Ward 6 is currently open to 27 beds but does increase to 33 beds in response to increase demand and operational pressures. The Ward establishment is set for 27 beds.

Cost of increasing the number of beds to 33: £454,545

Outcome:

No establishment change recommended at this time.

Plan:

- To capture when surge capacity used.
- To use the updated SNCT to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag data and harms data, (falls, pressure ulcers, infections).

Emergency Department

Bradford Teaching Hospitals
NHS Foundation Trust

Due to sustained pressure within the Adult Emergency Department (ED) and the creation of additional zones and seating areas to accommodate patients, a review of staffing has been undertaken by the Department Leadership team.

The review suggests ED's establishment needs to be updated to reflect patient acuity, demand and patient's flow through the department.

Outcome:

No establishment change recommended at this time.

Plan:

- To use the Emergency Department SNCT to determine optimal nurse staffing levels.
- To review the impact of changes made to the urgent care pathway and flow of patients through the ED.
- To develop a Business Case to outline the investment required to reflect the changes in ED over the last 24 months and what is needed to support the department to respond to future demands.

Childrens Staffing:

Bradford Teaching Hospitals
NHS Foundation Trust

NNU skill mix within existing establishment

- No changes affecting budget proposed.
- To extend the Senior Nurse supervision of the Special Care area of the unit from 07:30-17:30 7 days a week to 07:30-20:00.
- This will be achieved by utilising the existing band 6 budgets to provide 07:30-20:00 cover.
- Role has successfully created a support and education structure for junior staff and families in the clinical area.

Outcome:

Establishment change recommended.

Specific Request

Bradford Teaching Hospitals
NHS Foundation Trust

To increase Ward Management time from 0.5 WTE to 1.WTE for several wards and departments.

Estimated cost £25,472 per ward.

Outcome

No establishment changes recommended at this time.

Plan:

To review the specific responsibilities and risks associated with Westbourne Green and Westwood Park as uplift previous agreed (October 2023) once fully established).

Business Case Development:

Bradford Teaching Hospitals NHS Foundation Trust

Update on the areas requiring business case development to support the review:

- **Emergency Department:**
- **ENT and Ophthalmology Outpatients:** Increase in activity, treatment and complexity, business case required for increase in HCA's.
- **Endoscopy:** New unit planned for April 2025, a business case to request 12.8 wte B5 is in development.
- **Critical Care:** critical care network for ICU recommend a 35% uplift to unit budget from 21.5% to create sufficient headroom for all training requirements. This has not been adopted by Trusts in WYAAT.

Maternity Staffing:

Bradford Teaching Hospitals NHS Foundation Trust

Additional information is available via the Bi Annual Midwifery Staffing Report.

Recommendations:

- No additional financial requests in this paper and analysis, Board of Directors and People Academy previously approved the uplift in headroom to 24.3%.
- To continue to support the services proposal that to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care.
- To continue to support the long-term commitment to fund the establishment required to provide Midwifery Continuity of Carer Model as a default position.
- Given the 2024/25 financial pressures, defer the request to implement the Consultant Midwife for Reducing Inequalities until 2025/26.

Summary:

Bradford Teaching Hospitals
NHS Foundation Trust

The total changes recommended and supported by ETM as part of the establishment review is:

- A skill mix review on Ward 27 Cost Reduction £29,511.
- A skill mix review with the Neonatal Care unit: Cost Neutral.
- Where trainee nursing associates (TNA's) have progressed into registered nursing associates (RNA's) the budget will be realigned as required.

This does not result in any reduction in post that requires a change management process.

This does not include areas of business case development which will be assessed on a case by case basis as part of the Business Case and planning committee processes.

Recommendations

Bradford Teaching Hospitals
NHS Foundation Trust

- The Executive team are assured of the process undertaken and asked to support the recommendation of Chief Nurse. Where there are areas that have requested a change and this has not been recommended the Executive team are assured of the ongoing oversight and review in line with the National Quality Board recommendations.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.11

NURSING AND MIDWIFERY STAFFING ESTABLISHMENT REVIEW JUNE 2024

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Sean Willis Associate Chief Nurse Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the outcome and recommendation of the Chief Nurse 6 month strategic staffing review for June 2024	
Key control	This paper is a key control for the strategic objective to provide outstanding care for patients.	
Action required	For assurance	
Previously discussed at/ informed by	ETM 24.06.24 (E.6(4).24.9)	
Previously approved at:	*e.g. Academy / ETM / CSU group*	**Date**
	ETM	24/06/2024
	People Academy	03/07/24

Key Options, Issues and Risks

This paper provides an overview of the nursing and midwifery establishment reviews. The Chief Nurse is required to agree the staffing establishments and review these establishments on a 6 monthly basis to ensure safe, effective, and sustainable staffing in the right place, at the right time with the right skills.

There remain challenges in relation to high accident and emergency attendance, high patient acuity, increase complexity of physical and mental health presentations for adults and children, increased deconditioning and frailty in older adults and the need to maximise planned care.

The slide set (Appendix 1) shows a summary of the outcome and recommendations, Appendix 2 shows the detail of the Maternity Staffing review and Appendix 3 is a copy of the maternity red flag report.

The process was undertaken with consideration given to NHS England's Professional Judgement Framework for Safe Staffing. Where service developments have been identified or significant reviews needed, these will be considered as part of a formal business case process and are excluded from the recommendations of the review.

Requests which have not been supported by the Chief Nurse at this time have been included for information and assurance.

The paper summarises the outcome of the Chief Nurse's recommendation.

- To support the recommended skill mix review on Ward 27 to reflect the rehabilitation and care needs of patients who are medically fit for discharge. The Ward Leadership team have recommended a reduction of Registered Nurses and an increase in Nursing Associates, Healthcare assistants and Rehabilitation Support workers. This change is a cost reduction of £29,511

- To support a skill mix review within the Neonatal Unit, to extend the Senior Nurse supervision of the Special Care area of the unit from 07:30-17:30, 7 days a week to 07:30-20:00. This will be achieved by utilising the existing band 6 budgets to provide 07:30-20:00 cover. The Senior Nurse role has successfully created a support & education structure for junior staff and families in the clinical area. This change is cost neutral.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.11

Establishment change requests which have not been supported at this time are:

- Ward 23
- Ward 28
- AMU 1
- AMU 4

For all of these areas, to mitigate any specific risks we will:

- Prioritise recruitment to reduce their current vacancy gap.
- Undertake a safer staffing review, using the updated validated Safer Nursing Care Tool (SNCT) to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag and harms data, (falls, pressure ulcers, infections).
- To continue to collaborate with subject matter experts to support with specific safety concerns, (falls reduction, pressure ulcers, infections).
- To continue to proactively manage staffing risks to ensure we provide safe care across our wards. These include the use of bank staff, daily monitoring of staffing levels, escalation processes, senior oversight of any unmitigated staffing concerns and formal processes to flag and record staffing concerns in and out of hours.
- Continue to report shift fill rates for Registrants and Healthcare Assistants monthly.
- Continue Confirm and Challenge meetings to support effective rostering and optimise staff availability.

Adult Emergency Department.
Due to sustained pressure within the Adult Emergency Department (ED) and the creation of additional zones and seating areas to accommodate patients, a review of staffing has been undertaken by the department leadership team. The review suggests ED's establishment needs to be updated to reflect patient acuity, demand, and patient flow through the department.

Although a change of establishment has not been recommended at this time, the scale of the changes needed to support ED to provide outstanding care and prepare for future demand requires a workforce review outside of the establishment review process and an opportunity to assess the impact of changes made to the urgent care pathway and how these impact on ED.

We will undertake a safer staffing review, using the Emergency Department SNCT to determine optimal nurse staffing levels to be included alongside professional judgement, and outcome measures to inform the business case development with ED's Senior team.

Ward 6
Ward 6 is currently open to 27 beds but does increase to 33 beds in response to increase demand and operational pressures. The current Ward establishment is set for 27 beds, the cost of increasing the number of beds to 33 would require an increase in nursing and support staff.

The cost of opening ward 6 up to 33 beds is £454,545.

Although no establishment changes are recommended at this time, we will monitor the times surge capacity is used and continue to monitor patient safety data.

Critical Care Uplift.
We are aware of a recommendation from the West Yorkshire Critical Care network for organisations to consider an increase in the uplift to 35% to support professional development expectations. Currently we are not aware of any organisation within WYAAT who have increased their establishments to reflect this recommendation.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.11

Nursing Associates

Where trainee nursing associates (TNA's) have progressed into registered nursing associates (RNA's) roles the budget will be realigned as required. This will not lead to any reduction in post that require a change management process.

This paper provides the required assurance that Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) plans safe nurse and midwifery staffing levels across all wards and other departments.

To provide greater transparency, the paper provides detail of the strategic staffing review undertaken in line with the National Quality Boards requirements. The principles for undertaking safer staffing reviews are set out by the National Quality Board and Professional Judgement Framework, summarised in Appendix 4.

Analysis

Following review of all the areas, recommendations have been made as detailed in Appendices 1 and 2, with additional information in Appendix 3.

There has been significant progress in terms of developing the recruitment, retention, and recognition work plans across nursing and maternity services in line with national objectives and priorities.

There is an increased focus on the retention of the nursing and midwifery workforce, and we have seen a reduction in nursing and midwifery turnover rate over the last 12 months.

The process to agree the recommended establishment included, Directors and Deputy Director of Nursing, Deputy Chief Nurse, finance, human resources, and the Chief Nurse.

The principles set out in NHS England's *Professional Judgement Framework: A guide to applying professional judgement in nurse staffing reviews* was also considered when recommending this establishment review.

Recommendation

- The Executive Team (ET), Academy and Board of Directors (BoD) are assured of the process undertaken as part of the review in line with national recommendations.
- The ET, Academy and BoD are asked to support the recommendation of the Chief Nurse for the 6 monthly strategic nursing and midwifery staffing review.
- The recommendations will begin with immediate effect if approved and the budgets and the rostering system will reflect the changes recommended.
- The ET, Academy and BoD are asked to note that where there is a change in service delivery the staffing implications will be presented as part of a business case from the Clinical Service Unit with Chief Nurse oversight of the recommendations related to nurse or midwifery staffing.

The recommendations for maternity include:

- There are no additional financial requests.
- To continue to support the services to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care.
- To continue to support the long-term commitment made in 2021, to fund the establishment required to provide Midwifery Continuity of Carer Model as a default position.

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- Given the 2024/25 financial pressures, defer the request to implement the Consultant Midwife for Reducing Inequalities until 2025/26

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: Staffing
NHS England Effective Use of Resources: People
Other (please state):

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

Appendix 1 - Strategic staffing review presentation.
Appendix 2 - Maternity Staffing Review Report Bi-annual maternity staffing paper April 2024.
Appendix 3 - Copy of red flag report March to August (Maternity).
Appendix 4 - Principles and documents supporting Safer Staffing Review.

BI-ANNUAL MIDWIFERY STAFFING REPORT, APRIL 2024

Background:

This is the first of the bi-annual midwifery staffing reports for 2024 and follows the September 2023 paper presented to People Academy and Trust Board in October 2023.

In addition to the bi-annual midwifery staffing reports, Quality and Patient Safety Academy/Trust Board has been appraised of the midwifery workforce position monthly, as part of the Maternity and Neonatal Services reporting process.

The September 2023 paper concluded that the services priorities remained largely unchanged from the previous bi-annual recommendations and would continue to manage vacancy and recruit to the calculated establishment required to achieve safe staffing based on existing Midwifery Continuity of Carer (MCoC) models and pathways of care.

The service had identified that the increased Trust mandatary training requirements, plus the maternity specific core competency framework requirements had increased significantly and that this exceeded what was currently built into the current 22% built in headroom. People Academy and Trust Board approved the recommendation for an increase in 'headroom' to 24.3% to support the delivery of training compliance.

The second priority was to incrementally increase the midwifery workforce to introduce more MCoC teams with the ultimate ambition of achieving MCoC as a default position for all women. This approach is in line with National Maternity Transformation ambitions, a recommendation which remains unchanged except for the removal of a target date for achieving.

The Birth Rate Plus acuity tool had been commissioned and commenced in autumn 2023. The report is still to be finalised and a separate paper will be produced which will include the recommendations and aspirations for the service.

There were no additional financial requests for Trust Board consideration in the September paper and analysis.

The Trust Board was supportive of the recommendations and agreed to continue to support the long-term commitments previously made to fund the establishment required to provide MCoC as a default position and recommission the full Birth Rate plus tool in autumn 2023.

Previous bi-annual midwifery staffing reports have included recommendations required to work towards meeting the Royal College of Midwives (RCM) Leadership Manifesto, which in turn is an Ockenden 2020 assurance standard. To date the Board have been supportive of the recommendations made by the service.

The purpose of this report is also to evidence:

- A systematic, evidence-based process to calculate midwifery staffing establishment.

- Trust Board to evidence midwifery staffing budget reflects required establishment in line with Birth Rate Plus.
- The services are meeting the following national safety standards:
    - midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
    - All women in active labour receive one-to-one midwifery care.

This report provides the minimum evidential requirement for the Trust Board to meet Maternity Incentive Scheme (MIS), year 6, safety action 5 standard.

The review uses a methodology of professional judgement, Birth Rate Plus / birth to midwife ratios and a review of red flag and incident data.

Current Midwifery staffing position:

The Midwifery staffing position has remained challenging between the reporting periods 1 September to 29 February 2024 amid the continuing backdrop of well-publicised, national midwifery shortages.

The maternity service has been pro-active in having a 'rolling' recruitment process throughout the year as well as engaging in the Trust recruitment open days. This has resulted in small numbers of band 5 and band 6 midwives joining the team and has managed the expected annual attrition rates but has not impacted on the required increase to the establishment. The service has also successfully recruited International Midwives resulting in a small number of internationally trained midwives joining the Nursing and Midwifery Council (NMC) register and the midwifery and neonatal service.

Recruitment and challenges:

The vacancy figures for safe staffing at the end of February (6 months from the last report) was 7.04 whole time equivalent (WTE) and vacancy from the funded establishment was 32.46 WTE.

The vacancy rate for safe staffing at the end of April 2024 was 10.34 WTE and 35.76 WTE for the funded establishment.

It was proposed in the last paper that 23 newly qualified midwives (NQM) (21.29 WTE) would commence in post by January 2024, following the 2023 Local Maternity and Neonatal System (LMNS) recruitment. 21 WTE (19.41 WTE) NQM's commenced in post of which 2 (1.52 WTE) midwives are currently on maternity leave. 1 midwife (0.61 WTE) is still due to commence in post in June 2024 following a deferred start date.

A further 2 (1.92 WTE) midwives were also recruited from the centralised recruitment process and commenced in post during the same period.

There are 3 band 5/6 midwives (2.21 WTE) currently in the recruitment process and are due to commence following completion of their notice period and confirmation of HR checks.

The service has participated in the West Yorkshire and Harrogate (WY&H) LMNS centralised NQM recruitment campaign for the fourth year running. A verbal offer of employment has been given to 36 candidates (31.33 WTE).

Introducing 36 NQM's into the workforce will not be without its challenges. A more creative approach will be taken this year to ensure a robust induction, orientation, and preceptorship programme for all the candidates, by including rotation and time with the specialist areas of the services such as antenatal screening, quality and safety etc. These plans will focus on ensuring that the current workforce can provide the required support to the NQM's as well as the student midwives in clinical placement, without being overwhelmed, but also that the NQM's receive the time and support they require in their transition to becoming a registered midwife and practicing independently.

Workforce initiatives:

The service is currently supporting 5 International Midwives and 1 International Nurse. A protracted supernumerary period was required for 4 International midwives to ensure they have the skills and competency to practice safely and independently. They have recently started to work with indirect support and are now included in the midwifery staffing establishment on labour ward. The 5th and final internal midwife only commenced in June 2024 and is working supernumerary.

The service continues to support the career development of 2 Maternity Support Workers (MSW). 1 MSW commenced the apprentice midwifery programme at the University of Huddersfield in March 2023 and the 2nd MSW commenced in September 2023. Positive feedback has been received from both the apprentices who are enjoying their training and from the University in relation to their dedication and progress.

The Director of Midwifery has recently completed an improving population health fellowship with a project focused on raising the profile of midwifery amongst South Asian secondary school students. Engagement work has commenced with student representatives of the local population including visits to Bradford schools.

In March 2024, 5 nurses employed by the Trust commenced the MSc Midwifery (Shortened programme) which is a 2-year blended learning programme. These dual trained skilled staff will be of great addition to the service in 2026.

Retention:

The service has continued to focus on the wellbeing and retention of the workforce and has several strategies in place to support NQM, International Midwives, MSW's apprentices and staff new to the organisation:

- Substantive band 7 Specialist Midwife for Pastoral Support
- A Legacy Midwife (experienced midwives working alongside new staff in clinical practice)

- Robust preceptorship package
- Access to Professional Midwifery Advocates (PMA)
- A change in Band 7 job portfolio to support and develop MSW's and the midwifery professional development training plan.
- Early intervention and support for staff considering leaving the service or profession and ensuring there is information gained which the service can learn from when staff do leave the organisation.
- Development of a 'Diverse Workforce Forum', acknowledging the national and locally reported challenges staff from Black and Asian Minority Ethnic groups, experience of career progression
- There are several staff who have reported work related stress following a request that they rotate to another clinical area. Midwifery rotation is essential to maintain a safe service and ensure midwives have the skills to provide maternity care in all areas. Support from Occupational Health and Human Resource leads has been requested to help address this.

Sickness and Absence:

Midwifery and maternity staff sickness and absence rates as of February 2024 were as follows (rates above the 5.5% target are highlighted in yellow):

	FTE Days Sickness	FTE Days Available	% FTE Days Sickness	Year to Date %
389120003 Central Costs-Obs & Gynae	0.00	348.00	0.00%	**0.69%**
389121202 Maternity Assessment Centre	4.13	146.84	2.81%	**4.69%**
389121203 Mat-Ward M3	0.00	348.31	0.00%	**1.77%**
389121204 Mat-Ward M4	40.39	454.15	8.89%	**12.54%**
389121205 Labour Ward	10.97	841.06	1.30%	**1.92%**
389121207 Mat - Del Suite Theatre	43.21	162.79	26.55%	**8.20%**
389121208 Women's Health Unit	26.33	495.52	5.31%	**5.88%**
389121211 Antenatal Clinic	7.68	203.73	3.77%	**6.04%**
389121212 Community Midwifery	26.52	426.11	6.22%	**12.35%**
389121215 Mat - Midwifery Admin	0.00	52.20	0.00%	**0.64%**
389121224 Birth Centre	6.60	182.92	3.61%	**6.30%**
389122019 Pat Admin-BRI Maternity	7.99	395.17	2.02%	**6.74%**
389124321-Midwives	377.96	5,604.55	6.74%	**6.23%**
389M21229 Better Start Lottery Funding	0.92	198.76	0.46%	**1.63%**
389M24485 Specialist Midwife	67.28	585.03	11.50%	**5.96%**
389M24486 Smoking Cessation	0.00	100.53	0.00%	**0.00%**

Staff remain stressed, tired and continue to demonstrate reduced resilience, which not only affects short term absence. This is reflected in the NHS staff survey and Survey Culture and Engagement Survey Results (SCORE). Meetings are being held with staff in all areas to develop the top 2-3 priorities for improvements based on the survey findings.

The Maternity Matrons continue to closely manage long term sickness and absence alongside HR colleagues in line with Trust policy.

The Outstanding Maternity Services Workforce work stream also continues with several wellbeing initiatives such a ‘hug in a mug’ and ‘wellbeing tea trolleys’ which have been positively evaluated by staff. The service also actively engages with the Trust Thrive initiatives.

Mitigation:

Safety has been maintained across all areas of the unit by daily redeployment of staff, flexing inpatient beds to preserve safe staffing ratios, use of non-clinical and specialist midwives to support clinical areas. The escalation policy is then implemented in situations where activity and acuity are higher than staffing levels can support, diverting, as a last resort, women where appropriate and possible.

Monday to Friday a West Yorkshire & Harrogate (WY&H) daily sit rep is completed and staffing acuity huddle is attended by an operational matron from each hospital to identify service pressures and the ability to support and offer mutual aid. This was instigated following a serious incident at BTHFT and emerging concern managing the number of women requiring induction of labour, specifically an increase in delays due to high levels of activity, challenges with flow and bed capacity and safe staffing levels.

The Birth Rate Acuity app is being introduced which will assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. Training in the use of the tool has taken place and a soft launch planned in June 2024.

Suspension of the intrapartum element of some MCoC teams has continued. The Acorn team (for vulnerable women) recommenced a 24-hour intrapartum on call service 2 to 3 days per week in September 2023. A partial on call service will remain until this team is fully established.

The arrival of NQM in October/November will enable an enhancement of intrapartum care in some of the Midwifery Continuity of Carer (MCoC) teams, but this is likely to be delayed until the New Year.

<u>Obstetric Theatre</u>

There is a current vacancy of 2.12 WTE within the maternity theatre nursing team despite attempts to recruit by general job advert and via Trust open days. This vacancy occasionally compromises safe staffing levels on the Labour Ward, as midwifery staff are required to provide the emergency scrub cover.

Recruitment to these vacancies has been challenging. The first round of recruitment was unsuccessful in appointing suitable candidates. 1 WTE was appointed during the 2nd round of recruitment, and they will commence in September following completion of training.

The Band 6 lead Maternity Theatre Practitioner post is being substantively appointed to. The outcome of this recruitment will inform if a further round of recruitment for Theatre nurses is required.

National standards in relation to Theatre recovery care are not currently being met. Discussions are underway to explore models of care for maternity theatres. The options being explored are keep the current model and put a plan in place to meet the national standards or look at the feasibility of general hospital theatres taking over scrub and recovery responsibility.

MCoC:

Communication from the National Maternity Transformation team in September 2022, informed that the 2024 target to achieve MCoC as a default position for all women, had been removed. Trusts were formally asked to focus on achieving safe and sustainable staffing levels as a priority.

The national message is clear that MCoC is still the ambition, and that whilst the target date has been removed, Trusts should continue to assemble the 'building blocks' required to achieve this at such a time it is safe to do so, working with local, regional and national continuity leads to ensure that this is achieved.

This is very much the approach already taken at BTHFT and whilst no new teams are planned, the service continues to prioritise existing teams developed to support women from ethnic minority groups/vulnerable backgrounds. The removal of a target alleviates a significant recruitment pressure and enables us to evaluate the existing teams and make improvements/amendments as necessary. This approach continues until safe staffing levels are sustained.

The NHS England Maternity Workforce Deployment Tool will be completed to help the service plan how to safely deploy midwives to provide Midwifery Continuity of Carer as the default model of care.

Royal College of Midwives (RCM) Leadership Manifesto:

BTHFT maternity service mainly reflects the outlined recommendations of the Royal College of Midwives (RCM) Leadership Manifesto.

Since the September 2023 report a Head of Midwifery (HOM) Band 8c, is in post and a Band 8b, Deputy Head of Midwifery has been appointed to fulfil the Royal College of Midwives (RCM) Leadership manifesto and achieve compliance with the corresponding Ockenden recommendation.

The addition of Consultant Midwives, as recommended by the manifesto, is the next aspiration for the service. A Consultant Midwife to lead on reducing inequalities would support the service with further progressing, at pace, the local plans to meet the needs of the diverse, income deprived population of Bradford to improve access to care, care provision and outcomes. This post would also support the delivery of the March 2023, Three Year

Delivery Plan for Maternity and Neonatal Services, which has a key focus on reducing inequalities.

Annual Training Needs Analysis:

The 'Three Year Delivery Plan for Maternity and Neonatal Services' published in March 2023 requires trusts to undertake an annual training needs analysis and ensure training is available to all staff in line with the National maternity core competency framework version 2 (v2). Compliance with the core competency framework v2 is one of the safety standards within the Maternity Incentive Scheme (MIS).

A training needs analysis and a 3-year training plan is in place which meets the requirements of the National Maternity core competency framework v2 and is delivered over 5 days (39 hours) per year. This is required for each midwife employed, not whole time equivalent. This also does not include any dedicated protected time for Trust mandatory training or any additional individual training needs, for example leadership development, newborn examination training, professional midwifery advocate training, university modules or external training courses.

Despite the uplift in head room, realising staff to attend 5-days of training days per month remains challenging as maintaining a safe clinical service is paramount. To deliver the training plan 125 midwifery shifts are allocated for training days within the roster per month. Priority is given to ensure midwifery staff are protected with attending Practical Obstetric Multidisciplinary Training (PROMPT) and fetal monitoring training as a minimum.

Calculation of midwifery staffing establishment:

The tools utilised to calculate the required establishment for the birth rate include:

- Birth Rate + tool methodology.
- Midwife to Birth ratio.
- Planned versus actual midwifery staffing levels.
- Supernumerary co-ordinator status and 1:1 care in labour data taken from Cerner and SafeCare.
- Red flag incidents associated with midwifery staffing including mitigation to cover shortfalls.

Birth Rate + tool methodology:

Birth Rate + exists as the only recognised tool to calculate midwifery staffing levels. A report published in April 2021 following a full review. A summary of the report and recommendations was presented at the Executive Team Meeting in May 2021. A subsequent full review was last commissioned in November 2022 and a final report is awaited. This will be shared with the Trust Board in a separate paper once finalised.

A Birth Rate Plus tabletop review was last recalculated for September's 2023 Biannual staffing report to reflect the change in the annual birth rate from 5001 to 5159. The recommendation of 10% non-clinical and management roles was incorporated into the desk top tool.

Year 6 of the Maternity incentive Scheme requires the bi-annual staffing review to include the percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth Rate+ accounts for 8-10% of the clinical person establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

The service now has 29.06 WTE 'Additional Senior Management and Specialist Midwives'.

We have a current funded midwife establishment of 232.39 WTE.

A revised tabletop review has not taken place for this paper in view of the pending Birth Rate Plus report.

As discussed previously, although the target date for achieving MCoC has been removed, the message from National Maternity leaders is clear that MCoC should not be considered until safe staffing levels are achieved. However, achieving MCoC as a default position remains the overarching ambition. The Maternity Service at BTHFT has adopted this position over the last 12 months and at the current time has no intention to progress any new continuity teams or pathways but will continue to focus on women and birthing people from our most vulnerable populations.

Instead, the priority will be achieving the new Birth Rate + requirements for safe staffing levels based on existing MCoC pathways and models of care and then an incremental approached based on the new report findings. It is felt that this incremental approach is realistic and more achievable in the current climate of midwifery staffing shortages.

Trust Board is asked to continue to support the long-term commitment made in September 2021, to fund the establishment required to provide MCoC as a default position. The 2021 Birth Rate plus report calculated this as requiring 279.77 WTE. This new Birth Rate plus report will likely change this figure and a report will be produced to include what this report is calculating in relation to safe staffing figures and the WTE data required to deliver increasing percentages of MCoC.

Midwife to Birth ratio:

Based on the current agreed establishments of 248.2 WTE midwives, we aim for a midwife to birth ratio of 1:20.2. Please note, the figures below include all staff (including maternity leave and long-term sickness and absence) and an agreed over establishment to balance this.

A review of the previous six-month period is as follows:

Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2023	Feb 2023
1: 24.1	1:24.4	1:23.3	1:23.2	1:24.3	1:24.2

The ratio is calculated on the number of midwives employed and does not account for any monthly variations in staffing due to sickness and absence. Please note that this ratio is a Birth: Midwife (as previously described regionally and what was previously reported into the regional dashboard to exclude Band 8 midwives and the specialist midwife for Quality and Safety). This differs from the skill mixed numbers in the Birth Rate Plus tool.

Planned versus Actual midwifery staffing levels:

Details of planned and actual midwifery staffing levels are available to view on the monthly 'Heat map' data produced by the Chief Nurse team. Where staffing levels fall below planned, mitigation includes the redeployment of staff, including specialist midwives, to cover shortfalls. Beds are also reduced if necessary to maintain safe staffing levels. If these actions are insufficient, the maternity escalation policy is triggered and unit 'divert' declared.

Supernumerary labour ward co-ordinator status and the provision of one to one care in labour:

Supernumerary labour ward co-ordinator status:

The labour ward staffing model is as follows:

- 1 x Supernumerary Band 7 co-ordinator.
- 9 x Midwives including an additional Band 7 per shift.
- 1 x Obstetric Theatre practitioner. (This may be a theatre nurse or midwife).

There was 1 reported Red Flag recorded on Safe Care for failure to achieve supernumerary labour ward co-ordinator status, during the 6 months, 1 September 2023 to 29 February 2024.

The co-ordinator provided direct care to an antenatal woman for a short period of time as the midwife allocated to this woman was required as in theatre as the emergency scrub practitioner.

This is an isolated incident and is not a cause for concern and does not affect compliance with the standard described in the Maternity Incentive Scheme.

Provision of one to one care in active labour and mitigation to cover any shortfalls:

The table below demonstrates the monthly one to one care in labour rates taken from Cerner Maternity.

	Sept	Oct	Nov	Dec	Jan	Feb
Received 1:1 Care Overall	85.6%	85.0%	84.5%	90.5%	87.0%	86.6%

This metric is monitored by a Labour Ward Co-ordinator and Matron who review all cases where a no responses or absent response is recorded in EPR. They undertake data quality to ensure the accuracy of the data. This safety standard has been consistent since April 2023 but coincides with the Labour Ward establishment having the most vacancy and the workforce challenges previously highlighted during the same period.

In all cases where 1 to 1 care was not achieved there was no significant harms to mothers or babies.

An audit was undertaken to further understand the reasons 1 to 1 care was not achieved. This audit concluded that due to it being a retrospective audit it was difficult to ascertain what if any factors were instrumental in 1 to 1 care not being achieved and if a universal practice standard was followed.

The implementation of Birthrate plus acuity app will provide oversight of the workload acuity and staffing levels in the intrapartum and ward areas and will aid decision making regarding which area has the greatest clinical needs and risk. The delivery of one-to-one care in labour is a requirement built into the tool and therefore will aid with achieving this critical safety standard.

Maternity Unit 'Closures'

The CQC were concerned by the number of maternity unit closures reported in the 12 months prior to the November 2019 inspection. The NHSE/I Maternity Support Programme team also identified the number of units diverts as an area requiring further attention.

The decision to divert maternity services is often complex, multifactorial, and never taken lightly. Whilst midwifery staffing levels do trigger a need to divert on some occasions, this is never the single root cause and is usually combined with increased admissions to the intrapartum areas and high levels of acuity and complexity.

In the reporting period, 1 September to 29 February 2024, there were 0 full diverts, 15 partial diverts and 17 occasions where the need to divert was declared but the unit remained open due to neighbouring organisations being unable to accept admissions.

Partial diverts are declared when women, usually those requiring intrapartum care, are diverted to another unit, whilst BTHFT maternity continue to triage and see women with

other clinical issues such as reduced fetal movements. Partial diverts also include incidences where neighbouring units can initially accept women and then become unable to accept further, meaning that BTHFT then receive all admissions.

A total of 23 women were diverted to other units for care, some of whom returned to continue care at BTHFT after the event.

There were 17 occasions where the need to divert services was declared but neighbouring units were unable to accept. On these occasions the services continued to triage and admit women who have chosen BTHFT as their care provider.

November 2023 was a particularly challenging month with 5 partial diverts and 4 attempted diverts and this affected the ability to provide one to one care in labour and the quality of care provided to mothers and babies. Workforce and acuity challenges also created a increase in delays in women requiring planned induction of labour and sadly a women experienced a intrauterine death whilst awaiting her induction. This was reported as a serious incident and a detailed investigation completed.

Several immediate actions were taken in response to this incident, including the implementation of the WY&H LMNS daily sit rep and staffing and acuity huddle, Monday to Friday as previously mentioned in this report. A Quality improvement project is ongoing with the aim to reduce induction of labour delays and improve patient experience. This project has already demonstrated a reduction in delays and an improvement with patient experience. The Chief Nurse award was given to the Midwife leading on this quality improvement project at this year's Midwifery and Nursing awards.

Unfortunately, there is no consistent regional or national data available to act as a comparator and indicate whether BTHFT is an outlier in this area. It must also be noted that whilst unit escalation policies across the LMNS and the region are becoming standardised, units have very different ways of addressing capacity and staffing issues which makes it even more challenging to benchmark the BTHFT position.

For example, neighbouring units with more than 1 site rarely divert to other organisations, but frequently divert between their own units. Other organisations do not divert services as an acute response but divert women to other units for elective procedures such as induction of labour. This is not captured as a unit divert.

The updated maternity escalation policy has been brought in line with LMNS and Regional policies and reflects OPEL principles. The variation in how individual organisations consider what constitutes a divert of service, remains a hot topic at both LMNS and Regional level, and it is anticipated that steps to address and standardise this will be taken in 2024.

The table below provides a monthly break down of diverts, partial diverts and attempted diverts during the reporting period.

MONTH	DIVERTS	ATTEMPTED DIVERTS	PARTIAL DIVERTS	NUMBER OF WOMEN DIVERTED
September	0	7	2	5
October	0	0	1	1
November	0	4	5	13
December	0	2	0	0
January	0	3	5	3
February	0	1	2	1
TOTALS	**0**	**17**	**15**	**23**

Number of red flag incidents:

The Maternity Incentive Scheme, Year 6, safety action 5 has maintained the recommendation that Trusts continue to monitor the red flags as per previous year and include those in the six-monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.

Safety events associated with midwifery staffing are reported to the in-phase incident reporting system and are investigated by the maternity team. In the six-month time period 1 September to 29 February 2024 there were 28 reported incidents where service provision issues (eg staffing) was chosen as the incident reporting category.

All incidents were reviewed and graded as no harm and describe an inability to provide a level of care to the expected standard rather than physical harm or poor outcomes for mothers and babies. The 26 reported incidents include unit 'diverts/attempted/partial diverts' or implementation of the escalation policy. Red flag reporting is the default method of reporting shortfalls in staffing unless this has had a direct impact on a patient and then staff are advised to report an incident report.

Collating data from the In-phase system is not an accurate measure of staffing and acuity pressures and their impact on patients care. These issues are however considered as contributor factors when reviewing all clinical incidents reported within the system. Red flag data and the introduction of the Birth rate acuity app will assist in triangulating whether these issues had a direct impact on patient safety events moving forward.

Red Flag incidents are reviewed daily (Monday to Friday) by the midwifery matrons and are included in the daily Maternity SitRep submission to the LMNS.

Agreed Red Flags:

- Failure to provide 1:1 care in labour.
- Number of women waiting >30 minutes for epidural.
- Failure to achieve supernumerary labour ward co-ordinator status.
- Delayed or cancelled critical activity
- Missed or delayed care
- Staffing shortfalls
- Delay in triage after presentation
- Delay in induction process
- Number of women waiting augmentation/induction of labour for >12 hours.
- Delay in medical review
- Delay in transfer to labour ward from the birth centre
- Delay in transfer from MAC to Labour Ward.
- Delay in transfer from inpatient ward to Labour Ward.
- IT connectivity issues
- Unplanned omission in providing medications/delay in providing pain relief
- Delay in morning postnatal medical review
- Vital signs not assessed or recorded
- Additional Capacity Beds

Antenatal clinic does not currently use Safe Care due to their outpatient/session-based working with high variance in cover and activity requirements.

There were 687 Red Flag incidents recorded on Safe Care from 1 September 2023 to 29 February 2023. This is consistent with the number reported in the last 6 monthly report. Appendix 1 provides a breakdown of the red flags raised by area and category.

Key points:

- 102 of the 687 red flags relate to registered midwife (RM) short fall of less than 2 RM* per shift plus a further 194 red flags reporting an RM short fall. This continues to reflect the ongoing staffing challenges. It is possible that there is a small amount of ‘double counting’ and recording of staffing short falls in the 2 different columns, which will be reviewed by the Matron team. The Birth Centre is the highest area for reporting registered midwife (RM) short fall of less than 2 RM* per shift red flags as they often work with 1 midwife and a midwife support work due to staff redeployment.
- 53 red flags were due to delay in medical review and 6 red flags reported due to delay in morning postnatal medical review which is outside the scope of midwifery staffing and this paper. These are escalated to the Clinical Director.

- 42 red flags were reported for an inability to provide 1:1 care in labour for any period. However, this is inconsistent with the actual number of women reported on Cerner who didn't receive 1:1 care overall and suggests an under reporting of red flags pertaining to this area.

- 76 red flags were reported regarding delayed cancelled critical activity. These red flags are mainly in relation to the birth centre being closed due to staffing redeployment, resulting in women being cared for on the labour ward rather than their intended birth centre location or when care cannot be facilitated on the birth centre due to all the rooms being occupied. This data is being captured and reviewed separately as part of the Maternity Unit Self-Assessment (MUSA) framework project.

- 73 red flags were reported regarding delayed transfers to labour ward and 93 red flags for delays in the induction process. These flags coincide with the unit acuity and staffing pressures already described in this report and are reflective of the pressures other units are also experiencing both regionally and nationally. Delayed inductions of labour have been recognised as a safety concern within the LMNS and improvement work is ongoing to standardise the timeframes that Trusts use to constitute a delay in the various stages of the induction process and to share practices which will support a reduction in delays. The Trust also reports IOL delays within the fortnightly National Maternity SitRep. Locally, as part of the Outstanding Maternity Service Women's Journey work steam, the induction of labour subgroup has already implemented a number of improvements within this pathway, for example the use of balloon induction and this has further progressed to the offer of outpatient induction.

- Other red flags were reported but in small numbers. Some of these could have been reported within some of the red flag categories described above. Following the full implementation of the Birth Rate acuity app red flags will be reported via this system.

*It must be noted that clinical areas are never left with less than 2 team members and that staff are redeployed from other areas to maintain minimum safe staffing levels.

Conclusion:

The service believes that this report meets the Maternity Incentive Scheme required standard to demonstrate an effective system of midwifery workforce planning.

A tabletop Birth Rate + exercise has not been conducted since the last 6 monthly review due to the imminent completion of the full Birth Rate plus review commissioned in November 2023. The full report will be shared with the Trust Board along with a separate paper which includes the service aspirations to meet the recommendation.

In the interim the ongoing priorities remain largely unchanged from the previous bi-annual recommendations and are to continue to manage vacancy and recruit to the calculated establishment required to achieve safe staffing based on existing MCoC models and pathways of care. Once this is achieved the priority will be to incrementally increase the midwifery workforce to introduce more MCoC teams with the ultimate ambition of achieving MCoC as a default position for all women. This approach is in line with National Maternity

Transformation ambitions, a recommendation which remains unchanged except for the removal of a target date for achieving.

The service still strives to meet the Royal College of Midwives (RCM) Leadership manifesto and achieve compliance with the corresponding Ockenden recommendation. The next aspiration for the service is the addition of a Consultant Midwife to lead on reducing inequalities. It is appreciated that this will be a significant ask in the current financial climate and the service will defer this request until financial year 2025/26 unless there are any national requests to expedite.

The service remains committed to proactive recruitment and reinforcing the systems and processes in place to retain staff through preceptorship and pastoral care.

Models of care for maternity theatres are being explored to fulfil the National standards in relation to Theatre recovery care.

Despite the uplift in head room, realising staff to attend 5-days of training days per month remains challenging. To deliver the training plan 125 midwifery shifts are allocated for training days within the roster per month. Priority is given to ensure midwifery staff are protected with attending Practical Obstetric Multidisciplinary Training (PROMPT) and fetal monitoring training as a minimum.

The supernumerary status of labour ward co-ordinators is fiercely protected and is consistently 100% with only 1 reported red flag in a 6-month period.

The number of unit diverts/attempted diverts coincides with not achieving a 100% target of 1 to 1 care in labour. The introduction of the Birth Rate acuity app and closing the gap in the Labour Ward establishment vacancy, when the newly qualified midwives commence in October, will result in the achievement of this safety standard.

The workforce and acuity pressures are still impacting at times on the number of delays experienced by women on the induction of labour pathway. The service is looking at the data capture around delays in induction of labour, actively engaging with the LMNS improvement work to standardise measures and undertaking local quality improvement work. This work to date has already demonstrated a reduction in delays and an improvement with patient experience. The Chief Nurse award was given to the Midwife leading on this quality improvement project at this year's Midwifery and Nursing awards.

There are no additional financial requests for Trust Board consideration in this paper and analysis.

Recommendations:

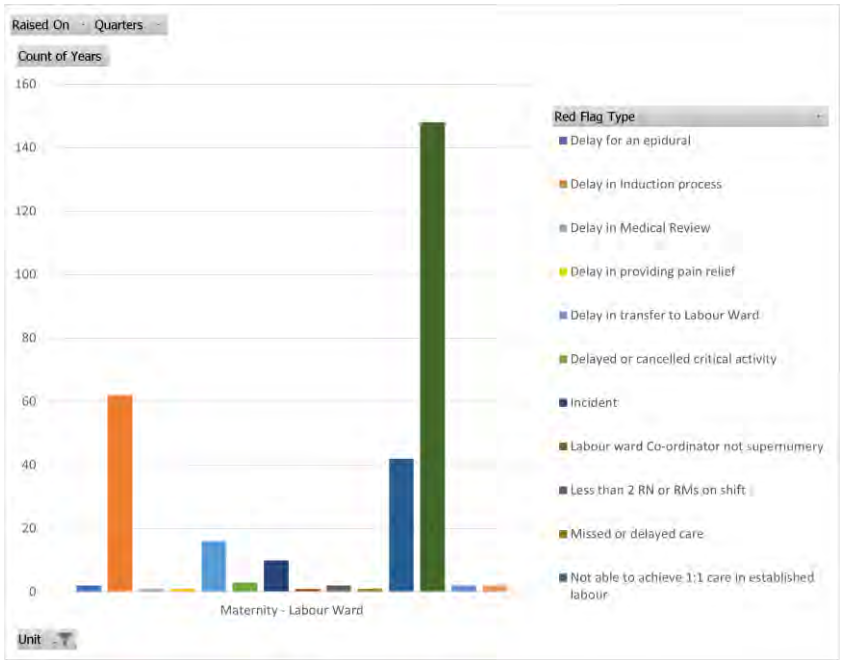
- Taking the safety concerns highlighted in the Ockenden and Kirkup reports and the ongoing national midwifery staffing shortage into consideration, Trust Board is asked to continue to support the services proposal that the first priority is managing vacancy and

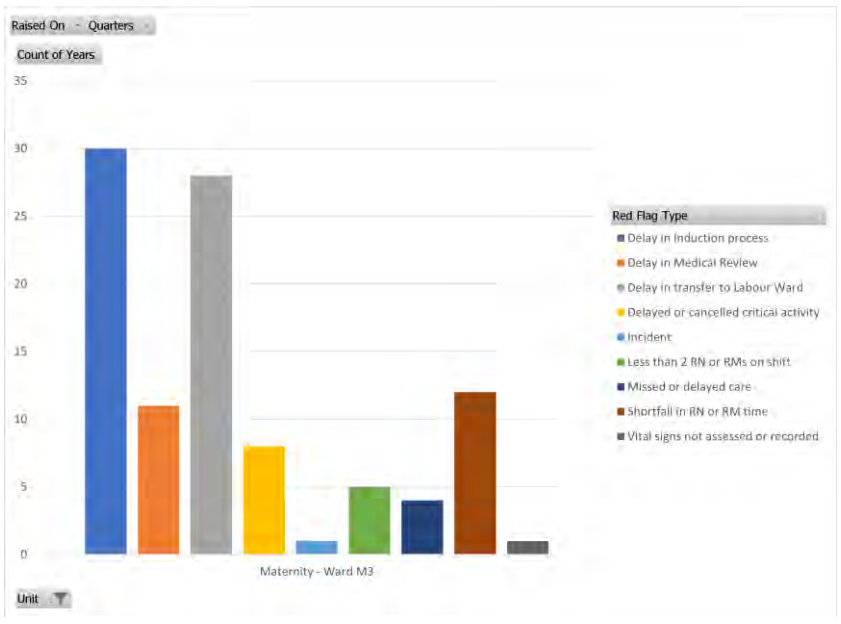
recruitment to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care.

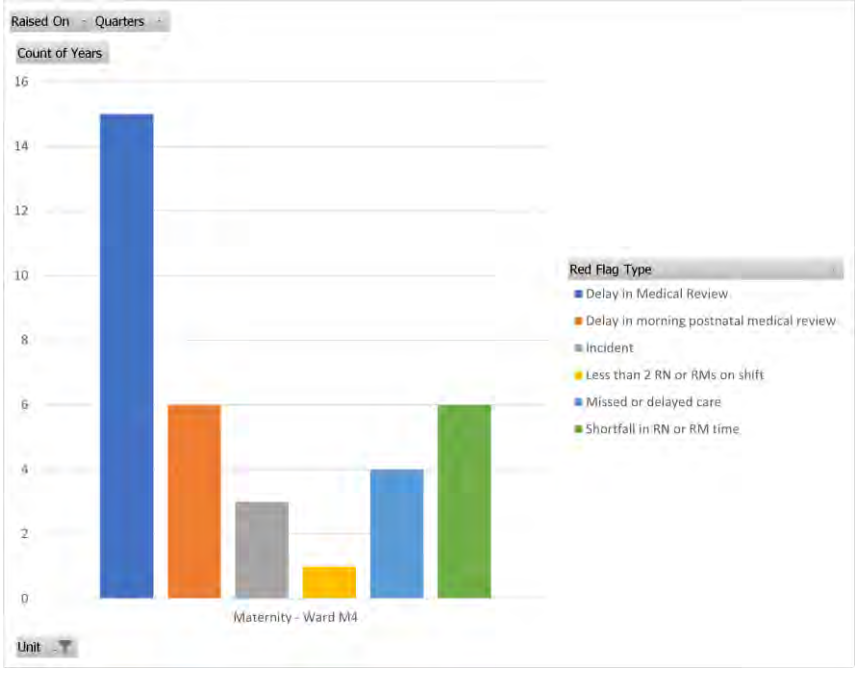
- Trust Board is asked to continue to support the long-term commitment made in 2021, to fund the establishment required to provide MCoC as a default position.
- Given the 2024/25 financial pressures, defer the request to implement the Consultant Midwife for Reducing Inequalities until 2025/26.
- **Appendices:**

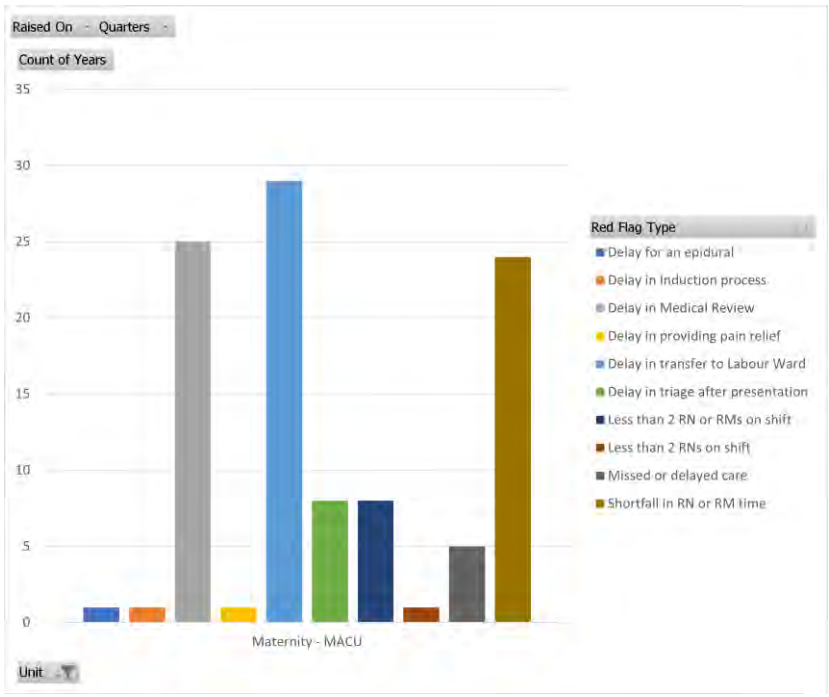
Appendix 1Red Flag report 1 September 2023 to 29 February 2024

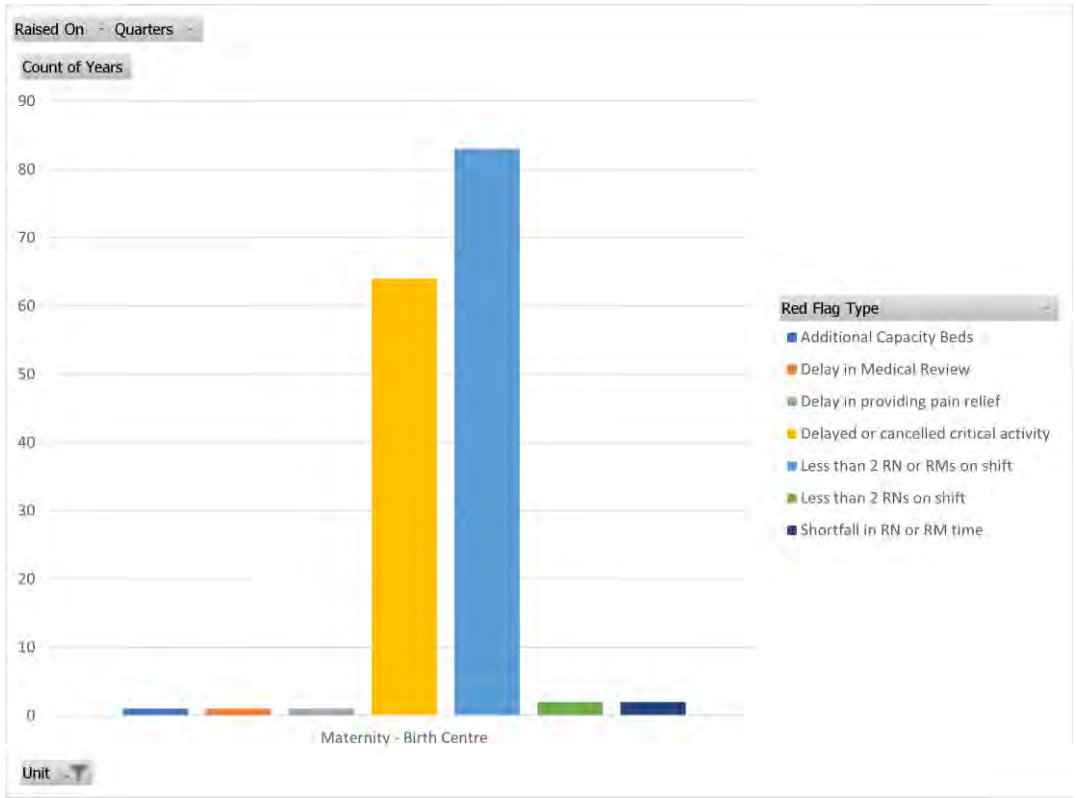
Row Labels	Additional Capacity Beds	Delay for an epidural	Delay in Induction process	Delay in Medical Review	Delay in morning postnatal medical review	Delay in providing pain relief	Delay in transfer to Labour Ward	Delay in triage after presentation	Delayed or cancelled critical activity	Incident	Labour ward Co-ordinator not supernumery	Less than 2 RN or RMs on shift	Less than 2 RNs on shift	Missed or delayed care	Not able to achieve 1:1 care in established labour	Shortfall in RN or RM time	Shortfall in RN time	Suspension of on call	Vital signs not assessed or recorded	Grand Total
Maternity - Bed Manager									1											1
Maternity - Birth Centre	1			1		1			64			83	2			2				154
Maternity - Labour Ward		2	62	1		1	16		3	10	1	2		1	42	148	2	2		293
Maternity - MACU		1	1	25		1	29	8				8	1	5		24				103
Maternity - Ward M3			30	11			28		8	1		5		4		12			1	100
Maternity - Ward M4				15	6					3		1		4		6				35
Grand Total	**1**	**3**	**93**	**53**	**6**	**3**	**73**	**8**	**76**	**14**	**1**	**99**	**3**	**14**	**42**	**192**	**2**	**2**	**1**	**686**

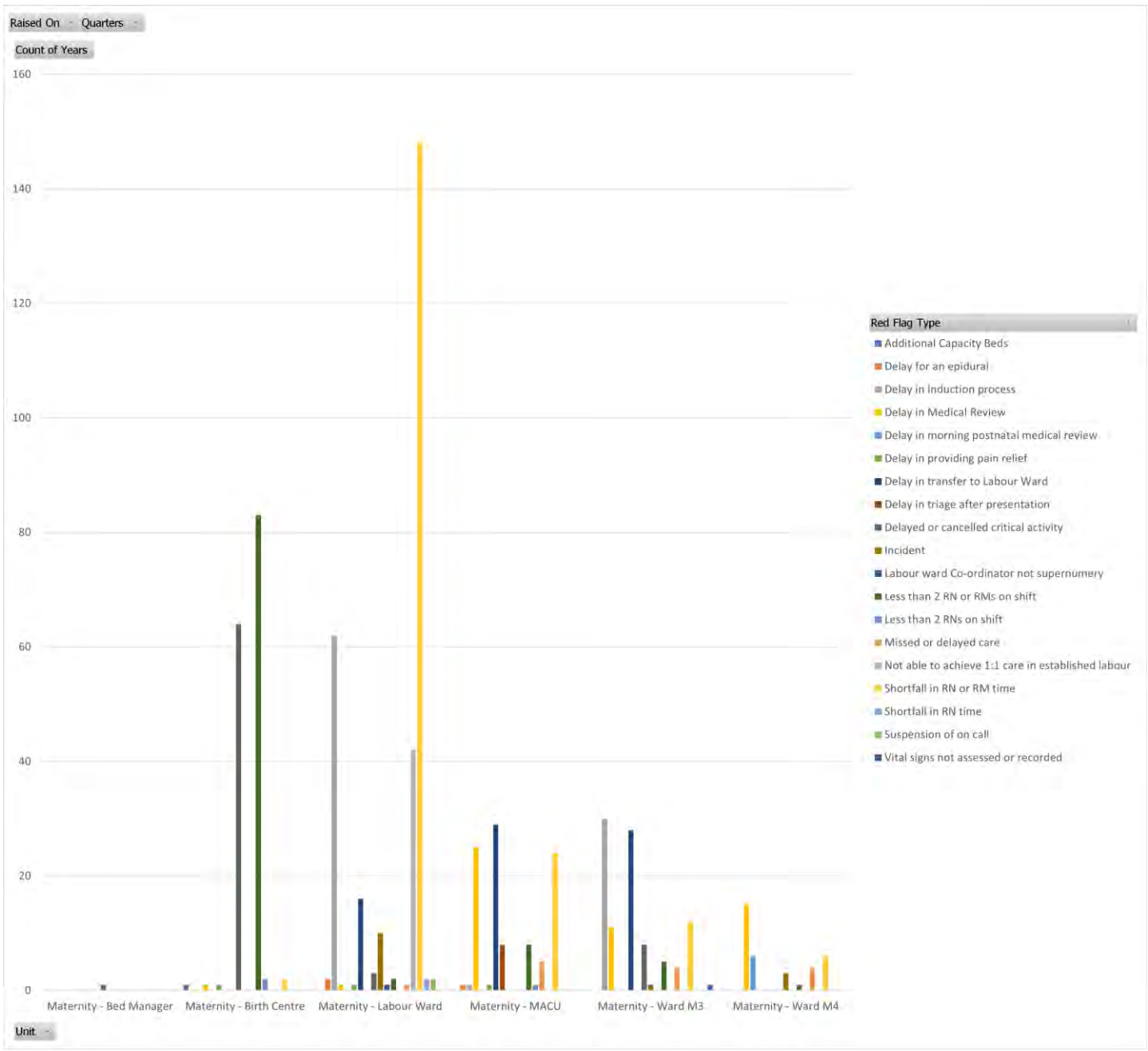







Raised On
Quarters
Count of Years
35
30
25
20
15
10
5
0
Maternity - MACU
Unit
Red Flag Type
Delay for an epidural
Delay in Induction process
Delay in Medical Review
Delay in providing pain relief
Delay in transfer to Labour Ward
Delay in triage after presentation
Less than 2 RN or RMs on shift
Less than 2 RNs on shift
Missed or delayed care
Shortfall in RN or RM time


Raised On
Quarters
Count of Years
90
80
70
60
50
40
30
20
10
0
Maternity - Birth Centre
Unit
Red Flag Type
Additional Capacity Beds
Delay in Medical Review
Delay in providing pain relief
Delayed or cancelled critical activity
Less than 2 RN or RMs on shift
Less than 2 RNs on shift
Shortfall in RN or RM time


Raised On
Quarters
Count of Years
160
140
120
100
80
60
40
20
0
Maternity - Bed Manager
Maternity - Birth Centre
Maternity - Labour Ward
Maternity - MACU
Maternity - Ward M3
Maternity - Ward M4
Unit
Red Flag Type
Additional Capacity Beds
Delay for an epidural
Delay in Induction process
Delay in Medical Review
Delay in morning postnatal medical review
Delay in providing pain relief
Delay in transfer to Labour Ward
Delay in triage after presentation
Delayed or cancelled critical activity
Incident
Labour ward Co-ordinator not supernumery
Less than 2 RN or RMs on shift
Less than 2 RNs on shift
Missed or delayed care
Not able to achieve 1:1 care in established labour
Shortfall in RN or RM time
Shortfall in RN time
Suspension of on call
Vital signs not assessed or recorded

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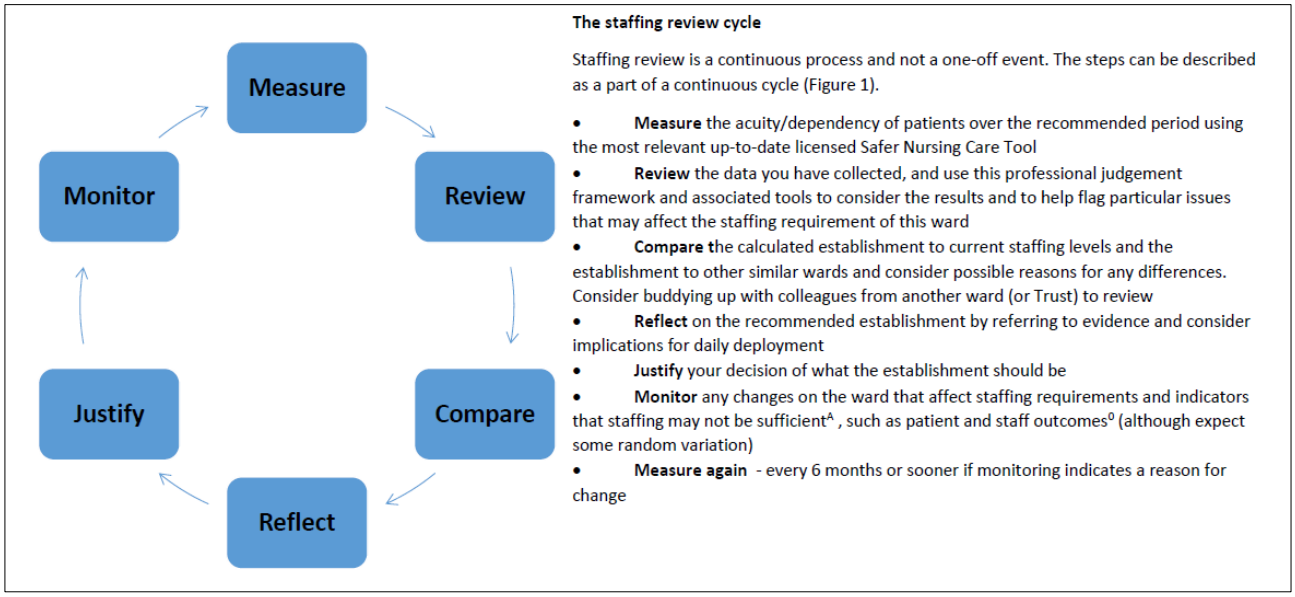
Appendix 4: Principles and documents supporting Safer Staffing Review

Reference Documents

- Professional Judgement Framework 2023. Saville et al.
- NHS improvement – developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing, October 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Maternity, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing (SSPS). An improvement resource for adult inpatient wards in acute hospitals 2016 (2017 approved).
- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014.
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England 2013.

Professional Judgement Principles 2023.



Summary of Safer Staffing Principles

The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition, improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, children and young people, neonatal units and maternity services. This document sets out a requirement for combining evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. This has continued to form the basis of the structure of the establishment review meetings and is embedded into practice.

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Figure 1: Principles of safe staffing

The safe, sustainable and productive staffing (SSPS) document describes that the key to high quality care for all, is our ability to deliver services that are sustainable and well led. For nurse and midwifery staffing, this means continuing our focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles set out in the SSPS document and should be embedded into practice:

- Right care.
- Minimising avoidable harm.
- Maximising the value of available resource.

Hard Truths commitments regarding the publishing of staffing data (Care Quality Commission, March 2014) states *'data alone cannot assure anyone that safe care is being delivered. However, research demonstrates that staffing levels are linked to the safety of care and that fewer staff increase the risk of patient safety incidents occurring'*. In order to assure the Board of Directors of safe staffing on our wards, this paper sets out the outcome of the strategic staffing review which has been undertaken in line with national guidance. The review has been a comprehensive assessment of each ward and department taking account of the following:

- Acuity and dependency data (from Safecare).
- Skill mix.
- Nurse to bed ratio.
- Incidence of pressure ulcers.
- Incidence of falls.
- Incidence of medication incidents.
- Incidence of complaints relating to nursing care.
- The friends and family test results.
- Red Flags.

BO.7.24.12 - LOOKING AFTER OUR PEOPLE

STAFF SURVEY RESULTS ACTION PLAN

REFERENCES

Only PDFs are attached

Bo.7.24.12 - Staff survey results action plan.pdf

Bo.7.24.12 - Appendix A - Final 2023 Staff Survey Action Plan v.260624.pdf

Meeting Title	Board of Directors		
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NHS STAFF SURVEY 2023 – FINAL ACTION PLAN

Presented by	Catherine Shutt, Head of Organisational Development and Staff Engagement	
Author	Debbie Jackson - OD Manager, Lisa Falkingham - Senior OD Manager, Cat Shutt - Head of OD	
Lead Director	Renee' Bullock - Chief People and Purpose Officer	
Purpose of the paper	To provide the final 2023 NHS Staff Survey Action Plan	
Key control	To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion	
Action required	For assurance	
Previously discussed at/ informed by	People Academy Executive Management Team	
Previously approved at:		**Date**
	Executive Management Team	24/06/2023
	People Academy	03/07/2024

Key Options, Issues and Risks

The NHS Staff Survey ran from September to November 2023, amid winter demand, cost of living pressures and against the backdrop of industrial action. Questions were aligned to the overarching categories of the NHS People Promise.

2,905 colleagues (43%) took part in the 2023 survey; this was an increase of 6% from the 2022 response rate of 37%. Nationally the average for NHS Trusts was 47%.

In summary, there were significant improvements compared to the 2022 results and we again improved our scores in every element of the People Promise.
The 3 main improvement areas are:

- We each have a voice that counts, ensuring staff feel secure raising concerns about unsafe clinical practice.
- Compassionate leadership, the organisation respecting individual differences, opportunities for development, effective appraisals and reporting bullying or abuse at work.
- We are compassionate & inclusive 'I would recommend my organisation as a place to work' and 'If a friend or relative needed treatment I would be happy with the standard of care provided'.

As a People Promise exemplar organisation, we have continued to work alongside established programmes of work which has enabled us to make improvements in the onboarding process, embed our financial wellbeing offer, and improve our rewards and recognition offering.

Analysis

The action plan has been created by the OD Team following engagement with colleagues and key stakeholders including our networks, Unions and People Academy since the results were shared in March 2024. The action plan is high level and is complementary to our separate WRES/WDES action plans as well as Workplace Civility Programme.

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This action plan therefore focuses on the top priorities that have been identified through engagement and after intensive analysis of the results. It also includes actions carried over from the 2022 plan which are currently being developed or delivered.

CSUs and corporate departments have been asked to review their localised results and develop complementary plans with the support of their HR Business Partner and the OD Team.

Progress of the action plan will be monitored by People Academy on a quarterly basis.

Recommendation

It is recommended that Board:

- Note the content of the action plan and the proposed timescales.

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	☐	☒

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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: 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)
☒	☐	☐	☐

1 PURPOSE/ AIM

The purpose of this paper is to share the final action plan which has been developed by the Organisational Development Team following engagement with colleagues and key stakeholders since the results were shared in March 2024. The action plan is high level and is complementary to our separate WRES/WDES action plans as well as our Workplace Civility Programme.

2 BACKGROUND/CONTEXT

The NHS Staff Survey ran from September to November 2023, amid winter demand, cost of living pressures and against the backdrop of industrial action. Questions were aligned to the overarching categories of the NHS People Promise.

Overall, the results nationally reflect the continuing challenges facing staff at all levels of the NHS workforce.

2,905 colleagues (43%) at BTHFT took part in the 2023 survey; this is an increase of 6% from 2022.

For BTHFT, the 2023 results show an increase in response rates across our benchmark group although this is below the national average and in summary, there have been significant improvements compared to our 2022 results and we have continued to improve our scores in every element of the People Promise. Figure 1 (below) shows that we are above average in all nine of the themed People promise areas.

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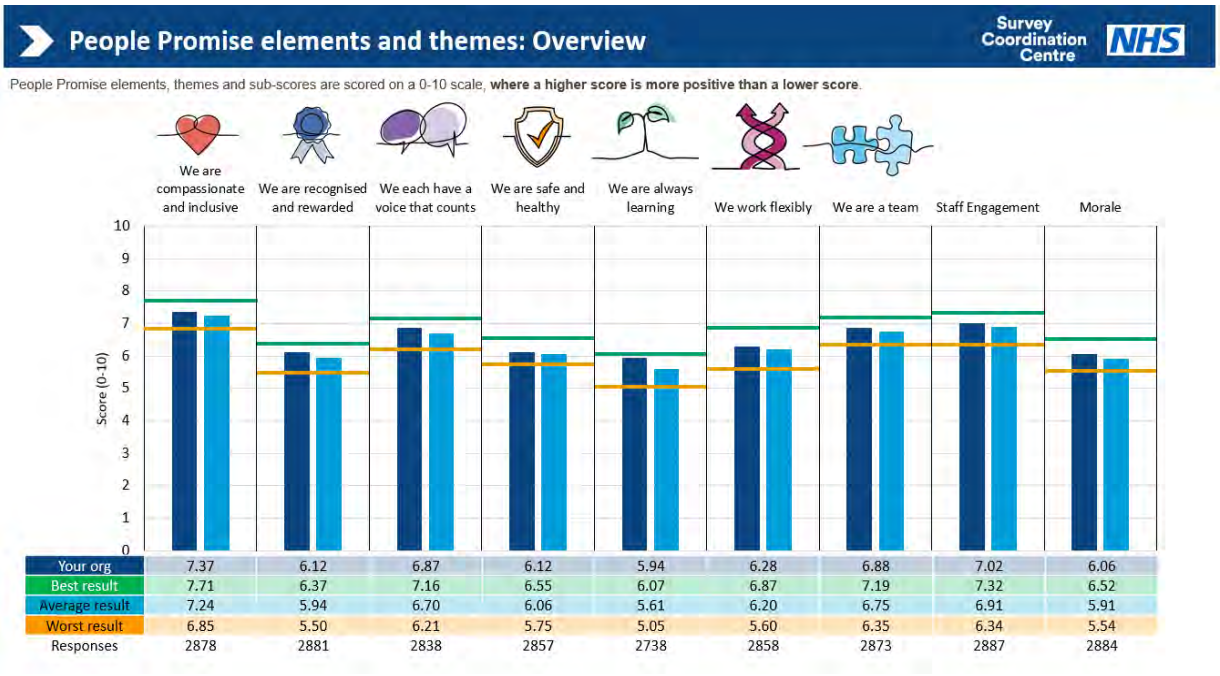


Figure 1 – BTHFT NHS Staff Survey results based on People Promise Themes

3 PROPOSAL

Our Thrive principles of wellbeing, development, voice and recognition are at the forefront of everything we do to ensure we are creating a workplace where our colleagues feel valued, engaged and have increased morale. How we do things, and our Trust values are also more important than ever, as well as ensuring colleagues feel safe at work and together, we continue to focus on taking care of ourselves and each other.

The action plan is based on these principles and priorities identified by stakeholder engagement and it is themed by the elements of the People Promise. The action plan can be found as **Appendix A.**

4 RECOMMENDATIONS

It is recommended that Board:

- Note the content of the Action Plan and the timescales highlighted.

5 Appendices

A – 2023 Staff Survey Action Plan.

Appendix A - 2023 NHS Staff Survey Action Plan

We are Compassionate and Inclusive

Area of focus	Actions to be taken	Leads	Timescale
Compassionate Leadership	**Thriving Together** Deliver the NHS Culture and Leadership Programme (Thriving Together) diagnostic stage and use data to inform our cultural priorities.	Head of OD / Leadership and Team Development Manager	Q2, Q3, Q4
Inclusion	**Staff Equality Networks** Work with our Staff Equality Networks to raise the profile of Equality, Diversity & Inclusion across the Trust, including the development of 'Allies/ Ambassadors'.	Head of EDI	Q3
	Race Equality Work with our Race Equality Staff Inclusion Network to develop approaches to anti-racism, aligned to the Root out Racism movement, and taking into account our Trust staff survey results around discrimination and issues highlighted in the "too hot to handle" report.	Head of EDI	Q3

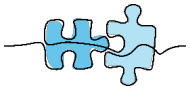
We are Recognised and Rewarded

Area of focus	Actions to be taken	Leads	Timescale
Reward	**Awards Celebration** Plan and host the annual Trust awards ceremony (September 2024).	Head of OD / Thrive Lead	Q2

We each have a Voice

Area of focus	Actions to be taken	Leads	Timescale
Autonomy and Control	**Staff Survey** Expand on newly formed network of Designated Staff Survey Leads to assist with engagement at local level to increase our 2024 Staff Survey response rate – key for driving improvements and a vital component of employee voice. The DSSL's proved a success in the areas where we utilised them in 2023 to increase engagement with the staff survey.	Senior OD Manager / OD Manager	Q2
Raising Concerns	**Just and Learning Culture** Establish a task and finish group to: -Review the different processes currently in place for raising concerns across the Trust; -Ensure mechanisms for feedback to colleagues are accurate and timely; Collaborate with FTSU guardians and stakeholders to review the process to enable all to speak up with confidence and review the approach and impact.	Freedom to Speak Up Guardian / Senior OD Manager	Q3
Raising concerns	**Thrive Live** Co-ordinate events across the Trust. Encourage teams/departments to engage with Thrive Live promoting the opportunity to have a conversation with the Chief Executive and executive team to hear Trust updates, news and ask relevant questions.	Head of OD / Staff Engagement Officer	Q2

 *We are Safe and Healthy*			
Area of focus	**Actions to be taken**	**Leads**	**Timescale**
Other questions	**Healthy Food** Work with key stakeholders across the Trust and establish relationships with current food providers to look at ways that we can provide hot nutritious, affordable food options that our people can access whilst at work including night shifts.	OD Manager / Head of Facilities	Q3
Negative Experiences	Source appropriate training/development/coaching and mentoring for colleagues in non-clinical patient facing roles to ensure they are confident in dealing with multiple, challenging situations effectively, including de-escalation techniques, dealing with conflict and difficult conversations (customer service training)	Senior OD Manager / Education	Q3
Physical violence	**Physical Violence** Working with the VPR task and delivery group explore initiatives available that lead to a reduction in the instances of physical violence that occur at work from managers, colleagues and patients/service users or their relatives. Review the current VPR plan and include such initiatives with timescales and process for review. Ensure the violence prevention and reduction policy is reviewed as required.	Violence Prevention, reduction lead.	Q3
 *We are Always Learning*			
Area of focus	**Actions to be taken**	**Leads**	**Timescale**

Development	**Personal Development** Bring together all development opportunities available to colleagues to enable them to identify appropriate next career steps. Create an easy to navigate page on Thrive with all offers available.	Head of OD / Leadership and Team Development Manager	Q3
	Manager Development Develop a new, inclusive offer to all managers by: • Creating 'guiding principles' to underpin a review and refreshment of leadership offers. • Reviewing existing leadership pathways. • Creating a new offer for all managers to have a consistent understanding of what is expected of a manager at BTHFT. • Deliver new offer to all managers	Head of OD / Leadership and Team Development Manager	Q2 Q3 – Q4
 *We are a Team*			
Area of focus	**Actions to be taken**	**Leads**	**Timescale**
Team Working	**Team Development** Design, develop and deliver a team training package which encourages team collaboration to identify solutions to the challenges they encounter, building relationships, resilience, and trust.	Head of OD / Leadership and Team Development Manager	Q4
Staff Engagement			

Area of focus	Actions to be taken	Leads	Timescale
Motivation	**Thrive** Refresh Thrive intranet portal making it easier to navigate and explore a wide range of communication methods and approaches to engage a wider inclusive audience e.g. blogging.	Head of OD / Thrive Lead	Q3
Morale			
Area of focus	**Actions to be taken**	**Leads**	**Timescale**
Thinking About Leaving	**Stay Conversations** Review and encourage 'Stay' conversations across the Trust and continuously improve approach based on feedback and learning.	Assistant Director HR Recruitment, supported by the Recruitment and onboarding Lead	Q2
Stressors	**Thrive Hive** Develop and launch the 'Thrive Hive' a central hub where colleagues can access a wide variety of activities which are open and accessible to all. The aim is create a sense of belonging in the organisation which will produce significant benefits to all and play a fundamental part in achieving positive patient outcomes.	Senior OD Manager / OD engagement officer	Q2
Free Text Comments	**Actions to be taken**	**Leads**	**Timescale**
All	489 free text comments were received from staff. Free text comments grouped into themes - main themes were civility/incivility; managers; pay; and staff levels. Free text comments shared with Director of HR (Interim) and HR BPs. HR BPs to share details of free text comments specific to their service areas and discuss next steps.	Head of HR / HR BP's	Q2

BO.7.24.13 - EQUALITY & DIVERSITY COUNCIL UPDATE

BO.7.24.14 - REPORT FROM THE CHAIR OF THE FINANCE AND PERFORMANCE ACADEMY

REFERENCES

Only PDFs are attached

Bo.7.24.14 - Report from the Chair of the Finance and Performance Academy - 22 May 2024.pdf

Bo.7.24.14 - Report from the Chair of Finance and Performance Academy 3 July 2024.pdf

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Date	11 July 2024	Agenda item	Bo.7.24.14

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 22nd May 2024

Key escalation and discussion points from the meeting
Alert:
Financial Report Month 1 – the Trust is reporting a £708k adverse variance to plan at month 1, in the main due to savings not being delivered through the closing the gap programme.
Advise:
Urgent and Emergency Care Operational Improvement Plan – The Academy were pleased to see the work underway to improve performance across urgent and emergency care. Performance remains strong in Urgent and Emergency Care but may dip over the next few months as a consequence of the continued financial challenge across health and social care. **Treasury Management –** The Academy were advised on the latest treasury management position and forecasts. As the financial position becomes more challenging, this impacts on the cash position. The Academy agreed to see the treasury management report quarterly going forward in order to more closely review the position. **Pathology Joint Venture –** it was pleasing to see that both joint ventures had delivered surpluses in 2023/24. The Academy asked to see the performance metrics in addition to the finance numbers going forward for these services going forward. **Service Development Post Implementation Reviews –** The Academy received the latest set of service development reviews. The investment in the Procurement team has delivered a substantial return on investment, this will be counted as part of the waste delivery plan. **Performance Highlight –** The Academy received and reviewed the monthly comprehensive performance report. Performance across the Trust remains strong in comparison to our peers. Work continues with the local authority to mitigate the impact of local authority savings plans on our length of stay position.
Assure:
Closing the Gap – the Director of Strategy and Integration took the Academy through the process through which the Trust will deliver the savings required to close the financial gap. An 8 week cycle of meetings has been established to govern the approach. The Academy approved the vision the programme has agreed and were assured by the process that is

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now in place. The first report that will show progress against the programme will be shared at next month's Finance and Performance Academy.

Budget Setting Process – A paper was received that described how budgets and efficiency targets for 2024/25 have been allocated across the Trust's Clinical Support Units and other operational and corporate departments. A number of decisions have been made by the Executive Management Team to support this process.

High Level Risks - The Academy was assured that all relevant risks had been identified, reported to the academy and were being appropriately managed. No risks had been added, closed or changed in score.

Report completed by:

Julie Lawreniuk
Academy Chair and Non-Executive Director
May 12th, 2024

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.14

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Committee

Date of meeting: 4th July 2024

Key escalation and discussion points from the meeting
Alert:
Monthly Finance Report – the Academy were not assured that the 2024/25 financial plan would be delivered but were assured about the work that is underway to mitigate this risk. A number of forecast scenarios were shared with the Academy showing a best case deficit of £15.1m and a worst case deficit position of £28.6m, compared to our planned deficit of £14.1m. These scenarios were based on the position at Month 2, which is too early in the financial year to draw any concrete conclusions from. It is anticipated that more clarity will be derived from the Month 3 position once this is available. The Academy also noted the associated risk to the Trusts liquidity and cash position should the financial plan not be delivered.
Advise:
Act as One Programme Update – A number of schemes continue to be delivered through our Act as One system programme approach. The Academy received a presentation highlighting the work underway across all of the programmes. **Closing the Gap Update –** the Academy were pleased to see the first closing the gap dashboard showing progress and delivery across all schemes. 206 schemes have been identified to date and £22.9m of potential savings identified against the £38.9m required. It was pleasing to see the amount of work underway across the Trust to close this gap but the risk to not delivering the required level of savings is high. The Academy discussed the rounded approach to reporting on the closing the gap programme across Academies and through the Board. **Operational Highlight Report** – Performance across the Trust remains strong. Attendance through Emergency Care has been high with some of the busiest days on record occurring over the last week. Improvements in occupancy and flow through the hospital are resulting in improved length of stay (LoS) performance and discharges figures. The Home First pilot will start in Bradford on the 21st July. Airedale piloted this earlier this year and have seen some good results. Ambulance handovers are being reported at 17 minutes, which is better than the 18 minutes plan target, our performance is the best in the West Yorkshire Association of Acute Trust. Throughout the highlight report it was pleasing to see our approach to improving through learning from others. **2024/25 Capital Plan** – the Academy approved the 24/25 capital plan for £42.8m noting that a few of the numbers may need to be updated as the plan develops.

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Assure:

Revised Academy Terms of Reference and Workplan – the Academy approved the changes to our TOR noting that in the next set we need to include the Trust Improvement Strategy and reflect the change from Finance and Performance Academy to Finance and Performance Committee. The work plan has been updated to include Estates and Facilities and Sustainability.

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 risks had been added, closed or changed in score.

Operational Improvement Plan Referral to treatment (RTT) – A presentation was shared with the Academy highlighting the work underway on our RTT improvement plan. A number of the transformational projects in this area are attempting to go further on plans in order to contribute towards the closing the gap programme. There has been a collaborative approach to implementing a new Data Quality app that gives services a real time view of which patients are on their lists.

Emergency Preparedness Resilience and Response (EPRR) update – The Academy were confident that the necessary work is being done in this area and were further assured by the internal audit report that has given significant assurance in this area.

Report completed by:

Julie Lawreniuk
Academy Chair and Non-Executive Director

4th July 2024

BO.7.24.15 - REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE

REFERENCES

Only PDFs are attached

Bo.7.24.15 - Report from the Chair of Audit Committee May 24.pdf

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.15

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Audit Committee

Date of meeting: 21 May 2024

Key escalation and discussion points from the meeting

Alert:

Limited assurance internal audit reports – the Committee received two limited assurance reports, E-Job Planning and Consultant and SAS Doctors job planning and were grateful for the attendance of the Director of Human Resources and the Chief Medical Officer respectively to respond to the report, provide context and explain the management response. The issues raised by both reports were similar regarding the need to update job plans. The Committee agreed with management's proposal to focus on specialties which were a priority for review by the Trust. *The Committee requested the People Academy to accept responsibility for monitoring progress on improvement in the rate of updated job plans throughout 2024/25*

Advise:

Review of Terms of Reference – following a review of the recently published and updated Audit Committee Handbook, the Committee was advised that the Committee Chair and colleagues in Corporate Governance had reviewed the Audit Committee's Terms of Reference and was proposing some amendments to the scope of responsibility of the Committee where there appeared to be duplication with the responsibilities of Academies. These proposals will be brought to the Board for approval with the recommendation of the Audit Committee. Clarification will be sought at forthcoming Board events about responsibility for oversight of cyber security.

Assure:

Annual Governance Statement – The Chief Executive presented the draft Annual Governance Statement for 2023/24. Mindful of the conclusions of the Board at its meeting on 9 May 2024, the Committee approved the wording concerning compliance with the provider license and, with minor amendments to the rest of the draft Statement, is recommending approval of the Annual Governance Statement when it is presented to the Board.

Head of Internal Audit Opinion – the Head of Internal Audit Opinion is a key element of the Annual Governance Statement, and the Audit Committee received a draft Opinion giving "significant assurance" that "there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and the controls are generally being applied consistently". The Committee was advised by the

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Head of Internal Audit that although there were a small number of audits to be finalised, there were no findings in those audits that would lead to a change in this opinion.

Counter Fraud – the Committee received a suite of reports and was assured of the arrangements that were in place. The Trust is rated green against the national Counter Fraud Functional Standards Return (self-review tool). There is one of the national standards that the Trust is not fully compliant with, but the Counter Fraud Officer advised that full compliance should be achieved next year in line with the NHS Counter Fraud Authority's timescales.

Year-end reports – the Committee reviewed the annual reports of the three academies and the Charitable Fund Committee and concluded, as far as the members were able, that they had met their terms of reference during the year. The Committee thanked those involved for the completion of those reports. The Audit Committee approved its own annual report for submission to the Board. It also reviewed its own processes against the good practice checklist in the Audit Committee Handbook and will make improvements in the very few areas where current processes were not fully in line with best practice. The Committee was unable to assess its effectiveness in terms of how the Committee operates as the two current members able to attend this meeting had only been in place for two months of the year. The Committee will use the good practice checklist to guide its approach during 2024/25 and will, as a minimum, review itself against good practice in order to inform 2024/25 year-end governance reports.

Business Continuity and EPRR – in accordance with current Terms of Reference the Committee received an informative report on the Trusts current arrangements, compliance with the NHS Northern and Yorkshire requirements and plans for 2024/25. The Board is aware of the current level of compliance from previous reports and the context for this. Ongoing oversight is provided by the Finance and Performance Academy.

Cyber Security - the Committee received a report on the current cyber security position in the Trust and the ongoing improvement plan. The Committee took assurance from the improvements that had taken place during the year, the audited self-assessment against the Data Protection and Security Toolkit, and externally awarded accreditations. The Trust noted and agreed with the current high-level risk for cyber security.

Report completed by:

Bryan Machin
Committee Chair and Non-Executive Director
22 May 2024

BO.7.24.16 - REPORT FROM THE CHAIR

REFERENCES

Only PDFs are attached

Bo.7.24.16 - Report from the Chair.pdf

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.16

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 my engagement with partners, stakeholders and governors since my previous report provided to the Board in May 2024	
Key control	N/A	
Action required	For Information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Engaging with Partners and Stakeholders

The Board is asked to note that I have now had introductory meetings with the majority of the Chairs from across West Yorkshire. The key focus of our discussions has been on the issues facing our Place, West Yorkshire Association of Acute Trusts and the wider system. To date I have visited Helen Hurst, Chair of Calderdale and Huddersfield NHS FT and, Keith Ramsey, Chair of Mid Yorkshire Teaching NHS Trust – meeting at Pinderfields Hospital I've visited Marie Burnham, Chair of the South West Yorkshire Partnership Trust at their Wakefield Headquarters and also visited Linda Patterson, Chair of the Bradford District Care NHS FT at their headquarters in Saltaire. I welcomed Brodie Clark, Chair of Leeds Community Healthcare NHS Trust who visited me here at our Trust. My meetings with Linda Pollard, Chair of Leeds Teaching Hospitals NHS Trust and Sarah Armstrong, Chair of Harrogate and District NHS FT took place virtually.

I have yet to meet with Andrew Gold, Chair of Airedale NHS Foundation Trust, and I hope to do so shortly.

2. Council of Governors

- **Council of Governors meeting scheduled for 18 July 2024**

Our next Council of Governors meeting to be held in public will take place on Thursday 18 July from 3.45 to 5.15pm. Following this the Council will hold a meeting in private to consider confidential matters.
Prior to our Council Meetings we have two sessions scheduled: one covering our Trust Strategy and the other, a 'back to the floor' patient experience visit.

- **Governor Elections 2024**

I am very pleased to advise that we have filled five of the six vacant seats on our Council of Governors. The following three members have been elected unopposed.

- Philip Turner, Keighley,
- John Waterhouse, Bradford East
- Andrew Waller, 'Rest of England and Wales'

We are particularly pleased that two of these cover our 'targeted seats' which have previously been difficult to recruit to. You will find their profile information on our website here.

Following the conclusion of the elections on 2 July; we have one returning governor, Ibrar Hussain, elected to represent Bradford West, and one new governor, Sharon Taylor, elected to represent Bradford South. Once the pre-appointment checks are complete, Ibrar and Sharon will formally join our Council.

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Philip, John and Andrew are now formally on board and undertaking their various welcome induction sessions.

- **Feedback to the Council following Board of Director meetings**

I met with governors in May to provide an update on the items discussed at May Board. I have now convened routine feedback sessions following our Board meetings. My next session is scheduled for 6.00pm on the day of our Board meeting.

- **Governor attendance at key sessions**

In recent months Governors have attended the CSU (Clinical Service Unit) to Academy event on 6 June with a further invitation extended to them for the next event scheduled for 12 September. I have also requested that Governors put a hold in their diary for the Trust Awards event for 2024 where we will be . recognising those staff colleagues who have achieved 30 years of NHS Service and, our staff awards celebrating the excellent contribution of teams and individuals for effective, compassionate and inclusive care of our patients.

- **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.

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.

3. Constitution Review 'task and finish group'

At the council meeting on 18 July, I will be seeking to establish a 'task and finish group' to undertake a thorough review of the Constitution. The Constitution is then expected to be presented to the Board for approval in September and then to the Council in October. If any NED is interested in joining the group, please signal your intentions in the first instance by emailing corporate.governance@bthft.nhs.uk

Recommendation

The Board is asked to note this report.

BO.7.24.17 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

- Bo.7.24.17 - Report from the Chief Executive (cover).pdf
- Bo.7.24.17 - Appendix 1 - PRN01288_i_Urgent and emergency care recovery plan year 2 - Building on learning from 2023-24_160524.pdf
- Bo.7.24.17 - Appendix 2 - PRN01417 Patient safety and quality of care in pressurised services.pdf
- Bo.7.24.17 - Finance Report - Month 3.pdf

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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 May 2024.	
Key control	N/A	
Action required	For information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Patients

Performance

BTHFT continues to benchmark positively against the Emergency Care Standard (ECS) at a West Yorkshire Association of Acute Trusts (WYAAT), Regional and National level. Our current position is in the upper decile of Acute Trusts in England. 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). This has impacted positively on a range of UEC metrics.

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. With strong internal processes continuing or being refined we have seen discharge and occupancy metrics improve despite these challenges.

Collaborative work is ongoing with Yorkshire Ambulance Service (YAS). Mapping the ambulance handover process has now been completed with issues identified and owners allocated. A new handover process, approved and communicated to the teams by YAS and BTHFT is due to start on 26th June. Work also continues to improve the accuracy of handover data recorded by YAS and used for external oversight of relevant metrics. Performance has seen improvements during June and will improve further as actions from process and assessment area reviews are delivered.

Outpatient and elective transformation schemes are being supported by GIRFT further faster. This is a clinically led approach to understanding opportunities presented by variation in data compared to peers. Specific deliverables are also being identified for targeted work under the Closing The Gap (CTG) programme with dedicated senior operational leadership and allocated improvement resource. The St Luke's Hospital (SLH) Day Case Unit, the new Endoscopy unit, and the Community Diagnostic Centre (CDC) will also increase the amount of elective activity being delivered by BTHFT.

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Work to reduce elective waiting times continues and whilst almost all services have delivered against the target to have no waits over 65 weeks, there will be some in T&O and ENT. Both areas are being intensively supported to recover the position as quickly as possible. Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.5% in May 2024. Validation is now better coordinated between teams and the themes from corrections are being fed into preventative work. Web-based waiting list management tools will be implemented across the CSUs in July which is expected to improve oversight of pathways.

In response to the histopathology delays impacting on our cancer pathways an improvement programme is in place which will address the underlying issues of concern. The first step has been to complete a detailed demand and capacity exercise leading to the funding of additional consultant histopathologist to increase reporting capacity. The continued commitment to prioritising outpatient and theatre capacity for cancer pathways will also 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. One stop neck lump and Dermatology hubs are two recent improvements making a positive difference. Improvement plans will also look to address the increasing demand patterns for cancer referrals so that performance is sustainable.

Urgent and emergency care recovery plan year 2: Building on learning from 2023/24.

A letter issued by NHSE (see Appendix 1) on 16th May acknowledged the work hospitals had undertaken to support the delivery for recovering urgent and emergency care and outlined the additional actions required to maintain progress towards achieving the level of ambition set out in the annual planning guidance:

- improve A&E performance with 78% of patients being admitted, transferred or discharged within 4 hours by March 2025
- improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25

The planning guidance asked systems to focus on 3 specific areas:

1. maintaining the capacity expansion delivered through 2023/24
2. increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
3. continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

Progress would be measured by the following support metrics:

- reducing ambulance handover delays
- reducing admitted and non-admitted time in EDs, with an intention of reducing long waits, particularly for mental health patients

- maintaining average G&A core capacity across the year at the level achieved in the last quarter of 2023/24, equivalent to at least 99,500 beds nationally, allowing for seasonality
- improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day)
- reducing average delays post discharge ready date (combining the two published metrics (a) the percentage of patients discharged on their discharge-ready date and (b) the average delays for patients not discharged on their DRD)
- improving length of stay in NHS commissioned community beds

In addition to last years schemes, there will be up to £150 million of capital allocated within NHS operational capital budgets in 2025/26, to incentivise both highest performance and greatest improvement in performance since 2023/24.

The progress against the year 2 plan will be monitored internally by BTHFT and also by local Urgent Care Boards.

Patient Safety and Quality of Care in Pressurised Services

Whilst our own performance against the UEC standards remain strong, a recent broadcast by channel 4 Dispatches aired on 24th June highlighted the experiences of patients attending the emergency department at Royal Shrewsbury Hospital in the Midlands and served to highlight the need for health and care systems, however busy and pressured, to provide care and treatment delivered with kindness, dignity, and respect.

In a letter (appendix 2) received from Sarah-Jane Marsh , National Director for Integrated Urgent and Emegrency Care and Deputy Chief Operating Officer at NHS England, and colleagues Dr Emily Lawson, Professor Stephen Powis and Dame Ruth May, we are asked as a Board to assure ourselves that as well as delivering the expectations contained within the UEC recovery plan, that the actions be routinely undertaken to ensure patients treated here at BTHFT receive safe, effective, kind, compassionate and respectful care. I have asked our CNO, CMO and COO to work together to ensure our appropriate response to this letter and oversight to be provided by the Quality Committee.

St Luke's Day Case Unit (SLH DCU)

The development of SLH DCU is progressing, however the target for handover has now shifted further handover is expected on the 31 August 2024 in comparison to the original date of mid-April 2024. This is due to the contractors ability to procure the cladding for the building. 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 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 towards the end of 2025. We are expecting information on a Guaranteed Maximum Price by the end of July 2024 which will then be presented to Board for a formal decision on next steps.

2. People

PRIDE Month 2024

June marks PRIDE Month, an annual celebration dedicated to recognising and supporting LGBTQ+ identities and communities. Our LGBTQ+ Staff Equality Network has been active in promoting this cause. To highlight key messages, we developed a screensaver which has been displayed across the Trust. Additionally, a celebratory event is scheduled for 26 June in the main concourse at BRI. This event aims to raise the profile of LGBTQ+ equality and to encourage staff participation in the Trust's LGBTQ+ network.

Sharing Good Practice in Equality, Diversity, and Inclusion (EDI)

On 13 June Kez Hayat, Head of EDI, participated in an online event hosted by AUDIT Yorkshire and 360 Assurance. This event provided an opportunity to share insights from our recent accolade, the Nursing Times Workforce Award for "Best Employer for Diversity & Inclusion." Supported by Ruth Haigh, EDI Manager, Kez joined a panel of inspiring speakers to present to over 50 senior NHS managers and board members from across Yorkshire, Humber, and the Midlands. The presentation, which highlighted our EDI initiatives, progress, and the importance of the staff voice, was very well-received and garnered positive feedback from the attendees.

Healthy Living Week

We celebrated Healthy Living Week from 10-15 June. In collaboration with external partners and charities, we distributed over 150 bags of healthy snacks to wards and departments, including all satellite community sites. To further promote healthy living, we launched a dedicated page on Thrive, and hosted pop-up stalls where colleagues could sample nutritious food provided by Compass. These initiatives were designed to encourage healthy eating habits across the Trust.

Thrive Live Sessions

We have revitalised our Thrive Live events, now scheduled from July 2024 through to March 2025. These sessions are designed to facilitate open dialogue between colleagues and the Executive Management Team. They offer a platform to discuss what is working well within the Trust and areas for improvement. Each session will be hosted by members of the Executive Team and senior

managers relevant to the specific service area being visited. The first session is set to take place at the end of July in the Education Services department.

3. National Updates

National updates

Information sharing advice for practitioners providing safeguarding services

The government has published updated information sharing advice for practitioners providing safeguarding services for children, young people, parents and carers. The advice outlines the importance of sharing information about children, young people and their families in order to safeguard children. It should be read alongside the statutory guidance Working together to safeguard children 2023.

The guidance has been reviewed by the Children's safeguarding team to assess the impact for the Trust. They are taking actions to ensure that our practice is in line with this guidance where this is not already the case, in particular strengthening education and ensuring that it is embedded in everyday practice.

NHS England appoints first medical director for mental health and neurodiversity

Dr Adrian James has been appointed by NHS England to a new role supporting the transformation of services for people with mental health needs, autism, a learning disability and those who are neurodiverse.

Death certification reform and the introduction of medical examiners

On 9 September 2024, the statutory Medical Examiner system will be implemented in England and Wales - please see Death certification reform and the introduction of medical examiners - GOV.UK (www.gov.uk). Following that date all deaths, whether in secondary care or in the community, will need to be considered by a Medical Examiner. We have scrutinised 100% of all in-hospital deaths for the past 2 years, and are already scrutinising the vast majority of community deaths.

As part of the reforms, a new MCCD form to be used. This will mean the current MCCD form cannot be used from 9 September and separate guidance will be published on how to complete and send the new MCCD. The new MCCD will require sign-off by the Medical Examiner unless the death is being referred to the coroner.

The change in regulations will mean the Department for Health and Social Care (DHSC) will take over responsibility from Local Registration Services (LRS) for printing and distributing the new MCCD from 9 September 2024 with new MCCD forms being printed and distributed in advance of 9 September. Later this year or next year it is anticipated that the MCCD paper forms will be replaced by an electronic MCCD.

During the week beginning 24 June, DHSC has published guidance on gov.uk regarding distribution and the replenishment solution as well as a list of organisations (and their postcode) to whom DHSC is intending to distribute MCCD booklets. The National Medical Examiner Office will be alerting medical practices, hospitals and hospices that new MCCD booklets will be arriving next month and the actions they need to complete to be fully ready for 9 September when the new regulations take effect and to ensure they read the published guidance when it is published.

In week commencing 1/7/24, BTHFT held its latest recruitment process for Medical Examiners, and we are now fully recruited (13 MEs in total) Our MEs are a mixture of hospital clinicians and GPs. This additional recruitment was following additional funding to allow a 7 day per week service including Bank Holidays, which will facilitate early release of the deceased and make the process of registration as smooth as possible for bereaved families.

4. Regional updates

Our ICB advocating for primary care

Our NHS West Yorkshire ICB continues to act as strong advocates for primary care and are working with colleagues from across the system to ensure that there is a 'blueprint' for the future way in which the service is delivered. This work, under the leadership of the 'Fuller Board', sits alongside the Primary Care Access and Recovery Programme.

Thanks to Richard Barker, Regional Director for NHS England

I'd like to say thank you to Richard Barker, the Regional Director for NHS England for the North East and Yorkshire, who retired at the end of June following a 40-year career in the NHS. The messages of support and thanks to Richard from across the system are a testament to his commitment to the people we work with and the people we provide services for. I will keep the board updated on the appointment of our new regional director, once the recruitment process has concluded. Robert Cornall, Regional Director of Commissioning and Transformation has been appointed as Interim Regional Director for NEY Region.

Tom Riordan to leave post as Leeds City Council Chief Executive

Leeds City Council's Chief Executive Tom Riordan has announced his intention to leave at the end of the year to explore new opportunities. After 14 years at the helm of the second-biggest local authority in the country, Tom has decided the time is right to try fresh challenges. I'd like to wish Tom all the best and thank him for the support he has given to our integrated care system.

5. Place updates

Formal Partnership Board Meeting – 17th May

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The formal Partnership Board meeting took place on 17th May and the papers can be found here. The system is responding to the wider financial pressures which in turn is helping to develop our own response to our financial challenges in a consistent way. The meeting also gave an opportunity to review governance arrangements both for the Partnership Board and the sub-committees that report into the Board. This means going forwards, we are reducing the frequency of the Partnership Board to bring it in line with the NHS West Yorkshire ICB meetings and therefore it will now be quarterly.

Take the Mic night

This event gave young people from across our place an opportunity to use their creative talents to share their experience of mental health. The success of the night has resulted in plans for a follow up event later this year. This was covered in one of my recent weekly messages, where I also focused on the wider work we are doing across our place under the healthy mind priority.

Community marathon helps develop links between care homes and communities in Keighley

Residential and nursing homes from across the Keighley district came together for their first community marathon event on Sunday 21 April. Over 120 residents from across 13 residential and nursing homes in the Keighley district ran, walked or were pushed in wheelchairs to complete laps across Keighley Green. They covered a total distance of 26.2 miles, the equivalent of 4½ marathons! The event was part of a wider project that is taking place as part of our Bradford District and Craven Health and Care Partnership's Integrated Health & Care workstream, in collaboration with the Voluntary and Community Sector Alliance (VCSA) to improve links between care homes and communities.

Bradford's biggest sensory room opened in The Broadway

A new space for those with sensory processing needs was officially opened in The Broadway on Wednesday 22 May. The room in is a calm space for neurodivergent visitors to retreat to if they feel overwhelmed. Sensory rooms allow users to calm down and relieve any stress as well as improve focus by allowing exploration in a safe engaging environment.

Winners announced at Bradford Sports Awards

The eighth Bradford Sports Awards took place on Friday 17 May, with over 350 people coming along to recognise those who are motivating others to lead more active and healthy lifestyles. A full list of winners and those who were highly commended can be found on the Bradford Sports Awards website.

Bradford Council now has a WhatsApp channel

A new WhatsApp channel has been launched by Bradford Council. By signing up to the channel Bradford district residents can receive important news and information from across the district. Sign up today

Winners announced for New Voices Bradford

A BBC talent search to find the next voices of Bradford to report on the UK City of Culture has announced the three winners. Zumba instructor Irene Kaali, optometrist Humaira Bham and car sales advisor Olivia Wright were chosen from hundreds of hopefuls who applied. The New Voices Bradford winners, will get the opportunity to join the BBC team to help report upon the year of culture across TV, radio, digital and online.

Two Bradford projects receive King's Award for Voluntary Service

Bangladeshi Youth Organisation (BYO) and Bradford4Better have both been recognised for the work they've been doing with local communities as they picked up the King's Award for Voluntary Service (KAVS). The KAVS celebrates the outstanding work of local volunteer groups across the UK. Equivalent to an MBE, KAVS is the highest Award given to local voluntary groups in the UK, and they are awarded for life.

6. Partners

- **WYAAT Programme Executive, 4th June and 2nd July**

I attended the WYAAT Programme Executive meeting on 4th June where we received updates on non-surgical oncology, specialised commissioning, and LIMS, and received the collaborative report and HCP report with a specific discussion around the aseptics action plan. We also heard the latest update on the cost review and efficiency workstreams, before presentations from two bidders (Deloitte and PWC) for the cost review.

I was on annual leave for the meeting on 2nd July but Sajid Azeb, Chief Operating Officer, attended on my behalf. The meeting included updates on the aseptics action plan and LIMS deployment, and the group considered options for collaborative procurement and imaging platforms. There was also discussion on the procurement of electronic chemotherapy system, and the WYAAT Memorandum of Understanding review and annual report was also received.

7. National Reports

Urgent and emergency care recovery plan year 2: Building on learning from 2023/24

Please see the update included in section 1 of this report.

The report can be accessed here: https://www.england.nhs.uk/publication/urgent-and-emergency-care-recovery-plan-year-2-building-on-learning-from-2023-24/

PRN01359 - Maternity and neonatal services - listening to women and families letter

Please see the update included in the report - Bo.7.24.7 – Maternity and Neonatal Services Update.

The report can be accessed here: https://www.england.nhs.uk/long-read/maternity-and-neonatal-services-listening-to-women-and-families/

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

PRN01368 - Letter: Publication of the infected blood inquiry final report

The Infected Blood Inquiry published its findings on 20 May 2024, following its establishment in 2017. The Inquiry explored the impact on patients who received infected blood mainly between 1984 - 1998 and the reasons behind the failure to protect them. The majority of those affected had bleeding disorders such as Haemophilia, and the infections were mostly HIV and Hepatitis B and C. It is estimated that in total 3000 deaths in the UK may be attributable to the receipt of infected blood, blood products or tissue. Patients and families of those affected have shared their experiences, and some of those patients were cared for by BTHFT. Following the publication of the Inquiry Report, a joint open statement was issued by Ray Smith as CMO for BTHFT and David Crampsey as MD for Airedale apologising unreservedly for past failings, but stressing the changes in practice and national policy that have been made to ensure that this cannot happen again. The letter outlines the support available for those affected, and the next steps that will be taken.

The letter can be accessed here: https://www.england.nhs.uk/long-read/publication-of-the-infected-blood-inquiry-final-report/

Revised Oversight and Assessment Framework letter

The letter can be accessed here: https://www.england.nhs.uk/long-read/revised-oversight-and-assessment-framework/

Respiratory syncytial virus (RSV) Vaccination Programme

The letter can be accessed here: https://www.gov.uk/government/collections/respiratory-syncytial-virus-rsv-vaccination-programme

Patient Safety and Quality of Care in Pressurised Services (Referenced in section one)

The letter can be accessed at appendix 2.

Recommendation

The Board is asked to note this report.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

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	
☒	☒	☒	

To:

- All ICB and Trust:
  - chief executives
  - medical directors
  - chief nurses
  - directors of finance
  - chief people officers
  - chief operating officers
  - regional directors of operations

Cc:

- ICB and trust chairs
- Regional:
  - directors
  - directors of commissioning
  - directors of system transformation

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

16 May 2024

Dear colleague,

Urgent and emergency care recovery plan year 2: Building on learning from 2023/24

Thank you to you and your teams for the progress made over 2023/24 in delivering the actions set out in the Delivery plan for recovering urgent and emergency care (UECRP). Despite significant headwinds in the form of unprecedented industrial action and higher than anticipated demand, the hard work of NHS and social care colleagues across the country has seen marked year-on-year improvement in the headline ambitions set out in the plan.

2023/24 was the first non-pandemic year since 2009/10 that A&E 4-hour performance was better than the previous year, with over 2.5 million more people completing their A&E treatment within 4 hours compared to 2022/23. Response times for Category 2 ambulance calls also improved; over the year, the average response time was 14 minutes faster compared to the previous year.

Other benefits for patients included:

- tens of thousands more people received the care they needed to return home quickly and safely thanks to the expansion of same day emergency care (SDEC) services
- on average, around 500 fewer patients a day had to spend the night in hospital because of a discharge delay, and 13% more patients received a short-term package of health or social care to help them continue their recovery after discharge

- urgent community response teams provided 720,000 people with an alternative to going to hospital between April and January
- virtual wards have supported more than 240,000 people to get the hospital-level care and monitoring they needed in the comfort of their own home

Maintaining progress

The UECRP is a 2-year plan. The level of ambition for 2024/25 was recently set out in the NHS priorities and operational planning guidance:

- improve A&E performance with 78% of patients being admitted, transferred or discharged within 4 hours by March 2025
- improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25

This operational planning guidance asked systems to focus on 3 areas to deliver these ambitions:

1. maintaining the capacity expansion delivered through 2023/24
2. increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
3. continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

This letter and its supporting annexes aim to help systems and providers as they plan and prioritise over the coming weeks, in order to make progress over the summer and improve resilience ahead of winter, by bringing together in one place what we know works in support of the key requirements set out in planning guidance.

Evidence-based actions to support delivery

Over the last year we have learned a significant amount from systems and providers – both through engagement as well as the early findings of formal evaluation – about how best to deliver for patients and for staff in the context of a challenging financial environment.

Annex 1 summarises the actions that work, and maps these against the requirements set out in planning guidance. Annex 2 provides further detailed information on those evidence-based delivery actions that we know will make a difference, as well as providing the supporting evidence and case studies.

This document is focused on acute and community services, and the needs of people with mental health issues in those services. It does not specifically address mental health settings; however, many of the principles and delivery actions will apply, such as working jointly with local government and social care partners to make effective use of the Better Care Fund for mental health pathways.

Working with local government, adult social care and the voluntary sector

The effectiveness of UEC services relies on the NHS, local authorities, providers of health and social care services, and VCSE partners working together across the UEC pathway. Throughout the last year, there have been excellent examples of partnership working to prevent avoidable hospital admissions, speed up discharge and improve outcomes for patients.

During 2024/25, continued partnership working – including with patients, families and carers – will build on and strengthen this joint approach. Annex 3 sets out the shared objectives, and this letter is being sent in conjunction with a letter from the Department of Health and Social Care to local authorities to ensure alignment across systems. This will help sustain a joined-up, collaborative approach to improving UEC services and outcomes for patients.

Delivery support

NHS England has also heard from systems and local teams what support offers have been helpful, and the support offer in 2024/25 has been refined as a result.

The UECRP set out an approach to UEC tiering support. Over the last year, this approach has supported improvements for challenged systems and providers, and helped to reduce unwarranted variation. It has been aligned with support for local government through the joint NHS England and DHSC Discharge Support and Oversight Group, which works with challenged systems to support improvements in discharge across all local partners. Annex 4 provides an analysis of the progress made by systems in Tiers 1 and 2, as well as additional learning on success factors.

For 2024/25, NHS England will continue to apply the same tiering approach, providing support to systems that are below target and/or are outliers on key metrics. The support will take account of learning from our review of tiering work to date, in particular by better aligning with NHS England's other tiered offers to systems, the Recovery Support Programme team and cross-government offers such as the BCF support programme, and by ensuring clear agreement of priorities for improvement across national, regional and local teams.

NHS England also offered a Universal Support Offer (USO) to drive improvement and innovation across 10 high impact areas, which included working with the BCF support programme for those areas that require a joined-up approach across health and social care, such as capacity planning for intermediate care and effective implementation of care transfer hubs.

Feedback from participating systems highlighted benefits to working in this way, although other systems reported finding it difficult to engage with. This feedback has been built into our approach to supporting systems in 2024/25, and will also underpin future support packages for local systems to deliver improvement in clinical outcomes and productivity. There will be a continuing focus upon the 10 high impact areas for 2024/25 within the wider holistic approach; these have been incorporated into Annex 1 with additional detail and evidence-based actions to support further improvements within Annex 2.

Measuring progress

In addition to the 2 headline ambitions, the planning guidance sets out that systems and regions should focus on reducing the number of over 12-hour waits in emergency departments (EDs), including for mental health patients awaiting admission to a mental health bed.

NHS England will also be regularly considering the following supporting metrics in assessing performance and where additional support may be required:

- reducing ambulance handover delays
- reducing admitted and non-admitted time in EDs, with an intention of reducing long waits, particularly for mental health patients
- maintaining average G&A core capacity across the year at the level achieved in the last quarter of 2023/24, equivalent to at least 99,500 beds nationally, allowing for seasonality
- improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day)
- reducing average delays post discharge ready date (combining the two published metrics (a) the percentage of patients discharged on their discharge-ready date and (b) the average delays for patients not discharged on their DRD)
- improving length of stay in NHS commissioned community beds

Accountability

Building on the experience from 2023/24, the NHS will continue to ensure the key elements of implementation and delivery support are in place, starting with clear accountability for delivery through the NHS Oversight Framework. The new operating framework will also provide clarity on outcomes and priorities, while providing local flexibility on how to deliver.

The oversight framework sets out the key outcomes expected of integrated care boards (ICBs), and will be supported by regional UEC delivery boards as well as a national programme board that will review any issues occurring across regions.

On a day-to-day basis, a new OPEL framework has supported aligned accountability on operational risk management, managed at integrated care system (ICS) level through our system co-ordination centres. Over winter 2023, this new framework has supported the 24/7 National Co-ordination Centre, and enabled NHS England to provide targeted support when there has been pressure. NHS organisations continue to work routinely with local authorities to manage operational risks that require co-ordinated health and social care action.

The OPEL frameworks for mental health and community services are now being developed. The frameworks will use the same principles as the acute care OPEL 2023/24 (that is, digital, clinically relevant and consistent). NHS 111 OPEL and revised acute care OPEL will be part of a weighted system aggregated score, to increase both the pace and rigour of our response to patient safety within the entirety of the UEC pathway.

Transparency

Over the last 12 months the NHS has made strong progress on improving the availability of data to support service improvement and transparency for patients and the public. Key developments included:

- publication of 12-hour waits
- development and publication of a new dataset derived from the discharge ready date (DRD)

For 2024/25, a key priority will be to continue to improve the collection and quality of DRD data and data on reasons for discharge delays, and to improve data collection on community services. This includes ensuring that all relevant trusts are reporting high-quality data on DRD, to enable comparison at trust, local authority and ICS levels. This will help drive effective shared action across the NHS and social care to improve timely discharge. By July 2024, all community providers of NHS commissioned services should be reporting into the Community Services Data Set. These metrics will support better local and national assessment of flow and capacity.

Capital and incentives

A total of £250 million of operational capital was provided in 2023/24 to support estate and technology improvement relevant to UEC. A further £150 million of capital was also allocated in 2024/25, as part of a scheme to incentivise higher performance in 2023/24.

This year, £150 million of operational capital is being distributed for improvements that will support front door services and flow through EDs, to support improvements in ED performance. NHS England regional teams are working with systems to progress business cases; further details will be available once these have been agreed.

In addition, there will be up to £150 million of capital allocated within NHS operational capital budgets in 2025/26, to incentivise both highest performance and greatest improvement in performance since 2023/24. An outline of the scheme is set out below:

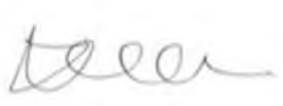
- improved 4-hour performance (measurement at year end, with a further element to incentivise improvement throughout the year)
- improved Category 2 performance (incentivised throughout the year)
- reduction in 12-hour delays in an ED (incentivised throughout the year)

Schemes will not be mutually exclusive. Capital will be allocated to the ICB for the Category 2 ambulance response performance and improvements, and to individual trusts and their nominated partners (which may include community and mental health trusts) for the A&E schemes.

Thank you again for the incredible work that you and colleagues have done together to improve the timeliness, quality and safety of care for patients requiring urgent and emergency treatment over the first year of the UECRP. We hope this further information is

helpful in the planning you are doing now for the second year, and we look forward to continuing to work with you to support further improvements over the course of 2024/25.

Yours sincerely,



Sarah-Jane Marsh CBE
National Director of Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Dr Julian Redhead
National Clinical Director for Integrated Urgent and Emergency Care
NHS England

Annex 1: Summary of supporting actions

Operational planning guidance requirement	Evidence-based actions to support delivery
1. Maintain the capacity expansion delivered through 2023/424	
1A. Maintain acute G&A beds at the level funded and agreed through operating plans in 2023/24	• Maintain and monitor the 99,500 core G&A bed capacity over 2024/25. At system level this means maintaining the growth achieved by Q4 2023/24 on average over the course of the year, adjusting for seasonality.
1B. Maintain ambulance capacity and support the development of services that reduce ambulance conveyances to acute hospitals	• Maintain hours on the road/deployed ambulance staff hours. • Increase clinical assessments of calls in NHS 111 and ambulance control rooms compared to 2023/24. • Maximise opportunities to establish 'call before you convey' best practice models to increase direct referral to alternative services. • Continue the focus on deploying the paramedic workforce, including ambulance support staff, in the most effective way. • Embed culture improvement by implementing the recommendations set out in the Culture review of ambulance trusts.
1C. Focus on reduction in ambulance handover delays to support system flow	• Reducing handover delays will be a key focus and action for systems to deliver in 2024/25 and will remain a metric to better assess flow across UEC pathways and support improved patient outcomes. The delivery actions and best practice examples to support this are included across other domains above and below.
1D. Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care	• Working jointly across ICBs and local authorities, ensure that commissioned intermediate care capacity meets projected demand, supported by the additional £400 million in the 2024/25 Discharge Fund. Plans should accurately forecast capacity needs, considering the most appropriate balance between different discharge pathways, and identify the workforce capacity and skill mix changes required to deliver sufficient rehabilitation and reablement activity to support discharge. Plans will be assured through the Better Care Fund (BCF) assurance process. • Use the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, and the Community rehabilitation and reablement model, to identify how to improve service and workforce models.
1E. Improve access to virtual wards through improvements in utilisation, access from home pathways, and a focus on frailty, acute respiratory infection, heart failure, and children and young people	• Maintain capacity and improve occupancy of virtual wards, expand access to step-up and step-down capacity, and improve length of stay by pathway, through implementing best practice as set out in the virtual ward framework. • Work together locally, including with social care providers, to increase access to virtual ward services that provide an alternative to hospital attendance or admission ('step up' virtual wards) including increasing the home referrals and directing patients from ED and SDEC following initial assessment where appropriate. • Consider specialty pathways and teams according to local demand, including paediatric virtual ward services and capacity.

Operational planning guidance requirement	Evidence-based actions to support delivery
2. Increase the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes	
2A. Focus on reductions in admitted and non-admitted time in ED	• Continue to focus on initial assessments, including continuing to increase the proportion received within 15 minutes of arrival, and increase the proportion of patients redirected to alternative services. • Work with providers to improve flow into and through acute beds by reducing excess length of stay and variation in high volume, high bed use pathways. • Review critical interventions along patient pathways in hospital and ensure they are aligned with best flow practice principles. • Review and audit trust internal professional standards, using the ECIST guide as a starting point. • Build on the rollout of psychiatric liaison services to support Type 1 EDs working towards ambition of responses within 1 hour of referral. • Reduce mental health patient time in EDs, including reducing length of stay for patients in acute beds waiting for a mental health bed, and in mental health beds. Systems, including local government, should focus on improving whole mental health pathway patient flow.
2B. Focus on reductions in the number of patients still in hospital beyond their discharge ready date (DRD)	• Continue to improve in-hospital discharge processes. Ensure early discharge planning, including effective involvement of patients, carers and families, in line with statutory guidance on hospital discharge and community support. • Working across the NHS and social care, maximise the effectiveness and maturity of care transfer hubs to improve quality and timeliness of discharge for patients with complex needs. • Working across the NHS and local authorities, implement trusted assessments to reduce duplication and ensure information is shared through the pathway.
2C. Focus on reductions in length of stay in community beds	• Increase productivity and capacity of community bed-based services based on maturity self-assessments. • Extend the implementation of best practice flow principles to community beds, including tracking length of stay. • Reduce discharge delays from community bedded units through process improvements, and through timely access to ongoing packages of care supporting transition and continuation of rehabilitation and reablement at home, building on good practice in care transfer hubs in acute settings.
2D. Improve consistency and accuracy of data reporting	• Ensure all trusts are consistently and accurately recording key metrics including SDEC activity in ECDS, community discharge information on the community SitRep/SUS, DRD, data on reasons for discharge delays, and the Ambulance Data Set. • Ensure system co-ordination centres are fully embedded and made ready for system OPEL. • Consider how to disaggregate data based on age, to understand demand and monitor performance for children and young people.

Operational planning guidance requirement	Evidence-based actions to support delivery
3. Continue to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge	
3A. Increase referrals to and the capacity of urgent community response (UCR) services	• Increase UCR referral volumes and number of patients treated. • Explore the use of technologies and point of care testing to optimise existing capacity, and consider referral pathways from technology enabled care (TEC) providers and SDEC.
3B. Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week	• Ensure SDEC compliance of 12 hours a day, 7 days a week. • Increase utilisation by working with partners (including ambulance trusts) to increase the proportion of patients with direct access, direct referrals from outside the ED (NHS 111, 999 and primary care), and reduce variation in the proportion of ED patients who are treated through the SDEC. • Increase productivity by implementing the minimum standards of delivery outlined in the SAMEDAY strategy. • Improve consistency of reporting SDEC into the Emergency Care Data Set (ECDS) by March 2025.
3C. Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week	• Ensure acute frailty service compliance of 10 hours a day, 7 days a week, implementing a comprehensive geriatric assessment at the front door, and the minimum standards in the FRAIL strategy, to increase patient flow and the proportion of patients over 65 with a Clinical Frailty Score. • Understand and work across systems to reduce numbers and variations in care home referrals to ED.
3D. Provide integrated care co-ordination services	• Work to understand the total demand for services that provide an alternative to an ED attendance for urgent care needs, complemented by a review of capacity holistically across all relevant services. Work with local authorities to link this to BCF demand and capacity planning for intermediate care. • Establish core operational integrated care co-ordination structures as a minimum by October 2024, with a focus on paramedic access to clinical advice to support alternative pathways to ED. • Ensure surge acute respiratory infection provision, including for children.

Annex 2: Further detail on supporting actions

Learning from the first year of UECRP

The approach to developing this document has been 2-fold. Learning has been drawn from regular conversations with systems across health and social care, which has highlighted the interventions and approaches that have been easier to implement, and what would need to be true to replicate this elsewhere.

Systems that are further ahead with implementation have documented their approach in case studies; examples are given in these annexes.

We have also begun to see emerging learning from the evaluation approach that was set out in the UECRP. This includes some insights from Sheffield University's literature review, alongside emerging findings from qualitative evaluation by the REVAL team at Manchester University. The National Institute for Health and Care Research (NIHR), a partner to NHS England in evaluating the UECRP, along with the case study authors, will make these findings available in due course.

Overall, NHS England has heard and seen that the broad approach set out in the UECRP is the right collection of activities to enable the NHS, working with local authorities, social care providers and VCSE partners, to deliver the ambitions of the plan.

NHS England has also heard from systems and local health and social care teams implementing the UECRP on the ground that they would value the opportunity to continue with their delivery and embedding of changes into Year 2. Teams have also asked for evidence-based, structured products to highlight the key components of the interventions, and to support prioritisation of their delivery.

We have been told – and seen in the data – that some of these interventions have been easier to implement routinely across systems than others. Both standardising the approach to delivering services across health and social care to improve support for frailty, and standardising the approach to inpatient flow and length of stay, have been raised as consistent challenges. Further work is underway with partners and stakeholders across the country to establish and document a more succinct approach to improving these pathways.

To help and support delivery into Year 2 of this plan, NHS England has responded to this learning in 2 ways. The approaches that work have been collated and refined into a set of evidence-based actions for health and social care systems to support delivery of and progress towards the headline ambitions, alongside links to further guidance, evidence and examples of best practice. These actions are set out below, grouped under the 3 UEC priority areas for this year: maintaining UEC capacity, improving the productivity of that capacity, and continuing to shift care out of acute hospitals.

In implementing these actions, working with social care and VCSE partners, systems should include, wherever appropriate, children and young people, patients with mental health needs and dementia, people with learning disabilities, autistic people and those experiencing homelessness within their plans.

In these newer pathways, or those that have been more challenging to implement, evidence of what works is being codified to support wider national learning. Some of this detail is already available, with some further detail to follow shortly.

Interventions for frameworks that are already available	Care transfer hubs SAMEDAY framework for same day emergency care Combined adult and paediatric acute respiratory infection hubs Discharge ready date guidance (includes DRD definitions) Discharge guidance (including homelessness checklist)
Interventions for frameworks that will be published shortly	Virtual wards Single point of access/integrated care co-ordination centres
Pathways for which work is ongoing with local and regional teams over the coming weeks	Standardisation of services to support older people with frailty Standardisation of inpatient flow and length of stay

Priority 1: Maintaining and increasing the capacity expansion delivered through 2023/24

During 2024/25, systems should continue to ensure that UEC capacity is maintained or, where appropriate, expanded. Alongside the increase in physical capacity, and in line with the NHS Long Term Workforce Plan, systems should continue to take action to support the UEC workforce, including enabling staff to work more flexibly.

Learning during 2023/24

During 2023/24, the NHS delivered significant capacity expansion, supported by over £1 billion of new revenue and £250 million of new capital investment. The NHS and local authorities also worked together to agree how to deploy the £600 million Discharge Fund, alongside the wider BCF, to improve capacity for supported discharges and reduce discharge delays, delivering a 13% increase in supported discharges in 2023/24 compared to 2022/23 and – despite a 6% increase in emergency admissions over this period – a 4% reduction in the average daily number of acute hospital patients with delayed discharges.

This capacity expansion has had an impact, as evidenced by the improved overall performance in the UECRP's 2 headline ambitions against the previous year. Modelling underpinning the planning guidance highlights the relationship between capacity increases and ED performance, largely driven by bed occupancy. Further modelling highlights the

relationship between handover performance and handover delays, and by extension Category 2 performance.

Evaluation from newer interventions, such as virtual wards, has also begun to build a picture of where and how improvement can have most effect. For example, there is strong evidence that virtual wards are associated with reducing avoidable attendances and admissions to hospital, as well as supporting early discharge and reducing length of stay in acute beds.

- There is growing positive evidence of impact from site evaluations:
  - East Kent's 50-bed step-up frailty virtual ward has seen a reduction in non-elective admissions for older frail cohorts (75+). A South East region-wide evaluation is due to be published demonstrating similar results across the region
  - South and West Hertfordshire Health and Care Partnership experienced a reduction in hospital bed days from the implementation of a COPD ward hospital at home pathway with an observed reduction in both inpatient length of stay and the number of repeated hospital admissions
  - evaluation of the Mid and South Essex frailty virtual ward found that readmission rates to an acute bed within 30 days of discharge were 26.5% lower than the 30-day readmission rate seen nationally for acute frailty wards.
- Virtual wards also deliver cost savings, as demonstrated in an economic analysis by NICE, which found that in aggregate the services have provided a significant net financial benefit due to avoided hospital activity. Across multiple evaluations, there is also consistent evidence of very positive patient experience of virtual ward services.

Learning from joint ICB/local authority capacity and demand planning for intermediate care through the BCF has reinforced the importance of actively reviewing projected need for different types of intermediate care, including both step-up and step-down care. It has also reinforced the importance of working with community and social care providers to plan services and associated workforce requirements so that they better match projected needs, including a focus on a 'Home First' approach to reablement and recovery. Local areas have also reinforced the importance of understanding the relationship between average length of stay in different types of intermediate care and the capacity available to meet projected demand.

This learning has informed the planning guidance requirements and the supporting delivery actions set out below for 2024/25. Further evidence is set out in case studies and links throughout this section.

Based on evidence from last year, key supporting actions for 2024/25 include:

1A. Maintain acute core G&A beds as a minimum at the level funded and agreed through operating plans in 2023/24

- Core G&A bed numbers should be maintained through monitoring and maintaining the average of 99,500 beds over 2024/25, adjusted for seasonal trends.

1B. Maintain ambulance capacity and support the development of services that reduce ambulance conveyances to acute hospitals where appropriate

- **Ambulance trusts** maintaining the increase in deployed staff hours established in 2023/24, to maintain the peak increase in capacity agreed in operating plans.
- **Systems** increasing clinical assessment in NHS 111 and control centres compared to 2023/24, in line with national implementation principles for Category 2 segmentation. This will ensure that patients who do not need a face-to-face response are transferred to the most appropriate service and supports effective prioritisation for ambulances. This may include increasing access to paediatric expertise through a NHS 111 Paediatric Clinical Assessment Service, where supported by evaluation and business case development.
- **Systems** maximising opportunities to establish 'call before you convey' best practice models to increase direct referral to alternative services, where clinically appropriate. These best practice models include early access to a named senior clinical decision-maker so that patients with the most urgent need are seen sooner.
- **Ambulance trusts** deploying the paramedic workforce, including ambulance support staff, in the most effective way to meet ambulance capacity requirements in line with local need.
- **Ambulance trusts** embedding culture improvement alongside the delivery of operational targets, by implementing the recommendations set out in the Culture review of ambulance trusts.

Case study: Moorfields Eye Hospital NHS Foundation Trust – Virtual Eye Pathway

'The Virtual Eye Pathway' is an integrated virtual consultation pathway between NHS 111 and the Moorfields Eye Hospital within North Central London (NCL) and North East London (NEL) ICBs, which aims to reduce the number of calls related to urgent eye conditions that result in avoidable ED attendances.

With the new pathway, NCL and NEL ICB callers to NHS 111 with urgent eye conditions will be briefly assessed and then transferred to a virtual waiting room, after which they shortly receive a specialist ED virtual ophthalmology assessment provided by a Moorfields clinician. The clinician then streams patients to the most appropriate service (often an opticians, a minor eye condition service or Moorfields itself) or provides advice and guidance to enable self-treatment.

Since the Virtual Eye Pathway launched in March 2023, 30% of patient callers who would previously have resulted in a Type 1 ED attendance have been avoided, with patients directed elsewhere. Those referrals that do result in an A&E attendance have the benefit of being validated by a specialist clinician in advance of attendance. Wider benefits have included reduced patient wait times within NHS 111, especially where specialist ETC ophthalmology assessment is required, and reduced Type 1 ED referrals overall. In addition, access to this service has been expanded via the 111 Online channel so that users of NHS 111 Online can obtain urgent eye care assessment directly through this

online channel. The virtual eye service is also linked to the London 111 natural language pathway development, so that users who declare urgent eye problems will streamline directly to this service via NHS App/111 Online.

1C. Reduce ambulance handover delays to support system flow

- Handover delays still present a significant challenge to increasing ambulance service capacity, particularly in certain areas. Due to the impact on patient care, reducing these delays will be a key focus and action for systems to deliver in 2024/25. This will remain a metric to better assess flow across UEC pathways and support improved patient outcomes.

Case study: Barts Health NHS Trust – REACH service

The Remote Emergency Access Coordination Hub (REACH) is a UEC collaborative in North East London set up in October 2020. Developed and hosted by Barts Health NHS Trust initially as a response to COVID-19, it aims to co-ordinate and deliver the most appropriate secondary emergency care for patients.

Ambulance service paramedics, urgent community response (UCR) and primary care clinicians on scene with a patient are able to call the REACH service to receive emergency medicine consultant-led clinical advice regarding best options for the patient, including support for appropriate non-conveyance. The REACH service provides collaborative decision-making with the caller, facilitating remote treatment and discharge or direction to alternative care pathways where appropriate, which improves patient experience and optimises utilisation of both community and in-hospital resources such as UCR, SDEC and virtual wards.

In 2023, REACH took 11,600 calls from clinicians in the community (93% of those from London Ambulance Service) and 4,200 referrals from NHS 111, with 10,300 patients managed without in-person ED attendance. This equates to a 29% ambulance conveyance rate, a statistically significant reduction in ambulance arrivals in all boroughs served.

With strongly positive patient and staff feedback, a system-wide saving of over £1.5 million a year and an estimated saving of 156 tonnes of CO_2 emissions, REACH has proven to be a safe and effective clinical co-ordination service.

1D. Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care

- **ICBs and local authorities** will need to review their BCF demand and capacity plans to ensure that commissioned capacity meets forecast need, to support both discharge and step-up care. Systems should ensure accurate estimates of demand from discharges and from community referrals are used to commission the appropriate volumes and types of intermediate care capacity, supported by the increase in the Discharge Fund (from £600 million in 2023/24 to £1 billion in 2024/25). Plans will

include making clear assumptions for average length of stay, and will actively consider the most appropriate balance between Pathway 0, Pathway 1, Pathway 2 and Pathway 3 discharges. They will take account of variations in demand over the course of the year and building potential ability to flex into forecasting models. Further support setting out the joint requirements for the NHS and local government to deliver the objectives of the BCF is included within the Better Care Fund 2024/25 addendum and associated demand and capacity planning templates. Plans will be assured through the BCF assurance process to ensure they are robust and deliverable.

- When conducting demand and capacity planning, **systems** should work with community and social care providers to ensure there is sufficient workforce capacity with the appropriate skill mix to deliver the required capacity. This 'right sizing' of capacity has been successfully achieved in some systems by making more effective use of both registered and unregistered workforce, and by using other community roles to support rehabilitation and reablement both in people's homes and, where appropriate, in community beds.
- The Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, and the Community rehabilitation and reablement model, set out the approach to service delivery.

Case study: Oxfordshire ICB – out of hospital care for people experiencing homelessness

Through start-up funding from the DHSC Out of Hospital Care Programme, Oxfordshire has implemented an excellent hospital in-reach and step-down service, which is helping transform patient's lives, prevent a return to rough sleeping, and dramatically reduce discharge delays and avoidable readmissions from acute and mental health hospitals.

Under the leadership of a dedicated programme manager, and with support and funding from the ICB, BCF and health and care partners, the programme has appointed experienced housing officers co-located in acute and mental health hospitals. They bring extensive legal knowledge related to housing applications in addition to working knowledge of local housing and homelessness services to support ward staff in planning individual's transition from the hospital.

Oxford has opened 4 step-down houses with 27 beds in the community, which include access to rehabilitation, reablement and recovery services, a social worker, occupational therapist, clinical psychologist and community based mental health workers. This service enables individuals to recover their mental health in the community and develop independent living skills, and facilitates services coming together collaboratively to support the individual.

The service has supported over 250 planned discharges from hospital (50% from mental health wards). Where a discharge has included a stay in a step-down house, there has been a 24% reduction in emergency hospital admissions and a 56% reduction in presentations to EDs. Over the 12-month evaluation period, mental health bed days were

reduced by 89% – saving the NHS £657,000. Patients are no longer ‘stranded’ in hospital and very rarely return to rough sleeping

1E. Improve access to virtual wards through improvements in utilisation, access from home pathways, and a focus on frailty, acute respiratory infection, heart failure and children and young people

- **Systems** maintaining capacity of virtual ward/hospital at home (HaH) beds, and expanding access by ensuring utilisation is consistently above 80%. Guided by feedback from systems, a new virtual wards operational framework will be produced in spring/summer 2024 to help tackle variation, achieve further standardisation and ensure the benefits of virtual wards/HaH can be realised at scale.
- **Systems (including local authorities) and providers** working together locally to increase the proportion of virtual ward beds accessed from home ('step up' virtual wards), including directing patients from EDs and SDEC following initial assessment where appropriate. In doing so, it would be helpful to pay particular attention to improving the coverage of paediatric virtual ward services and capacity.
- A new patient-level dataset for virtual wards (the Virtual Ward Minimum Data Set [VWMDS]) is being developed. When launched, **providers** will be expected to submit to the VWMDS, supporting local systems to have enhanced operational oversight of virtual wards as well as to enable national benchmarking. Further information on rollout will be published in due course.

Case study: Cambridge University Hospitals – virtual wards

In November 2022, CUH developed a virtual ward designed to deliver hospital-level care for patients in their own homes, using remote monitoring technology. The focus was on delivering 45 occupied virtual ward beds by September 2023 that delivered step-down discharge care, to free up capacity in the hospital.

A significant amount of pathway development work was undertaken to make the service available to every specialty in the hospital. Key to this was use of a remote digital monitoring technology, which allowed the team to monitor the vitals of all their patients continuously and spot when a patient was deteriorating. This helped build confidence with clinicians to refer their patients, given assurance as to the level of care and monitoring they would receive.

In just over 1 year of being operational, the CUH virtual ward has onboarded over 1,500 patients from 23 different specialties, including frailty, oncology, surgery, orthopaedics, cardiology and respiratory. It has exceeded its occupancy figure by almost double and the patient experience survey has a 97% satisfaction score. The wider benefits are considerable, with significant length of stay and associated bed day savings. CUH is now developing its model further to start delivering step-up and admissions avoidance care, and eventually include access pathways from primary care and care homes too.

Virtual Ward Bed Day Savings	

Priority 2: Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes

It is important to ensure that UEC and acute capacity is being used as efficiently and productively as possible. This includes the NHS, local government and other system partners working together to improve the timeliness of discharge from hospital and community settings.

Learning during 2023/24

Actions taken in Year 1 of the UECRP to improve post-pandemic productivity have demonstrated a length of stay reduction in overnight emergency admissions of over 4% in 2023/24.

Health and care systems across the country have driven length of stay reduction through initiatives such as:

- Using the discharge ready date (DRD) metric (first published in November 2023) to understand the proportion of patients not discharged on the same day as they are clinically ready for discharge (that is, no longer meet the criteria to reside), the average length of stay, and the distribution of those delays (that is, the proportion discharged 1 day, 2–3 days, 4–6 days, 7–13 days, 14–20 days and 21+ days after their DRD). These data support systems to understand variation both between trusts and between local authority areas, and to identify where to target improvements.
- Implementing and maturing their care transfer hubs to manage discharges for patients with more complex needs. A Sheffield University NIHR review of reviews – with acknowledged limitations of the evidence base – found evidence in the published literature that care transfer hubs show promise both for patient flow and UEC performance and for quality of patient care, in areas such as reducing all-cause mortality, hospital readmissions and ED visits.

This learning has informed the planning guidance requirements and the supporting delivery actions set out below for 2024/25. Further evidence is set out in case studies and links throughout this section.

Based on evidence from last year, key supporting actions for 2024/25 include:

2A. Reduce admitted and non-admitted patient time in emergency departments

- **Service providers (in and out of hospital)** working together to continue the focus on initial assessment. Continue to increase the proportion of assessments received within 15 minutes, and to increase the proportion of patients redirected to alternative services such as urgent treatment centres, SDEC and acute frailty services, as well as urgent care response and virtual wards.
- **Trusts** ensuring that their medical model of care for the first 72 hours is optimised to eliminate the longest waits in the ED.
- Building on the evidence that inpatient flow interventions are an effective way to decrease ED wait times, **systems working with providers** to improve flow into and through acute beds by reducing excess length of stay and variation in high volume, high bed use pathways.
- **Trusts** seeking to understand their non-elective length of stay in key medical specialties, particularly respiratory and cardiology, and how they compare to the national mean and best in class via GIRFT model hospital datasets. Where evidence-based, robust clinical pathways exist (for example, fractured neck of femur, stroke, STEMI, AF), trusts can review whether clinical pathways currently meet key time stamps and take steps to monitor current levels of adherence as well as instigate plans to improve this.
- **Trusts** ensuring critical interventions during a patient's in-hospital stay are in place, delivered in a timely way. This includes:
    - a review by a senior decision-maker within the first 12 hours in hospital
    - early planning and conversations around the patient's anticipated discharge needs with full involvement of patients, carers and families in line with statutory guidance on hospital discharge and community support
    - a care plan involving the patient and family/carer, and assessment against patient-centred questions
    - a daily ward and board round (including weekends) on each ward.
- **Trusts** reviewing and auditing their internal professional standards, using the ECIST guide as a starting point.
- Actions to address the long waits that occur for many mental health service users are also beneficial, including:
    - **systems** building on the successful rollout of psychiatric liaison services to all Type 1 EDs by working towards the ambition of responses within 1 hour of referral

- **systems and providers, including local government,** reducing mental health patient time in ED by tackling long length of stay of patients in acute beds waiting for transfer to a mental health bed, and the length of stay for those in mental health beds
- **systems, including local government,** focusing on improving whole pathway patient flow through mental health, including dedicated improvement action on discharge as set out in the 100 day mental health discharge challenge and GIRFT programme.

Case study: Lincoln County Hospital, United Lincolnshire Hospitals NHS Trust – admitted pathway criteria to admit (CTA) audit tool

Lincoln County has had long-standing challenges with exit block. Working with ECIST, it developed a pilot to incorporate the criteria to admit audit tool into its standard admission processes, via a designated shift within the consultant rota, 8am to 6pm, 7 days a week.

The CTA consultant reviewed all patients with a plan to admit to an inpatient bed, including those who had been seen by the acute medical or specialty teams. If the patient had improved clinically, or were deemed not to meet the criteria at the time of review, then alternatives to admission were sought.

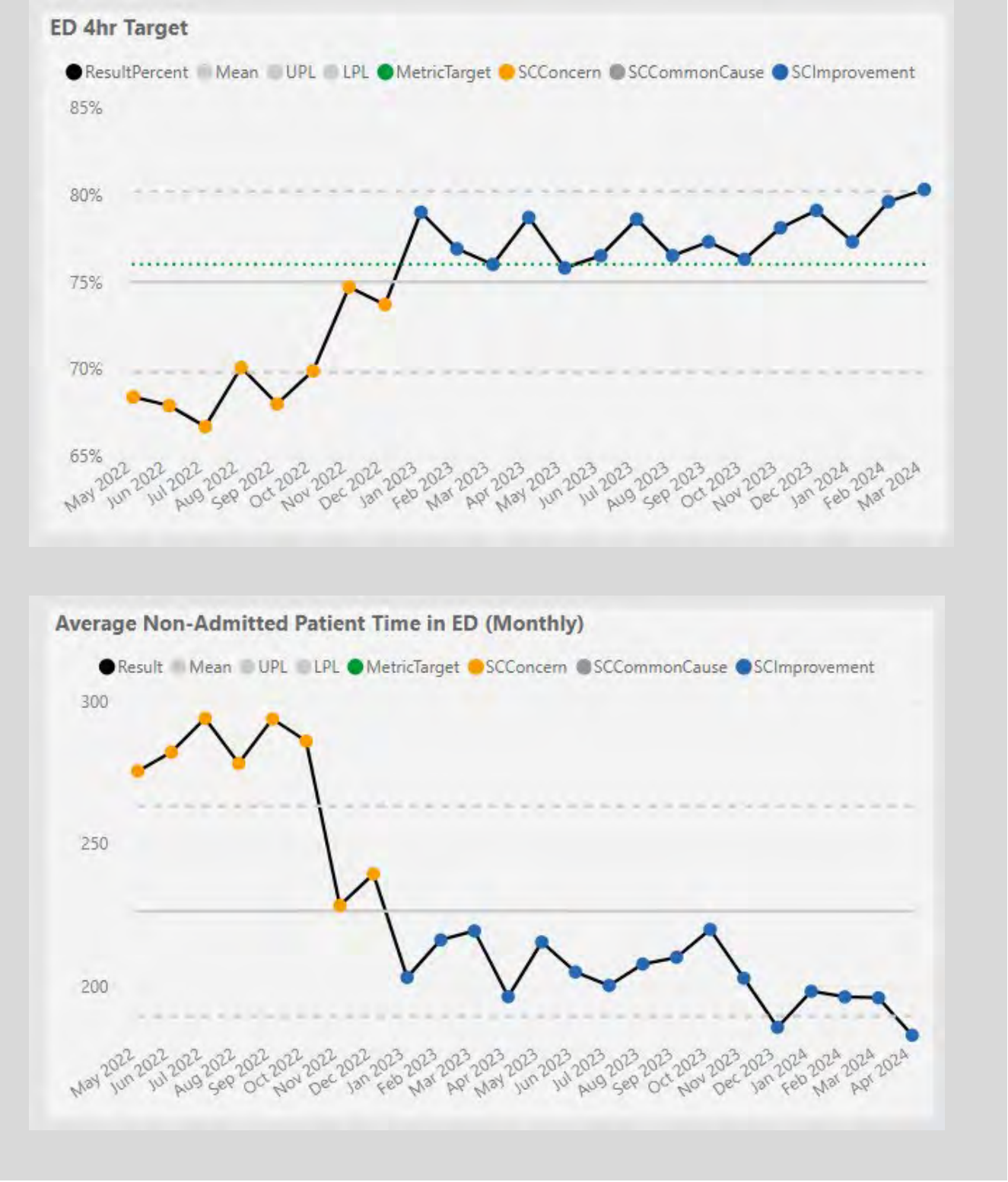
Early findings from the pilot have shown that this shift reduces admissions by 5–10 a day – approximately 8–16% of total admissions. Findings from an initial CTA audit suggest that over a week this equates to approximately 50 fewer admissions than pre-pilot with a resultant saving of 260 bed days a week. Every admission avoided also results in a decrease in bed wait time for the remaining admitted patients, improving overall performance as well as outcomes for those patients.

Case study: Norfolk and Norwich University Hospital – non-admitted pathway senior decision-makers

Norfolk and Norwich University Hospital prioritised a focus on the non-admitted pathway mostly utilised by walk-ins, identifying that ED crowding had a negative impact on efficiency and hypothesising that improvements in this area would yield multiple gains downstream.

Following a review of the ambulatory pathway model it established that placing a senior decision-maker (wherever possible at consultant level) as the first point of contact for the patient would yield the greatest dividends in terms of making better use of ED alternatives, ensuring patients received more guided work-ups, and resulting in more rapid turnarounds for those patients seeking primary care and not UEC.

This team was put in place in November 2022, made up of nursing, medical and healthcare assistants, and has seen a massive step change in the non-admitted pathway, with corresponding change in 4-hour performance.



2B. Reduce the number of patients still in hospital beyond their discharge ready date (DRD)

- **Acute providers** continuing to improve in-hospital processes to improve timeliness of discharge, including early discharge planning from the point of admission and early involvement of care transfer hubs where patients are likely to have more complex discharge needs.

- **ICBs and local authorities, working with acute trusts and community/social care providers** maximising the effectiveness of their care transfer hubs, and ensuring their care transfer hubs become increasingly mature over the course of the year. This includes extending the scope of care transfer hubs to discharge from community beds where practical and ensuring effective governance for care transfer hubs, including a senior responsible officer across the NHS and local authority, clear escalation routes and reporting, underpinned by high-quality, shared data. This includes ensuring the right mix of nursing, therapy and social work professionals are available to work directly with patients, families and carers to plan timely and effective discharge, with appropriate support for recovery and reablement, and effective arrangements through both ward-based teams and community/social care providers to ensure timely and effective transfers of care. Care transfer hubs should work closely with ward-based teams to ensure a 'Home First' approach to discharge, with a focus on strength-based, person-centred decision-making and full involvement of patients, carers and families.
- **Systems, including both the NHS and local authorities,** implementing trusted assessments to reduce duplication and ensure information is shared appropriately through the pathway. Care transfer hubs work best when they have the authority, knowledge of the local care landscape, processes and staffing mix to make effective decisions that provide the right support to go home, based on patient need and agreed by health and social care providers, supported by clear processes for case management from the point of admission until discharge, and escalation of challenges. Consideration may be given to holding a waiting list for each discharge pathway, so that if a discharge fails, the next person who could take up that bed or package of care is identifiable.
- **Systems and providers** ensuring patients no longer meeting the criteria to reside are discharged as early as possible in the day. Actions to deliver this include working with services outside the hospital to co-ordinate an early discharge, and avoiding bedding discharge lounges or, if there is no option, reverse boarding them with patients due for discharge the next day, reducing acuity (and therefore risk) within the discharge lounge.
- **ICBs and local authorities, working with acute trusts and community/social care providers**, using the new discharge metrics (derived from discharge ready date [DRD] data) and data on reasons for delay to identify how to increase the proportion of patients discharged on their DRD (that is, when they no longer meet the criteria to reside) and how to reduce the average length of discharge delays. This includes tackling the longest delays that are likely to be associated with poorer outcomes for patients.

Case study: South & West Hertfordshire – single point of contact

The Single Point of Contact (SPOC), South and West Hertfordshire's 'care transfer hub', merges health and social care discharge functions into one place to facilitate people to be discharged from hospital rapidly, safely and appropriately.

Operating since 2020, professionals from Hertfordshire County Council's Integrated Discharge Team, Central London Community Healthcare NHS Trust and West Hertfordshire Teaching Hospital NHS Trust work together to support on average 700 discharges a month; the majority of which are via discharge to assess. This is more than double the number of people discharged with support in 2019. The SPOC uses a 'discharge information form' completed by health professionals to fully understand a person's needs and take a strengths-based approach to supporting discharge to the most appropriate place, preferably home.

The SPOC enables:

- cross-organisation, person-centred triage and decision-making of referrals
- the person and their family carer to be involved in their discharge planning from the point of admission
- the person to be discharged with the support most appropriate for them with assessment being undertaken outside the acute hospital, achieving better long-term outcomes
- simplified referral and discharge processes, reducing the amount of time a person spends in hospital when there is not a medical reason to do so
- effective use of SHREWD, a shared data tool, to monitor real-time demand and escalate any issues or challenges, while also feeding in data to the 'DTA dashboard' which is used to inform system-level decision-making on capacity and demand activity
- West Hertfordshire to operate within national guidelines and best practice

The SPOC also works with the Impartial Assessor (Hertfordshire Care Providers Association) which supports timely transition from hospital to care homes by undertaking any assessments on behalf of the home and ensuring communication at every step.

Case study: Waltham Forest – care transfer hub

Waltham Forest's care transfer hub has representation from community services, their acute provider and the voluntary sector. It also has local authority input from Waltham Forest (including a dedicated broker and housing representative), Redbridge and West Essex to input into multidisciplinary team (MDT) discussion and provide updates on each patient awaiting discharge.

It has found success from its care transfer hub model for a number of reasons. It has established strong, partnership ways of working, which include twice daily attendance at MDT discussions that are held virtually. Data sharing agreements are also in place to support access to partner's systems and it has effective case management processes. Since introduction of its hub, Waltham Forest has achieved more discharges down Pathway 1 and fewer Pathway 3 discharges.

Waltham Forest also operates an in-house 'bridging service' where support workers and co-ordinators as part of the hub can provide care for Pathway 1 Waltham Forest patients for up to 5 days. This can support people to be discharged more quickly; an assessment of care needs is subsequently taken at home, the patient has quick access to equipment and reablement is provided at each care visit. It has found that as well as reducing length of stay in hospital, this has resulted in better outcomes for the patient.

Case study: Swindon – care transfer hub

In January 2023, Swindon launched its care transfer hub with representatives from the ICB, Swindon Borough Council, Great Western Hospitals NHS Foundation Trust, First City Nursing and acute and community therapy leads. The aims of introducing the hub included improving patient experience, streamlining referral processes and applying an MDT approach to triaging referrals and facilitating timely discharge to improve flow.

People who are identified as individuals who may require additional support on discharge are referred electronically to the care transfer hub by wards. This can happen at any time during their admission, from both acute and community hospital wards. Each day, including weekends, the MDT comes together to make a decision for their discharge pathway and relevant referrals are passed onto the appropriate team. The hub also holds daily NCTR calls to discuss discharges due that day and the following day, where actions are set to facilitate discharge and cases can be escalated.

The hub is also underpinned by a strong 'Home First' model. Individuals who are discharged down this pathway will be supported, via a multidisciplinary approach, for ongoing health and social care assessments. Staff make joint visits to minimise duplication and delays and, if required, ongoing care will be arranged for the individual. There is a system response in place under the SOP if there is a risk of readmission to maintain safety.

2C. Reduce length of stay in community beds

- **Systems** continuing with the actions identified to increase productivity of community bed-based services following the maturity self-assessment undertaken in July 2023.
- **Systems** extending the implementation of best practice flow principles to community beds.

- **Systems** reducing discharge delays from community bedded units through timely access to ongoing packages of care that support transition and continuation of rehabilitation and reablement at home, reducing days away from home.
- **ICBs and local authorities** exploring ways to track length of stay in intermediate care services locally, helping to improve the use of bedded and non-bedded intermediate care for people whose rehabilitation and reablement needs requires it.

2D. Improve consistency and accuracy of data reporting

- **Systems** ensuring all trusts are consistently and accurately recording key metrics, including SDEC activity in the Emergency Care Data Set (ECDS) and the Ambulance Data Set.
- **All NHS-commissioned community bed providers** being registered and submitting regular data to the Community Discharge SitRep, with updates to the dataset in mid-2024.
- **All acute and specialist providers** ensuring that they are submitting high-quality and timely DRD data for monthly publication, and that reasons for discharge delay are captured accurately in SitRep or Faster Data Flow returns.
- **Systems** ensuring system co-ordination centres are fully embedded, including operational standards and digital 'near real-time' footprint.
- **Systems** having arrangements in place to disaggregate data based on age, to understand demand and monitor performance for children and young people.

Priority 3: Developing services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs

During 2024/25, health and social care systems need to build on work underway to develop services that support a reduction in attendances and admissions to hospital, and to improve access to those services.

ICBs should work with local authorities, social care providers and VCSE partners to ensure an integrated approach to providing health and social care, where necessary, for people with urgent care needs – and to continue to strengthen proactive care for people most at risk of emergency admissions, including care home residents and people receiving domiciliary social care.

Parents and carers should be provided with access to clear, accurate information about common illnesses in children and young people, promoting self-care and access to the right care at the right time.

Learning during 2023/24

In Year 1 of the UECRP, health and social care systems have been working to build capacity that supports people to have their urgent needs met outside a traditional ED.

Zero-day length of stay (0LoS) has increased year on year since the introduction of a mandate to support SDEC service provision 12 hours a day, 7 days a week.

There has been a 11% growth in 0LoS emergency admissions during 2023/24, attributed in the majority to SDEC growth. Many systems have successfully introduced and matured their SDEC services to reduce both wait times and admission rates for some patients when compared to an ED or acute medical unit.

This learning has informed the planning guidance requirements and the supporting delivery actions set out below for 2024/25. Further evidence is set out in case studies and links throughout this section.

Based on evidence from last year, key supporting actions for 2024/25 include:

3A. Increase referrals to and the capacity of urgent community response (UCR) services

- Systems increasing referrals to, and number of patients treated in, UCR services, building on the success to date of these services in preventing patient deterioration and reducing pressures on other health services. This work has been most successful where:
  - there has been a focus on referrals from wider system partners including 999, NHS 111 and care homes to improve step-up pathways as forms of both attendance and admission avoidance
  - technologies (including point of care testing) have been implemented to optimise existing capacity
  - referral pathways from technology enabled care (TEC) providers and SDEC have been supported.

Case study: Oxford Health NHS Foundation Trust – urgent community response

The UCR service in Oxford, part of Oxford Health NHS Foundation Trust, delivers crisis response for people who are at risk of a hospital admission in the next 24 hours. It provides assessment, treatment and support in the patient's home to avoid a hospital admission.

To help keep people at home, Oxford's UCR team have developed strong collaborative working between themselves and secondary care. A 'consultant-on-call' service has been introduced where the UCR clinicians have direct access to an Oxford Health consultant geriatrician, which enables a clinical conversation to take place. Together they devise an agreed treatment plan for the person, often resulting in the person remaining at home instead of being conveyed.

Patients are reporting positive experiences of receiving care through UCR with patients saying the service is "amazing", "brilliant", "excellent" and one patient commenting that they were "grateful for remaining at home".

3B. Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week

- **Systems** continuing to develop access components, and encourage specialist SDEC development (such as frailty or paediatric) according to local demographic need.
- **Systems, including ambulance trusts,** increasing utilisation of SDECs by:
  - increasing the proportion of patients with direct access, increasing direct referrals from outside the ED (NHS 111, 999 and primary care)
  - reducing variation in the proportion of ED patients who are treated through the SDEC
  - implementing the minimum standards of delivery outlined in the SAMEDAY strategy.
- **Providers** working to improve consistency of reporting SDEC into ECDS by March 2025.

Case study: Imperial College Healthcare NHS Trust – SDEC access improvement project

Imperial College Healthcare NHS Trust has focused on improving access to SDEC across both its sites, St Mary's Hospital and Charing Cross Hospital. Direct electronic booking was introduced in June 2023, allowing the local NHS 111 provider and the ambulance trust emergency clinical assessment service (ECAS) to book patients directly into a slot at either SDEC unit without the clinician having to telephone the unit first.

Utilisation of this pathway showed a slow but steady rise as clinicians became familiar with the service – supported by a range of engagement efforts – rising from an average of 15 referrals a month to 55 referrals a month, an increase of over 250%. Associated benefits include a reduction in clinical touchpoints, unnecessary triage and multiple handovers of care, as well as alleviating pressures within the ED.

Following the success of the direct electronic booking pathway, St Mary's then introduced a direct access trusted assessor model for the ambulance service, whereby paramedic crews could bypass ED and convey patients direct to the SDEC unit. Direct conveyances have increased from an average of 20 a month at pilot launch to 36 a month in March 2024. Imperial has since gone live with direct access at Charing Cross as well.

3C. Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week

- **Acute frailty units** implementing the minimum standards in the FRAIL strategy supported by initiatives to increase patient flow through direct access, front door frailty identification, timely access to diagnostics and access to specialist clinicians where appropriate.
- **All acute trusts** implementing a comprehensive geriatric assessment at the front door, to increase the proportion of patients over 65 with a Clinical Frailty Score.

- **Systems** working to understand and reduce variation in care home residents' attendances at EDs.

Case study: Hillingdon Hospital – frailty assessment unit

Recognising the disproportionate impact that older adults with frailty have on ED performance, admissions and hospital bed days, Hillingdon Hospital used 2022/23 winter funding to develop its Frailty Assessment Unit in order to address these issues.

Following a successful pilot a business case was approved for the unit to continue operating under the new model throughout winter 2022/23 and is now business as usual. Through a combination of avoided admissions and reduced length of stay for patients admitted through the Frailty Assessment Unit, they were able to show a reduction of 127 bed days occupied by inpatients with a Clinical Frailty Score of 5 or more compared to the previous winter.

The frailty team continues to see between 150 and 200 patients a month including 26% of all patients with a Clinical Frailty Score of 6 or more who attend ED and SDEC, and have received good or very good feedback on 100% of the friends and family surveys.

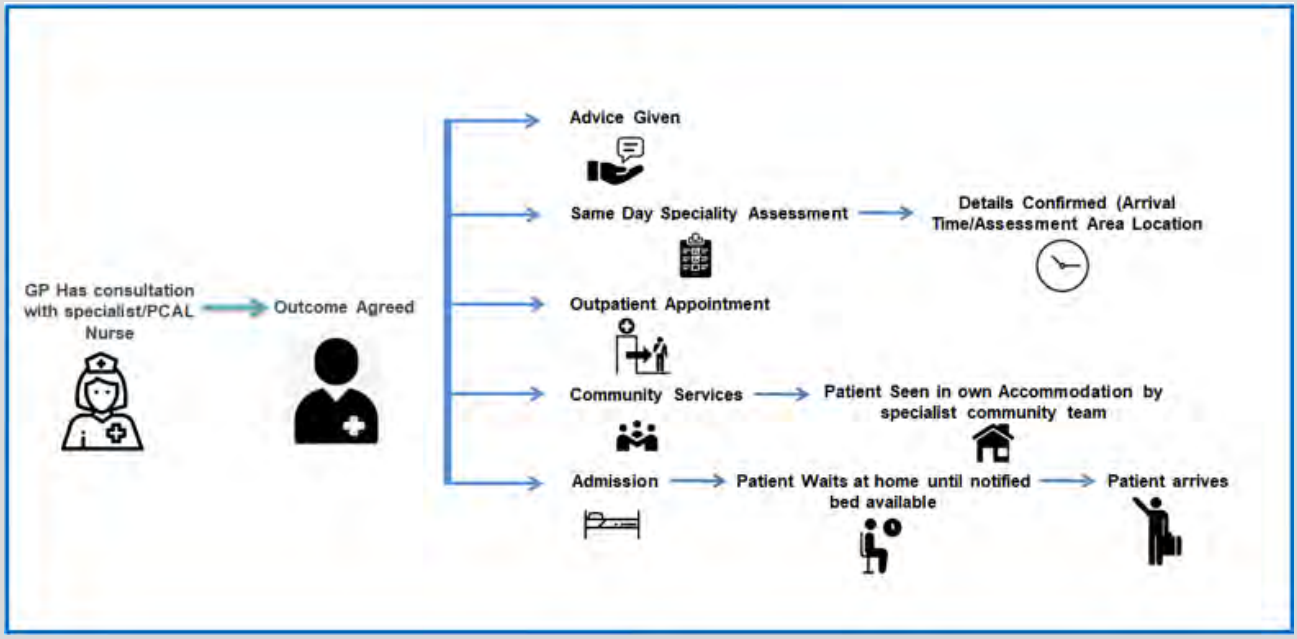
3D. Provide integrated care co-ordination services

- **ICBs and local authorities** working to understand the total demand for services that provide an alternative to an ED attendance for urgent care needs, complemented by a review of capacity across all relevant services, including UCR, community pharmacy and SDEC. Linking this to BCF demand and capacity planning for intermediate care.
- **Systems** working towards having core operational integrated care co-ordination structures as a minimum by October 2024, to help ensure the best response to patient needs, with a focus on paramedic access to clinical advice to support alternative pathways to ED.
- **Systems** ensuring they have plans to surge acute respiratory infection (ARI) capacity as required. For some systems, this may include the provision of ARI hubs, including paediatric ARI hubs for children. Analysis of ARI hub appointments from December 2022 found that ARI hubs can reduce pressure on ED attendance and free up capacity in general practice while improving same day access.

Case study: Leeds – Primary Care Access Line (PCAL)

The PCAL model aims to provide access to a range of services to prevent ambulance conveyance or attendance at ED, specifically for health and care professionals (HCPs), often GPs and ambulance CAS. HCPs are able to have a clinical conversation with PCAL and receive guidance such as direct booking and referrals to SDEC and other secondary care services, as well as pathways to community and out-of-hospital services. The model is nurse-led but the team are drawn from a variety of acute and primary care backgrounds.

The service has grown from 10 calls a day in 2003 to 225 calls a day (over 80,000 calls a year) in 2022/23, with access to over 50 clinical pathways, and Leeds showing lower than average ambulance waits in ED compared to regional peers. The service has particularly high levels of positive feedback from Yorkshire Ambulance Service clinicians and has been nominated by users for national awards.



Annex 3: Joint working between the NHS and local government

The effectiveness of UEC services relies on the NHS, local authorities, and providers of health and care services working together across the UEC pathway. Throughout the last year, there have been excellent examples of ICSs bringing together organisations across health, social care and wider community services to prevent avoidable hospital admissions, improve discharge from hospital, community and mental health settings, and improve outcomes for patients.

During 2024/25, the NHS and local authorities, working with the full range of relevant providers, VCSE organisations and patients, families and carers, will need to build on and strengthen this joint approach, working together with the following goals:

Build on progress in reducing discharge delays and improving discharge outcomes

- **Further improvements in demand and capacity plans for intermediate care,** based on reviewing patterns of demand and capacity in Year 1 and Year 2 and ensuring demand and capacity plans link with both NHS planning assumptions for UEC and local authority planning assumptions for adult social care.
- **Further optimisation of care transfer hubs** by implementing the 9 priority areas of focus as set out in the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, with a particular focus on cohorts with the most complex needs, including patients experiencing homelessness, complex dementia or mental health conditions.
- **Enhanced focus on improving discharge from community settings,** building on the work done on implementing care transfer hubs in acute settings.
- **Sustained focus on early discharge planning and 7-day discharge arrangements,** working across hospital wards, care transfer hubs, care providers and care homes.
- **Embedding a 'Home First' approach** to support recovery at home.

A stronger focus on preventing avoidable hospital admissions

- **Improving proactive care** through collaboration across the NHS, adult social care and related services for people most at risk to prevent people's needs from escalating; for instance, through falls prevention, home adaptations and assistive technology, telecare, and healthcare input into residential and nursing home settings.
- **Providing rapid community-based forms of crisis response** to avoid, where possible, acute hospital stays, including strengthening social care input into virtual wards.

Joint planning of workforce interventions

- **Developing the therapy and reablement workforce** needed for high-quality intermediate care.

- Developing the workforce needed to provide **specialist care for people with more complex needs** (for example, dementia nursing).
- **I**mplementing **new workforce models** as set out in the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge

Case study: Stockport Place, Greater Manchester ICS and Stockport NHS Foundation Trust/Pennine Care NHS Foundation Trust – high intensity use (HIU) service

Stepping Hill Hospital ED is supported by a HIU service, which identifies the top 250 A&E attenders within a 3-month period for dedicated support. The service is non-punitive, non-medical and is focused on supporting people with 'chaotic' or difficult lives while offering social, emotional and practical support. The impact of HIU services is significant, with a broad estimate of between 300 and 400% ROI, as well as the immeasurable benefits to patients:

James, 47, lived alone and had Crohn's disease and was on a waiting list for a stoma, but his surgery was cancelled. In this time, his mental health rapidly declined, and he attended ED 80 times in 12 months, sometimes twice a day – the majority by ambulance – and resulting in 11 non-elective admissions.

The HIU service adopted an assertive outreach approach, working on meeting his wider social needs including linking into the Crohn's Network for peer support. Furthermore, the HIU lead expeditated the necessary procedure and joined up his care. James' attendances to A&E stopped altogether and his mental wellbeing has improved incredibly. He now feels he can live life to the full and is very grateful for the intervention, saying "I know I can, but I don't want to have to attend A&E ever again."

To support these objectives:

- **ICBs and local authorities** will already be planning how to make most effective use of the BCF, including the £1 billion Discharge Fund (an increase of £400 million over 2023/24), to provide services that best meet people's needs for community-based care and support and maximise health and independence.
- **NHS England and the Department of Health and Social Care (DHSC)** will continue to work with the NHS and local authorities with the greatest UEC pressures to help develop system-wide improvements, building on the work of the Discharge Support and Oversight Group but with an enhanced focus on admissions avoidance and on flow through intermediate care. This will include further work to spread good practice in capacity and demand planning for intermediate care and in the use of care transfer hubs.
- **NHS England and DHSC**, through the joint Discharge Support and Oversight Group, will use data on discharge delays and reported reasons for discharge delays, alongside other available data, to measure progress across the NHS and local authorities in improving discharge, including improving flow through both bed-based

and home-based intermediate care, whether NHS commissioned, local authority commissioned or jointly commissioned.

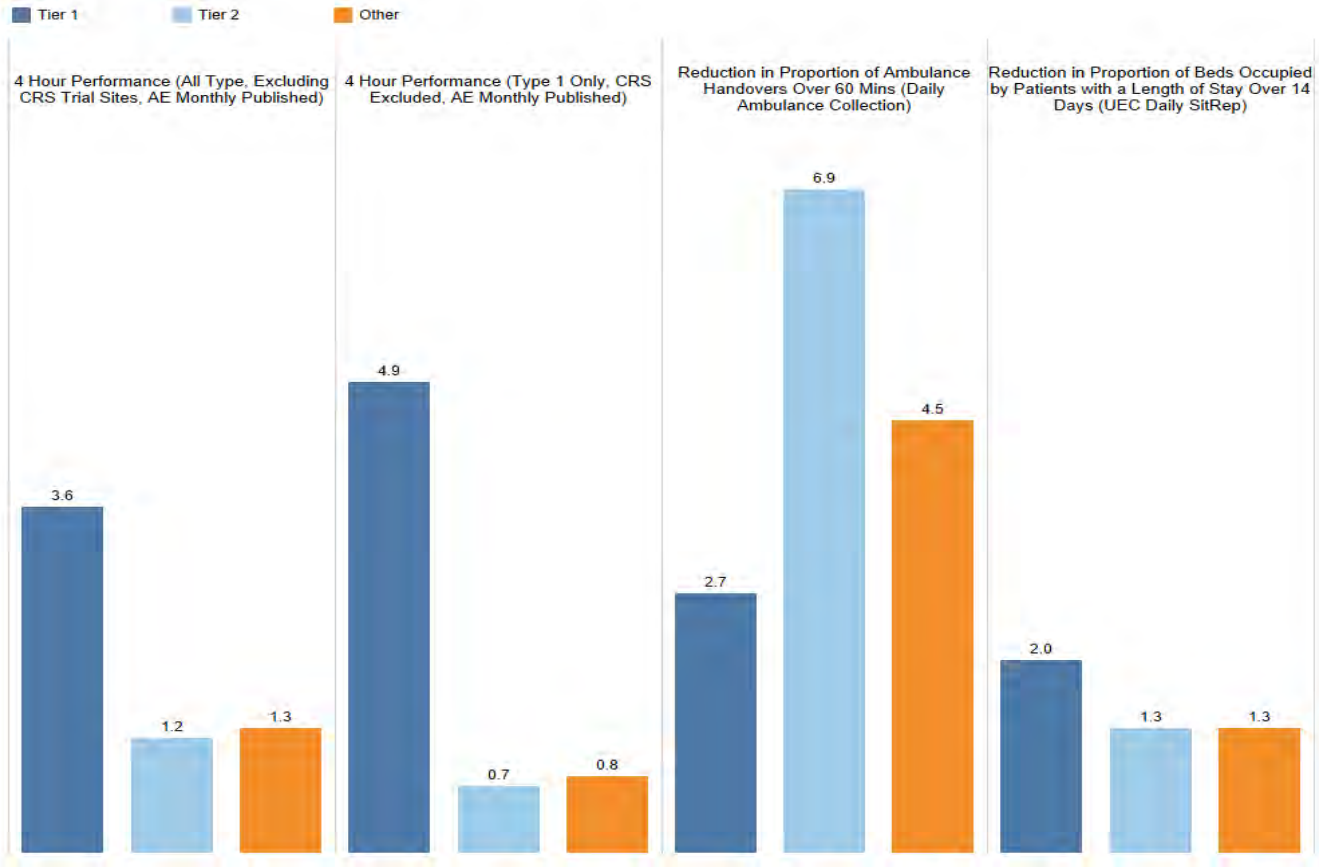
- **NHS England and DHSC** will go further to align and improve the universal and targeted support available through NHS England and the BCF support programmes.

Annex 4: Learning from UEC tiering

Analysis of the UEC tiering approach has shown that Tier 1 and Tier 2 improvement over the last year has been material, particularly in 4-hour performance.

Although all tiers have shown a percentage point increase in key metrics since UEC tiering support commenced. Tier 1 and Tier 2 systems with a Type 1 ED have shown a greater percentage point increase in some of these metrics. As can be seen in the chart below, Tier 1 trusts saw a 3.6 percentage point improvement in 'All Type' 4-hour performance and a 4.9 percentage point improvement in 'Type 1' performance. Tier 2 systems in turn showed a greater improvement than Tier 3 in reduced ambulance handover delays.

Improvement by percentage point in tiering metrics (original cohort)



Early findings from reviews of tiering support indicate that this approach works best where:

- strong system leadership provides system accountability and assurance of delivery and long-term, sustainable improvement
- collective, system-wide improvement is delivered through collaboration across the entire UEC pathway, including primary care, community services and mental health
- improvement approaches and performance oversight are supported and driven by data
- prioritisation of improvement opportunities is focused on the interventions that will have the greatest patient impact

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

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

26 June 2024

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh

National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer

NHS England

Dr Emily Lawson DBE

Chief Operating Officer

NHS England

Professor Sir Stephen Powis

National Medical Director

NHS England

Dame Ruth May

Chief Nursing Officer

England

FINANCIAL PERFORMANCE REPORT	MONTH 2

Meeting:	**Board of Directors (Public Meeting)**
Meeting Date:	**11 July 2024**
Agenda Item:	**Bo.7.24.17**

KEY HEADLINES

1. Year to date I&E position (£7.9m deficit) marginally better than plan.
2. Significant in month run rate improvement in Month 3 (£1.8m improvement).
3. Positive impact of financial controls, budgetary management and efficiency programme seen in Month 3 improvement (with greater impact expected from these measures in Month 4).
4. Indicative year end forecast scenarios have improved by £7m since Month 2 (it remains too early in the year for more accurate forecasts).
5. Indicative year end mid-case forecast deficit £27m (£13m behind plan).
6. Best case forecast remains delivery of the planned £14m deficit.
7. Closing the Gap (CTG) efficiency programme has delivered £3.9m of savings to date - £1.5m behind plan at Month 3.
8. Mid-case forecast CTG delivery £25.1m is £13.8m below plan (£2.1m improvement on late June forecast).
9. Opportunities exist to bridge the savings shortfall and are being pursued via Closing the Gap programme.
10. Significant progress made in engagement in the Closing the Gap programme across the organisation.
11. Major unresolved risks remain to delivering the financial plan in full with a risk of a significantly greater deficit than planned.
12. A deficit greater than the planned £14m deficit would result in external revenue cash support being required.

1. SUMMARY INCOME & EXPENDITURE POSITION

I&E	Annual Budget £m	In Month Budget £m	In Month Actual £m	In Month Variance £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Income	**575.1**	**48.1**	**48.7**	**0.6**	**144.1**	**146.0**	**1.9**
Expenditure	**(589.1)**	**(49.8)**	**(50.1)**	**(0.3)**	**(152.2)**	**(153.9)**	**(1.7)**
Pay	(390.5)	(33.7)	(32.3)	1.4	(97.0)	(98.3)	(1.3)
Non-Pay	(198.6)	(16.2)	(17.9)	(1.7)	(55.2)	(55.6)	(0.4)
Grand Total	**(14.0)**	**(1.7)**	**(1.5)**	**0.3**	**(8.1)**	**(7.9)**	**0.2**

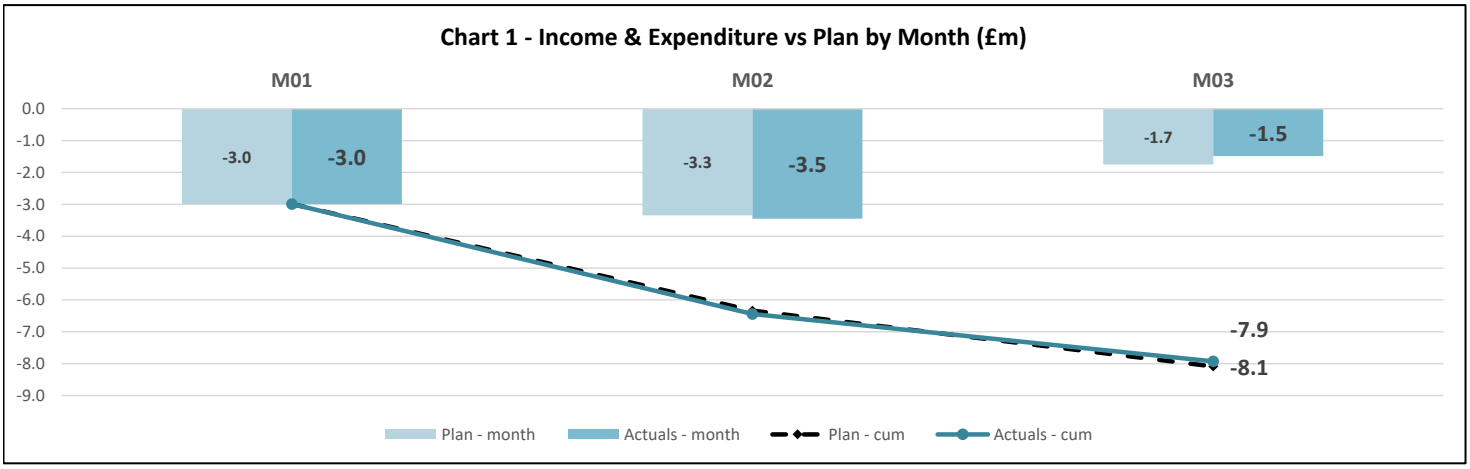
Commentary

Internal and external reporting is now based on the phasing included in the final annual plan submitted to NHSE in June 2024. NHSE required the cumulative provider plans to Month 2 to be re-phased to be broadly identical to Month 2 reported actuals (ie nil variance to plan at Month 2).

The Trust has reported a £7.9m cumulative deficit at Month 3. This position is £0.2m better than the planned £8.1m deficit and reflects a £0.3m favourable variance in month.

This position includes £0.2m of costs related to the industrial action at the end of June. NHSE has not confirmed whether offsetting funding will be provided for IA costs in 2024/25 and consequently no such funding is assumed in the Month 3 position.

The reported position assumes recovery of 100% of the ERF funding included in NHS contract plans for 2024/25, however up to date coded ERF activity data is not yet available and NHSE is yet to issue a comprehensive baseline against which to monitor. ERF funding is variable in 2024/25, with overpeformance resulting in increased funding and under-performance likely to result in a loss of funding. There is therefore a risk that the reported Month 3 income position may deteriorate once the baseline and fully coded activity information is available.



Commentary

In the month of June, the Trust posted a deficit of £1.5m. This represents a significant and material improvement on the April and May deficits, which were £3.0m and £3.5m respectively. The improvement in monthly run rate seen in June was £1.75m compared to the preceeding two months.

This run rate improvement is attributed in large part to the impact of additional financial controls that were introduced in Quarter 1, together with increased budgetary control within the Clinical Service Units and corporate departments and increasing contributions from the Closing the Gap programme as schemes begin to be implemented.

It would not be prudent to rely upon a single month's improved run rate to forecast full delivery of the financial plan and it must be recognised that the phasing of the £14m annual deficit plan becomes increasingly challenging in the later months of the finanical year. Further run rate improvements on a significant scale will be required to deliver the plan in future months.

However, the basic straight line extrapolation of the year to date position which informs one of the year end forecast models has improved by £7m in Month 3 compared to the extrapolation at Month 2.

2. IN MONTH I&E RUN RATE MOVEMENTS

2a. Run Rate Changes - Summary

I&E	M1-2 Ave £m	M3 £m	Run Rate Change £m	Annualised Change £000s	Change to Basic Extrapolation 24/25 £000s
Income	46.9	47.4	0.5	5.8	1.9
Pay	(32.1)	(31.1)	1.0	12.1	4.0
Non-Pay	(18.0)	(17.5)	0.5	6.2	2.1
Grand Total	**(3.2)**	**(1.2)**	**2.0**	**24.0**	**8.0**

** Tables 2a and 2b exclude R&D and the costs of industrial action*

Commentary

Table 2a shows the run rate improvements have arisen in all areas of income and expenditure (Appendix 1 breaks this run rate analysis down into more detail). If the Month 3 performance were to be repeated for 12 months, then this would result in a £24m improvement compared to a continuation of the Month 1-2 run rate. The extrapolation of these changes results in a base case £8m improvement in the remainder of 2024/25.

Income has improved due to increases to NHS commissioner contracts totalling in excess of £0.5m being agreed since May reporting.

The monthly pay run rate has improved by £1m. £0.5m of this improvement relates to non-recurrent costs incurred in April and May but reductions have also been seen in consultant PRA, Bank expenditure and overtime costs. Agency costs increased marginally in June.

The most substantial non-pay improvement was a £0.7m reduction in drugs expenditure. Drugs cost movements between months can be volatile and visibility of future months' expenditure will be required to gain confidence that this represents a sustained cost reduction.

2a. Run Rate Changes - by Department

I&E	M1-2 Ave £m	M3 £m	Run Rate Change £m	Annualised Change £m	Change to Basic Extrapolation 24/25 £000s
Diagnostics and Corporate Operational Services	(7.0)	(6.8)	0.3	3.2	1.1
Planned Services	(13.6)	(13.3)	0.3	3.4	1.1
Unplanned Services	(12.2)	(12.1)	0.1	0.8	0.3
Estates & Facilities	(3.6)	(3.3)	0.3	4.1	1.4
Corporate Services	(2.2)	(2.1)	0.1	1.0	0.3
Contract Income	42.3	42.5	0.2	2.8	0.9
Central Budgets	(6.9)	(6.1)	0.7	8.7	2.9
Grand Total	**(3.2)**	**(1.2)**	**2.0**	**24.0**	**8.0**

** Tables 2a and 2b exclude R&D and the costs of industrial action*

Commentary

Table 2b confirms that the Month 3 run rate improvements have been spread across all of the organisation's spending departments. While the improvement must be sustained into future months to confirm this is a trend rather than an anomaly, this widespread improvement does suggest the cost reductions are influenced by actions initiated in Quarter 1 to control costs and also represent a positive response from the Trust's budget holders to increase their focus on cost control and budgetary management.

2c. Run Rate Changes - Premium Variable Expenditure

I&E	M1-2 Ave £000s	M3 £000s	Change £000s	Annualised Change £000s	Change to Basic Extrapolation 24/25 £000s
ERF income	7,569	7,569	(0)	(0)	(0)
Interest Receivable	352	320	(31)	(378)	(126)
Bank	(2,613)	(2,559)	54	651	217
Agency	(703)	(752)	(50)	(595)	(198)
Consultant PRA	(410)	(247)	163	1,954	651
Overtime AfC	(102)	(74)	28	336	112
In / Outsourcing	(304)	(202)	102	1,222	407
Discretionary non-pay	(362)	(254)	108	1,291	430
Grand Total	**3,427**	**3,800**	**373**	**4,480**	**1,493**

Commentary

The Trust's Closing the Gap programme and the recently introduced cost controls seek to deliver reductions in a range of areas of premium variable expenditure and some defined variable income streams, as summarised in Table 2c.

The initial success of these initiatives and controls can be seen in many of the changes highlighted in table 2c. However the impact must and will increase as the controls become more embedded if the annual plan is to be delivered.

There are a number of positive trends within the data which are not yet reflected in the monthly position. For example, the final two weekly Payroll runs in June (for bank staff) were £30k lower than the average for the preceeding 11 weeks). This trend has continued into the first week in July. The annualised impact of this run rate improvement is a £1.5m reduction in Bank expenditure, only half of which is reflected in the June position and extrapolation reported in Table 2c.

3. EFFICIENCY PROGRAMME (CLOSING THE GAP)

3a. Efficiency Programme Summary by Risk Rating

Scheme Risk Rating (deliverability)	YTD Target £000s	YTD Actual £000s	YTD Variance £000s	Annual Target £000s	Forecast Delivery £000s	Forecast Variance £000s
Low Risk	5,319	3,101	(2,218)	38,868	13,365	(25,503)
Medium risk	(0)	629	629	(0)	6,498	6,498
High Risk	(0)	141	141	(0)	5,197	5,197
Grand Total	**5,319**	**3,870**	**(1,449)**	**38,868**	**25,060**	**(13,808)**

Commentary

The annual plan requires £5.3m of efficiencies to be delivered to Month 3. A total of £3.9m of savings have been recorded, which leaves the Closing the Gap programme £1.4m behind plan at Month 3. The shortfall has been offset by increased income, expenditure controls not recorded as efficiencies under the Closing the Gap (CTG) programme and delayed expenditure on agreed revenue developments.

The risk adjusted forecast is delivery of £25.1m of effiencies, which would result in a £13.8m shortfall against the required £38.9m of financial improvements.

The risk adjusted Month 3 CTG forecast is a £2.1m improvement on the £22.9m forecast provided in late June.

2b. Efficiency Programme Summary - Risk Adjusted Plan Status

Scheme Risk Rating (deliverability)	Full Year Opportunity £000s	Part Year Opportunity 24/25 £000s	Risk Adjusted Full Year Opportunity £000s	Risk Adjusted Part Year Opportunity 24/25 £000s	CSU Forecast 24/25 at Month 2 £000s
Low Risk	17,319	15,300	17,319	15,300	13,365
Medium risk	14,564	12,551	8,738	7,531	6,498
High Risk	25,111	18,637	7,533	5,591	5,197
Grand Total	**56,994**	**46,488**	**33,591**	**28,422**	**25,060**

Commentary

The totality of schemes under development and identified efficiency opportunities is calculated to be up to £57m on a full year basis. The part year opportunity in 2024/25 of these opportunities is £46.5m. This indicates that the Trust's budget holders and the Closing the Gap workstreams have the opportunity to bridge the forecast £13.8m savings gap. The significant challenge faced is in converting these opportunities into deliverable schemes and implementing the changes required to realise the financial benefits.

Risk Adjustment Methodology

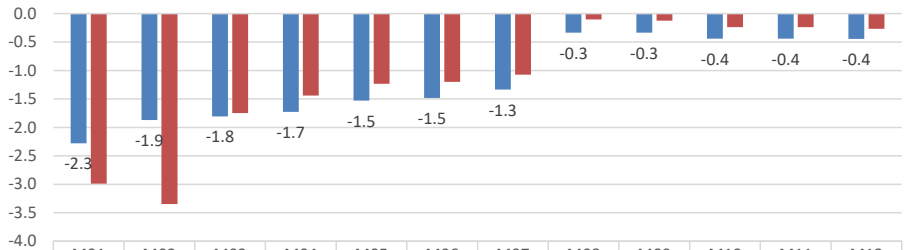
The value of schemes that are mature and assessed as having a low risk to delivery are not risk adjusted and are reported at 100% of the part year value. Medium risk schemes are only included at 60% of the part year value and schemes with a high risk of under-delivery are reported at 30% of the part year value.

A total of £46.5m of unadjusted opportunities have been recorded as deliverable within 2024/25. The Trust's risk adjustment methodology reduces this down to a £28.4m opportunity based on the assessed maturity and likelihood of delivery of each of the schemes. Finally, the CSUs and Workstream leads have provided their own forecasts for delivery against the schemes, including start dates, and this results in the lower figure for actual forecast delivery of £25.1m.

The focus of the Closing the Gap programme is on supporting Workstreams and CSUs to develop and implement their plans further so that confidence in scheme delivery and consequently the level of forecast savings improves on a month to month basis.

4. INCOME & EXPENDITURE - FORECAST OUTTURN SCENARIOS

Chart 2 - Planned Monthly Deficit - Revised Plan vs Original Plan (£m)



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Original Plan	-2.3	-1.9	-1.8	-1.7	-1.5	-1.5	-1.3	-0.3	-0.3	-0.4	-0.4	-0.4
Revised Plan	-3.0	-3.3	-1.7	-1.4	-1.2	-1.2	-1.1	-0.1	-0.1	-0.2	-0.2	-0.3

Original Plan Revised Plan

Commentary

The red columns in Chart 2 reflect the phasing of the final plan submitted in June 2024. The planned monthly deficit becomes increasingly challenging as the year progresses.

The notable improvement required from Month 8 onward reflects the phasing of the additional £5m stretch efficiency target. The Trust is required to deliver a position close to break even each month in Quarter 4.

3. Income & Expenditure - Forecast Outturn Scenarios

Details	Worst Case £m	Mid Case £m	Best Case £m
Efficiencies delivered in scenario	*13.4*	*19.9*	*32.9*
M3 run rate extrapolated	**-32.3**	**-32.3**	**-32.3**
Non-recurrent costs in M3 extrap	2.0	2.0	2.0
Phased pressures in plan	-5.0	-5.0	-5.0
CTG run rate improvement	1.8	8.3	21.3
Forecast Outturn	**-33.6**	**-27.1**	**-14.0**
Planned Deficit	-14.0	-14.0	-14.0
Forecast Variance	**-19.6**	**-13.1**	**0.0**

Commentary

At Month 3, it is too early in the financial year to present a fully reliable forecast outturn position. A range of high level scenarios based on the run rate to Month 3, and which take into account a very limited number of variables, is presented above.

It should be noted that none of the forecast scenarios presented include any estimate of the risk that ERF activity and income may be below planned levels - this is a significant risk that will be monitored once definitive coded activity data becomes available.

In all scenarios, the underlying run rate prior to CTG savings is forecast to deteriorate in line with the phasing of the annual plan. Inflationary pressures are expected to increase as the year progresses and recruitment into strategic business case investments, eg SLH DCU, the CDC and the Endoscopy Unit will continue to increase costs. Costs such as depreciation will also grow as the year progresses.

The key variable is clearly the level of delivery from the CTG programme (see tables 2a & 2b). The mid and worst case scenarios are based on the risk adjusted CTG forecasts at Month 3 and the best case scenario assumes sufficient cost controls and efficiencies are implemented to deliver the £14m deficit plan.

There remains significant risk to delivering the existing £25.1m CTG forecast and delivery of the additional savings and cost controls to achieve the planned £14m deficit is not confirmed at this stage. There is a plausible but extremely challenging scenario in which the plan may be delivered by year end, however the risks to delivering this plan cannot be overstated.

The Month 3 position is encouraging, but this improvement must be sustained and taken further to bridge the forecast gap in Quarters 2 - 4.

5. CASH FORECAST

Commentary

Failure to deliver the I&E plan may feasibly result in a reliance on external revenue cash support from NHSE in 2024/25.

I&E - The Trust is forecasting a reduction in cash of £17.9m relating to I&E performance. The main driver for this reduction in cash is as a result of £14.0m I&E deficit. Cash also decrease following movements in working capital £3.9m.

Capital - the Trust is forecasting £29.3m cash decrease from capital investments This includes investing £42.8m and £18.8m movement in capital payables. The Trust is expecting to receive £17.2m PDC this financial year and report £19.9m depreciation (this includes capital depreciation £18.5m and lease depreciation £1.4m).

The Trust is forecasting to hold £17.0m cash at the end of the financial year. £12.9m cash in bank will be held on behalf of Research and Development deferred income leaving £4.1m for the Trust.

APPENDICES (INCOME AND EXPENDITURE DETAILS)

Appendix 1 - Detailed I&E Run Rate Movements

I&E	M1-2 Ave £m	M3 £m	Change £m
INCOME	**46.90**	**47.38**	**0.48**
NHS Contract Income	42.28	42.52	0.24
Other Income	2.24	2.49	0.25
HEE Income	2.02	2.05	0.03
Interest Receivable	0.35	0.32	(0.03)
PAY	**(32.08)**	**(31.07)**	**1.01**
Substantive	(28.35)	(27.52)	0.84
Bank	(2.61)	(2.56)	0.05
Agency	(0.70)	(0.75)	(0.05)
Vacancy Factor	(0.00)	(0.00)	(0.00)
Consultant PRA	(0.41)	(0.25)	0.16
Targeted reserves	(0.00)	(0.00)	(0.00)
NON-PAY	**(18.00)**	**(17.49)**	**0.51**
Drugs	(5.09)	(4.41)	0.68
Efficiency Target outstanding	(0.00)	(0.00)	(0.00)
In / Outsourcing	(0.23)	(0.35)	(0.11)
Pathol. & Imaging	(0.99)	(0.94)	0.05
Clinical supplies	(3.89)	(4.36)	(0.47)
Non-Clinical supplies	(5.82)	(5.45)	0.37
Depreciation	(1.51)	(1.50)	0.01
PDC Dividend	(0.47)	(0.47)	(0.00)
Targeted reserves	(0.00)	(0.00)	(0.00)
Grand Total	**(3.18)**	**(1.18)**	**2.00**

Appendix 2 - Detailed I&E Budget Position

I&E	Annual Budget £000s	In-month Budget £000s	In-month Actual £000s	In-month Variance £000s	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s
INCOME	**575,052**	**48,094**	**48,660**	**566**	**144,119**	**145,989**	**1,870**
NHS Contract Income	502,114	41,844	42,521	677	125,534	127,089	1,555
Other Income	27,971	2,322	2,489	167	6,989	6,977	(12)
HEE Income	23,044	2,101	2,054	(47)	6,115	6,098	(17)
R&D Income	20,323	1,694	1,277	(417)	5,081	4,801	(279)
Interest Receivable	1,600	133	320	187	400	1,023	623
PAY	**(390,498)**	**(33,672)**	**(32,283)**	**1,390**	**(96,975)**	**(98,296)**	**(1,321)**
Substantive	(387,633)	(33,668)	(28,513)	5,155	(96,944)	(87,179)	9,765
Bank	(4,593)	(377)	(2,567)	(2,191)	(1,148)	(7,801)	(6,653)
Agency	(268)	(22)	(752)	(730)	(67)	(2,158)	(2,091)
Consultant PRA	(556)	(46)	(450)	(403)	(139)	(1,158)	(1,019)
Vacancy Factor	2,552	441	(0)	(441)	1,323	(0)	(1,323)
NON-PAY	**(198,554)**	**(16,170)**	**(17,862)**	**(1,692)**	**(55,230)**	**(55,621)**	**(391)**
Drugs	(53,348)	(4,445)	(4,414)	31	(13,336)	(14,601)	(1,265)
Clinical supplies	(50,029)	(4,257)	(4,370)	(113)	(12,538)	(12,185)	352
In / Outsourcing	(3,089)	(261)	(346)	(85)	(772)	(811)	(39)
Pathol. & Imaging	(11,921)	(999)	(942)	57	(2,980)	(2,917)	63
Non-Clinical supplies	(80,583)	(6,514)	(5,814)	700	(20,125)	(19,167)	958
Depreciation	(19,578)	(1,631)	(1,501)	131	(4,894)	(4,516)	379
PDC Dividend	(5,696)	(475)	(475)	(0)	(1,424)	(1,424)	(0)
Targeted reserves	(5,307)	425	(0)	(425)	(4,479)	(0)	4,479
Efficiency Target outstanding	30,997	1,987	(0)	(1,987)	5,319	(0)	(5,319)
Grand Total	**(14,000)**	**(1,748)**	**(1,484)**	**264**	**(8,086)**	**(7,928)**	**158**

Appendix 3a - Agency Expenditure by Staff Group

Staff Group	M01 £000s	M02 £000s	M02 £000s	YTD £000s	Annual Plan £000s	Straight Line Forecast £000s	Forecast Variance £000s
Consultants	205	268	331	804	1,752	3,216	1,464
Other Medical Staff	20	34	24	78	312	311	(1)
Nurses, ODPs & Midwives	225	245	195	665	2,664	2,661	(3)
HCAs				0	360	0	(360)
Physiotherapists	6	11	15	32		128	128
Pharmacist	29	26	18	73	101	293	192
Radiographers	45	42	34	121	307	483	176
Other Clinical Roles	12	7	19	39		156	156
Estates & Facilities	71	70	74	215	1,488	861	(627)
A&C	45	45	42	132	500	528	28
Total Agency Spend	**658**	**749**	**753**	**2,159**	**7,484**	**8,636**	**1,152**
Annual Plan	**819**	**819**	**782**	**2,420**			
Variance to Annual Plan	**(161)**	**(70)**	**(29)**	**(261)**			

Commentary

The annual plan includes maximum agency expenditure of £7.5m (a £2.5m reduction from 2023/24). At Month 3, agency expenditure was £2.2m against planned spend of £2.4m, meaning agency expenditure is £0.26m below plan at Month 3.

The plan phased greater reductions in agency spend from Quarter 2 onwards. A straight line extrapolation of Month 3's agency spend results in £8.6m of agency costs which would be £1.2m above the annual plan.

The Closing the Gap programme and the Variable Pay Panel that was introduced in June 2024 are the mechanisms by which the Trust plans to control agency expenditure and to improve the run rate to manage within the £7.5m planned envelope.

INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.7.24.17 - Integrated Dashboard May 2024 (cover).pdf

Bo.7.24.17 - Integrated Dashboard May2024.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

Integrated Dashboard – May 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 information	
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	11 July 2024	Agenda item	Bo.7.24.17

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

May 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

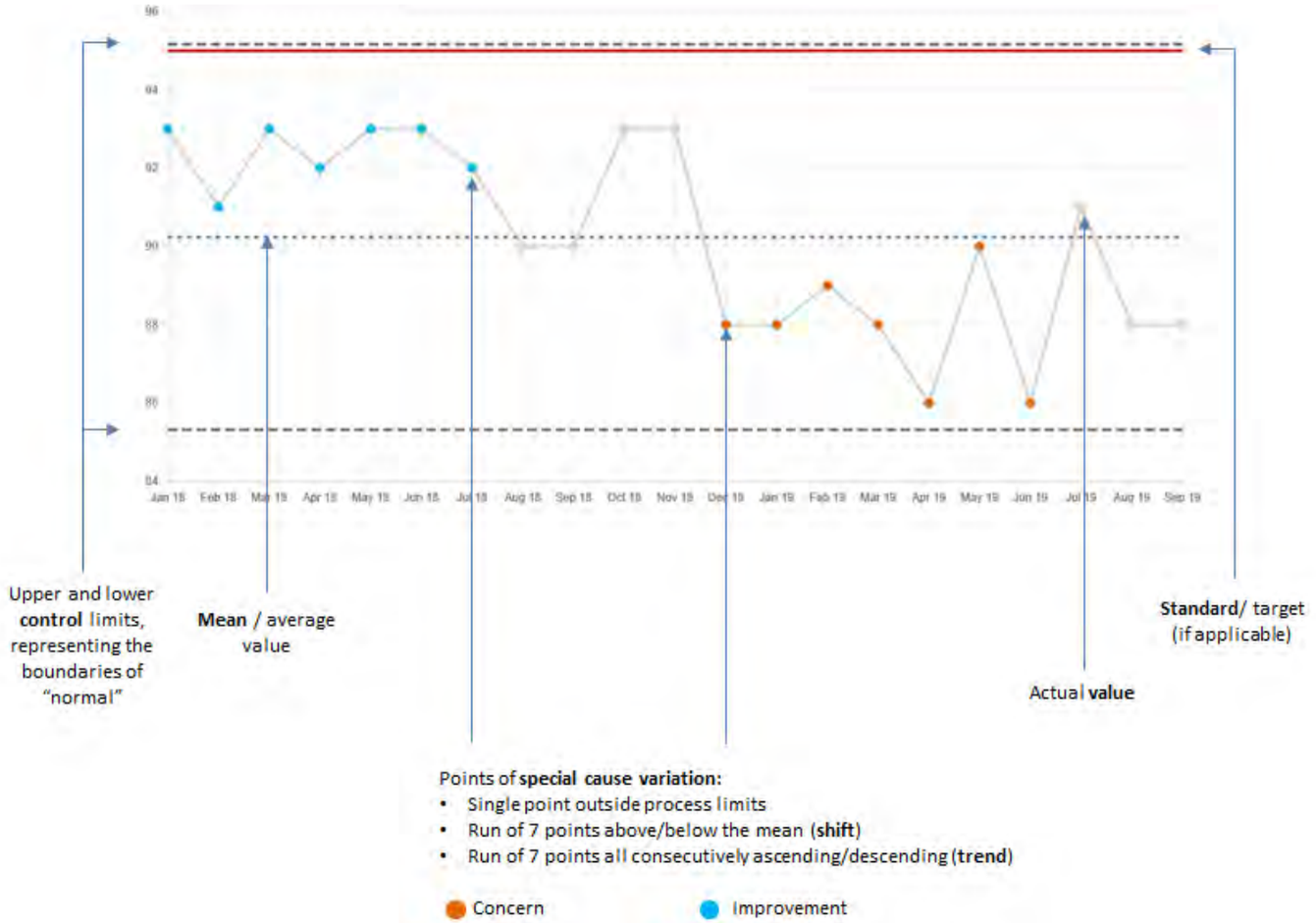
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

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.

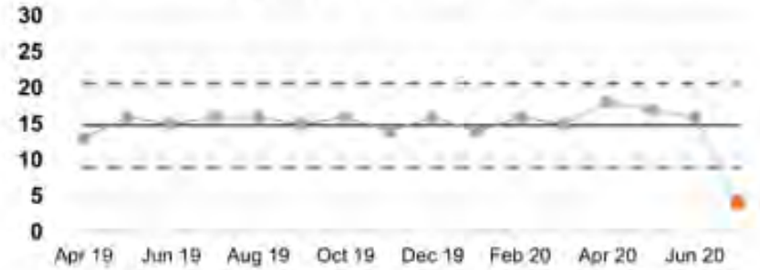
SPC charts



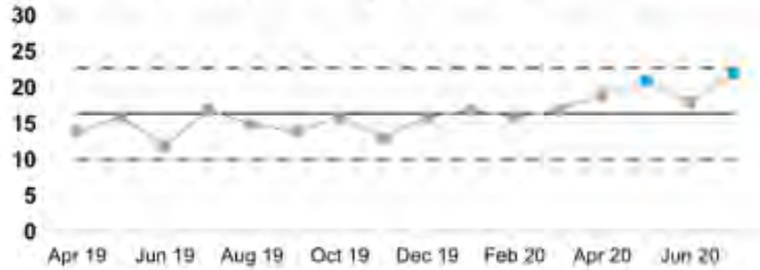
Interpreting Statistical Process Control Charts

SPC rules : special cause variation

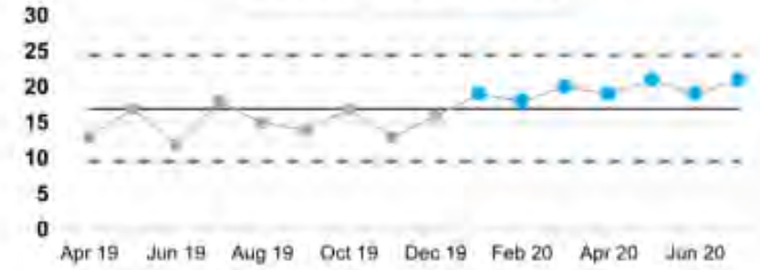
A single point outside the process limits



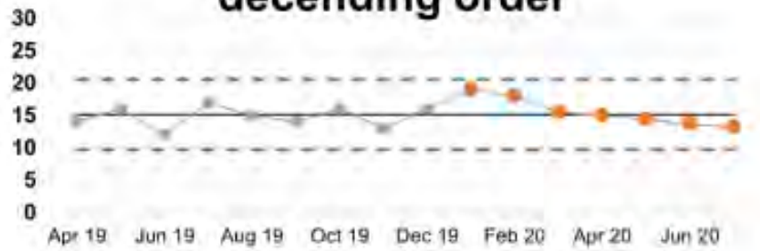
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or decending order



Operational Performance – Executive Director: Sajid Azeb

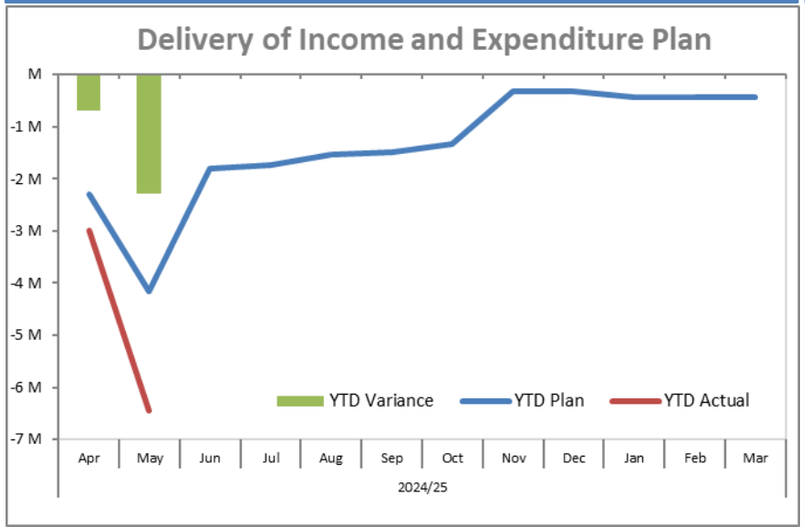
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	May-24	44.8%				56.40%
% Ambulance Handover <30 Mins - * All	May-24	75.5%				77.60%
% Ambulance Handover <60 Mins - * All	May-24	91.9%				86.30%
Ambulance Arrivals - * All	May-24	3,326				3200
Bed Occupancy - * All	Apr-24	94.50%	93%			90.70%
Cancer 2 Week Wait - * All	Apr-24	86.05%				93.80%
Cancer 28 Day Faster Diagnosis	Apr-24	78.30%				81.6%
Cancer 31 Day 1st Treatment	Apr-24	95.00%				92.6%
Cancer 62 Day Wait - * All	Apr-24	70.50%	75%			74%
Day Case Rate - * All	May-24	89.40%				88.90%
Diagnostic Waiting List - * All	May-24	8,876				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	May-24	77.60%	95%			72.50%
DTA to Admission > 12 Hours	May-24	4.6%				2.01%
DNA Rate - All	May-24	8.57%				8.85%
ED - Time to Initial Assessment - * All	May-24	22.00				24.4
ED Attendances - * All	May-24	13,094				11,993
ED Attendances (% < 4hr) - * All	May-24	81.60%	77.30%			75.60%
Elective Theatre Sessions Volume Completed	May-24	532				521
Length of Stay 21+ Days - * All	May-24	125.5				103.5
Not Meeting Criteria to Reside - * All	May-24	13.39%	14.79%			13.06%
Outpatient Attendances	May-24	43,325				41,567
Outpatient Attendances % New or with Procedure	May-24	56.50%				56%
Outpatients Discharged to PIFU	May-24	3.23%				2.14%
Patients Discharged on/before DRD	May-24	81.4%				81.90%
Pts in ED >12 Hrs - * All	May-24	823				680.1
RTT 18 Weeks (%) - * All	May-24	64.70%				68.90%
RTT 18 Weeks (Total Pathways) - * All	May-24	35,733	30571			35,619
RTT 52 Week Breaches - * All	May-24	435				613.3
RTT 65 Week Breaches - * All	May-24	67				81.6
Theatre Capped Utilisation	May-24	86.10%				82%

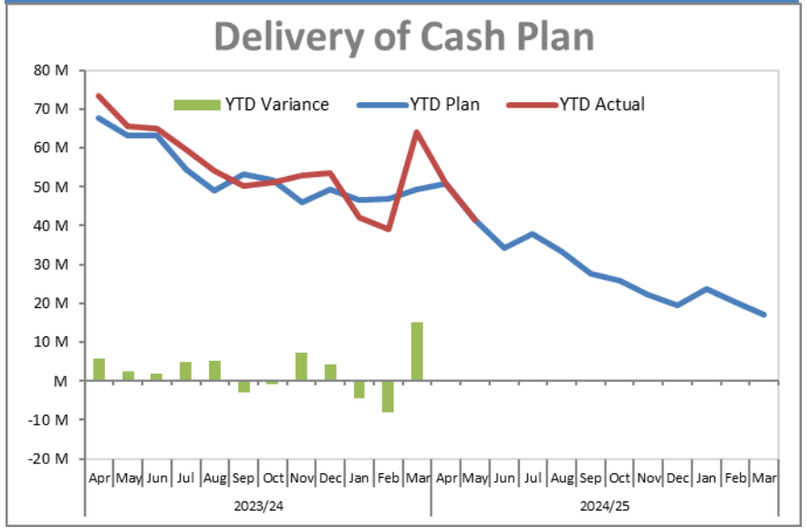
Finance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

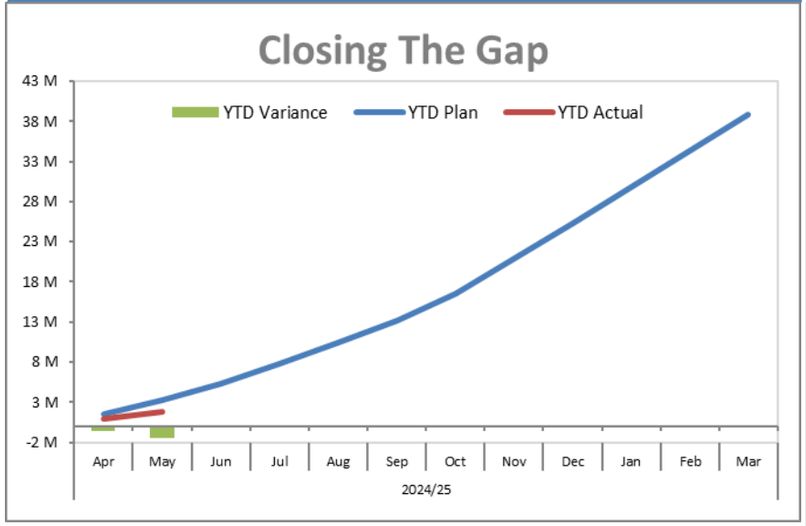
April 2024 – -£6.4m



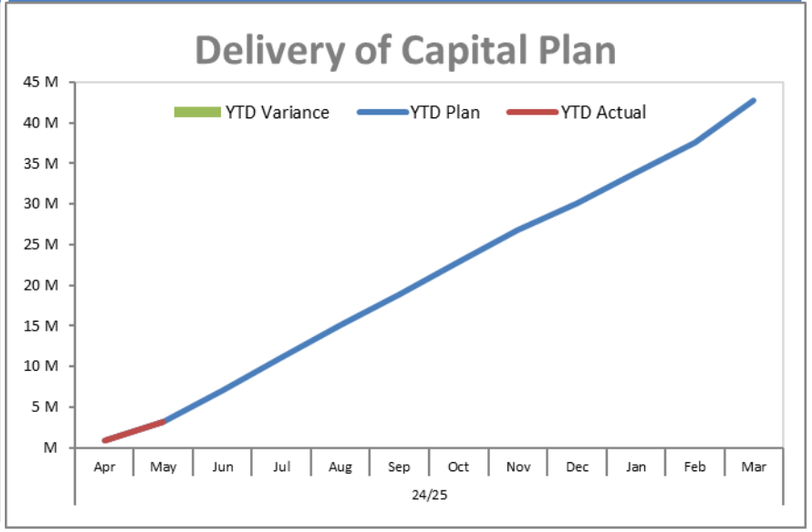
May 2024 – £41.6m



May2024 - £1.86m



May 2024 – £3.2m



Analysis

Income & Expenditure

The Trust's Month 2 Income & Expenditure position is a deficit of £6.5m. This is £2.3m worse than the originally planned deficit of £4.2m The Closing the Gap programme is £1.5m behind plan and is the key driver for the adverse I&E position.

NHSE required providers to re-phase their plans in June 2024 to ensure the plan at Month 2 aligns exactly to the reported actuals. Against this revised plan, the Trust has formally reported zero variance to NHSE.

Cash

Year to date cash is £41.6m which is in line with the re-phased plan submitted to NHSE.

The Trust is forecasting to hold £17.0m cash at the end of the financial year. £12.9m cash in bank will be held on behalf of Research and Development deferred income leaving £4.1m for the Trust.

Capital

Capital expenditure to Month 2 was £3.2m which is in line with the re-phased plan submitted to NHSE. It is forecast that the full capital budget of £40.7m will be spent in 2024/25.

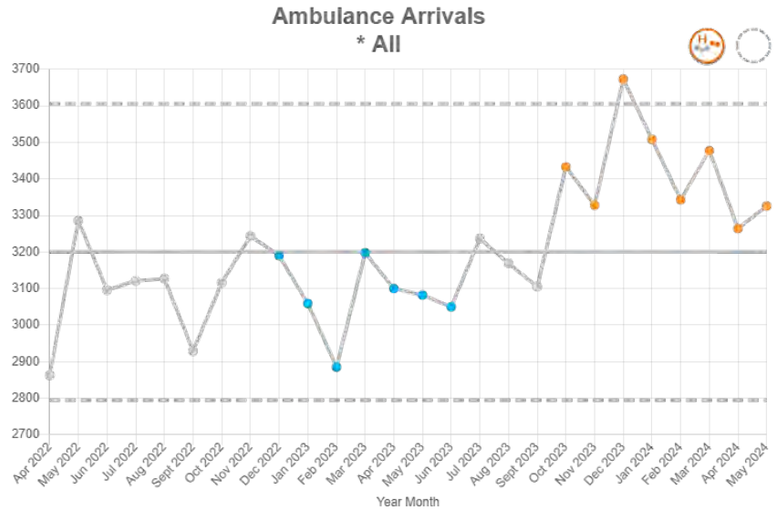
Closing the Gap

The Closing the Gap programme has delivered £1.8m of cost reductions at Month 2 against a target of £3.3m, resulting in a £1.5m shortfall. The risk adjusted year end forecast is delivery of £22.9m of savings against the £38.9m target, leaving a shortfall of £16m. Further work is ongoing to validate this forecast which is expected to change materially in the coming months.

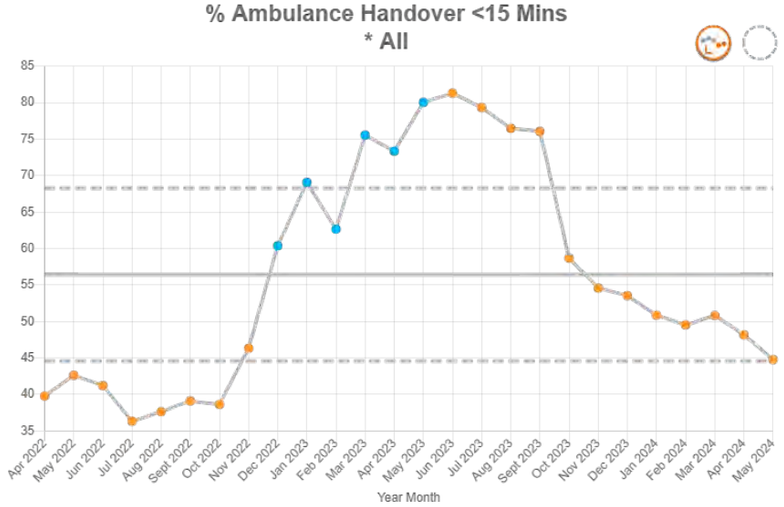
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

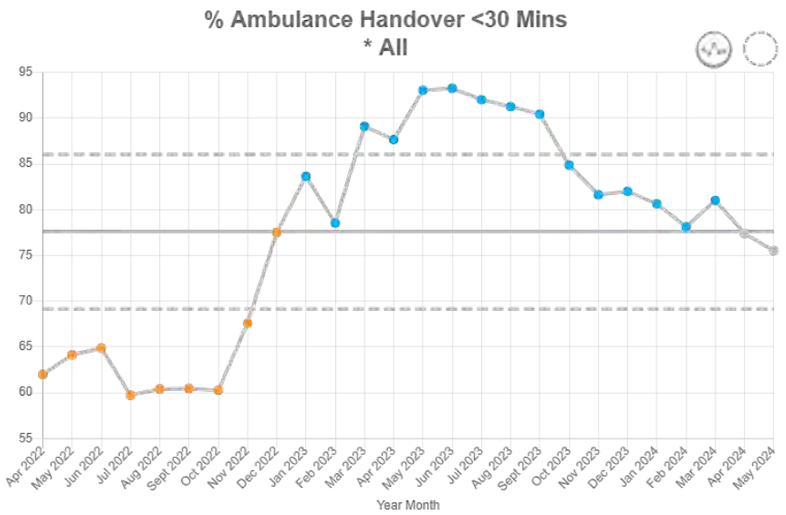
May 2024 – 3,326 ambulance arrivals
Special cause variation of a **concerning** nature



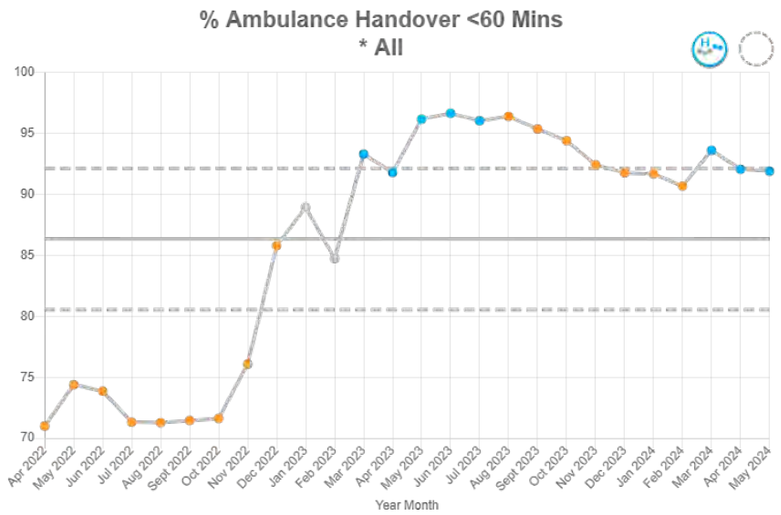
May 2024 – 44.8% ambulance arrivals
Special cause variation of a **concerning** nature



May 2024 –75.5% ambulance arrivals
Common cause variation



May 2024 – 91.9 % ambulance arrivals
Special cause variation of an **improving** nature



Analysis

Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 44.80% in May compared to 48.19% in April. The average number of ambulances arriving daily in remained comparable to the increased numbers in recent months whilst the acuity of patients arriving by ambulance also remained high, up by c.28% 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

Ambulance handovers continue to be recorded on the YAS Ambulance Mobile Device Terminal (AMDT) only. Whilst this has reduced duplication for YAS colleagues, there are still discrepancies with data accuracy - significant internal validation remains in place with a c.49% discrepancy in handover clock stops.
Collaborative work is ongoing with YAS, mapping the ambulance handover process has now been completed with issues identified and owners allocated. A new handover process, approved and communicated to the teams by YAS and BTHFT is due to start on 26th June.
Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions and executive-level oversight continues to ensure rapid intervention for any handover delay more than 1 hour.

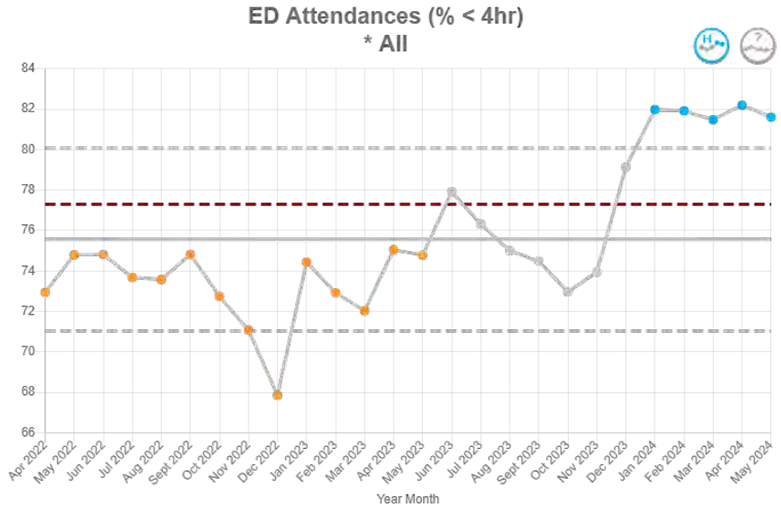
Benchmarking

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.

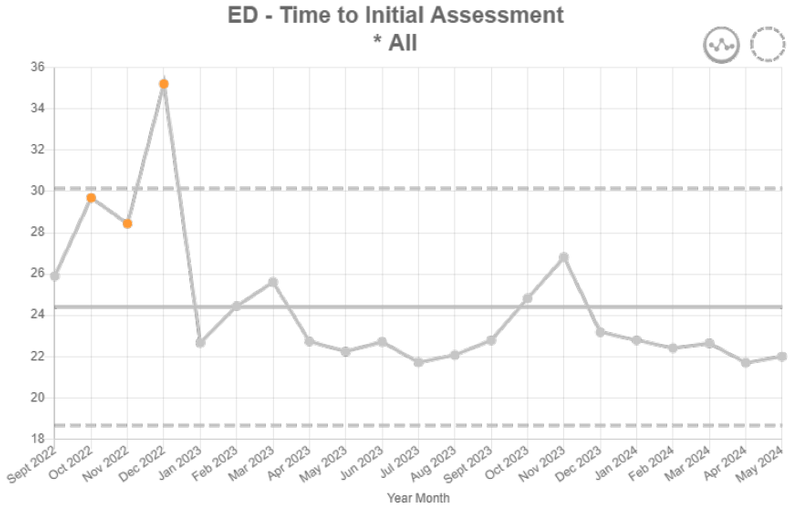
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

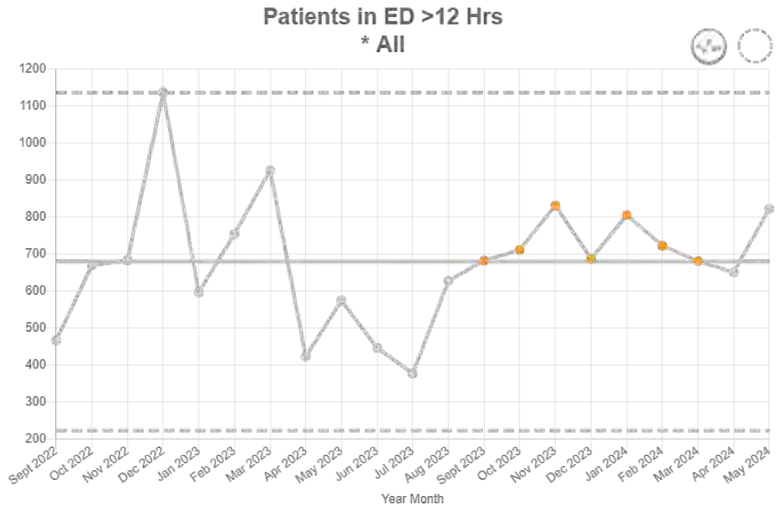
May 2024 – 81.6% - Year end target 77.3%
Special cause variation of an **improving** nature



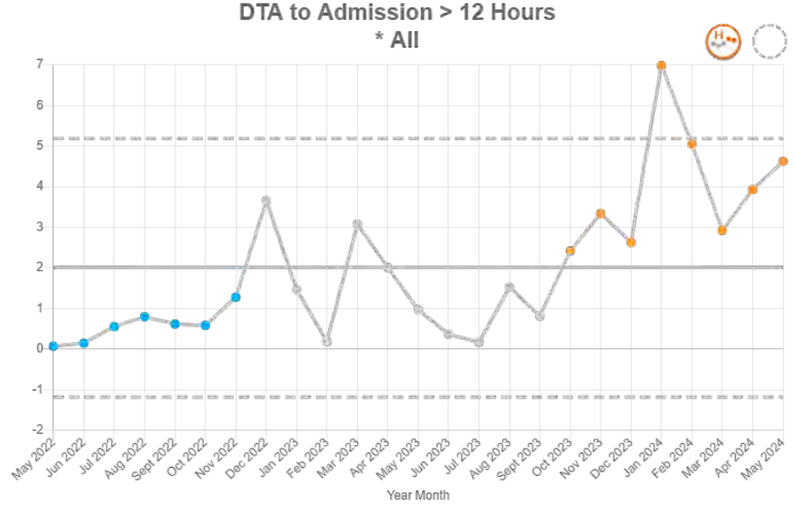
May 2024 – 22 minutes
Common cause variation



May 2024 –823 patients
Common cause variation



May 2024 – 4.6%
Special cause variation of a **concerning** nature



Analysis

ECS performance for Type 1, 2 & 3 attendances was 83.06% for May 2024 and is currently forecast at 82.34% for June 2024. The position remains in the upper decile of Acute Trusts in England.
Daily attendance continued to remain high in May with an average of 422 ED arrivals per day; an increase of c.6% compared to the same time last year in addition to a c.25% increase in high acuity.

Risks, Mitigations and Assurance

Front door streaming is supporting improved time to initial assessment and 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 reduced to 95.08% in May 2024 although high acuity and issues within the social care sector continue 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.

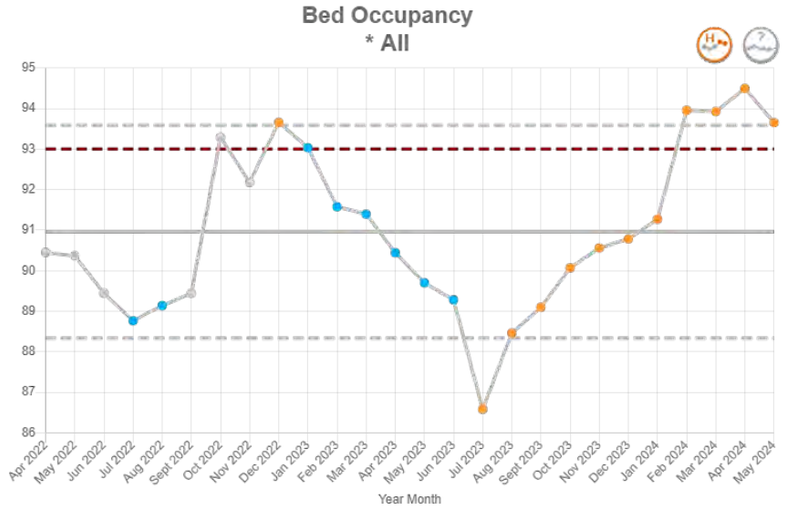
Benchmarking

Performance is above national, peer and WY averages. For ECS the Trust performs in the upper decile of Acute Trusts in England.

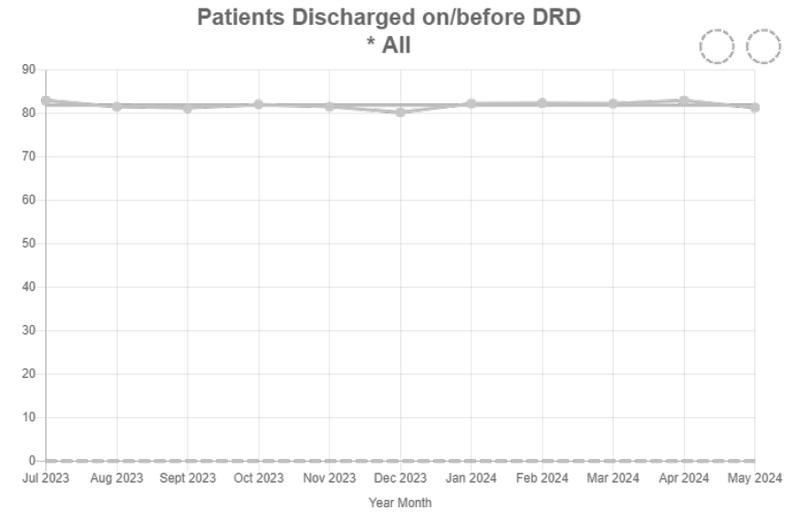
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

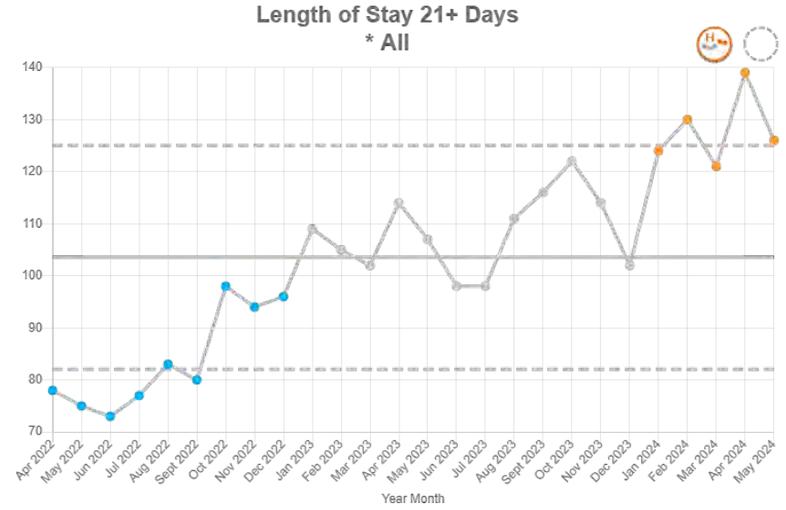
May 2024 –93.7% occupancy – Year end target 93%
Special cause variation of a **concerning** nature



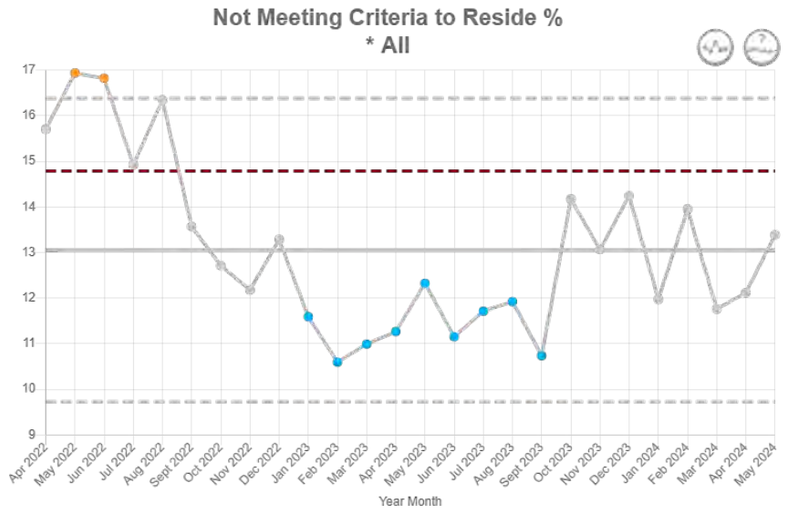
May 2024 –
Common cause variation



May 2024 – 125.5 patients
Special cause variation of a **concerning** nature



May 2024 –13.4% 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 124 in May 2024 with further improvements forecast in June (108). 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. With internal processes continuing discharge and occupancy metrics have shown improvement despite these challenges.

Risks, Mitigations and Assurance

A 7-day consultant of the week model remains in place, ensuring all inpatients receive a senior review daily and the Deputy Directors of Nursing and Matrons conduct a weekly review of 'Super Stranded Patients'. A 'Criteria to Reside' meeting occurs twice weekly with the operational management teams in the MAIDT, Local Authority (LA) and Therapies to identify and address complexities to discharge, whilst challenging unnecessary delays to discharge planning.
Weekly exception escalation calls were held throughout April with the LA to increase the number of people being discharged on Pathway 1, although the number of people awaiting external provision continues to remain a challenge. Discharge to Assess and improvements around all 3 discharge to assess pathways can be found in the IMC blueprint which was signed off by the Healthy Communities Board at the end of April. The Home-First Assessment Team (H-FAST) pilot at AGH is proving a success, BTHFT have a meeting in June to discuss a pilot roll-out and agree a launch date of the model.

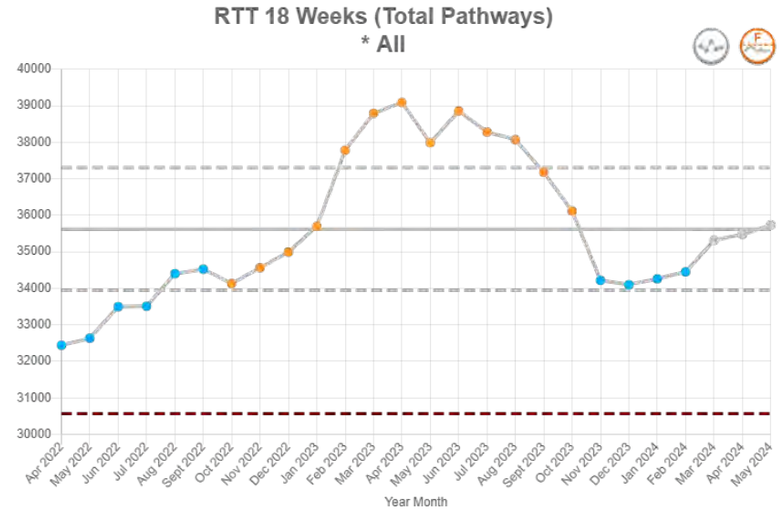
Benchmarking

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.

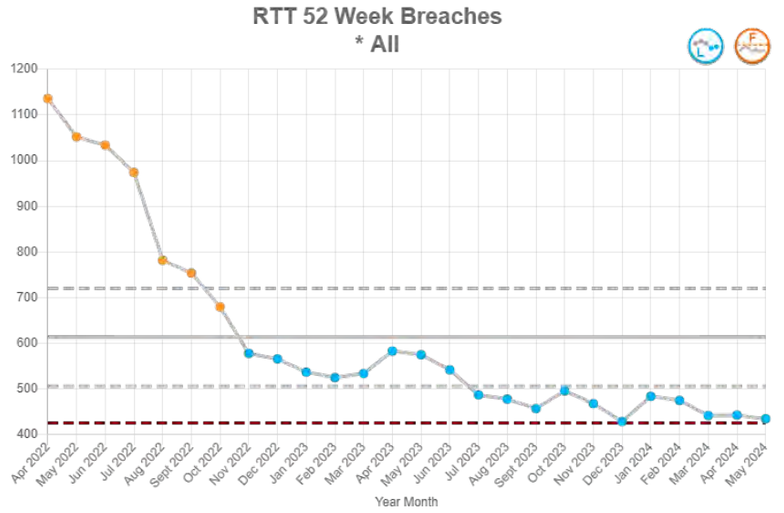
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

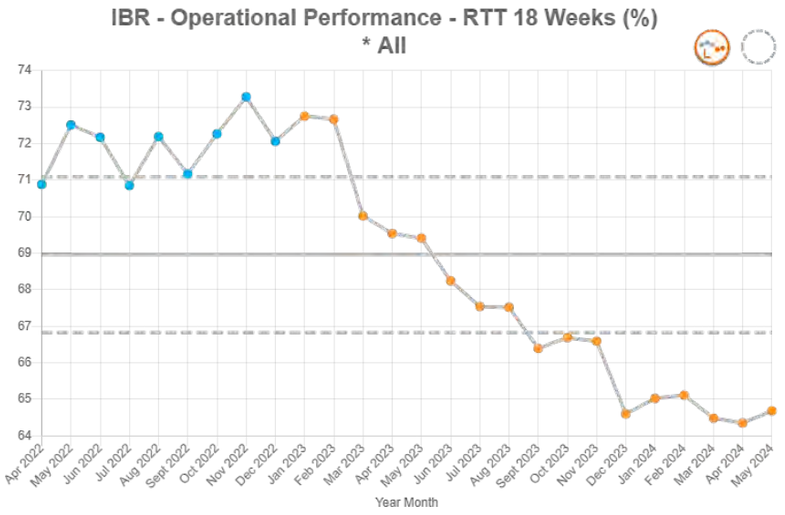
May 2024 – 35,733 pathways – Year end target 30571
Common cause variation



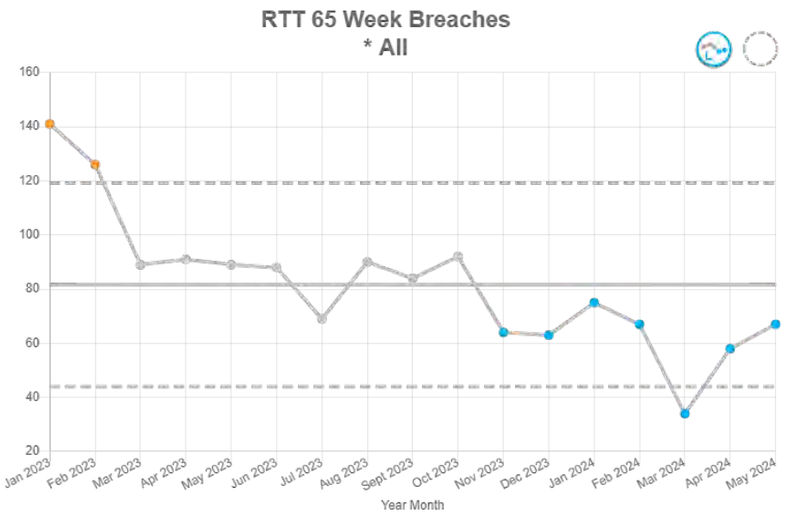
May 2024 – 435 pathways – Year end target 426
Special cause variation of an **improving** nature



May 2024 –64.7%
Special cause variation of a **concerning** nature



May 2024 –67 patients
Special cause variation of an **improving** nature



Analysis

The RTT waiting list size remained slightly above plan in May 2024 and is projected to continue to do so in June 2024. Whilst activity, particularly for admitted pathways remains below plan this trend will likely continue.
There was no patient reported over 78 weeks at the end May but there were 67 patients beyond 65 weeks, predominantly in Trauma & Orthopaedics who are being supported to maximise available theatre capacity to reduce their long wait breaches going forward. Despite this recovery work it is expected we won't meet the target to have zero by the end of August.

Risks, Mitigations and Assurance

Outpatient and elective transformation schemes are being supported by GIRFT further faster. This is a clinically led approach to understanding opportunities presented by variation in data compared to peers. Specific deliverables are also being identified for targeted work under the Closing The Gap programme with dedicated senior operational leadership and allocated improvement resource. 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.

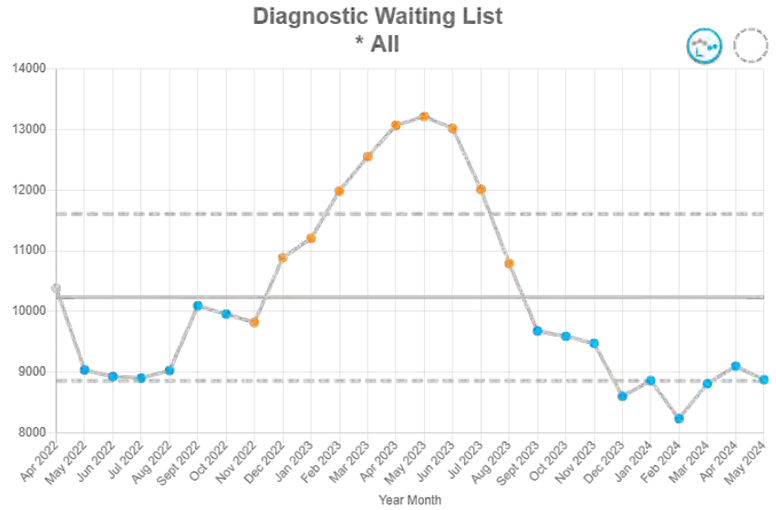
Benchmarking

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.

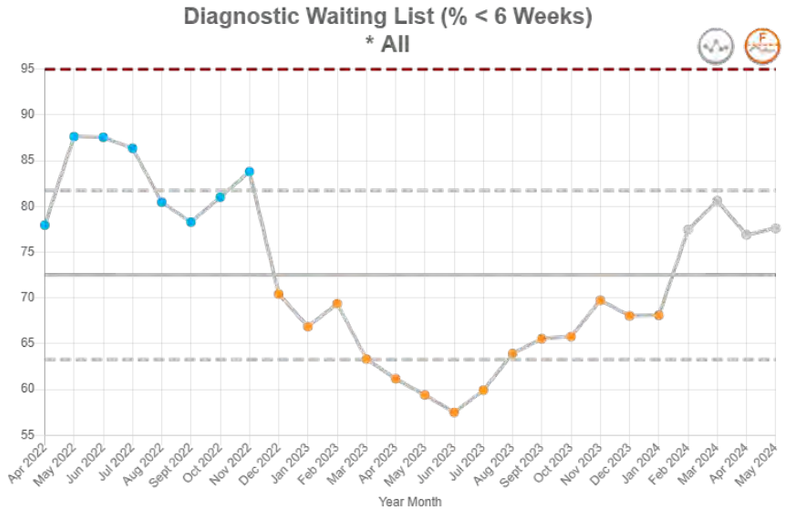
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

May 2024 – 8,876 pathways
Special cause variation of an **improving** nature



May 2024 – 77.6% <6 Wks – Year end target 95%
Common cause variation



Analysis

DM01 performance for May 2024 remained behind plan at 77.6% with ongoing capacity issues within Audiology and MRI. Recovery is excepted from July as consistent capacity plans progress.
CDC capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. Process and efficiency improvements are being explored to further capitalise on this resource.

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 continues. 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.

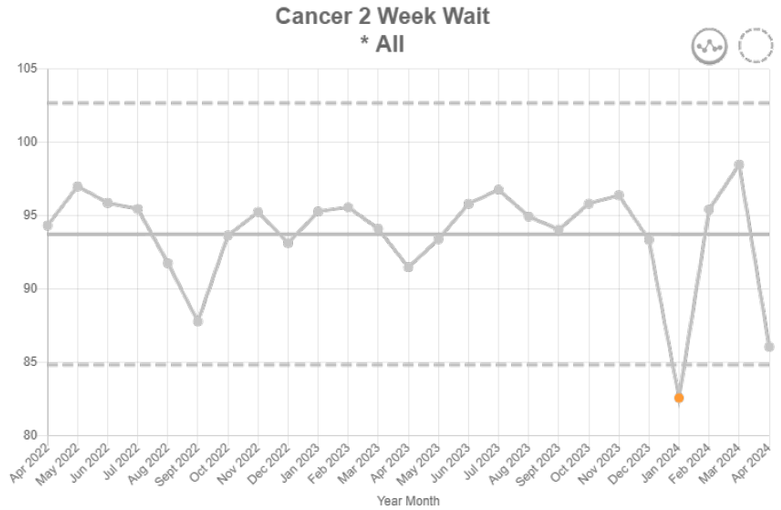
Benchmarking

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.

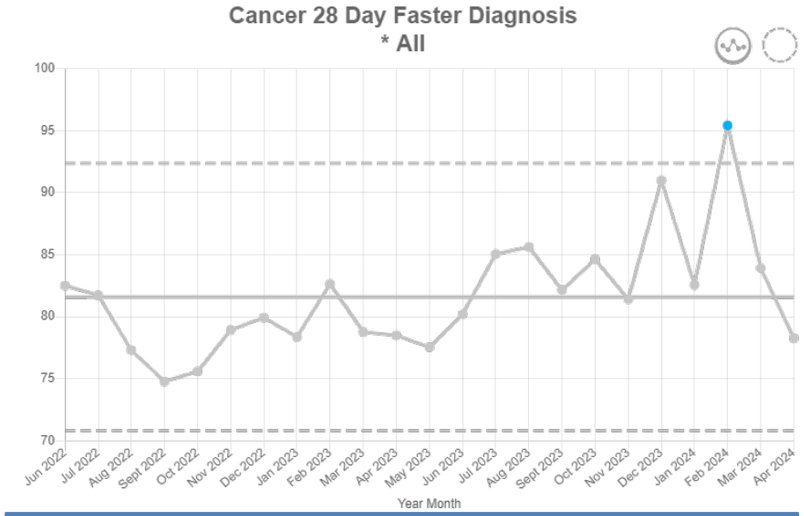
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

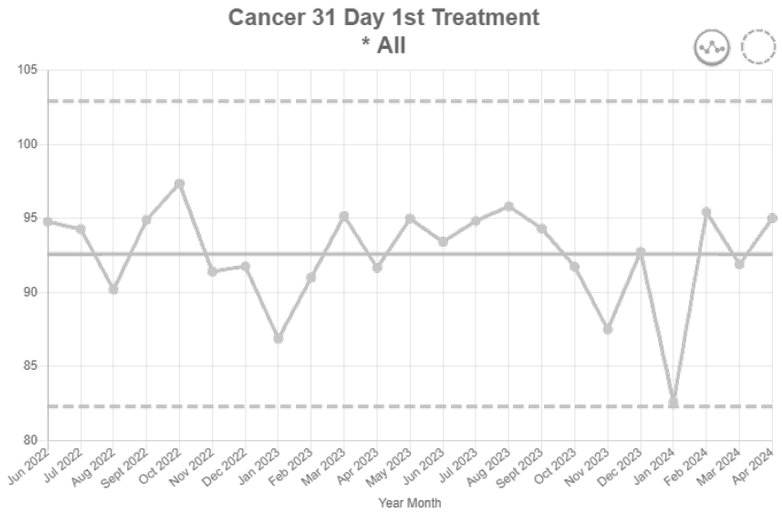
April 2024 – 86.1%
Common cause variation



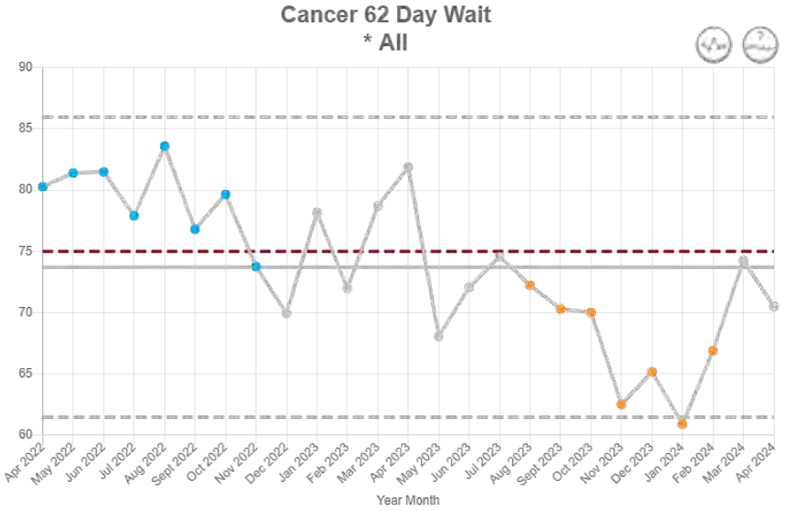
March 2024 – 85.2%
Common cause variation



April 2024 – 95%
Common cause variation



April 2024 –70.5%
Common cause variation



Analysis

The 28-day faster diagnosis standard (FDS) performance was above target at 82.2% in April. There are however challenges within this phase with 2WW volumes impacting performance for that metric and histopathology delays still impacting on skin pathways.
31-day general treatment has improved but remains below target. Treatment numbers have reduced slightly which has added to the growing 62-day backlog so improvements into June will support the overall position. Overall 62 day performance remains a challenge but the number waiting beyond this target is reducing.

Risks, Mitigations and Assurance

A Cancer 'Time-Out' to develop a shared clinical vision for the Trust's Cancer Strategy took place in June.
The HISTO programme along with recruitment of consultants and AP/EP demand and capacity work is supporting the diagnostic phase. With most of the delays being for Skin this doesn't always impact the reported FDS as the decision to treat will be before the patient informed date, but patient experience is impacted negatively, and the improvement plans will address this.
National Bowel cancer awareness campaigns have increased demand for Lower GI. Additional clinics have been added throughout May and a review of booking processes continues to maximise utilisation going forward.
Work on MDT streamlining continues with a targeted focus on system wide improvements for notifying patients of a benign cancer diagnosis and improving reporting processes.

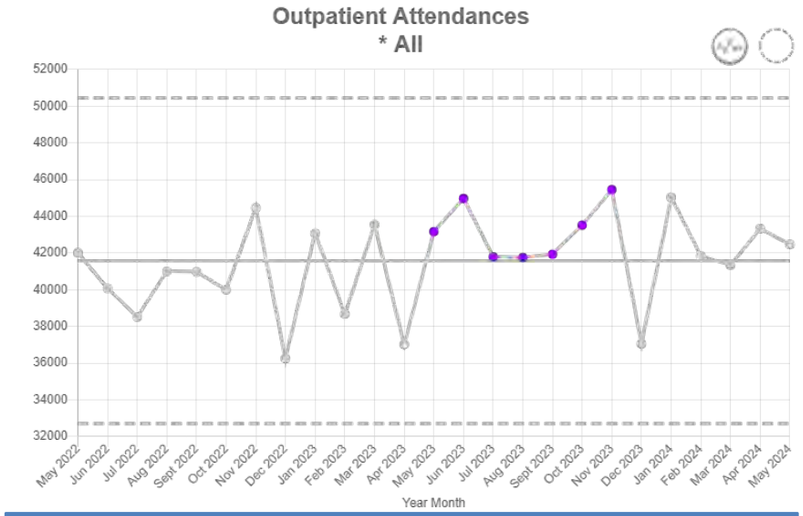
Benchmarking

The Trust is in the upper decile for 28-day FDS and above national and peer average for 62-day general treatment.

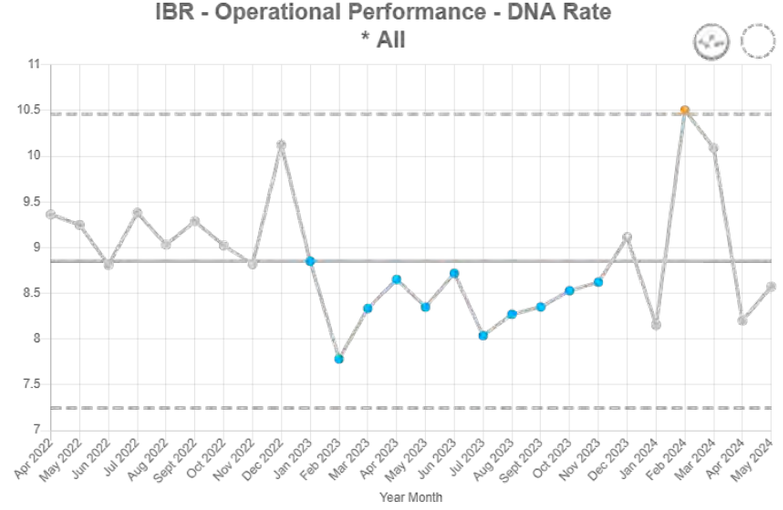
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

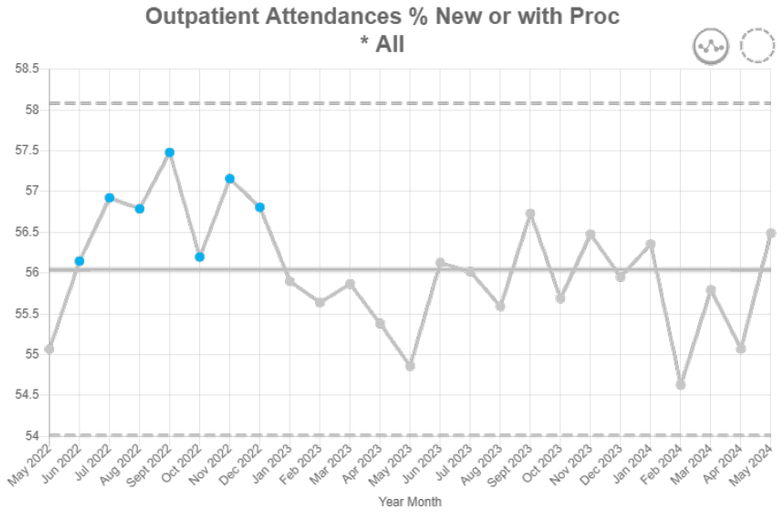
May 2024 – 43,325
Common cause variation



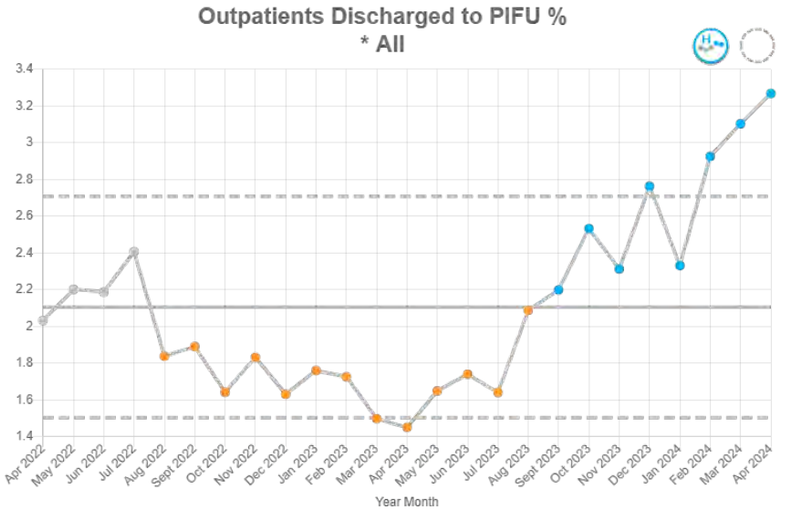
May 2024 – 8.6%
Common cause variation



May 2024 – 56.5%
Common cause variation



May 2024 – 3.2%
Special cause variation of an **improving** nature



Analysis

Outpatient activity delivered again slightly above plan in May 2024 and is projected to remain in line with plan in June 2024. Follow ups are not yet reducing but PIFU use has increased.
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 opportunities and is currently being launched with all CSUs. One focus is optimising outpatient pathways to improve earlier interventions and decision making to reduce follow up appointments.
Increasing OPPROC, increasing clinic session delivery, and increasing session productivity are three of the main deliverables within the CTG elective productivity workstream.
The Trust is also exploring what else can be done to improve attendance at appointments, particularly for communities with poorer health outcomes. Options to improve attendances might include additional transport support or community-based clinics.

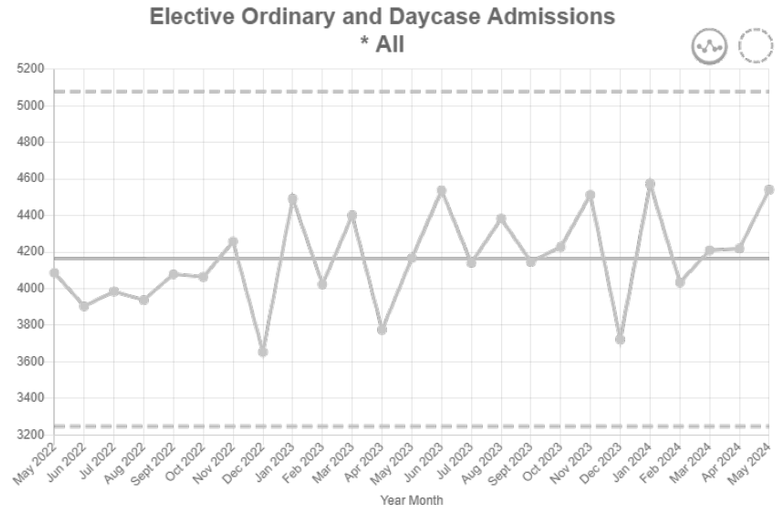
Benchmarking

GIRFT further faster packs are identifying DNA improvement opportunities at a service level which are being explored as part of this work.

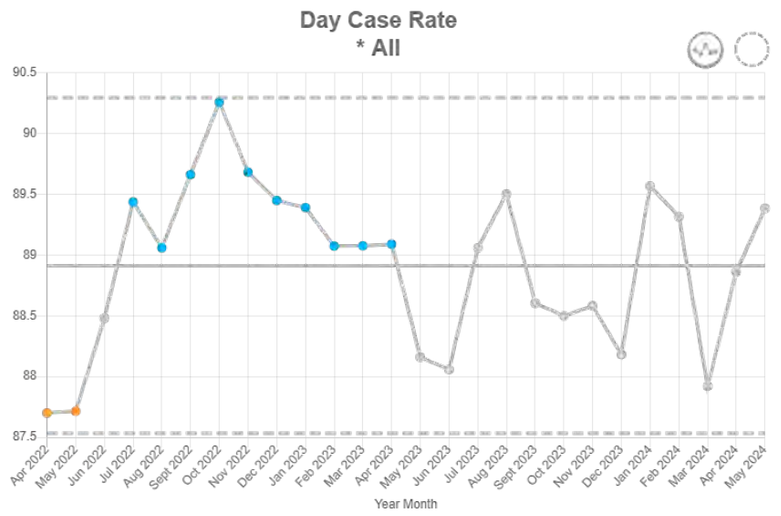
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

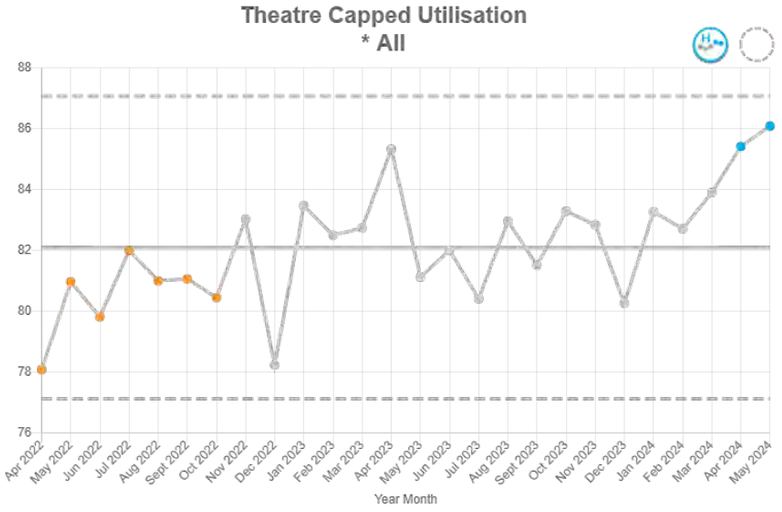
May 2024 – 4,541
Common cause variation



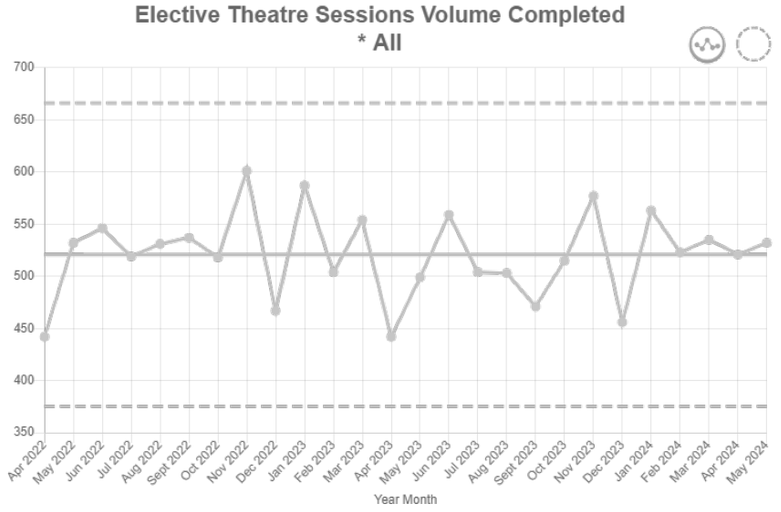
May 2024 –89.4%
Common cause variation



May 2024 – 86.1%
Special cause variation of an **improving** nature



May 2024 – 532
Common cause variation



Analysis

Inpatient activity delivered on plan in May 2024 and is projected to remain in line with plan in June 2024. Lists are running at expected levels whilst patients per list and capped utilisation remain relatively stable. Patients treated per list are lower than historic levels which is a key area of focus for elective productivity gains.

Risks, Mitigations and Assurance

Trust-wide theatre improvement initiatives continue to focus on scheduling efficiency by confirming theatre timings, updating the 'group and save' process, and monitoring phone call confirmations for patients attending for procedures.
The number of same-day cancellations reduced significantly in June 24 as a result of a reduction in DNAs and patients not being fit for surgery, as well as a reduction in the number of lists running out of time through better scheduling.
Forward wait areas are now live for General Surgery, Urology, Gynaecology, Ophthalmology, ENT and OMFS and should support a reduction in inter-case delays.
Weekly access meetings are utilising forward-view reports which enable services to take action to ensure theatre lists are fully utilised.

Benchmarking

The Trust is above the national average for day case rates, and capped utilisation.

People – Renee Bullock

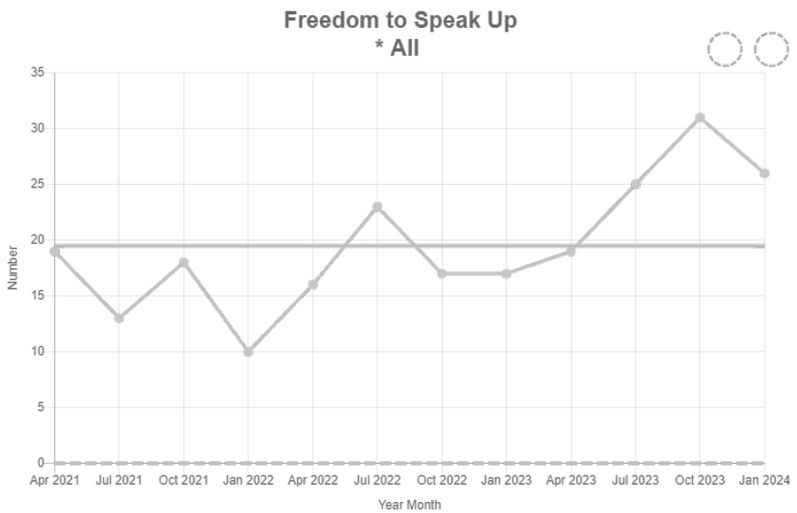
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	May-24	1.59%				2.42%
Agency - WTE	Jan-24	114.23				147.70
Appraisal Rate - Non-Medical	May-24	76.22				75.30%
BAME Split - Band 8+	Mar-24	18.7%				17.45
BAME Split - Bands 1-5	Mar-24	48.2%				43.91
BAME Split - Bands 6-7	Mar-24	27.6%				25.57
BME - * All	Mar-24	41%				38.47
BME - Senior Leader	Mar-24	19%				17.45
Core Manadatory Training - * All	May-24	93.6%				90.20%
Disability Declaration - * All	Mar-24	4.9%				3.9%
Freedom to Speak Up - * All	Jan-24	26.00				13.81%
Harrassment and Bullying - Disciplinary Action	Mar-24	3				0.67
Harrassment and Bullying - Informal Action	Mar-24	1				3.00
Harrassment and Bullying - In-progress	Mar-24	3				7.00
Harrassment and Bullying - No Case To Answer	Mar-24	3				3.00
Harrassment and Bullying - Resigned	Mar-24	1				0.67
Harrassment and Bullying - Total Investigations	Mar-24	11				14.33
Job Planning - Allied Health Professionals	May-24	47%				49%
Job Planning - Medics	May-24	37%				25%
Job Planning - Nurses	May-24	59%				60%
Nursing Agency Fill Rate - %	May-24	14.0%				12.9%
Nursing Bank Fill Rate - %	May-24	64.0%				46.3%
Staff Advocacy - Contacts	Mar-24	10				14.00
Staff Advocacy - Contacts Not Resolved	Mar-24	1				0.00
Staff Advocacy - Formal Complaints/Investigations	Mar-24	0				0.67
Staff Advocacy - In-progress	Mar-24	3				0.67
Staff Advocacy - Outcome Unknown	Mar-24	3				0.33
Staff Advocacy - Resolved Informally	Mar-24	3				9.00
Staff Sickness - * All	May-24	5.8%				6.5%
Staff Sustainability - * All	May-24	99.3%				98.8%
Staff Turnover - * All	May-24	9.0%				11.4%

People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

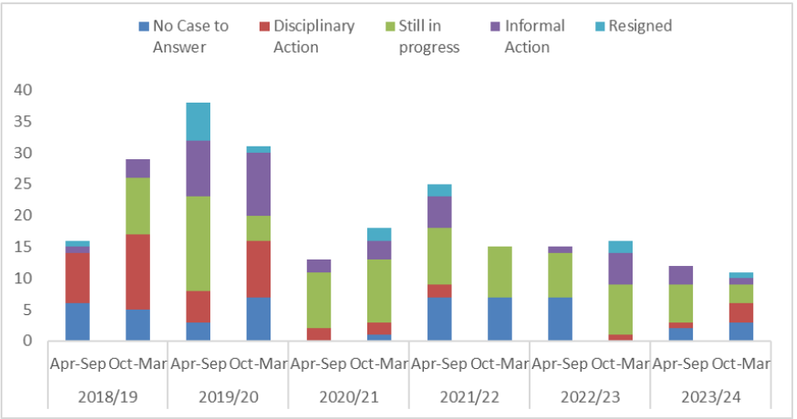
2023/24 Quarter 4 – 26



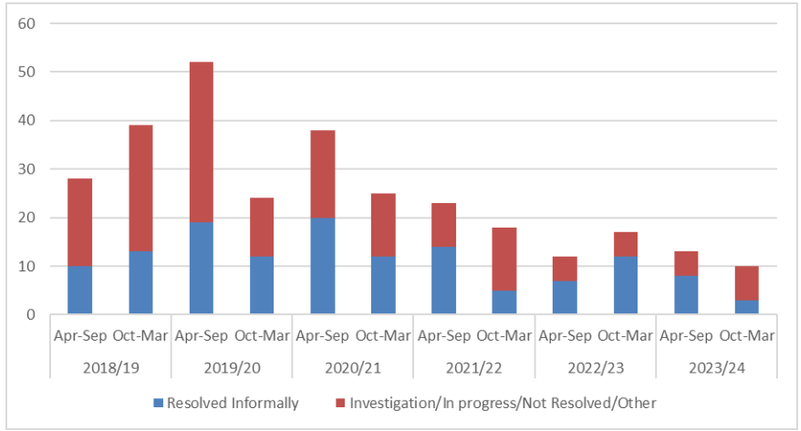
2023/24 October to March– Staff Advocacy

Apr 18 - Sep 18	28	5	10	6	3	4	5,270.02	0.53%
Oct 18 - Mar 19	39	18	13	5	3	6	5,421.48	0.72%
Apr 19 - Sep 19	52	11	19	6	4	12	5,464.63	0.95%
Oct 19 - Mar 20	24	3	12	2	1	8	5,529.22	0.43%
Apr 20 - Sep 20	38	4	20	5	1	8	5,696.26	0.67%
Oct 20 - Mar 21	25	1	12	2	1	9	5,691.45	0.44%
Apr 21 - Sep 21	23		14				5,694.76	0.40%
Oct 21 - Mar 22	18	5	5	4	0	4	5,693.90	0.32%
Apr 22 - Sep 22	12		7				5,694.38	0.21%
Oct 22 - Mar 23	17		12				5,692.48	0.30%
Apr 23 - Sep 23	13	2	8	2		1	5,696.65	0.23%
Oct 23 - Mar 24	10	0	3	3	1	3	5,376.91	0.19%

2023/24 October-March Harassment and Bullying



2023/24 October to March –Staff Advocacy



Analysis

Harassment & Bullying Outcomes: A very slight reduction in the number of formal cases since the last 6-monthly update and with 80% of cases concluded within the 6-month period from October 23 to March 24. Just 1 case resulted in a recommendation for informal action, 3 cases resulted in disciplinary action and a further 3 resulted in 'no case to answer'.

Contacts with staff Advocacy Service: The number of contacts with the Staff Advocacy Service has dipped again slightly in the last 6 months and due to the nature of cases being supported those resolved informally reduced to 30%.

Freedom To Speak Up: There were 26 concerns raised to the FTSU team in Q4. The total number of concerns raised in 2023/24 was 101. This is the highest number of concerns raised since the start of FTSU. The team have done a lot of promotion over the year which may account for increase and staff may feel safer to raise concerns to the FTSU team. The highest number of concerns had an element of inappropriate attitudes and behaviours and the highest group of staff raising concerns were nurses and midwives which equates to the staffing profiles of the Trust.

Risks, Mitigations and Assurance

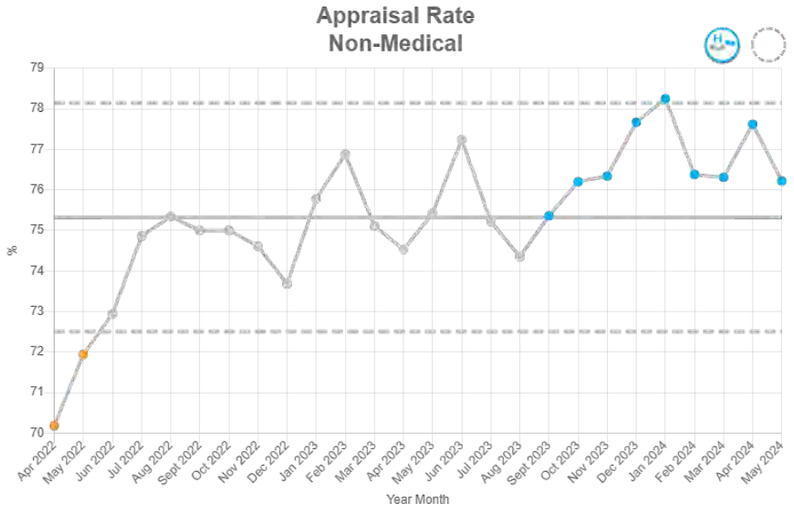
Harassment & Bullying Outcomes: Our Trust wide civility in the workplace campaign is making excellent progress. The Introduction of a new people charter, workplace mediation service, refresh of the staff advocacy service, EDI training for line managers, poster campaign, refresh of the harassment & bullying policy and drama-based training (based around case studies) will all play a crucial role in the wider culture change required to reduce the number of formal cases, with a focus on "nipping issues in the bud" at an early stage.

Contacts with staff Advocacy Service: Four new staff advocates have been trained and have started to take on cases. Work has also started to refresh the comms for the Staff Advocacy Service (including a refreshed leaflet and poster). A comprehensive re-launch of the service will take place in the coming months as part of a wider implementation plan for the new Respect, Civility & Resolution policy to ensure all staff are aware of this fantastic resource and can benefit from their support in resolving conflict, informally, at an earlier stage.

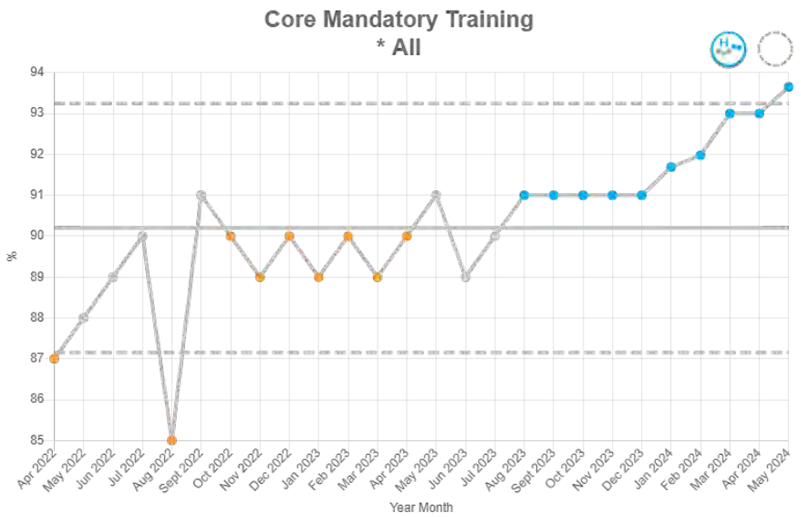
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

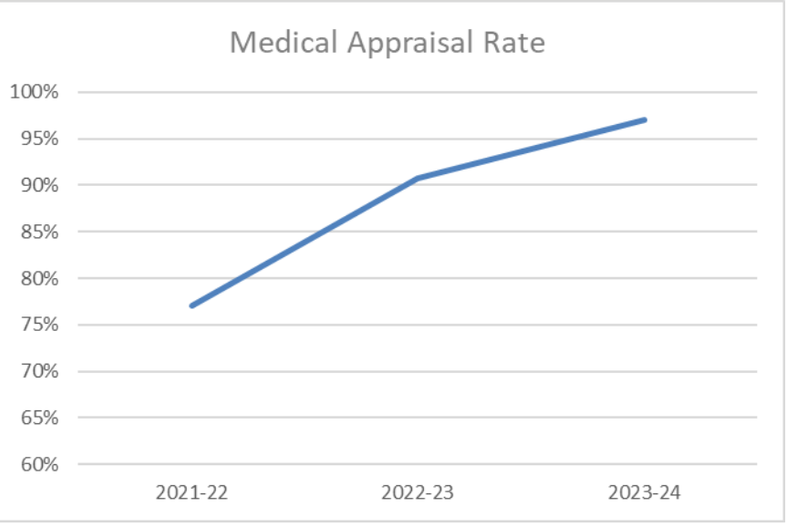
MAy 2024 -76.2%
Special cause variation of an **improving** nature



May 2024 -93.6%
Special cause variation of an **improving** nature



March 2024 – 97%



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
Since April 2024 the target for non-medical appraisal has been set at 85%. Appraisal compliance has followed an upward trajectory since the beginning of the year when it was 76.31% , as of the end of April it was 77.62%.

Medical Appraisal Rate
Medical Appraisal year from 1st April 2023 to 31st March 2024: 498 (97%) doctors received an Outcome Measure 1 (Completed appraisal).
16 (3%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal).

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.
- BLS overall compliance is currently 79%, the education team are actively targeting staff to complete to improve compliance.
- Safeguarding Adults compliance remains below 60% but has seen a 2% increase in compliance from last month, work continues to improve the overall compliance
- Targeted actions continue for subjects below 85% 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**

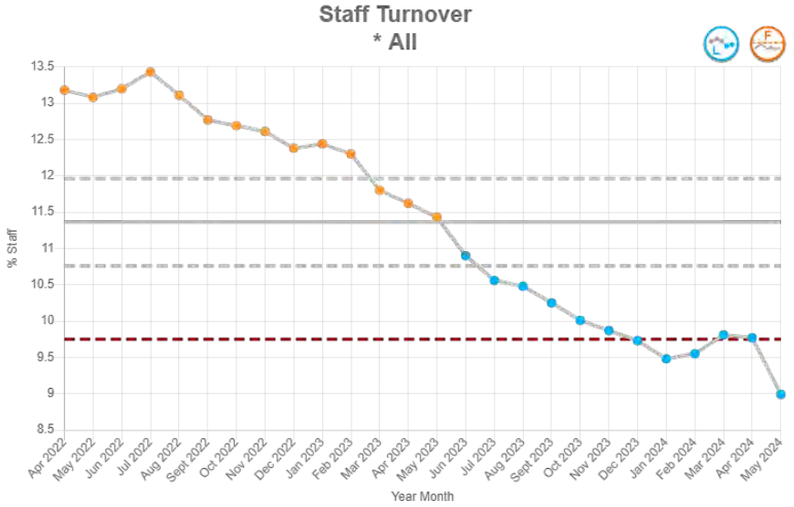
Appraisal

Appraisals are central to creating an environment of continuous learning and improvement; they unlock the potential of our people, developing individual performance and driving personal and professional development. Appraisals ensure everyone is working towards our Trust Strategic Objectives; understand how they contribute to achieving our Vision and are clear of what is expected of them.

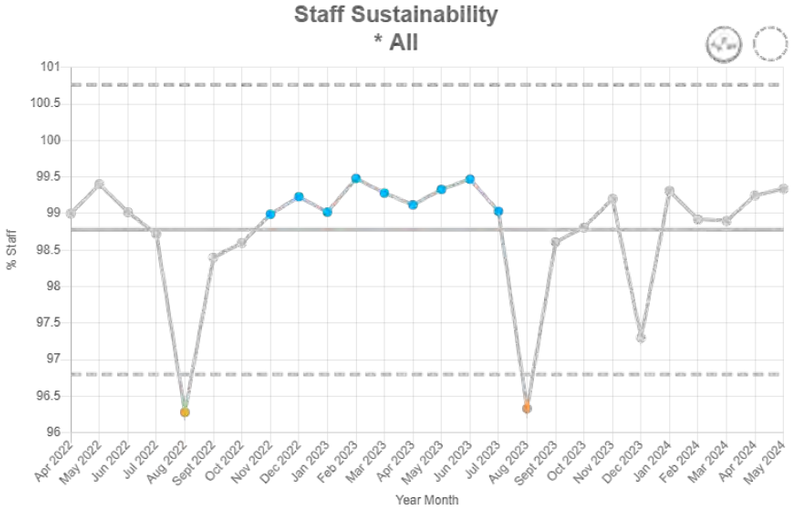
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

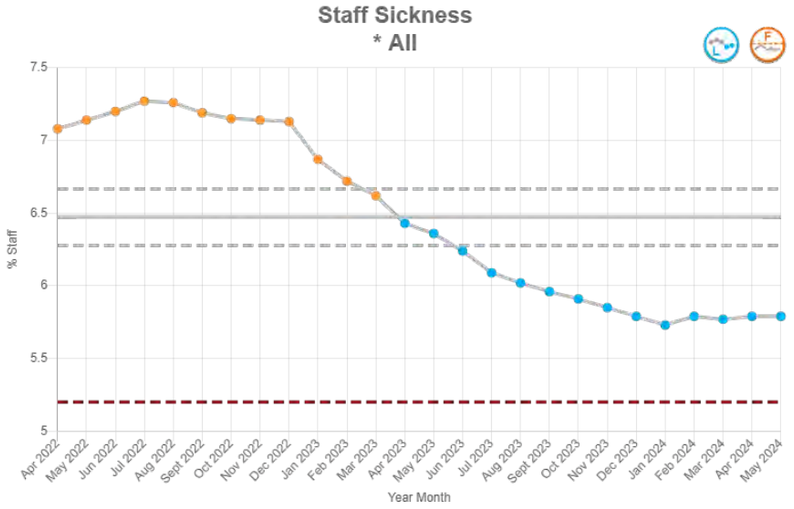
May 2024 -9.0%
Special cause variation of an **improving** nature



May 2024 – 99.3%
Common cause variation



May 2024 (rolling 12 months) -5.79%
Special cause variation of an **improving** nature



Analysis

Sickness for the month of May is 5.36% and the YTD is 5.79%, this has been a slight decrease from April which was 5.63% and YTD being 5.79%. In Staff Groups the highest areas are in Additional Clinical Services at 7.93%, Estates and Ancillary staff at 8.57% and Nursing & Midwifery at 5.20% and the rest remain under 5.55%.The overall sickness % has been under 6.5% for the past 12 months and has steadily decreased, but from October 2023 has been steady above 5.5% but below 6%.

The monthly **turnover** rate in May is 8.99%, a decrease from 9.77% in April 2024. Over the last 12 months there is a gradual and consistent decrease in turnover from 11% in April 2023, reducing to 9% from December 2023, with a slight upturn from January 2024 to date. May has seen the first time in two years where it is below 9%.

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 May 2024 is 99.3%, which is a slight increase from 99.25% in April 2024. The rate over the last 12 months has been consistently around 98% to 99% , with a dip in August to around 96% due to the rotations for junior doctors.

Risks, Mitigations and Assurance

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%. The last few months there has been a downward trend and since April 2023 the % has been below 6%. The following supportive measures have been put into place for managers;

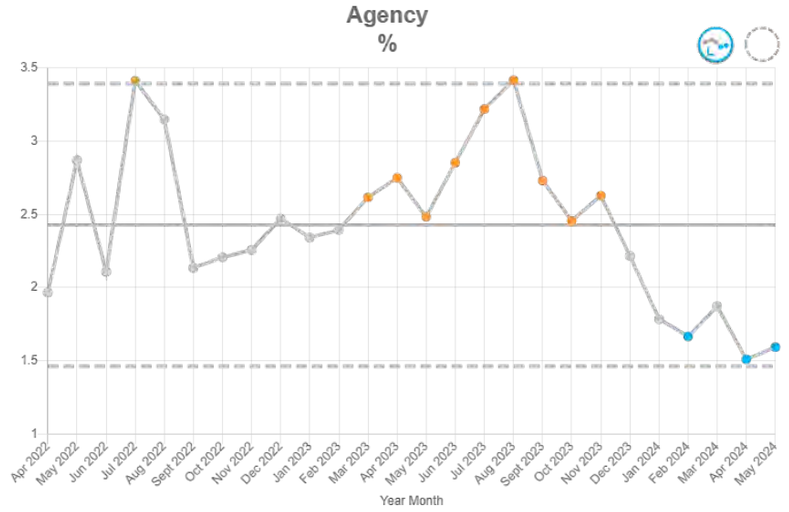
To support closing the gap and enable managers to work towards achieving financial targets, HR will deliver briefing sessions on a variety of management topics. The first will include support, guidance, advice, and top tips on the application of the Trust' Health Wellbeing and Attendance Policy and Organisational change policy.

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. The HRBPs attend monthly CSU Triumvirate and Performance meetings where sickness rates, and actions to improve these are discussed. There are regular Management of Attendance training provided monthly as well as more specified training for all the CSU's and Departments.

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 remained as had the effect of reducing turnover. This dip has been evident in previous years.

People – Engagement – To be in the top 20% Employers

May 2023 – 1.59%
Special cause variation of an **improving** nature



Bradford Teaching Hospitals
NHS Foundation Trust

Analysis

Workforce Agency %
There has been an overall increase in agency use in May, this has been an in the following staff groups AHP's, Medical and Dental, Nursing and Midwifery.

There has been a reduction in agency use during May for the following staff groups Professional Scientific & Technical, Admin and Clerical, Estates and Facilities.

Healthcare scientists and Additional clinical services have used no agency.

Risks, Mitigations and Assurance

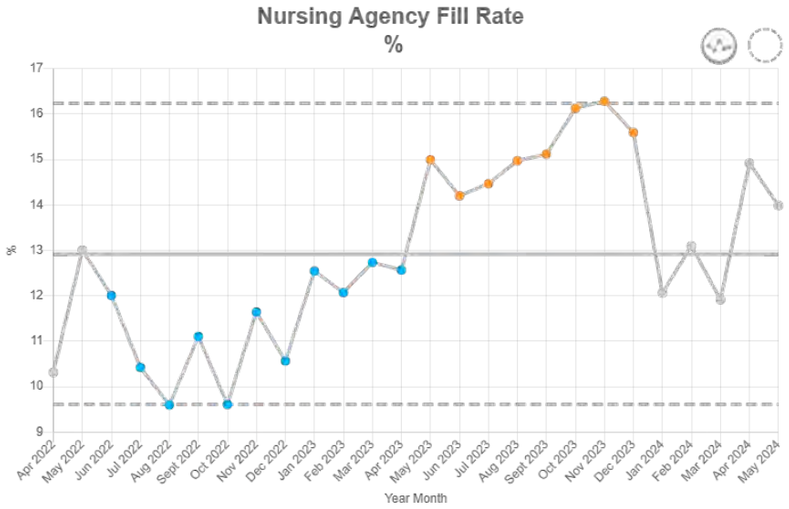
Workforce Agency %

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 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 supporting the creation of a WYAAT banks for AHP's. They are also going to create a central bank for Professional Scientific & Technical staff and pharmacy. This will give the trust a bank for all staff groups therefore reducing the resilience on agency workers and achieving our agency reduction plan.

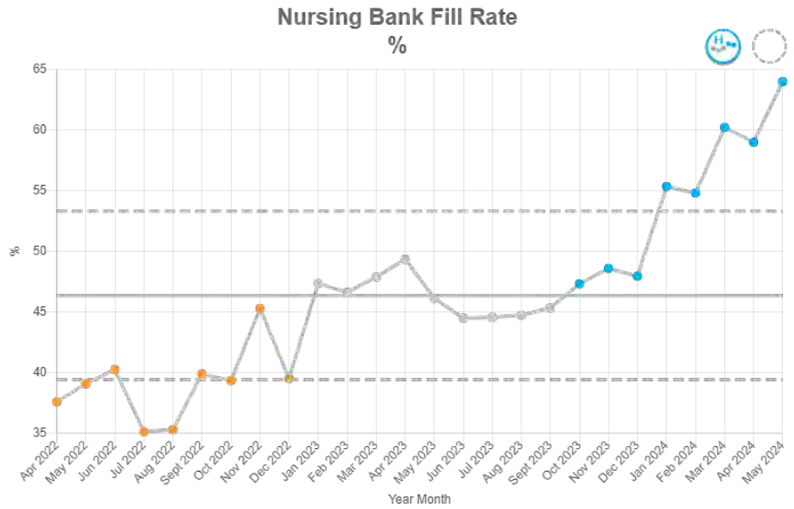
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

May 2024 -14.0%
Common cause variation



May 2024 – 64.0%
Special cause variation of an **improving** nature



Analysis

Nursing Agency
Agency staff filled 621 shifts in the month of May. This is split 621 registered and 0 unregistered staff. Out of the 621 filled registered shifts, 412 were filled with registered theatre staff. In May Agency fill rates increased for theatre staff by 1.8% for registered staff. Agency fill rates for HCA's are 0 as these have not been in use since September 2023.
Nursing Bank
Registered bank fill rates have increased in May by 5%. Unregistered bank fill rates have increased by 3.2% in May compared to April. Requests have also reduced from 4478 in April to 4440 in May.

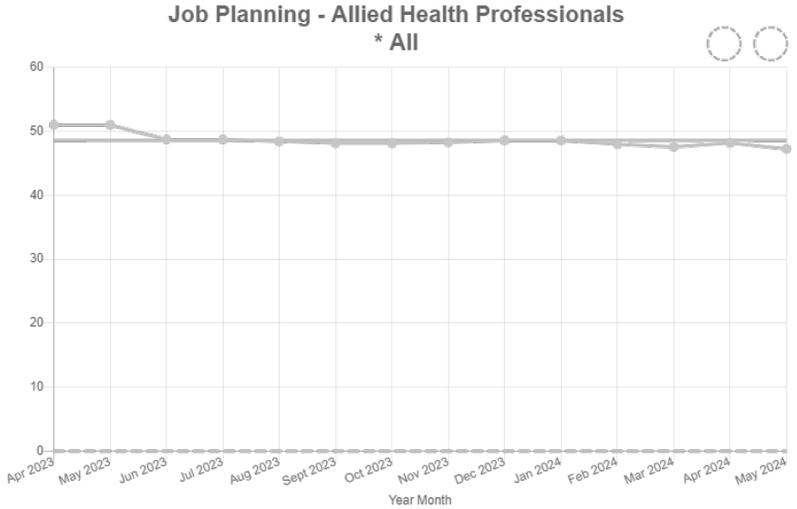
Risks, Mitigations and Assurance

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.

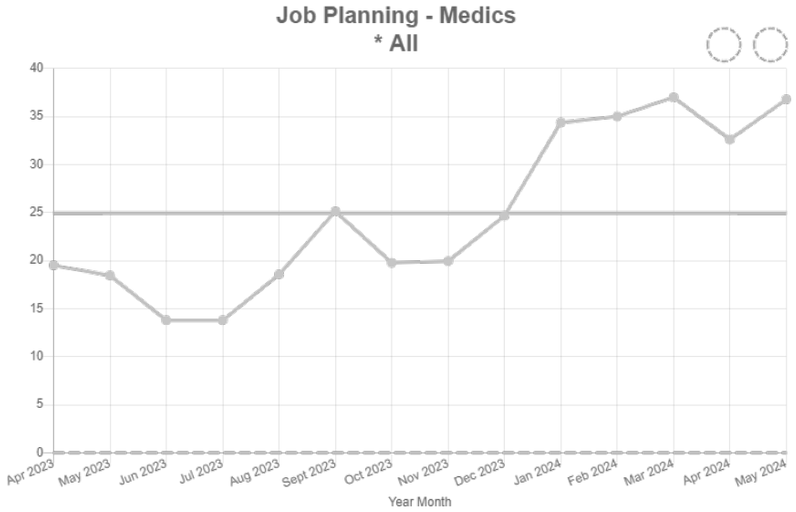
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

May 2024 -47.3%
Common cause variation



May 2024 – 36.8%
Common cause variation



May 2024 – 59.2%
Common cause variation

Analysis

The focus has been on medic job planning as pay is directly linked to medic job planning. Now that the correct access is in place for new starters etc, that additional access has been granted to prevent bottlenecks and training has been completed for all staff that require it. This has provided a significant increase in signed off job plans for medics. Going from under 20% last year to 36% in May this year. The Trust is undertaking service redesign which will mean it will take longer to complete signed off job plans in some areas. We have revised our target to 80% signed off by 31/03/2025.

The Flexible Workforce team are now focusing on ensuring that the correct access is in place for new starters etc, that additional access has been granted to prevent bottlenecks and training has been completed for all staff that require it to support AHP's and Nursing

Risks, Mitigations and Assurance

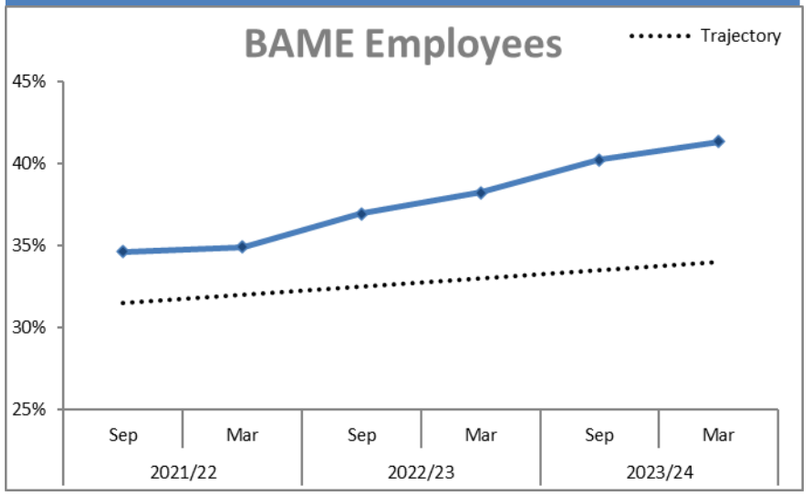
The Flexible Workforce team are currently conducting checks to ensure what is in a job plan reflects what an individual medic is being paid. Any variations are being reviewed and a change form submitted if required.

The Trust recently had an audit on job planning. All the recommendation from this audit have either been completed or are in the process of being completed.

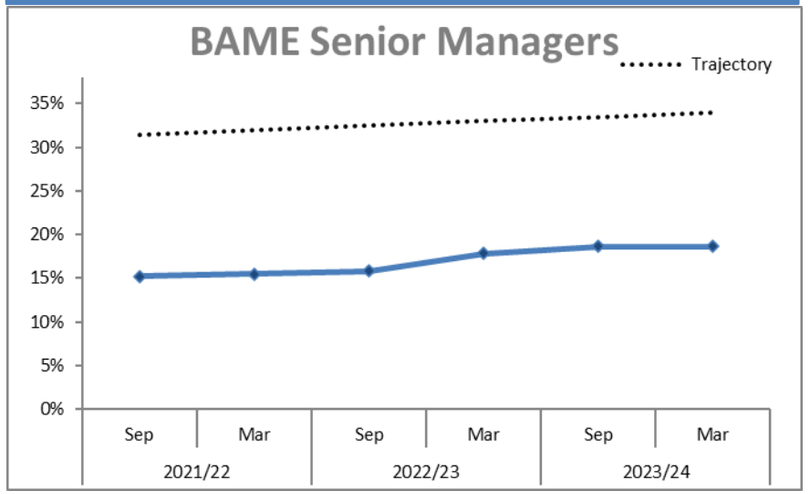
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

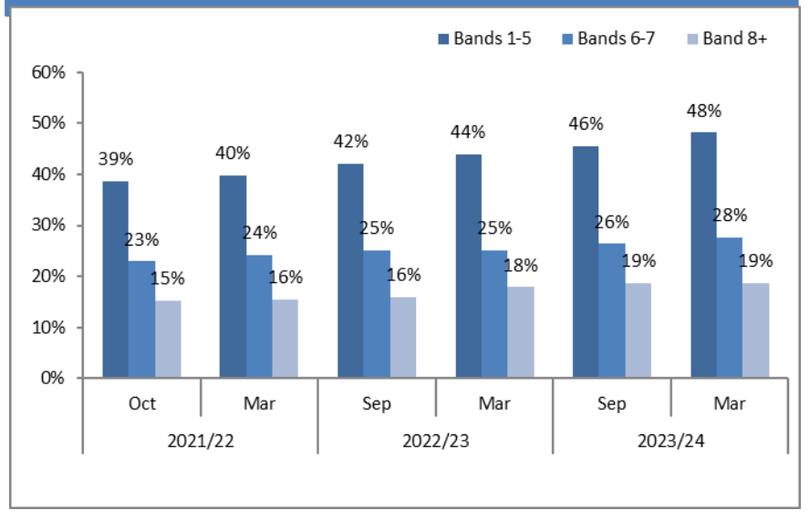
2023/24 Quarter 4 - 41.34%



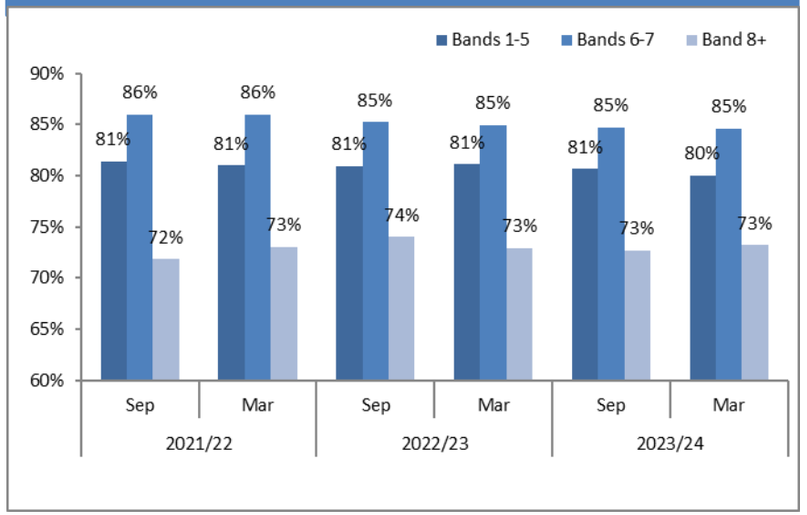
2023/24 Quarter 4 – 18.65%



2023/24 Quarter 3 – BAME employee % by band



2023/24 Quarter 32– Female workforce by band group



Analysis

The proportion of **Ethnic Minority employees** in the workforce continues to increase rising from 40.2% to 41.3% as we continue to exceed our target of having an overall workforce reflective of the local population (35%). **Representation at Senior Management level** (Band 8+) continues to be more challenging and despite a 1% increase in the last year, there has been no change in the last 6 months (remaining at 19%). Ethnic minority staff are over-represented in Bands 1-5 (2% increase to 48%). However, a 2% increase in Bands 6&7 (to 28%) is encouraging. With 77% women in the workforce as a whole; **women continue to be over-represented in the lower to middle bands** (80% at Bands 1-5 & 85% at Bands 6&7) and slightly under-represented at senior management levels (73% at Band 8+).

Risks, Mitigations and Assurance

At our current rate of trajectory, achieving our ambition to have a senior workforce reflective of the local population (35% by 2025) continues to be challenging. This will continue to be a key focus of our refreshed WRES action plan for 2024/2025, as we continue to focus our efforts on providing development opportunities for aspiring leaders from an ethnic minority background and in ensuring we consider more innovative positive action approaches to recruitment for senior level roles as they arise and engaging with the race equality staff inclusion network in ensuring that development offers meet the needs of our ethnically diverse staff.

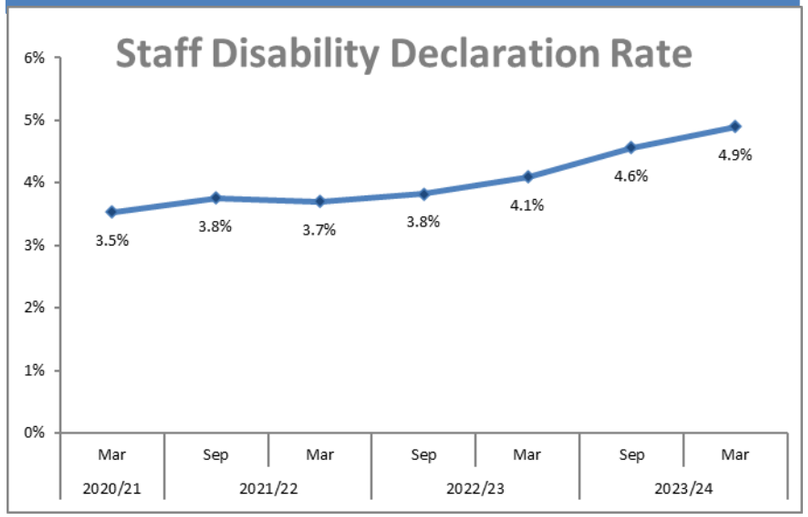
Our gender pay gap and next steps for gender equality were taken to People Academy in March. We will be working collaboratively with our gender equality reference group and the wider ICS over the next few months to address gender inequalities in the workplace, with focus on women in leadership and addressing potential blockages to development, with particular focus on flexible working for front line workers and including focus on encouraging more men into traditionally female roles.

Collaborative work has commenced to overhaul our recruitment & selection and onboarding processes to ensure they are equitable, supportive and inclusive for all.

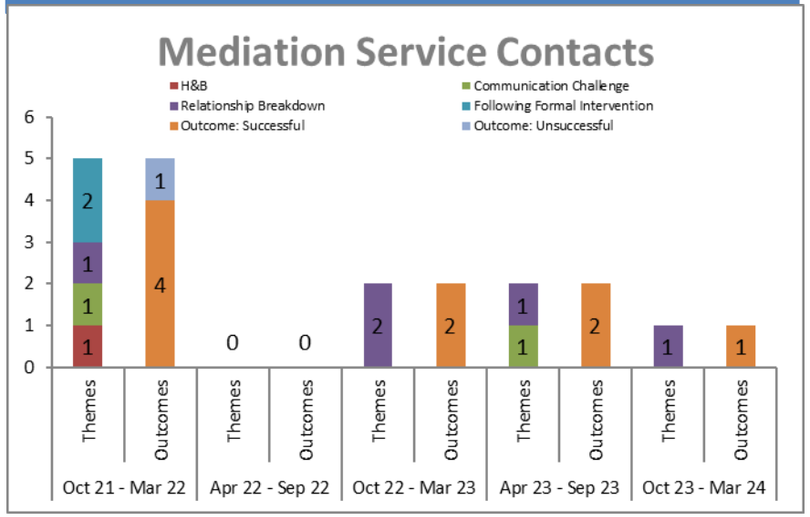
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

March 2024 - 4.9%



2023/24 Quarter 4



Analysis

Having remained fairly static for some time, our **disability declaration rate** as recorded in the Electronic Staff Record (ESR) is starting to improve. There has been a further small but positive increase in this percentage over the last 6 months up to 4.9%.

Despite a number of referrals just 1 **mediation** has successfully taken place since the last update. This was a follow-up mediation which resulted in some further successful outcomes being agreed, which is positive. 3 further cases are currently in the initial discussion stages.

Risks, Mitigations and Assurance

Disability Declaration: Whilst the 2022 staff survey results only represent 37% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 25% in 2022) who declared a disability/ long term health condition, indicating there may be a number of staff who are not declaring their status in ESR. We continue to work with our Enable staff network in increasing confidence to declare a disability. The WDES Innovation Fund display and video has been shared widely on a regional and national basis, and with a number of events taken place across the Trust to raise the profile of disability equality and managing long-term health conditions. This has been really helpful in raising the profile of EDI across the Trust and has recently generated lots of interest from wider staff in joining the Enable network and with staff registering their interest for key roles within the network core group. Compassionate leadership approaches (including supporting staff with long-term conditions) forms part of the safe space discussions taking place as part of the face-to face EDI Managers training.

Mediation provides a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud'. The mediation service will become a key component of the newly developed Respect, Civility and Resolution policy and process when it is finalised over the next couple of weeks and whilst the EDI team are working to raise the profile of mediation through the EDI Managers training, the service should benefit from a re-launch as part of the implementation phase of the new policy.

Quality – Executive Director: Dr Ray Smith and Karen Dawber

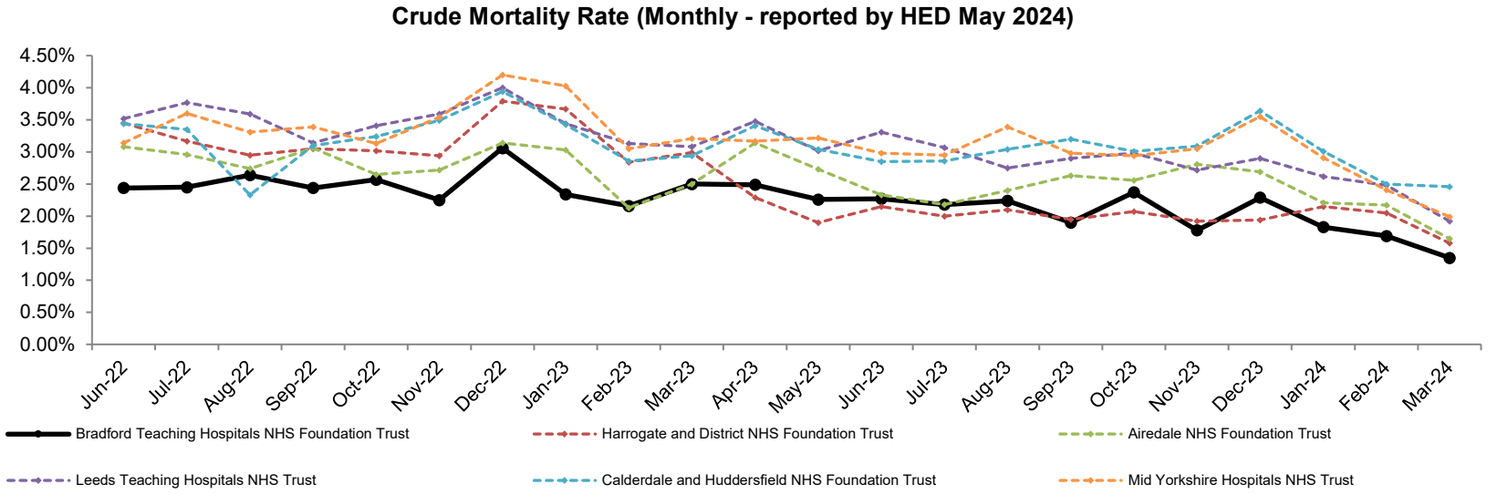
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Breast Feeding Initiation Rates - * All	Apr-24	66.67%				63.30%
Cooling Babies - * All	Apr-24	4				0.7
Falls - With Harm	May-24	47				46.6
Falls - With Harm per 10,000 bed days	May-24	22.70				20.23
Falls - With Severe Harm	May-24	0				0.88
HCAI - C. Difficile	May-24	2				3.3
HCAI - E.coli	May-24	8				7.23
HCAI - MRSA	May-24	0				0.31
Medicine Reconcilliation - % Reconcilliation	Apr-24	70.00%				61.57%
Pressure Ulcers - All Categories per 10,000 bed days	May-24	24.10				19.1
Pressure Ulcers - Category 2 per 10,000 bed days	May-24	18.9				11.43
Pressure Ulcers - Category 3+ per 10,000 bed days	May-24	3.87				2.6
Readmissions - * All	Mar-24	9.3%				8.99%
SHMI - * All	Feb-24	117.5				113.6
Still births - * All	Mar-24	0				238.00%
Structured Judgement Review - Total number of in-patient Adult Deaths	May-24	126				121.70
SJR Scoring 3 or above indicating adequate to excellent care (12 month rolling)	May-24	1				

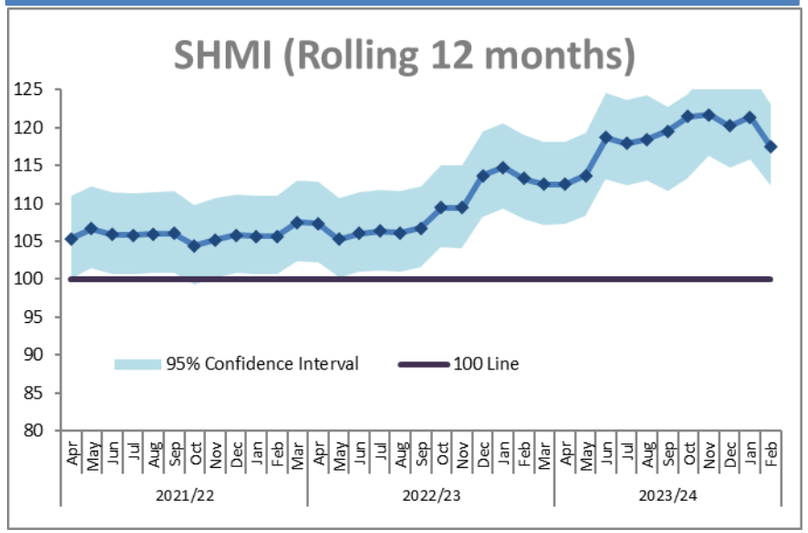
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

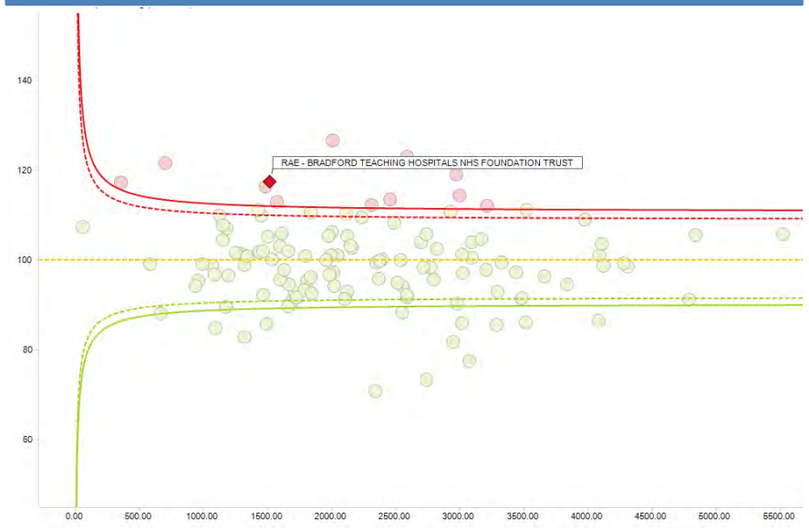
May 2024 – 1.35%



February 2024– 117.52
Special cause variation of a **concerning** nature



February 2024– 117.5
High (>95%)



Analysis

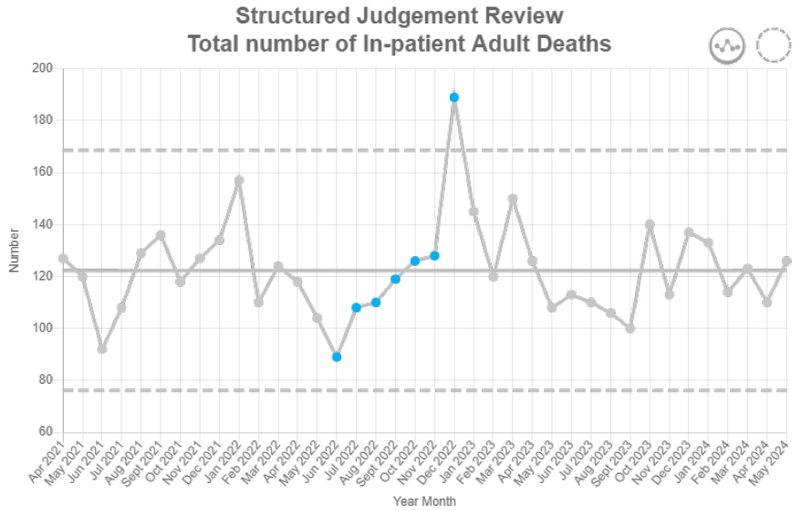
Our crude mortality rate continues an overall pattern of reduction at 1.35%. We continue to have the lowest crude mortality rate in West Yorkshire.
Whilst SHMI is still high at 117.5, the collaborative work between the Learning from Deaths Team and Business Intelligence has seen the metric reduce by over 4 points since last month. Work continues on coding issues which will help to reduce our SHMI moving forward.

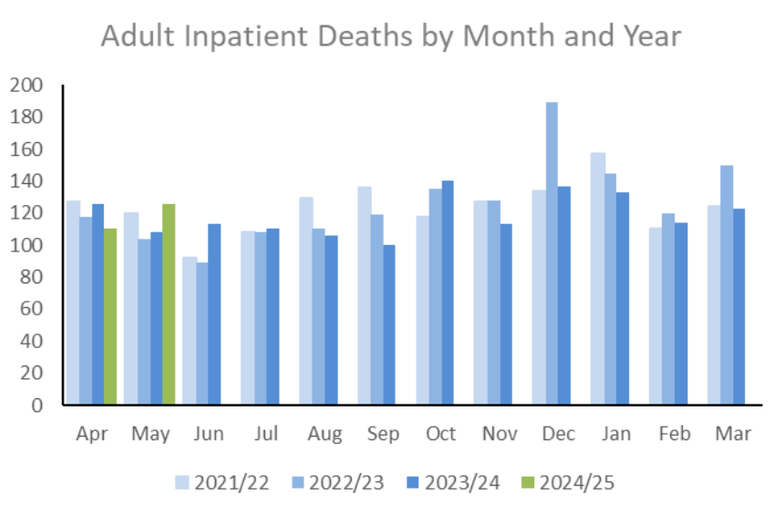
Risks, Mitigations and Assurance

Clinical Effectiveness - To provide outstanding care for patients

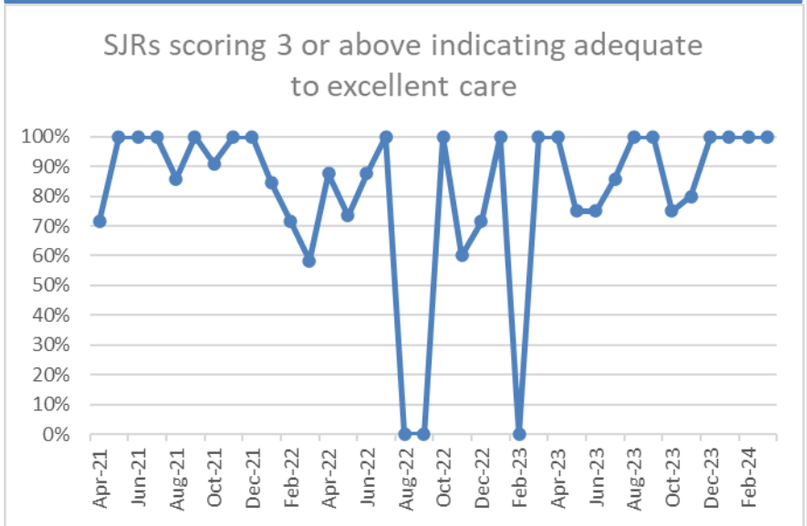
Bradford Teaching Hospitals NHS Foundation Trust

May 2024 - 126
Common cause variation

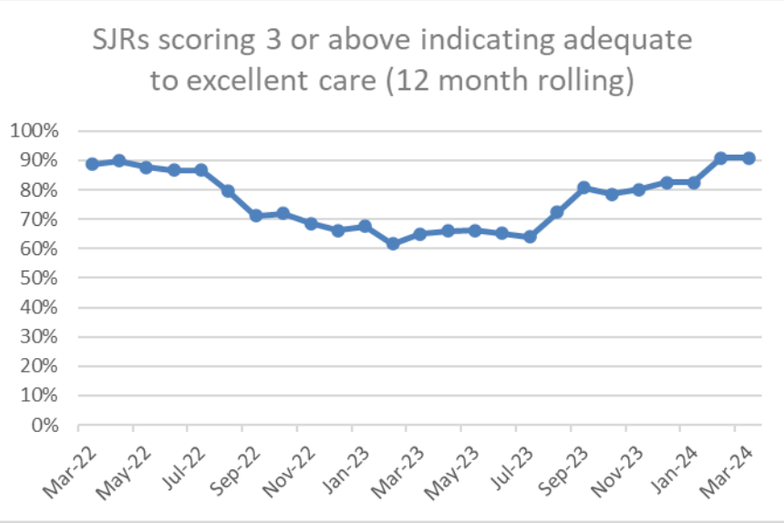




March 2024 – 100%



March 2024 – 90.9%



Analysis

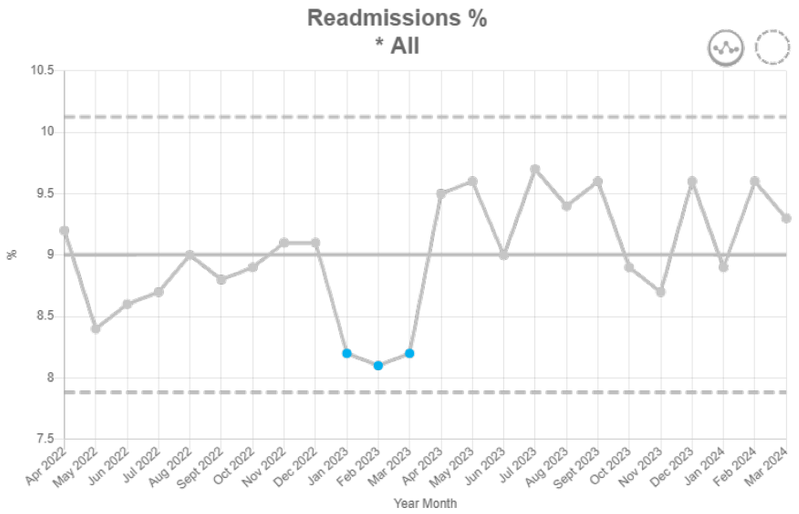
In May 2024 the Trust saw 126 adult inpatient deaths. This is slightly higher than past months of May but is not a significant increase. The Learning from Deaths Team will continue to monitor monthly mortality numbers and act if significant increases are observed.
Quality of Care observed through the Structured Judgement Review (SJR) process has been steadily increasing and currently sits at 90.9% for the past 12-months. All learning from reviews and the Mortality Review Improvement Group (MRIG) will continue to be reported at Academy as and when required.

Risks, Mitigations and Assurance

Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals
NHS Foundation Trust

March 2024– 9.3%
Common cause variation



Analysis

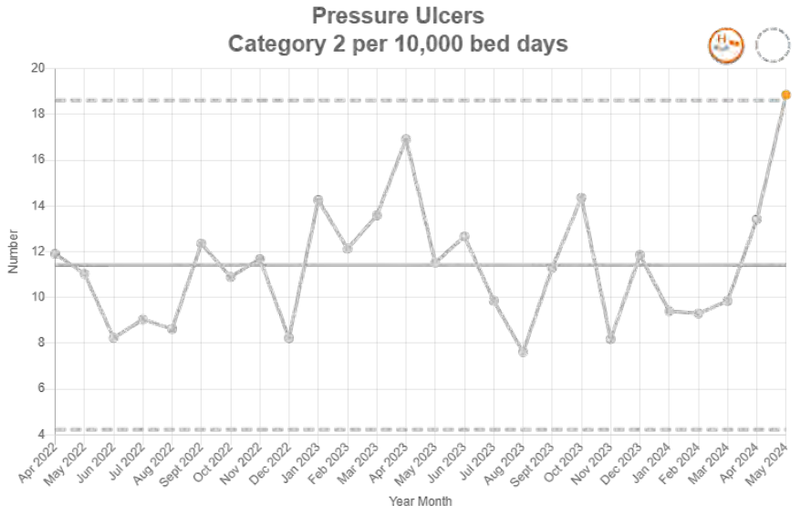
Overall re-admissions within 28 days in 2024 have increased slightly compared to 2023.
However by speciality, re-admissions for medical and care of the elderly patients have reduced slightly, whilst there seems to be a trend of increases amongst general surgery, gynae and paediatric patients. Further work with the CSUs is on-going to understand what is driving the increase in re-admissions within this cohort of patients.

Risks, Mitigations and Assurance

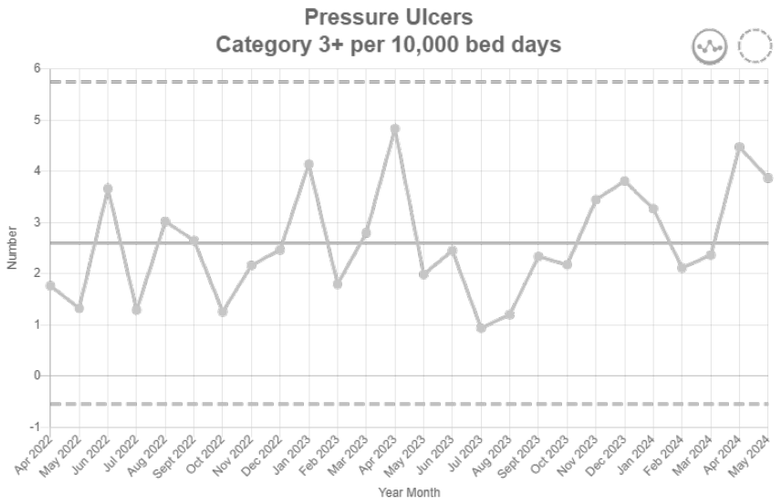
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

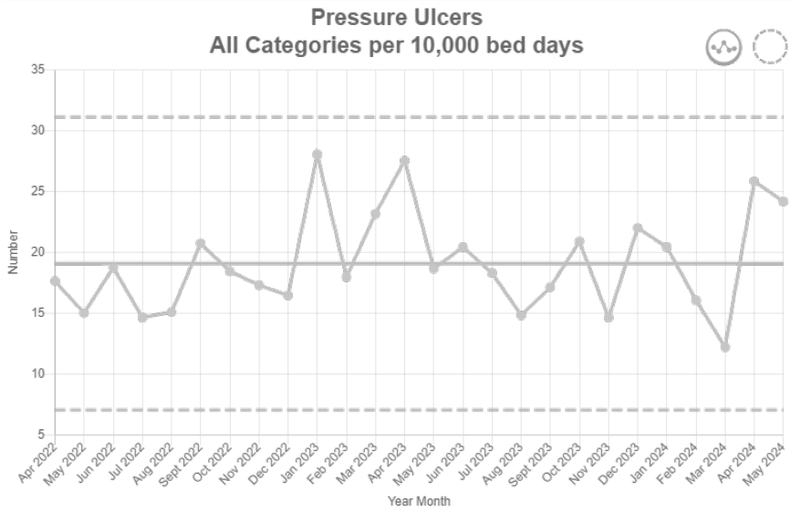
May 2024 – 18.9
Special cause variation of a **concerning** nature



May 2024 – 3.87
Common cause variation



May 2024 – 24.1
Common cause variation



Analysis

In May the number of pressure ulcers per 10,000 bed days remained above the control limit with a very small reduction from April. However, the category 2 incidents rose above the upper control limit, incidentally the deep tissue injury incidents fell well below the control limit although it is unclear whether there is a correlation between these sets of data.
Of the category 2 incidents over 20% developed on ward 23. It should be noted that there is an upward trend of incidents on the ward over the past 4 months.

Risks, Mitigations and Assurance

Risks:
1. Upward trend of pressure ulcer incidents on ward 23.
2. Ward 26 incidents rose in March. Incident numbers have reduced but are above the median for that ward.

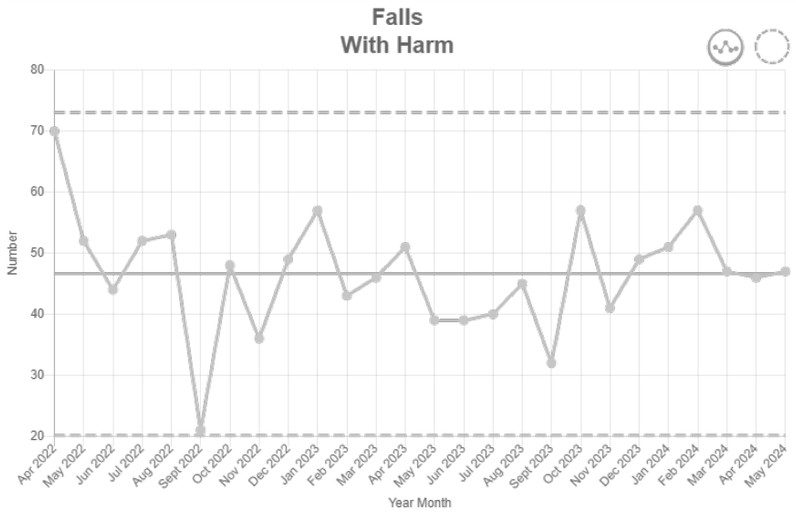
Mitigations:
1. Education and training has been offered to ward 23 and 6 sessions have been delivered covering pressure ulcer prevention and wound care.
2. Meeting arranged between TVN, Quality Improvement manager, ward 23 manager and tissue viability champion to explore an improvement plan utilising QI methodology.
3. Ward 26 – quality improvement plan has been developed with support from QI team and TVN team.
4. Update to pressure ulcer SSKIN bundle on EPR has been completed. Some of the changes are a result from learning as well as staff feedback. Date of release to the live domain to be confirmed.

Assurance:
1. Education and training is being delivered to new starters and existing staff (e.g. HCA bootcamp, e-learning modules) and bespoke training to clinical areas.
2. The pressure ulcer improvement group meets monthly and ward teams share their data (pressure ulcers, training figures), learning from incidents and improvement plans. Most ward areas have presented to the group at least once. There is a focus on training, completion of accurate and timely skin assessment and documentation that supports care delivered.
3. Pressure ulcer policy is under review and will include the latest national guidance on the prevention and management of pressure ulcers.

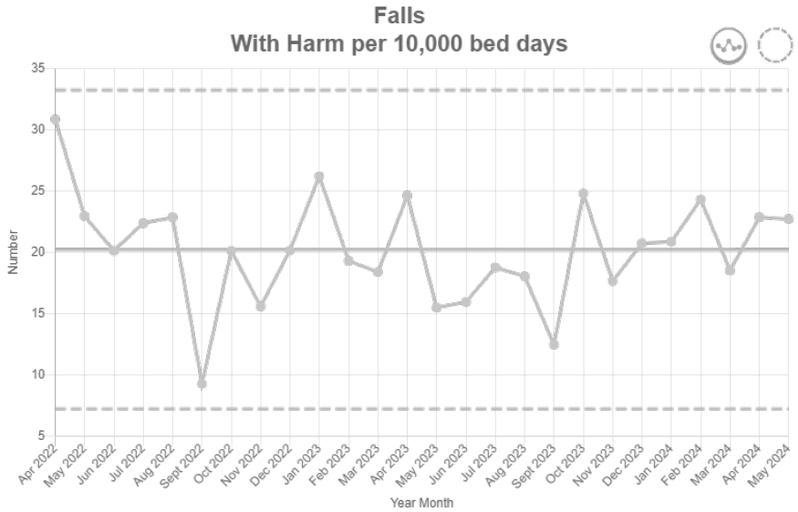
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

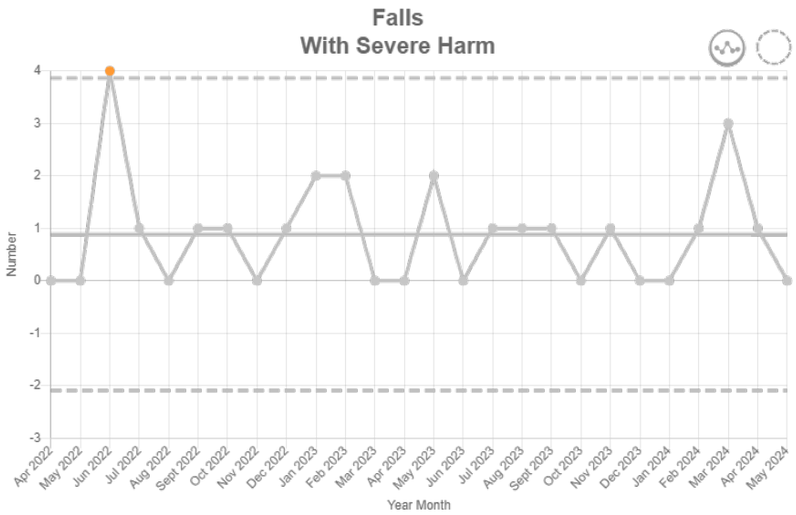
May 2024 - 47
Common cause variation



May 2024 –22.7
Common cause variation



May 2024 - 0
Common cause variation



Analysis

- There were no falls with moderate harm or above during May.
- Reported falls with harm are predominantly bruises, grazes and small lacerations.
- Falls overall remain within tolerance and we are beginning to see a downward trend.

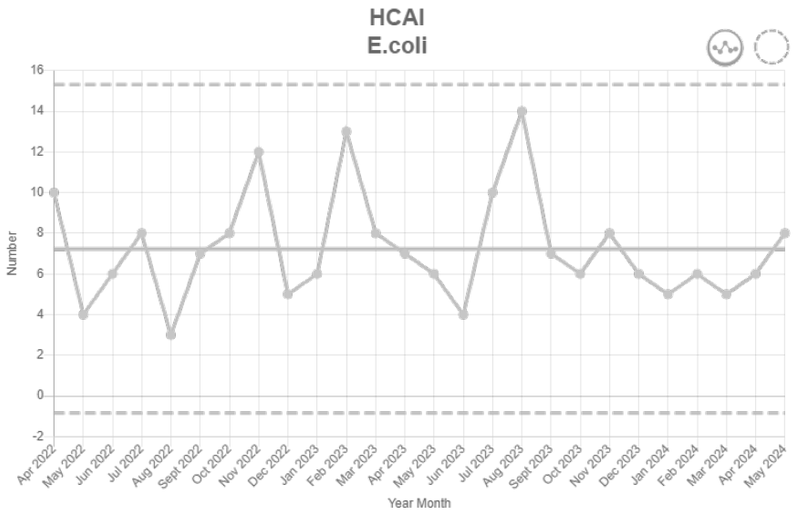
Risks, Mitigations and Assurance

- The Lead Nurse for Falls is now a substantive post and successfully recruited into.
- Every fall that occurs within the Trust continues to be reviewed by the lead Nurse for Falls to ensure that all appropriate post falls care has been provided and learning identified.
- All falls are reviewed using the Royal College of Physicians hot debrief and after action review process in line with PSIRF with referral to SEG where appropriate should a PSII need to be considered.
- There is focused bespoke support and training provided by the Lead Nurse to wards and areas who's falls rate is in the top 3 highest falls across the Organisation or where there have been specific issues or challenges identified.
- Key worker training dates continue and have been well attended to provide ongoing focused support to staff fulfilling those roles.
- The annual falls equipment review audit has been completed to support wards to identify if they have sufficient resources to manage the falls risks.
- Volunteers have been recruited to looking at supporting patients to be occupied and engaged on specific wards to reduce the risk of patients attempting to stand unsupervised. This is being monitored with a view to rolling this out to other high risk wards.
- Bedside visual checks are now accessible on EPR. This is an essential part of the multifactorial risk assessment that should be completed on all patients deemed at risk.

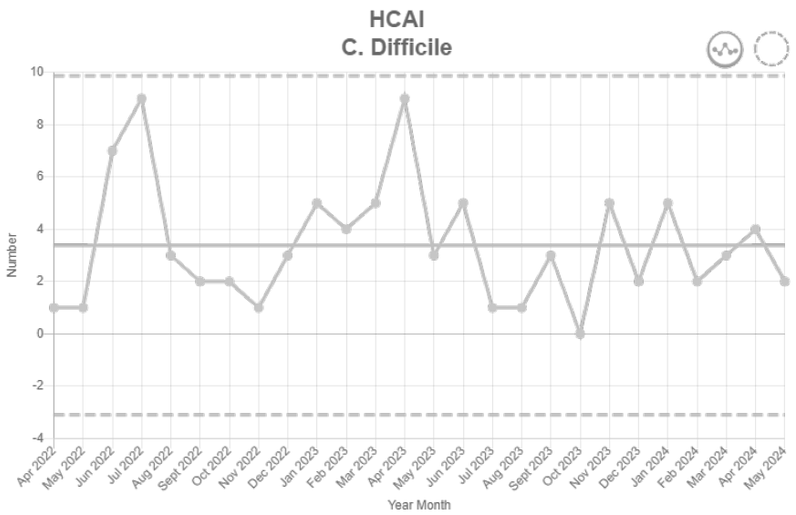
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

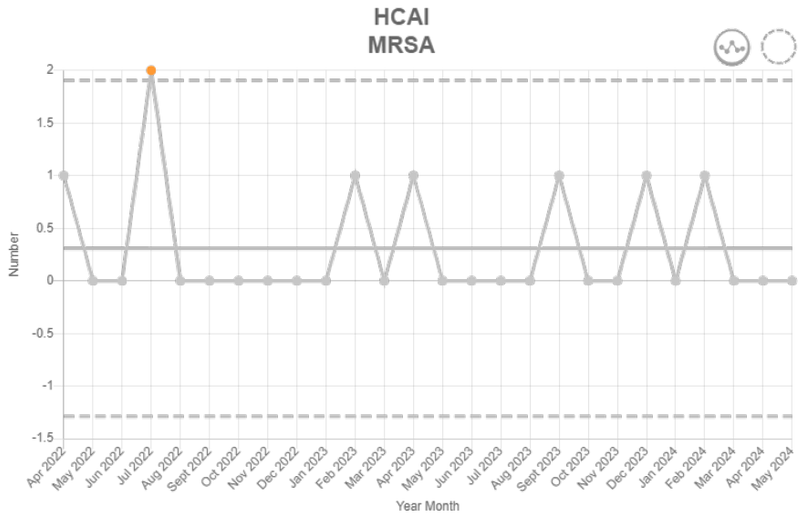
May 2024 - 2
Common cause variation



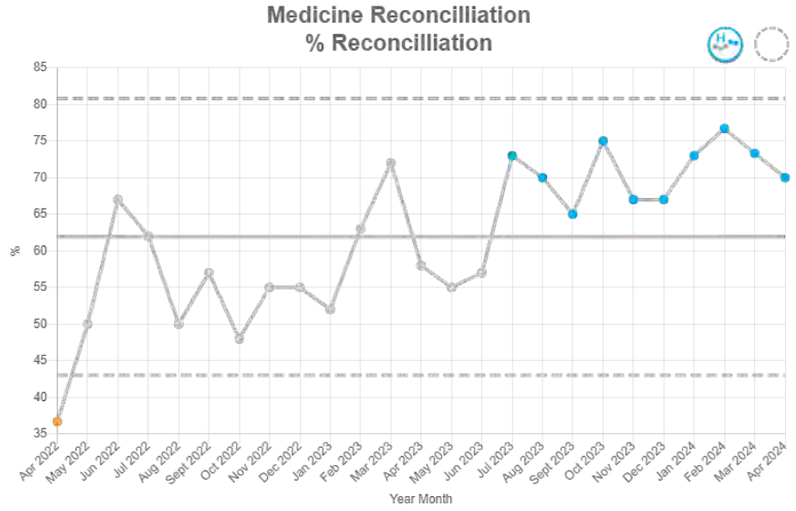
May 2024 - 8
Common cause variation



April 2024 - 0
Common cause variation



March 2024 – 70.0%
Special cause variation of an **improving** nature



Analysis

E. Coli Bacteraemia
Consistent improvement in E. coli bacteraemia has been observed in last few months after the peak in May 2023 especially since the implementation of hydration improvement project.

Clostridioles difficille Infection
Consistent improvement in C. diff infections has been observed in Last few months after the peak in April 2023 since a multidisciplinary team meeting was held to reduce the number of infections.

MRSA Bacteraemia
No MRSA bacteraemia have been observed in the last three months.

Risks, Mitigations and Assurance

Clostridioles diff Infections reduction plan.
CDI Improvement plan in place with regular updates.

- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Multidisciplinary team meeting in case of increase in the cases
- Adhoc and regular environmental audits
- Commode audits with IRIS on non-compliance
- Dedicated antimicrobial Stewardship pharmacist
- Data collection on compliance to Start Smart and Focus

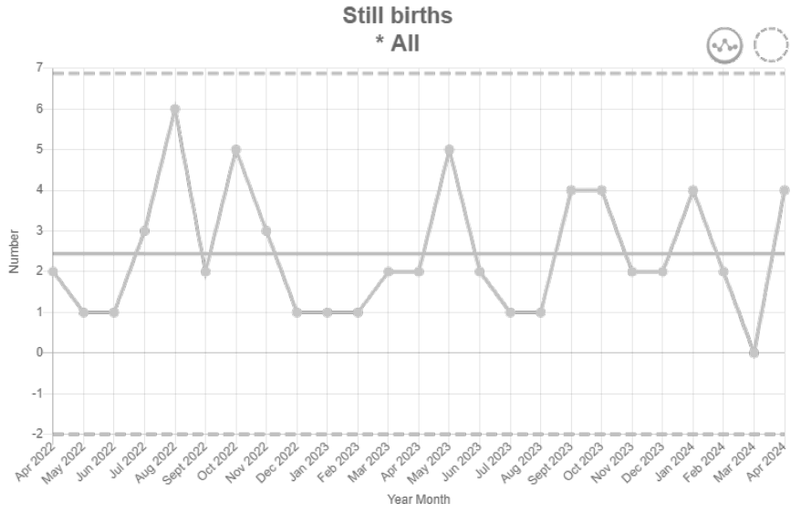
Bactearaemia Reduction plan

- A comprehensive improvement plan updated regularly
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Preparing for ANTT accreditation (Silver)
- Updated SOP for Central Venous Access devices (CVAD)
- Hand hygiene improvement campaign using Semmelweis hand scanners
- Support Gloves off Campaign
- Hydration improvement project
- Audits of Octenisan compliance (IRIS on non-compliance)
- Addition of a tool to ask patients about Octenisan bath

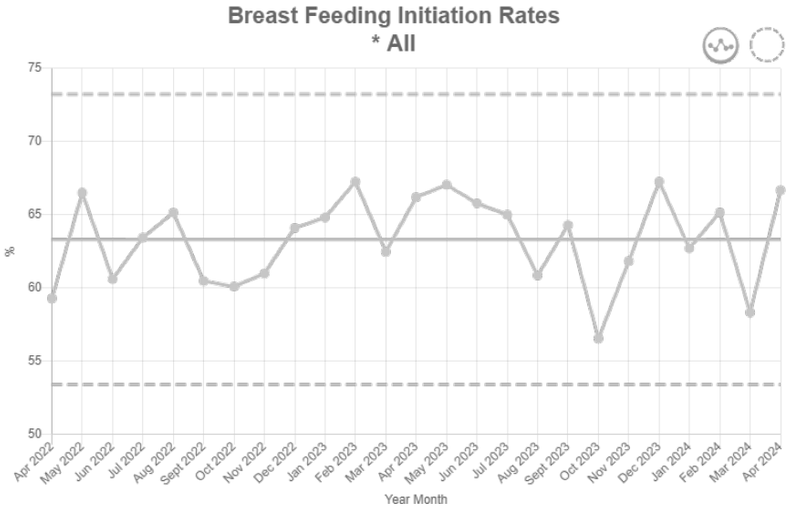
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

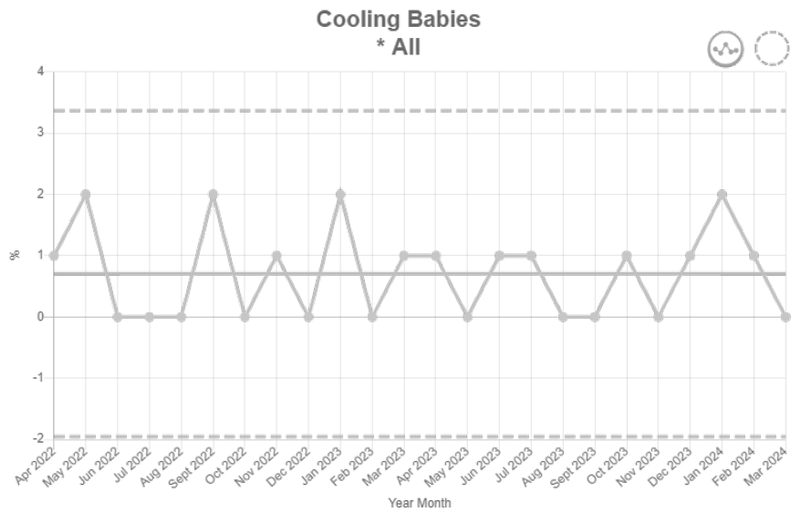
April 2024 - 4
Common cause variation

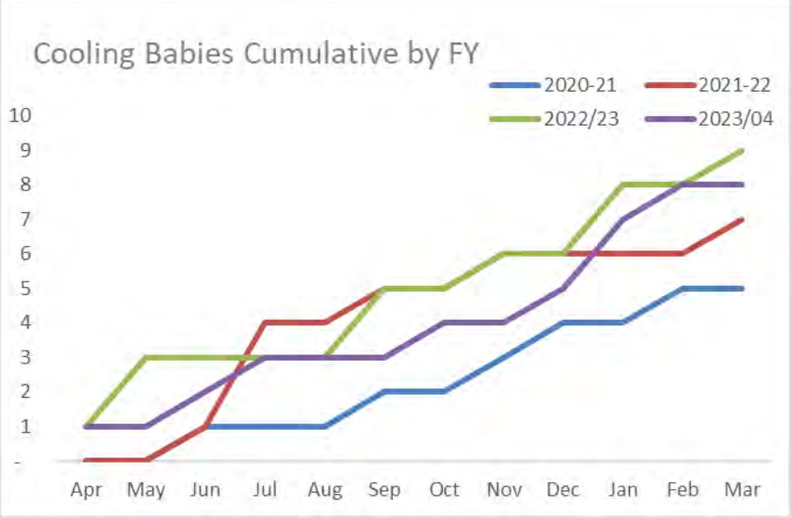


April 2024 – 66.7%
Common cause variation



March 2024 - 0
Common cause variation





Analysis

Stillbirths
There was an overall annual reduction in stillbirths in 2023
The stillbirths in 2024 to date include 3 babies who had known congenital anomalies and were not expected to survive.
Where there are 4 or more stillbirths in month, the service undertakes a thematic review to identify any themes/trends/emerging concerns. The 4 cases in both January and April were all different with no emerging themes.

Breastfeeding
The Infant Feeding co-Ordinator continues to lead on the education and training of maternity staff, working towards Baby Friendly accreditation.

Cooled Babies
All cases are reviewed by the MDT and those meeting the MNSI criteria are referred for independent investigation

Risks, Mitigations and Assurance

The service continues to focus on achieving full compliance with the Saving Babies Lives Care Bundle Version 3 and is currently on target.

The Butterfly Pathway is for families choosing to continue a pregnancy with a known fatal anomaly or life limiting condition. We have seen an increase in the number of Butterfly babies so far this year, which contributes towards the unadjusted stillbirth and neonatal death rates but should be viewed as positive, in that it provides parents with an alternative choice than termination and enables them to create memories, have control of decisions at a difficult time.

FINANCE REPORT

PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

Bo.7.24.17 - Performance Report - May 2024.pdf

Bo.7.24.17 - Operational Highlight Report - May 2024.pdf

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

PERFORMANCE REPORT – FOR THE PERIOD MAY 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 – 4 July 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 May 2024.

Analysis

Ambulance Handovers:

- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 44.80% in May compared to 48.19% in April. The average number of ambulances arriving daily has remained comparable to the increased numbers in recent months whilst the acuity of patients arriving by ambulance also remained high, up by c.28% when compared to the same time last year.
- Patient flow challenges across the Emergency Department and low capacity within the Amber Zone (related to increased attendances, admissions and delays admitting due to increased hospital bed occupancy) has resulted in increased handover delays.
- Ambulance handovers continue to be recorded on the YAS Ambulance Mobile Device Terminal (AMDT) only. Whilst this has reduced duplication for YAS colleagues, there are still discrepancies with data accuracy - significant internal validation remains in place with a c.49% discrepancy in handover clock stops.
- Collaborative work is ongoing with YAS, mapping the ambulance handover process has now been completed with issues identified and owners allocated. A new handover process, approved and communicated to the teams by YAS and BTHFT is due to start on 26th June.
- Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions and executive-level oversight continues to ensure rapid intervention for any handover delay more than 1 hour.

Emergency Care Standard (ECS):

- ECS performance for Type 1, 2 & 3 attendances was 83.06% for May 2024 and is currently forecast at 82.34% for June 2024. The position remains in the upper decile of Acute Trusts in England.
- Daily attendance continued to remain high in May with an average of 422 ED arrivals per day; an increase of c.6% compared to the same time last year in addition to a c.25% increase in high acuity.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

- Whilst average daily attendances for May remain high, increased streaming to the AECU service (up by 27% compared to December 2023) continues to have a positive impact on a range of UEC metrics.
- LoS metrics for both admitted and non-admitted patients have increased during May compared to the previous month, although LoS is currently projected to reduce for admitted patients in June.
- G&A adult bed occupancy reduced to 95.08% in May 2024 although high acuity and issues within the social care sector continue to impact the timely discharge of patients.
- 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 reduced to 124 in May 2024 with further improvements forecast in June (108).
- 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.
- The number of patients discharged on Pathway 1 remains a challenge due to the lengthy assessment processes in place and the availability of community provision across the Local Authority.
- Discharge to Assess and improvements around all three discharge to assess pathways can be found in the IMC blueprint which was signed off by the Healthy Communities Board at the end of April.
- Developments continue to be made across Place; the Home-First Assessment Team (H-FAST) is proving a success at AGH as the planned pilot site. BTHFT are now scheduled to go live in July.
- Work is ongoing to identify further areas for improvement, the clinical lead for patient flow and lead for complex discharge have offered challenge events to all ward areas for patients who no longer meet the criteria to reside. A Multi-Agency Discharge Event with multi-agency representatives from across place will be arranged in July 2024 to identify community improvements which can be made to support hospital discharge.
- The continuation and refinement of these approaches at BTHFT is preventing the extreme pressures experienced by other Trusts although some days remain very challenged.

Inpatient and Outpatient Activity:

- Inpatient activity delivered on plan in May 2024 and is projected to remain in line with plan in June 2024. Outpatient activity delivered slightly above plan in May 2024 and is projected to remain in line with plan in June 2024. Industrial Action (IA) planned for the end of June will result in a slight reduction in activity delivery, however services are working to minimise the impact on long waiters and patients with a high clinical priority.
- Outpatient and elective transformation schemes are being supported by GIRFT further faster. This is a clinically led approach to understanding opportunities presented by variation in data compared to peers. Specific deliverables are also being identified for targeted work under the Closing The Gap programme with dedicated senior operational leadership and allocated improvement resource.
- The use of PIFU continues to increase and EPR optimisation focussed initially on outpatient clinics will help enable some of the outpatient productivity gains identified.
- The work on reviewing Outpatient and Theatre sessions against job plan capacity, activity run rates and waiting list profiles has been completed and communication of the outputs is imminent.
- Scheduling review meetings have supported a reduction in same day cancellations in June 2024.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

- 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. The unit was due to be handed over during April 2024 however is currently delayed with handover expected at the end of August 2024.

Referral to Treatment:

- Referral to Treatment (RTT) performance remained stable in May 2024 at 64.69%. 52-week performance remains in the upper quartile and only slightly short of the upper decile.
- 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 no patient reported over 78 weeks at the end of May 2024 with no patient projected to breach 78 weeks at the end of June 2024.
- 67 patients breached 65 weeks at the end of May 2024, predominantly in Trauma & Orthopaedics (T&O) who are currently reviewing theatre capacity and allocations to support a reduction in long-waiters over the coming months. The number of patients waiting over 65 weeks is expected to increase in June 2024 to 77 as ENT are facing similar inpatient capacity issues as T&O. A recovery plan is in place.
- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.5% in May 2024. Validation is now better coordinated between teams and the themes from corrections are being fed into preventative work. Web-based waiting list management tools will be implemented across the CSUs in July which is expected to improve oversight of pathways.
- RTT recovery meetings will restart in September to provide deeper support to the services.

Diagnostic waiting times:

- DM01 performance for May 2024 was 77.63% which is an improvement on April's performance but is slightly behind the expected improvement trajectory.
- CDC capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. Process and efficiency improvements are being explored to further capitalise on this resource.
- MRI capacity has been challenged in May due to equipment issues and staff sickness. There is a shortfall in staffing to support the ideal capacity model and further work is needed to maximise potential and realise improvements.
- Insourcing to support recovery in Echocardiography will continue whilst plans are 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.
- Endoscopy have implemented FIT testing alongside STT (Straight to Test) to support streamlining of waiting lists, with further waiting list management and booking processes being reviewed and changes made. This will support plans for increased session utilisation at both BRI and the CDC. Easier identification of therapeutic procedures within this data is also being progressed which will both reduce admin time and allow separate waiting list management processes aligned to national guidelines for this cohort.
- The HISTO Improvement Programme continues. 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.

Cancer Wait Times:

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

- A Cancer Time Out session was held as part of the Cancer Board program of work to develop a shared clinical vision for the Trust's Cancer Strategy.
- 2WW performance dropped to below target at 86.06% in April but will improve in May. Demand remains high and has increased further for several tumour groups during this period. Each is reviewing their long-term capacity plans to reduce reliance on weekly escalations.
- The 28-day faster diagnosis standard (FDS) performance was above target at 82.22% in April. There has been significant focus on fast-track diagnostic turnaround times as part of the diagnostic improvement described in that section of this report. The recent launch of a one stop neck lump clinic will also help this phase.
- 31-day general treatment is forecast to improve in May following a dip during holiday periods. Cancer treatment within theatre remains a priority and early identification of capacity issues is in place. Head and Neck capacity is currently being reviewed but there are no other escalations at present. Urology is focussed on timely MDT and clinical oncology appointments within this phase.
- Performance is forecast to dip below the 70% target for the 62-day general treatment standard in May and June. The number of patients waiting over 62 days increased during April and May. There is no single cause for this with tumour groups experiencing increased complexity, reduced treatment, diagnostic delays, and patient-initiated delays.
- The new cancer IT system (Civica) is in project scoping phase with a planned go live of September. 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.

Recommendation

The Board is asked to:

- Receive assurance that overall delivery against performance indicators is understood.
- Note the escalation of areas of underperformance and be assured on the improvement actions.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.17

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)
☐	☒	☐	☐

Bradford Teaching Hospitals
NHS Foundation Trust

Operational Performance Highlight Report

Open Board of Directors – 11 July 2024

(for the period May 2024

Headline KPI Summary

Bradford Teaching Hospitals NHS Foundation Trust

Section	Headline KPI	Latest Month	Plan	Performance	3 Month Trend
1	Avg. Ambulance Handover	May-24	18:00	23:32	→
2	Emergency Care Standard	May-24	78.78%	83.06%	↑
4	Length of Stay ≥21days	May-24	135	124	→
8	18 Week RTT Incomplete	May-24	66.26%	64.69%	→
8	52 Week RTT Incomplete	May-24	1.26%	1.22%	→
11	6 Week Diagnostic Standard	May-24	85.90%	77.63%	→
12	Cancer 28 Day FDS	Apr-24	77.53%	82.29%	→
13	31 Day General Treatment	Apr-24	96.00%	95.02%	→
13	Cancer 62 Day General Treatment	Apr-24	72.14%	70.42%	→

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement

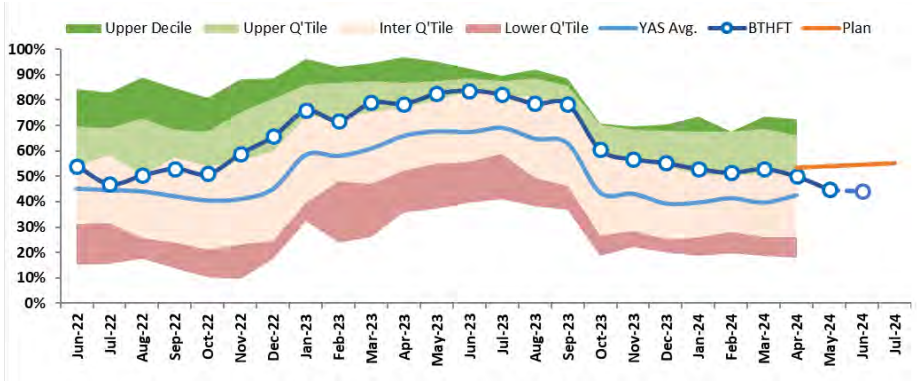
Urgent and Emergency Care (UEC)

1. Ambulance Handover Performance

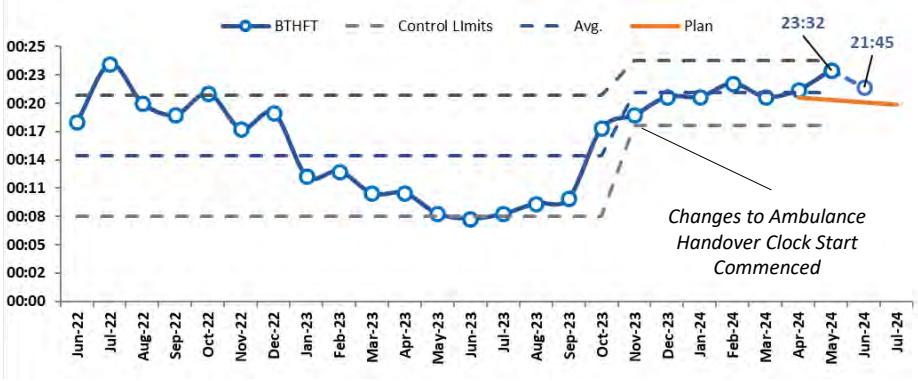
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Reduce Ambulance Handover Time

1.1 Ambulance Performance Benchmarked *(Source: YAS)*



1.2 Average Ambulance Handover Time *(Source: YAS)*



1.3 Additional Ambulance Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Avg. Daily Arrivals -	102	104	102	104	111	111	118	113	115	113	109	107	110
Total Turnaroud Time (MM:SS)	43:29	43:13	45:27	46:32	46:00	44:02	47:50	46:59	49:00	46:13	47:53	50:27	46:23
Avg. Handover Time (MM:SS)	08:25	08:54	09:58	10:30	17:35	18:57	20:48	20:48	22:10	20:48	21:30	23:32	21:45
% Handovers <30 mins -	96.1%	95.2%	93.8%	93.3%	87.4%	84.9%	84.7%	83.9%	81.2%	83.9%	77.4%	75.5%	78.0%
% >60 mins -	0.4%	0.6%	0.9%	1.6%	2.8%	3.9%	5.3%	4.6%	5.7%	3.1%	4.3%	5.7%	3.2%

Latest position

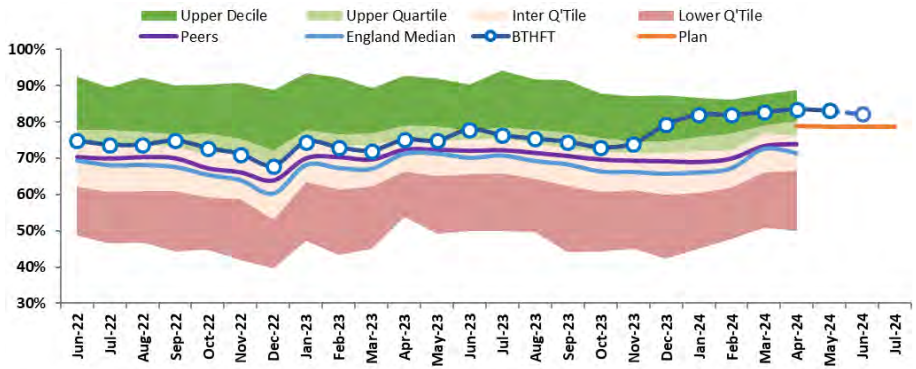
- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 44.80% in May compared to 48.19% in April. The average number of ambulances arriving daily in May have remained in-line with April however the acuity of patients arriving by ambulance continues to remain high, up by c.28% when compared to the same time last year.
- G&A bed occupancy and low capacity within the Amber Zone both continue to impact the ambulance handover process (issues relate to continued high attendance and acuity in addition to delays admitting due to increased hospital bed occupancy).
- Ambulance handovers continue to be recorded on the YAS Ambulance Mobile Device Terminal (AMDT) only. Whilst this has reduced duplication for YAS colleagues, there are still discrepancies with data accuracy - significant internal validation remains in place with a c.49% discrepancy in handover clock stops.
- Collaborative work is ongoing with YAS, mapping the ambulance handover process has now been completed with issues identified and owners allocated. A new handover process, approved and communicated to the teams by YAS and BTHFT is due to start on 26th June.
- Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions and executive-level oversight continues to ensure rapid intervention for any handover delay more than 1 hour.

2. Emergency Department Measures

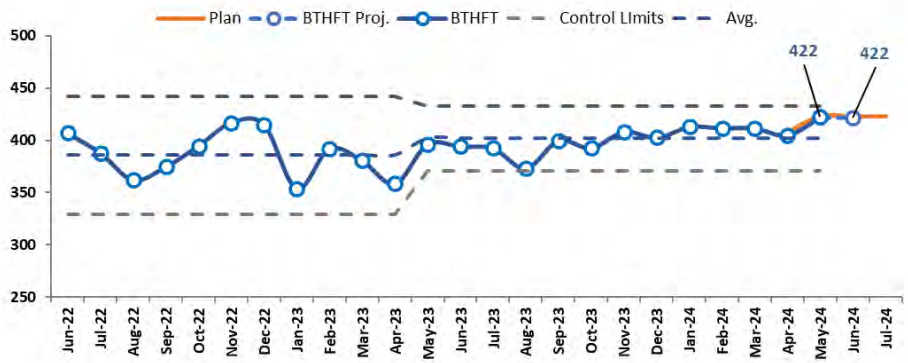
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Improve Waiting Times in A&E

2.1 ECS Performance Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



2.2 Average Daily Attendances (Type 1, 2 & 3) *(Source: EPR)*



2.3 Additional Emergency Department Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Type 1 Performance -	71.1%	68.8%	66.6%	65.3%	64.2%	65.1%	73.0%	75.7%	76.0%	75.3%	76.7%	75.0%	74.5%
Arrival to Assessment -	00:22	00:21	00:22	00:22	00:24	00:26	00:23	00:22	00:22	00:22	00:21	00:22	00:22
Assessment to Treatment -	01:52	02:01	01:59	02:07	02:05	02:21	02:33	02:39	02:32	02:27	02:21	02:33	02:30
Treatment Length -	02:09	02:09	02:19	02:22	02:27	02:39	02:40	02:36	02:41	02:29	02:35	02:34	02:42
LoS (Discharged P'ts) -	03:39	03:37	03:41	03:49	03:53	03:46	03:06	02:56	02:58	02:53	02:54	02:59	03:03
LoS (Admitted & Discharged P'ts) -	04:25	04:22	04:34	04:42	04:50	04:45	04:04	04:00	03:56	03:49	03:46	03:56	03:49

Latest position

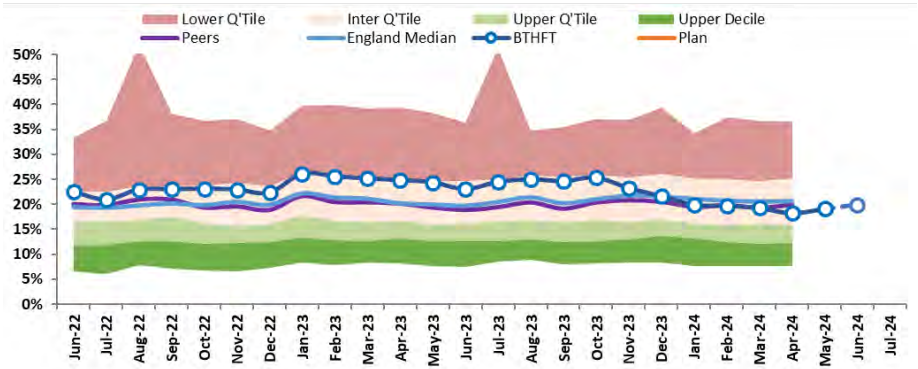
- ECS performance remains in the upper decile of Acute Trusts in England despite average daily attendances continuing to remain high (422 in May compared to 405 in April). In May BTHFT experienced an increase of c.6% in attendance and c.25% in higher acuity when compared to the same time last year.
- Streaming to the Ambulatory Emergency Care Unit (AECU) continues to have a positive impact on a range of UEC metrics with a steady growth in the number of patients now being streamed to the unit. In May 2024 c.27% of patients (2,607) attending ED were streamed to the AECU, up from 19% (1,840) compared to the first full operational month of December 2023.
- The expanded GP stream, supported by a primary care ANP, streamer and receptionist is in place providing rapid assessments into the primary care services. 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).
- These changes have provided the resilience needed to manage periods of high demand for patients who would have previously been delayed by hospital pressures despite not needing an admission to a hospital bed.
- The AECU consultant rota has led to improvements with speciality in-reach and a proactive approach from acute medics providing support in senior decision making. Maintaining flow and reducing admission from this part of the ED is a key part of the overall position.

3. Hospital Admission Measures

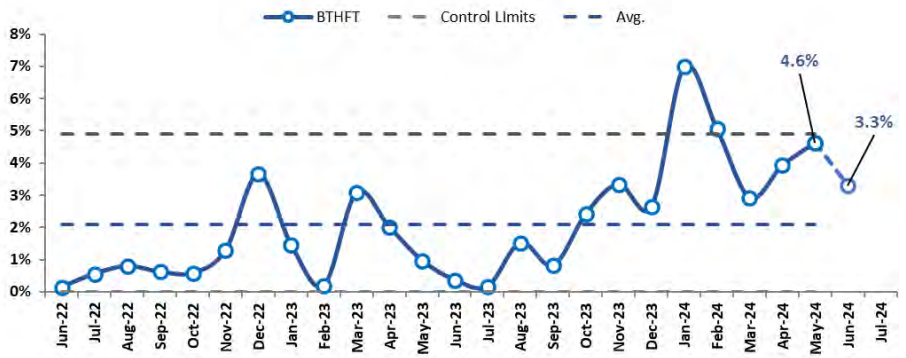
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Improve Admission Processes

3.1 BTHFT Conversion Rate *(Source: NHSE for Acute & Combined Trusts)*



3.2 % >12 Hour DTA to Admit



3.3 Additional Admission Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Avg. # Daily Admissions -	91	96	93	98	93	95	87	81	80	84	80	81	79
Avg. DTA to Admit -	03:28	03:10	03:51	03:51	04:05	04:45	05:00	06:15	05:31	05:04	05:08	05:32	04:42
LoS (Admitted P'ts) -	07:03	06:42	07:15	07:31	07:38	08:01	07:33	08:23	07:55	07:27	07:21	07:59	06:53
% 12 Hour ED LoS -	3.8%	3.1%	5.4%	5.7%	5.9%	6.8%	5.5%	6.3%	6.1%	5.3%	5.4%	6.3%	5.9%
Bed Occupancy (Total)	89.3%	86.6%	88.5%	89.1%	91.2%	92.8%	90.3%	94.5%	94.0%	93.9%	94.5%	93.6%	88.6%

Latest position

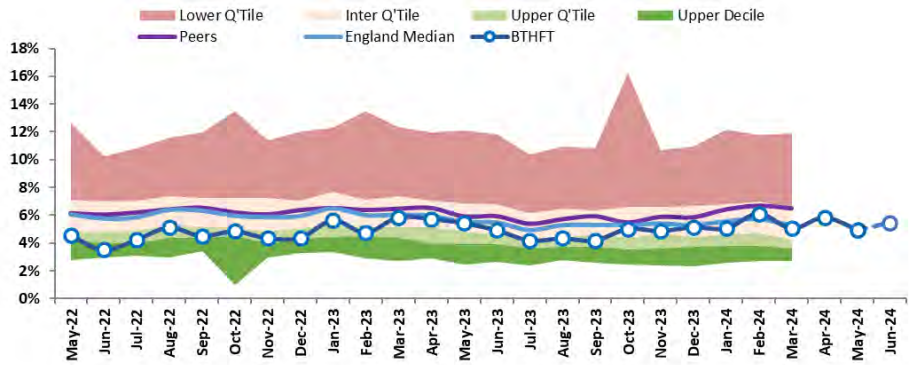
- The AECU also impacts positively on these metrics with reduced admissions/conversion rate following its full opening. Despite these improvements patients in the main ED can still have prolonged waits and this remains a focus for ongoing improvement activity.
- Bed occupancy remained above planned levels at 94.1% in May 2024, but has started to improve into June (Adult G&A bed occupancy is at 89.8% to date).
- Whilst bed capacity is increasing this has primarily been within ring-fenced areas, with Adult Elective and Non-Elective occupancy at 60.4% and 93.2% respectively for June with non-elective bed availability not fully aligning with acute demand, resulting in limited improvements to ED patient flow metrics.
- Within ED, the patient flow hub was relaunched in January 2024, providing situational oversight to ensure a high-level understanding of how many patients are in the department and the associated risks. It is a single access point for coordinating information and response to operational issues. Hub attendance includes multi-disciplinary teams, supporting early interventions. Bringing teams together provides a mechanism to identify complex requirements early to support the patients next steps and ongoing care plan.
- The ED team also attend the operational huddle twice a day, improving communication between the department and those facilitating ward flow, and the placement of patients waiting to be admitted from ED. This fosters a positive approach to problem solving and a better understanding of the shared challenges the teams face when the hospital is busy.

4. Inpatient Length of Stay (LoS) and Discharge KPI

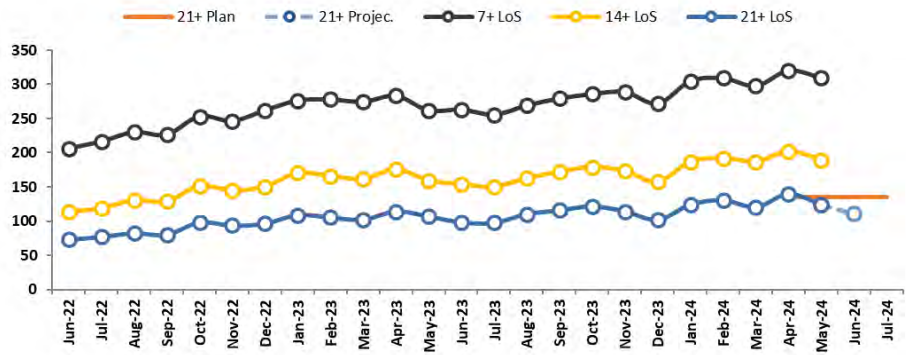
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Increase timely discharges from hospital

4.1 21 Day LoS Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



4.2 Patient LoS Profile *(Source: EPR)*



4.3 Additional Inpatient LoS Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
% of P'ts with Discharge Ready Date -		96%	94.7%	94.2%	93.2%	93.8%	94.3%	94.8%	94.8%	94.6%	94.5%	94.7%	94.4%
% of P'ts Discharged on/before DRD -		83%	81.6%	81.3%	82.1%	81.6%	80.3%	82.3%	82.4%	82.3%	83.0%	81.4%	82.6%
Avg. LoS stay beyond DRD -		3	4	3	4	5	4	4	5	4	5	5	4
% P'ts Not Meeting Criteria to Reside -	12.5%	11.5%	12.0%	14.0%	12.9%	12.4%	14.2%	12.6%	11.3%	12.2%	11.8%	13.4%	14.3%
Bed Occupancy (Adult) -	90.7%	87.2%	89.4%	90.2%	92.0%	93.1%	90.7%	95.1%	94.7%	94.7%	96.1%	95.1%	89.8%
Bed Occupancy (Paed) -	68.3%	78.0%	74.8%	73.4%	79.6%	89.5%	84.1%	86.1%	85.0%	83.5%	73.3%	75.1%	74.2%

Latest position

- In May, the overall bed occupancy and the number of patients with a length of stay > 7 days has improved with further LoS reductions expected to continue through June – the number of patients with a LoS of 21+ days as of 25th June was 94.
- BTHFT is now starting to benefit from closer working relationships with colleagues in community health and social care and voluntary services. The continuation and refinement of approaches at BTHFT continues to mitigate the pressures experienced by other Trusts.
- A 7-day consultant of the week model remains in place, ensuring all inpatients receive a senior review daily. The Deputy Directors of Nursing and Matrons conduct a weekly review of 'Super Stranded Patients'. A 'Criteria to Reside' meeting occurs twice weekly with the operational management teams in the MAIDT, Local Authority (LA) and Therapies to identify and address complexities to discharge, whilst challenging unnecessary delays to discharge planning.
- The number of patients discharged on Pathway 1 remains a challenge due to the lengthy assessment processes in place and the availability of community provision across the Local Authority.
- H-FAST pilot meetings for BTHFT commenced on the 10th June and will be on-going with a preliminary go live date of 22nd July.
- The LoS in community hospitals remains a challenge due to the time taken by Adult Social Care to allocate assigned work and complete Care Act, Mental Capacity Act (MCA) and Continuing Healthcare (CHC) assessments.

5. Delivering UEC Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

Ambulance Handover improvement:

- A meeting with participation and consultancy from the University of Bradford and Public Health **reviewing the ambulance assessment** area (AAA) is fit for purpose took place in May with recommendations on estates work. Signage has been ordered, with further work under review/ on hold as part of the Closing the Gap (CTG) programme.
- Additional portering dedicated to the AAA came to an end in April. Trust teams were reviewing future arrangements for portering to learn from the dedicated model and ensure peak times are covered.
- A **full mapping exercise** of the Ambulance Handover process was completed with both YAS and BTHFT colleagues in May. Observations of the process identified improvements in patient safety, quality of care and efficiencies during patient handovers for BTHFT and YAS. A jointly approved ambulance handover process, has been communicated to the teams by YAS and BTHFT and is due to start on 26th June.

Emergency Department improvement:

- Review of the **triage process for streamers** to ensure the correct pathway continues to be utilised. The Rapid Assessment and Treatment (RAT) model is the preferred model for assessing patients, however additional clinical decision makers are essential for this to be implemented. A further review of the model's feasibility is now required due to current financial challenges.
- Improvements to the AECU model to enhance the service and patient experience. Learning from nurses has helped develop an improved understanding of the department and work continues to **prioritise the wellbeing of staff and patients**. This will also help inform multi-disciplinary SDEC plans.
- Family Support Workers (FSW) have started in June, providing additional support in the Paediatric ED to reduce avoidable attendance.
- The Urgent Care Centre (UCC) workstreams 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 will also continue.

Inpatient LoS and Discharge improvement:

- The clinical lead for patient flow and lead for complex discharge have offered challenge events to all ward areas for patients who no longer meet the criteria to reside. A **Multi-Agency Discharge Event** with representatives from across Place will now be held in August 2024 to identify community improvements to support hospital discharge.
- The use of NHS volunteer responders from the Royal Voluntary Service is being explored to support with TTO's to be delivered post discharge to the patients' usual place of residence to improve patient flow, providing access of up to 237 volunteers in Bradford.
- The Virtual Royal Infirmary (VRI) project is looking to increase pathways for inpatients to reduce overall bed occupancy and improve flow. A **Virtual Multi-Disciplinary Committee** will be implemented with a focus on Long LoS.
- First phase of the Medical Day Case Unit (avoid admission and support discharge) on Ward 8 is due to commence on the 8th July.

Stroke improvement plan:

- Joint working/integration with AGH continues with all 4 task and finish groups now in progress with clear KPIs and outcome measures.
- As part of the rapid response action plan to improving therapy, insourcing contract providing additional therapy commences June 2024.
- A&E based stroke nurse commencing within the next month to improve time to stroke unit metric in SSNAP.
- Work is ongoing with the Virtual Ward to assess the suitability for earlier discharge from Ward 9.

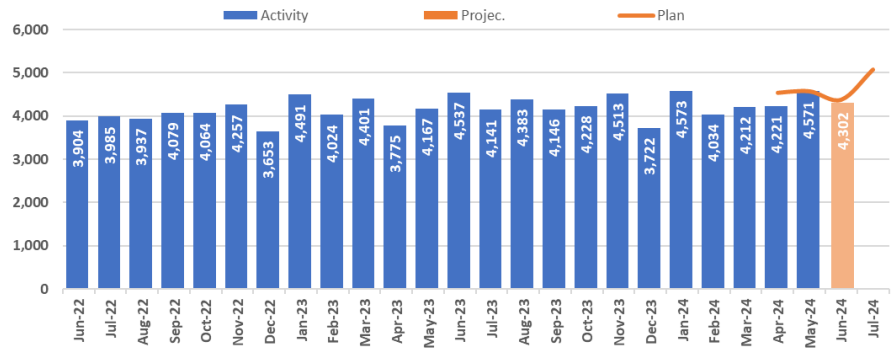
RTT and Planned Activity

6. Inpatient Activity

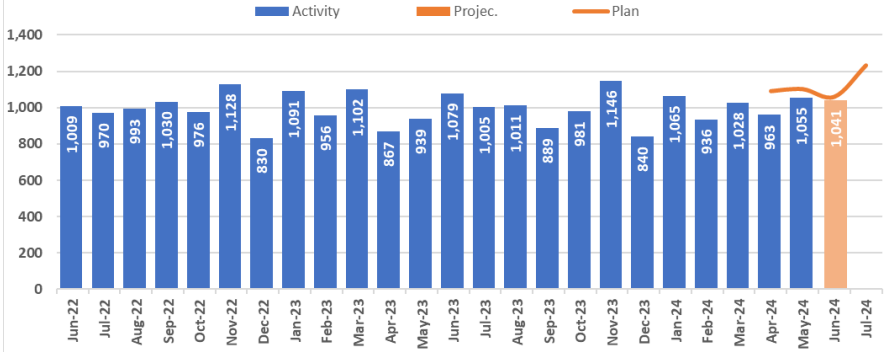
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Increase Elective Ordinary and Day Case volumes

6.1 Elective Activity *(Source: EPR)*



6.2 Patients Treated in Theatres *(Source: EPR)*



6.3 Additional Inpatient Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Admitted Clock Stops -	1,119	1,272	1,361	1,274	1,302	1,430	1,057	1,307	1,156	1,279	1,247	1,319	1,261
Number of lists run -	561	506	503	473	518	579	456	572	535	539	527	534	515
Patients Per List -	2.0	2.1	2.1	2.0	2.0	2.0	1.9	1.9	1.8	1.9	1.9	2.1	2.0
Capped Utilisation -	82.01%	80.41%	82.96%	81.51%	83.29%	82.84%	80.26%	83.27%	82.71%	83.90%	85.42%	86.09%	83.54%
Total Cancellations -	165	122	113	128	119	151	110	200	135	119	145	153	79
28-day Rebooking Breaches -	10	4	3	4	3	1	0	3	7	9	3	5	2
Decisions to Admit -	5,563	5,046	5,246	4,822	5,100	5,413	4,520	5,535	4,923	4,877	5,118	5,203	4,556

Latest position

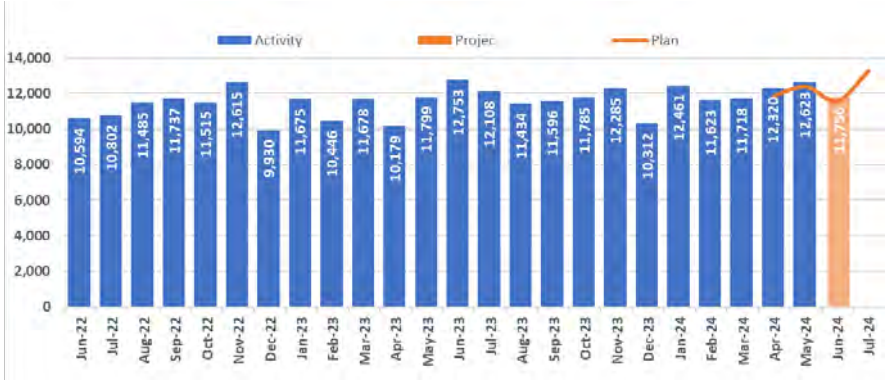
- Inpatient activity delivered on plan in May 2024 and is projected to remain in line with plan in June 2024. Industrial Action (IA) planned for the end of June will result in a slight reduction in activity delivery, however services are working to minimise the impact on long waiters and patients with a high clinical priority.
- Lists are running at expected levels whilst patients per list and capped utilisation remain relatively stable.
- Trust-wide theatre improvement initiatives continue to focus on scheduling efficiency by confirming theatre timings, updating the 'group and save' process, and monitoring phone call confirmations for patients attending for procedures.
- The number of same-day cancellations reduced significantly in June 24 as a result of a reduction in DNAs and patients not being fit for surgery, as well as a reduction in the number of lists running out of time through better scheduling.
- Forward wait areas are now live for General Surgery, Urology, Gynaecology, Ophthalmology, ENT and OMFS and should support a reduction in inter-case delays.
- Weekly access meetings are utilising forward-view reports which enable services to take action to ensure theatre lists are fully utilised.

7. Outpatient Activity

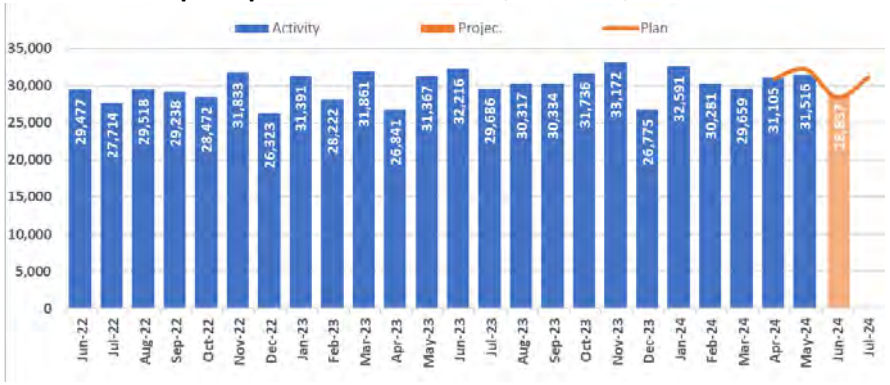
NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Objective: Transform how we deliver Outpatient care

7.1 First Outpatient Attendances *(Source: EPR)*



7.2 Follow Up Outpatient Attendances *(Source: EPR)*



7.3 Additional Outpatient Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Non Admitted Clock Stops -	6,708	6,315	6,084	6,514	6,891	6,933	5,461	6,810	6,230	5,909	6,474	6,589	6,139
DNA Rate -	8.72%	8.04%	8.27%	8.35%	8.53%	8.62%	9.11%	8.16%	8.42%	8.33%	8.21%	8.52%	8.16%
Follow Up Orders -	27,025	24,766	24,421	25,497	26,692	27,844	21,909	27,250	25,569	24,408	26,332	26,147	24,040
PIFU % -	1.73%	1.63%	1.63%	1.77%	2.13%	1.89%	2.35%	2.06%	2.43%	2.45%	2.57%	2.68%	2.61%
First to Follow Up Ratio -	2.53	2.45	2.65	2.62	2.69	2.70	2.60	2.62	2.61	2.53	2.52	2.50	2.45
Number of clinics run -	5,641	5,206	5,300	5,335	5,708	5,877	4,872	5,879	5,515	5,335	5,588	5,554	5,232
Patients Per Clinic -	8.0	8.0	7.9	7.9	7.6	7.7	7.6	7.7	7.6	7.8	7.8	7.9	7.8
GP Referrals -	7,709	7,028	7,451	6,757	7,259	7,308	5,532	7,390	7,016	6,905	6,743	7,257	5,853

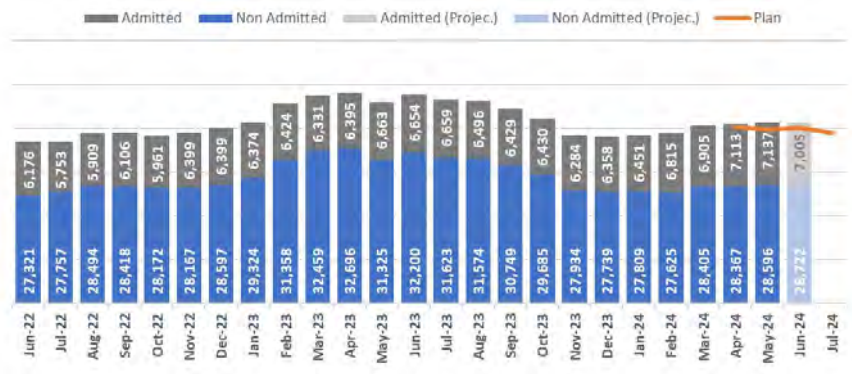
Latest position

- Outpatient activity delivered again slightly above plan in May 2024 and is projected to remain in line with plan in June 2024.
- Industrial Action (IA) planned for the end of June is expected to result in a slight reduction in activity delivery as inpatient capacity is being prioritised, however services will endeavour to minimise the impact on long waiters and patients with a high clinical priority.
- The work to improve activity levels of outpatients with procedures in line with the planning guidance is ongoing and more services have now been included within the project. The initial focus is set on increasing and improving accuracy of procedure recording on EPR back to 19/20 levels, while identifying and addressing mapping issues within the data warehouse.
- Patients continue to be routinely contacted via SMS as part of the waiting list management initiative aligned to the national validation toolkit recommendations. 77,170 patients have been contacted to date who meet the required criteria with 2,778 requesting discharge (3.6%).
- PIFU use increased to 2.68% in May (+0.11% to April).

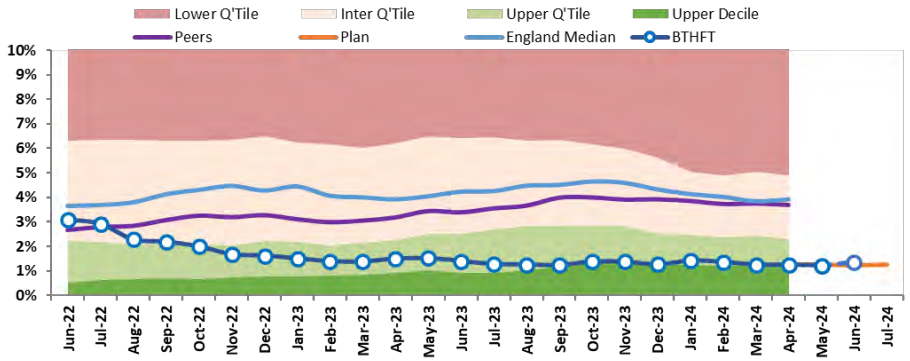
8. Referral to Treatment

Objective: Reduce waiting lists and eliminate long waits

8.1 RTT Incomplete Waiting List Size



8.2 52 Week RTT Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



8.3 Additional RTT Metrics

		Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
RTT Performance	-	68.25%	67.54%	67.52%	66.39%	66.69%	66.59%	64.60%	65.03%	65.13%	64.48%	64.35%	64.69%	64.85%
Incomplete (<18)	-	26,516	25,857	25,705	24,684	24,084	22,786	22,027	22,278	22,430	22,772	22,832	23,114	23,169
Incomplete (>18)	-	12,338	12,425	12,365	12,494	12,030	11,431	12,069	11,982	12,010	12,542	12,648	12,619	12,558
Incomplete (52+)	-	542	487	478	457	496	468	429	484	469	442	443	435	454
Incomplete (65+)	-	88	69	90	84	92	64	63	75	67	34	58	67	77
Incomplete (78+)	-	0	0	0	1	0	0	1	1	3	1	1	0	0
W/L Change	-	+866	-572	-212	-892	-1,064	-1,897	-121	+164	+180	+874	+166	+253	-6

Latest position

- The RTT waiting list size remained slightly above plan in May 2024 and is projected to continue to do so in June 2024. This trend will likely continue whilst activity for admitted pathways remains below plan.
- The number of patients waiting over 52 weeks remained stable in May 2024 but is projected to continue to do so in June 2024.The number of patients waiting over 65 weeks continued to increase in April 2024 due to ongoing theatre capacity issues in Trauma & Orthopaedics (T&O) and ENT.
- The T&O recovery plan continues to focus on improved list uptake which is expected to stabilise the position with improvement forecast from August. List efficiency will be explored as part of a longer-term plan but case complexity/duration has increased across elective and trauma lists.
- The ENT recovery plan is being launched and focuses on increasing surgical capacity while keeping within budget, similarly to T&O.
- 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.

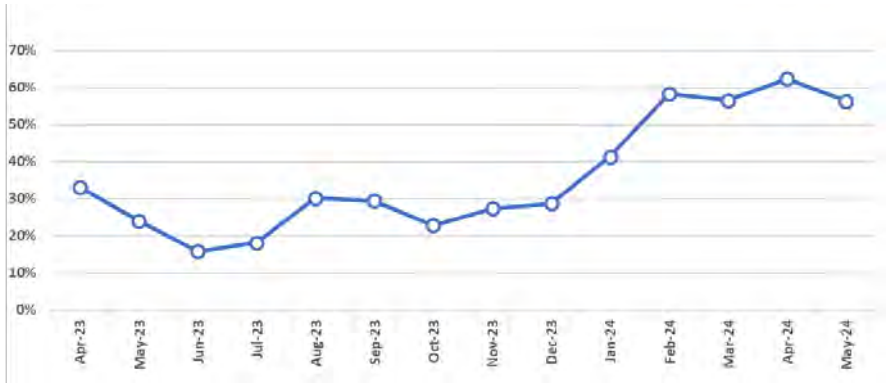
9. Waiting List Management and Validation

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Reduce errors to improve wait times

9.1 RTT Waiting List Confidence Level

9.2 Correction Rate



9.3 Additional WL Management and Validation Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
RTT LUNA DQ Metrics -	7,193	7,448	6,489	5,689	7,082	3,841	1,475	1,258	1,354	1,692	1,434	1,199
Correction Rate - Non RTT -	14.67%	15.27%	25.88%	25.67%	20.06%	17.63%	20.75%	14.84%	51.69%	55.35%	41.75%	39.54%
Non-RTT DQ Process Failures -	29,521	29,541	31,141	32,398	31,778	34,461	41,301	36,358	38,690	38,143	38,425	35,659

Latest position

- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.5% in May 2024. Targeted validation of incomplete pathways is sustaining the high confidence level and low number of DQ metrics on the RTT waiting list. Validation is now better coordinated between teams and the themes from corrections are being fed into preventative work.
- Targeted validation on Non-RTT new pathways which started in February 2024 is now complete and has resulted in a reduction of 11,594 referrals from the waiting list.
- All RTT and Non RTT validations by Corporate Access Team (CAT) are now being conducted on the web-based application and the application is now in position to be rolled out across the trust.
- Clearance of Non-RTT process failures is underway. However further resource is required due to large backlog and high occurrence of daily errors. CAT is currently in process of recruiting into 2 band 3 positions, which will be dedicated to clearance of process failures. DQIS team is working with Pre-Assessment and Ophthalmology teams on prevention of Non-RTT process failures. CAT is in the process of recruiting another DQIS member, once in place the support will be expanded to further specialities.

10. Delivering RTT/Planned Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

RTT and Planned Activity Improvement

- The work on reviewing Outpatient and Theatre sessions against job plan capacity has been completed and communication of the outputs is imminent. **RTT recovery meetings** will restart in September to provide deeper support to the services.
- The Day Case Unit (DCU) at St. Lukes Hospital will support an increase in sessions and an uplift in productivity with the ability to run high volume low complexity lists. The unit was due to be handed over during April 2024 however is currently delayed due to contractor issues.
- The implementation of the Theatre and Critical Care modules on Cerner is due in September 2024 and should support better functionality and oversight of patients being admitted all in one place, as well as providing increased reporting functionalities.
- The Trust is exploring what else can be done to improve attendance at appointments, particularly for communities with poorer health outcomes. We will be **liaising further 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.
- The **GIRFT Further Faster programme** includes recommendations on outpatient and inpatient opportunities and is currently being launched with all CSUs. Initial meetings have taken place with Respiratory Medicine, Rheumatology and Ophthalmology and have identified areas of opportunity for improvement and increased focus.
- **Referral and first OPA optimisation** are key parts of this work and will support early care planning and maximise the outcomes of clinic appointments as a result. PIFU update and a review of follow up process, supported by improvements in first appointments will help reduce follow up activity in line with national expectations.
- Elective productivity is also a workstream within Closing The Gap with a specific focus on the additional actions that can be taken or accelerated beyond what BAU improvement and GIRFT will support.
- **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. It will also help promote the work need to ensure all outpatient procedure is captured and reported correctly. 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.

Waiting List Management and Validation

- Web-based **waiting list management tools** were successfully launched across the Corporate Access Team (CAT). Tracking lists are also being developed on the application for all CSUs, with go-live date planned for July. This will allow elective services across the Trust to track and validate all RTT and Non-RTT pathways in one place and will result in improved functionality and better oversight of pathways.
- Further work is being carried out by BI on development of DQ dashboard showing **correction rate and DQ themes** to support the DQ prevention work with CSUs.
- Services are **clinically validating non-RTT patients** who are 12 months past their see by date in line with the validation toolkit. Text based validation and PIFU will be extended to this process as appropriate.
- Changes required to current **RTT sequencing on Cerner** has been approved by the EPR change board and EPR team has started the background work on implementing the changes. The output of this project will improve clinic outcome options for clinicians, in line with RTT pathway management.

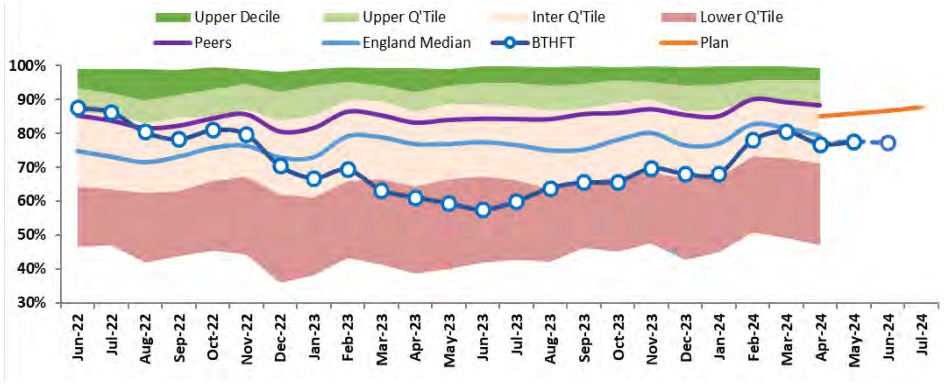
Cancer and Diagnostic Performance

11. Diagnostic Waiting Times

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Increase activity to reduce delays for diagnostic tests

11.1 DM01 6-week Performance *(Source: NHSE for Acute & Combined Trusts)*



11.2 Diagnostic Activity vs Plan

11.3 Additional Diagnostic Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
(Phys. M'ment) Activity -	1,499	1,435	1,531	1,218	1,294	1,273	1,102	1,522	1,671	1,850	1,754	1,781	1,799
(Phys. M'ment) Performance	88.1%	87.4%	86.2%	81.4%	70.3%	64.9%	58.2%	50.7%	61.6%	73.4%	77.1%	83.2%	83.8%
(Imaging) Activity -	9,845	9,793	9,935	9,156	9,252	9,817	9,085	9,765	9,755	9,058	9,399	10,350	10,354
(Imaging) Performance -	50.9%	52.0%	56.7%	60.1%	61.6%	69.8%	68.7%	73.2%	83.7%	82.6%	76.8%	75.7%	75.6%
(Endoscopy) Activity -	1,191	931	1,264	1,184	1,139	1,371	1,164	1,484	1,263	1,310	1,337	1,543	1,506
(Endoscopy) Performance -	74.7%	76.0%	75.5%	73.0%	80.3%	78.4%	90.1%	85.1%	86.0%	90.8%	77.1%	77.7%	74.4%

Latest position

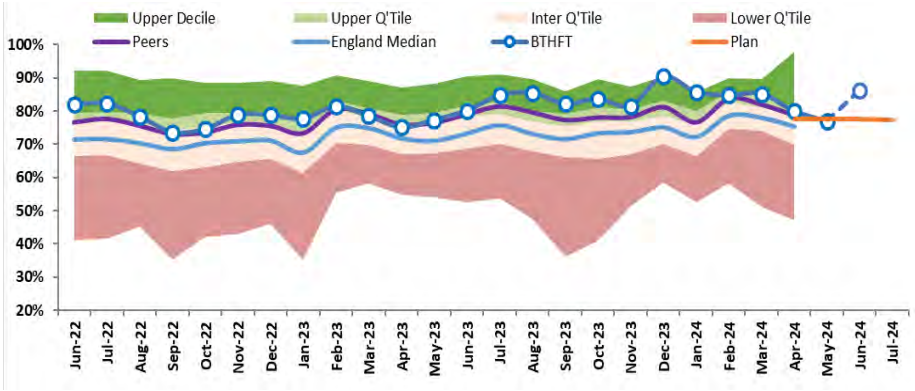
- CDC capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. Process and efficiency improvements are being explored to further capitalise on this resource however performance has plateaued. Recruitment to CDC posts continues in line with plans to maximize potential capacity.
- MRI capacity has been challenged in May due to equipment and staff sickness issues. Long term planning to build capacity by delivering a round-the-clock service is being explored including options to address the staffing challenge that this would bring.
- Endoscopy have implemented FIT testing to streamline referral volumes which is expected to have a positive impact from June onwards. This will support plans for increased session utilisation at both BRI and the CDC.
- Echocardiography plans are in place to ensure sustained service resilience with performance during May and June continuing to recover to summer 2023 levels of over 90%.
- Audiology continues to be challenged by gaps in clinical staffing. Request for aid from other services continues alongside exploring options for external aid, whilst working with consultants to develop a long-term sustainable plan.

12. Cancer Diagnostic Phase

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the Faster Diagnosis Standard (FDS)

12.1 28 Day FDS Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



12.2 28 Day Performance by Tumour Group vs 77% Standard *(Source: PPM)*

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Trust -	81.4%	91.0%	85.7%	84.8%	85.2%	82.3%	76.9%	81.8%
Breast -	97.2%	96.7%	95.6%	96.3%	93.8%	96.2%	96.8%	95.6%
Gynae -	75.3%	86.9%	70.7%	43.9%	55.0%	54.4%	46.3%	51.2%
Haematology -	43.8%	50.0%	13.3%	52.9%	41.2%	21.4%	31.3%	26.7%
Head & Neck -	86.7%	94.1%	82.2%	83.7%	83.8%	75.6%	77.4%	80.0%
Lower GI -	64.8%	80.2%	73.6%	76.2%	77.0%	68.1%	56.8%	62.1%
Lung -	78.4%	84.2%	78.6%	82.2%	93.1%	88.5%	92.1%	87.0%
NSS -	77.8%	90.0%	84.6%	75.0%	65.0%	73.3%	95.0%	90.0%
Upper GI -	90.8%	90.0%	78.5%	80.4%	88.2%	84.6%	73.6%	87.6%
Skin -	80.5%	93.9%	96.9%	95.0%	95.2%	95.6%	86.7%	94.0%
Urology -	72.0%	100.0%	70.9%	76.9%	73.6%	56.9%	71.9%	77.3%

12.3 Additional Diagnostic Phase Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
# 2WW Refs -	2,039	2,244	2,140	2,307	2,137	2,129	2,081	1,546	2,100	1,963	1,957	1,841	1,727
% 2WW Performance -	94.3%	96.9%	94.9%	94.2%	95.6%	96.4%	93.1%	82.0%	95.4%	93.5%	86.1%	91.5%	94.6%
FDS Performance -	80.2%	85.1%	85.6%	82.1%	84.6%	81.4%	91.0%	85.7%	84.8%	85.2%	82.3%	76.9%	81.8%
# FDS	1,905	2,015	1,987	1,676	2,078	1,776	1,652	1,188	1,536	1,510	1,374	1,560	1,516
# Undiag, unbooked >28 days -	176	185	209	246	251	301	157	288	189	233	290	369	318

Latest position

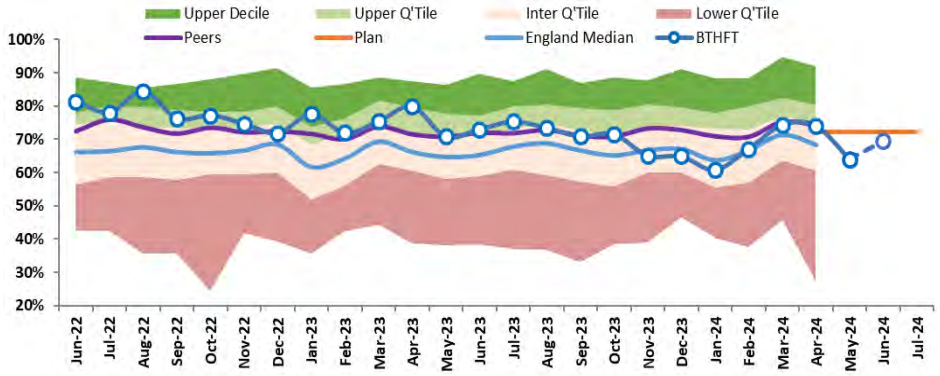
- Two week wait (2WW) performance ended in below target position of 86.06% in April and is expected to improve but remain below target into May due to the continued Bank Holiday period and sustained high referrals particularly in Breast and Breast symptomatic pathways related to national campaigns. Breast services continue to seek to run additional clinics to manage sustained referral volumes into the summer working closely with Radiology to support extra sessions.
- Skin demand is forecast to increase in line with better weather and seasonal trends. Services are preparing for this increase and additional support was put in from the WY&H Alliance across WYAAT given the pressure experienced across the WYAAT footprint.
- FDS performance remains above target and in the upper decile nationally. Histology delays continue to impact on this phase for certain tumour sites, this is being addressed via the HISTO programme along with recruitment of consultants and AP/EP demand and capacity work. With most of the delays being for Skin this doesn't always impact the reported FDS as the decision to treat will be before the patient informed date, but patient experience is impacted negatively, and the improvement plans will address this.
- Work on MDT streamlining continues with a targeted focus on system wide improvements for notifying patients of a benign cancer diagnosis and improving reporting processes.

13. Cancer Treatment

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the 62 Day Treatment Standard

13.1 62 Day Treatment Benchmarked *(Source: NHSE for Acute & Combined)*



13.2 62 Day Treatment Performance by Tumour Group vs 85% Standard

(Source: PPM)

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Trust -	65.8%	65.9%	60.9%	66.9%	73.3%	70.4%	64.0%	69.4%
Breast -	86.5%	73.2%	72.1%	75.0%	82.7%	88.6%	68.5%	83.9%
Gynae -	50.0%	45.5%	41.7%	25.0%	83.3%	62.5%	42.9%	75.0%
Haematology -	58.8%	61.9%	20.0%	33.3%	58.3%	38.1%	40.0%	80.0%
Head & Neck -	61.1%	36.4%	51.6%	33.3%	56.5%	62.5%	63.6%	50.0%
Lower GI -	65.7%	33.3%	81.5%	64.3%	76.0%	32.4%	57.9%	33.3%
Lung -	23.8%	68.8%	33.3%	44.4%	40.6%	60.0%	10.0%	50.0%
Upper GI -	41.7%	55.6%	47.6%	81.8%	75.0%	30.8%	50.0%	60.0%
Skin -	66.7%	72.7%	69.6%	84.6%	72.7%	76.7%	68.8%	76.0%
Urology -	69.7%	84.9%	68.2%	78.5%	91.9%	82.9%	79.7%	72.9%

13.3 Additional Cancer Treatment Metrics

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
# 31 Day Treatments -	279	319	271	263	281	254	312	248	335	278	251	259	183
31 Day Performance -	93.4%	94.8%	95.8%	94.3%	91.7%	87.5%	92.7%	87.5%	95.3%	91.9%	95.0%	93.0%	94.9%
62 Day Performance -	74.9%	75.8%	72.6%	73.5%	70.3%	65.8%	65.9%	60.9%	66.9%	73.3%	70.4%	64.0%	69.4%
# of >62 (GP Referral) -	43	53	52	52	55	66	67	53	63	53	41	62	73
# of >62 (All Types) -	57	69	70	70	83	104	97	88	101	79	51	80	90

Latest position

- 31-day treatment (time from decision to treatment) performance continued just below target at 95.02% for April having been impacted during holiday periods. Treatment numbers are forecast to remain low during May when a continued reduction is expected due to further Bank Holidays which have added to the growing 62-day backlog which peaked at over 100 during May. Improvements into June will support the overall position.
- Cancer treatment within theatre remains a priority and early identification of capacity issues is in place. Head and Neck capacity is currently being reviewed but there are no other escalations at present.
- 62-day performance is forecast to dip below the 70% target during May which will continue into June for 2024/25 due to continuing low treatment numbers. However, clearance of patients who had already exceeded the 62-day target due to diagnostic delays or the impact of holidays on clinician or patient availability does lead to a reduction in patients who have waited over 62 days in June.
- Although treatment volumes have impacted on performance against this standard, there is no single cause for this with tumour groups experiencing increased complexity, reduced treatment, diagnostic delays, and patient-initiated delays.

14. Delivering Cancer & Diagnostic Ops Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

Cancer Wait Times improvement

- The new cancer IT system (Civica) is in project scoping phase with a **planned go live of September**. 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.
- Pathway Navigator and Cancer Nurse roles have proven successful. A review is being undertaken by the Lead Cancer Nurse with a view to further expansion. MacMillan internship opportunity is being explored to develop **future CNS workforce** and attract nurses to these roles. This has been approved by the Lead Cancer Nurse and details of the course are being developed as a next step. Student Nurses have commenced placement with CNS's.
- Implementation of **One Stop Clinic** for palpable neck lumps is planned to be in place in July 2024 to support the diagnostic phase for this tumour group. Referral forms have been revised to ensure correct patients are referred to weekly clinic with access to ENT, Consultant Radiologist & US are currently with Primary Care for approval prior to go-live.
- A Cancer 'Time-Out' took place on the 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.
- The Histopathology Improving Services & Transforming Outcomes (HISTO) programme is underway with three workstreams (People, Place & Processes) in place, with the intention of improving turnaround times which will significantly impact cancer pathways. A Consultant Time Out planned for the 7th of July and active recruitment to posts continues with a consultant post approved for recruitment as additional capacity challenges are expected from July due to a further shortage emerging for a Breast Consultant.

Diagnostic Wait Times improvement

- Delivery of the **CDC programme** 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. Cardio-respiratory will be the last modality to come online later this month. Various recruitment to posts in support of the CDC continues.
- Sustainability of the Non-Obstetrics Ultrasound (NOUS) DM01 performance and plan for further obstetric growth is underway. Additional NOUS capacity through two scanners at the CDC is in place providing an additional 196 scans per week on average 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.
- MRI performance continues to be a focus with plans to explore extended scanning hours underway. This will require a system wide response and further support for workforce development.
- To achieve the 95% target by year end we will utilise learning from last year's recovery plans and translate into **longer term sustainability** plans for each modality. This will include capacity and demand modelling alongside pathway redesign where needed.

BO.7.24.18 - BOARD ASSURANCE FRAMEWORK, RISK APPETITE REVIEW AND HIGH-LEVEL RISKS

REFERENCES

Only PDFs are attached

- Bo.7.24.18 - HLRR - Board (cover).pdf
- Bo.7.24.18 - Appendix 1 - June_2024_Open Operational Risks_current scoring_15 or over_(19.06.2024) - Copy (2).pdf
- Bo.7.24.18 - Appendix 2 - Risk on a Page Report v1.pdf
- Bo.7.24.18 - Appendix 3 - Target Mitigation Dates.pdf

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.18

Board Assurance Framework, Risk Appetite Review and High-Level Risks

Presented by	Jacqui Maurice, Head of Corporate Governance	
Author	Executive Directors Laura Parsons, Associate Director of Corporate Governance/Board Secretary Katie Shepherd, Corporate Governance Manager	
Lead Director	Mel Pickup, Chief Executive	
Purpose of the paper	This paper provides a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives	
Key control	Understanding the Board's risk appetite related to the achievement of the Trust's strategic objectives is a key component of the Board Assurance Framework	
Action required	For assurance	
Previously discussed at/ informed by	High Level Risk Register: ETM; 13 May 2024 and 24 June 2024 Academies: • Quality and Patient Safety Academy; 22 May 2024 and 2 July 2024 • People Academy: 22 May 2024 and 3 July 2024 • Finance and Performance Academy: 22 May 2024 and 4 July 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 13 May and 24 June, 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 during May and early July 2024 (the planned meetings for June took place week commencing 1 July 2024).

The HLRR, showing all high level risks rated 15+ for June 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 May and June 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.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.18

Target Mitigation Dates

Risks beyond their target mitigation date

ETM noted there were three risks that had passed the target date for completion of the mitigating actions during May and June 2024.

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:
May 2024:						
447	16	8	Recommended Summary Plan for Emergency Care & Treatment (ReSPECT)	Karen Dawber, Chief Nurse	30/04/2024	Quality and Patient Safety Academy
June 2024:						
2509	16	9	The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks. The significant numbers awaiting assessment have a risk of delay in diagnosis and impact on long-term development. The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks.	Karen Dawber, Chief Nurse	01/04/2024	Quality and Patient Safety Academy
605	16	3	There is a risk to the delivery of the Haemoglobinopathy service due to staffing constraints which will have an impact on quality and patient safety	Ray Smith, Chief Medical Officer	31/03/2023	People and Quality and Patient Safety Academy

The target date for risk 447 has been updated to 30 June 2025. ETM noted that the mitigation dates for risks 2509 and 605 would be reviewed and updated as soon as possible.

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 May 2024, one new risk was accepted onto the HLRR.

In June 2024, three new risks were accepted onto the HLRR:

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:
May 2024:						
2542	16	1	Haemonetics Blood Track Kiosks End of Life	Ray Smith	11/06/2024	Quality and Patient Safety Academy
June 2024:						
605	16	3	There is a risk to the delivery of the Haemoglobinopathy service due to staffing	Ray Smith, Chief Medical	31/03/2023	People and Quality and

			constraints which will have an impact on quality and patient safety	Officer		Patient Safety Academy
2509	**16**	**9**	The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks. The significant numbers awaiting assessment have a risk of delay in diagnosis and impact on long-term development. The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks.	Karen Dawber, Chief Nurse	01/04/2024	Quality and Patient Safety Academy
396	**16**	**6**	There is a risk to the provision of a consistent Stroke Service due to a number of underlying issues: • Clinician and nursing vacancies, • Inconsistent delivery of the Stroke Responder Service • Nursing and AHP sickness and maternity leave on ward 6. • Cultural and behavioral issues within the ward. • Reduced provision of SALT Service due to recent vacancies (being addressed as a separate issue on the risk register.)	Ray Smith, Chief Medical Officer	01/09/2024	Quality and Patient Safety Academy

NB. There are a further two new risks added to the high level risk register during June 2024, however they will both be combined with risk 2542 (The Haemonetics Blood Track kiosks at BTHFT are now 'end of life'. If there is a mechanical failure Haemonetics will be unable to repair the kiosk/s rendering part / all of the system unusable. This means the paper traceability process will be used to collect blood / blood components and to verify the traceability / fate of all blood / blood components):

- Risk 810 (There is a risk of patient harm caused by: Administration of the wrong blood/blood component)
- Risk 1280 (There is a risk that patients requiring blood transfusion might receive blood with the wrong blood group, as a result of the wrong patients' blood being in the tube sent for G&S/cross match tests).

Risks which have been removed/closed

No risks have been removed/closed since the previous report.

Risks which have changed in score

ETM agreed no changes in risk score in May 2024.

ETM agreed two changes in risk score in June 2024:

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.18

Risk ID:	Current Score:	Previous Score:	Target Score:	Risk Description:	Lead Director:	Reason for change in score:	Academy:
June 2024:							
447	**12**	**16**	**6**	The risk is that a patient will be admitted or discharged with a ReSPECT form which contains a resuscitation related decision that will not be adhered to leading to resuscitation or not which contradicts their recorded wishes.	Karen Dawber, Chief Nurse	Digital solution now in place.	Quality and Patient Safety Academy
39	**12**	**16**	**8**	If we are unable to recruit to a number of unfilled pharmacy vacancies and provide cover to deliver a 7 day service then the Trust will not improve and sustain medicines reconciliation rates to above national average resulting in a regulatory risk to the Trust's aspiration to become an 'Outstanding' provider and an increased risk of harm to patients if unresolved	Sajid Azeb, Chief Operating Officer	18/06/2024 Medicines reconciliation above 70% as before, ongoing recruitment, still service gaps.	Quality and Patient Safety Academy and People Academy

Risks beyond their review date

ETM noted there was one risk beyond its review date in May 2024, and three risks beyond the review date in June 2024:

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:
May 2024:						
447	**16**	**8**	Recommended Summary Plan for Emergency Care & Treatment (ReSPECT)	Karen Dawber, Chief Nurse	30/04/2024	Quality and Patient Safety Academy
June 2024:						
187	**16**	**8**	There is a risk of harm to patients, staff and visitors within planned and un-planned care due to the Trust's inability to maintain safe staffing levels as a result of the sustained Covid-19 pandemic; potentially resulting in, poor experiences of care, increased patient and staff dissatisfaction, complaints, incidents, increased sickness levels, claims, and a negative impact on the reputation and financial status of the Trust.	Karen Dawber, Chief Nurse	30/05/2024	People and Quality & Patient Safety Academy
396	**16**	**6**	There is a risk to the provision of a consistent Stroke Service due to a number of underlying issues:	Ray Smith, Chief Medical Officer	01/06/2024	Quality and Patient Safety Academy

			• Clinician and nursing vacancies, • Inconsistent delivery of the Stroke Responder Service • Nursing and AHP sickness and maternity leave on ward 6. • Cultural and behavioral issues within the ward. • Reduced provision of SALT Service due to recent vacancies (being addressed as a separate issue on the risk register.)			
2549	**16**	**8**	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.	Ray Smith, Chief Medical Officer	13 May 2024	People and Quality & Patient Safety Academy

Risks 447, 396 and 2549 have been reviewed and review dates updated.

ETM noted that risk 187 would be reviewed and updated as soon as possible.

Update on ongoing risks

At the ETM meeting held on 24 June, an update was provided by the Chief Operating Officer in relation to risk 221:

Risk ID:	Score:	Risk Description:	Lead Director:	Academy/Academies:
221	**16**	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit	Sajid Azeb, Chief Operating Officer	Finance and Performance Academy & Quality and Patient Safety Academy

The Chief Operating Officer advised that a temporary Aseptic Mobile Unit has been installed at St Luke's Hospital until a permanent unit is in place. The temporary unit has now been handed over to the Trust following a long period of estates related work undertaken by the supplier to ensure that the unit is fit for purpose. The final works involve the commissioning of isolaters which require testing and sign off. It is expected that the mobile unit will be functional by the end of August/beginning of September following sign off of all necessary compliance standards.

Board Assurance Framework (BAF) and Risk Appetite

The BAF is currently being re-developed as part of the annual review process and following an external review of the Trust's governance arrangements. This was discussed at the Board Development session held on 13 June 2024 where the Board prioritised the existing BAF risks. The number of risks on the BAF (currently 17) will be reduced to remove any duplication and to ensure that the Board can focus on the risks with the highest priority. The risk appetite statement is also currently subject to an annual review and will be refreshed to align with the current context.

Further work will be undertaken with the Trust Chair and Audit Chair prior to the BAF and risk appetite statement being presented to the Academies and Board for approval.

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;
- note the update provided regarding the BAF and risk appetite statement.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.18

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 19/06/2024)

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)
171	3748	15 Feb 2022	Jen Green	Ray Smith	Business Meeting	Quality & Patient Safety Academy Finance and Performance	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	12	(3) Moderate	(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	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	03/05/24 - Skipton twlights (Monday, Wednesday and Friday) are now open. 11/04/24 After staff consultation, the CSU is due to open dialysis slots at Skipton from 22/04/24 on Monday, Wednesday and Friday initially. Discussion ongoing with Execs and Specialised Commissioning regarding funding and growth. 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	30 Sep 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently
221	3696	18 Aug 2021	Philip Moore	Sajid Azeb	Business Continuity	Finance and Performance Quality & Patient Safety Academy	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit. The risks are specifically:- 1. a patient safety risk arising from the potential inability to provide critical medicines such as chemotherapy and total parenteral nutrition 2. a reputational risk to the organisation arising from the potential failure of, and or regulatory intervention into the, pharmacy aseptic unit. 3. A risk to organisational performance against RTT targets arising from this risk due to the potential inability to deliver treatment within specified timescales. The risk arises from the due to:- 1. The unit being almost 25 years and no longer up to current design standards. 2. The inability of the air-handling unit and associated pipework being able to deliver the required number of room air changes per hour. 3. The poor design of said pipework meaning it is impossible to satisfactorily test the integrity of the terminal HEPA filters due to leak paths of unknown origin. 4. Some of the filter housings being modified by a third party from top entry to side entry meaning the airflows immediately prior to the	31 Jul 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	8	(2) Minor	(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	18/06/2024 Isolator repaired and serviced 14/06/2024. Delay was due to prolonged dispute as to which supplier was responsible for the repair. Deep cleaning of unit being arranged, then commissioning process can begin. 01/05/2024 Isolator repairs arranged for imminent completion. Commissioning of the unit to begin mid to late May 2024 with an expected completion a minimum of three months after the commissioning begins. 01/03/2024 Temporary unit ready for handover but issues with company provided 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	30 Sep 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue

70	3850	29 Mar 2023	Philip Moore	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	30 Jul 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	6	(2) Minor	(3) May recur occasionally	SOPs are in place to ensure processes are as safe as possible in the current accommodation. Additional accommodation has been sought with two further portakabins 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 accommodation including staff rest facilities. Work has been undertaken to relocate the pharmacy aseptic unit which will give opportunities to redevelop the BRI site.	Update 18/06/2024 Further delays with commissioning of temporary aseptic unit due to roof leak earlier in the year and faulty isolator requiring repair. Serviced 14/06/2024, now for deep clean. 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. This has been delayed due to the delay in the opening of the new aseptic unit.	31 May 2025	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
109	3810	14 Oct 2022	Jen Green	Ray Smith	Risk Assessment	People Quality & Patient Safety Academy	Highlighting the service risk for Haematology, o Risk to Acute consultant Rota and timely inpatient reviews o Risk to Outpatient delivery and the increase to wait times for Urgent / routine / cancer and the specialised Haemophilia patients o Risk to CNS and reg clinics o Service delivery for the whole Haemophilia service , surgical and outpatient work o Service delivery for complexity of haematology patients o In reach to transfusion service Non-RTT follow-up backlog is 3472, RTT is 93. 500 malignant f/u past due date increasing escalation list of >50 pts every week who needed OPA 8 weeks ago but not yet appointed	30 Jun 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		03/05/24 - Business case submitted to Execs for additional substantive consultant and x2 locum consultants to support with recovery. The CSU is currently awaiting feedback. There continues to be an escalation list for urgent treatment patients and there is an ongoing risk of potential harm to patients where treatment is delayed due to capacity issues. The CSU would like to request the risk score is raised to 20. 12/03/24 - Improved position due to the improvement 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. 11/11/23 - Locum in post and providing acute support with some outpatient work. The service continues to have clinic capacity issues with new routine referrals, urgent referrals and cancer patients on active treatment. The latter present a clinical risk if not seen in a certain time frame. Initial work has started regarding a service review but dedicated clinical leadership is required with	30 Sep 2024	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 May 2024	20	(5) Catastrophic	(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	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	31 Oct 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
2549		05 Apr 2024	Jen Green	Ray Smith	Risk Assessment	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	13-May-24	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	• Local monitoring of waiting times with adhoc additional sessions where possible • ETM 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 May 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue

257	3660	25 May 2021	Helen Jepps	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 Jul 2024	16	(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	02 Jul 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
605	3311	13 Dec 2018	Joanne Hickey	Ray Smith	Risk Assessment	Quality and Patient Safety Academy, People Academy	There is a risk to the delivery of the Haemoglobinopathy service due to staffing constraints which will have an impact on quality and patient safety	31 Oct 2024	12	(4) Major	(3) May recur occasionally	3	(3) Moderate	(1) Cannot believe that this will ever happen again	Control measures In reach consultant from Sheffield 3 Pa's Full CNS team Reg to rotate into service, for escalation and acute review of Patients for this patient group	16/05/24 - recent peer review has shown significant concerns regarding the consultant workforce and immediate action has been requested due to the reliance on the Sheffield consultant and no on site presence throughout the week. The CSU have revised the risk score to 16 given the concerns raised and the ongoing resilience to provide a Haemoglobinopathy service at Bradford. 12/04/24 - current SLA with Sheffield to provide an in-reach consultant service is still in place (expires September 2024. Demand and capacity work has been undertaken with the wider Hematology service with a view to increasing the consultant establishment. Any new consultant posts advertised will include Haemoglobinopathy in the job plan. 01/09/23 Delayed opening of the transfusion suite , impacting on patient views and patient experience. ,No local nominated haematology consultant for the service , Ophthalmology Screening problematic with little support from BTHFT team . Failure to meet Nice standard for pain relief in sickle cell crisis with no direct ward admission. No	31 Mar 2023	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.	30 Jun 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	30 Jun 2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
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 03/05/24 Currently working with execs around developing safe and sustainable senior medical staffing model.	31 Aug 2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently

2566		12 Apr 2024	Farah Naz	Sajid Azeb	Risk Assessment	Quality & 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.	01 Sep 2024	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	-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	• 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 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently
290	3627	10 Feb 2021	Chris Davies	Matthew Horner	Business Continuity	Health and Safety 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 £103m (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. This risk will remain on the risk register, as a high risk, for the foreseeable future in the absence of significant back-log maintenance funding and /or funding to allow the strategic development of the estate including the development of a new hospital. As the backlog	14 Aug 2024	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	15	(5) Catastrophic	(3) May recur occasionally	•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. •Planned Preventative Maintenance is undertaken as per HTM/Statutory and good practice guidance to maintain buildings and building services plant and equipment.	March 2024: The back-log program continues and planning for 24/25 is underway which includes, fire alarm, compartmentation and emergency light upgrades (year 2 of 8), plans to decontaminate the BRI duct continues. Plans to replace the SLH C&D block heritage bridge link continues with the planners and designers. Stakeholder groups continue. Nov 2023: Fire Safety scheme continues to progress, maternity building 80% complete, autronica system / phase 1 one progressing on the main BRI site. Cost in for Daisy Bank roof - £500k+ Sept 2023: The 5 year programme continues to progress using the allocated budget. •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	31 Mar 2025	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue

607	3309	26 Nov 2018	Nima Maleki	Ray Smith	Risk Assessment	Quality & Patient Safety Academy	There is a risk that due to capacity constraints within the Histopathology consultant workforce there is likely to be delays in samples being reported across all tumour sites leading to longer waiting times for diagnosis. Longer waiting times will delay treatment causing harm to patients. Constraints in the workforce is due to consultant vacancies and the number of trained doctors locally and nationally do not meet demand.	30 Jun 2024	12	(4) Major	(3) May recur occasionally	8	(2) Minor	(4) Will probably recur, but is not a persistent issue	•2 locums are in place •Some work is outsourced (as and when required) •Additional sessions are covered by existing substantive staff	03/05/24 - A business case has been submitted to Execs to seek approval for investment in biomedical scientists (BMSs) to increase dissection capacity for Histopathology in order to increase reporting capacity. While increasing the number of BMSs will not be an immediate solution to reducing Histopathology turnaround times, building capacity in the non medical workforce is a long term focus and a priority to increase service resilience, reduce costs and provide a quality and timely service for patients. A complex analysis is underway to determine the future model for the Histopathologist workforce. 12/04/24 - work continues re improvements, risk score has previously been revised to increase the likelihood to 5 due to the decreased staffing levels and a number of incidents in relation to delays in reporting. 12/03/24 - 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 &	31 Aug 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently
2509		16 Feb 2024	Helen Jepps	Karen Dawber	Business Continuity	Quality & Patient Safety Academy	The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks. The significant numbers awaiting assessment have a risk of delay in diagnosis and impact on long-term development. The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks. The significant numbers awaiting assessment have a risk of delay in diagnosis and impact on long-term development If the long waiting times continue then Children and young people will have a delayed assessment and initiation of support services. Resulting in a delay in diagnosis; with an impact on • the long term development of the child o delay in access to appropriate education and support o reduction in life opportunities o increase in unnoticed mental health issues o older children who could reach crisis (for e.g. self-harm) • increased parental queries/anxiety about the child • staff wellbeing and increased work load demands	01 Jul 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue	9	(3) Moderate	(3) May recur occasionally	Signposting for parents/carers to support agencies is provided when accepted for autism assessment, including the BEAT programme commissioned from AWARE VCS. Many support agencies can be accessed without a diagnosis. Staff have worked to make efficiencies in the pathway to increase capacity, e.g. non face to face elements, recent changes in pathway and working collaboratively between providers to reduce waiting times or hold ups. They offer support where possible to adhoc contacts from parents and carers requiring advice. Signposting for parents/carers to support agencies is provided when accepted for autism assessment, including the BEAT programme commissioned from AWARE VCS. Many support agencies can be accessed without a diagnosis. Staff have worked to make efficiencies in the pathway to increase capacity, e.g. non face to face elements, recent changes in pathway and working collaboratively between providers to reduce waiting times or hold ups. They offer support	1. BTHFT Autism Assessment Pathway Implementation Project 2. Ongoing involvement in System wide Autism pathway development	01 Apr 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue

2542		04 Apr 2024	Jill Parkinson	Ray Smith	Risk Assessment	Quality & Patient Safety Academy	The Haemonetics Blood Track kiosks at BTHFT are now 'end of life'. If there is a mechanical failure Haemonetics will be unable to repair the kiosk/s rendering part / all of the system unusable. This means the paper traceability process will be used to collect blood / blood components and to verify the traceability / fate of all blood / blood components. This results in: - A less effective process which will reduce traceability compliance for BTHFT. Traceability is a legal requirement as stipulated in the Blood Safety and Quality Regulations (BSQR 2005) and by the Medicines Healthcare Regulatory Authority (MHRA). BSQR and MHRA stipulate hospitals must maintain 100% traceability of all blood / blood components for 30 years. - Potential for staff to fail to manually check the time the blood / blood component has been out of temperature-controlled storage which could result in harm to a patient. - Extra time involved to manually check traceability compliance.	13 Aug 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue	1	(1) Negligible	(1) Cannot believe that this will ever happen again	Staff are competency assessed bi-annually on both the electronic and paper blood collection process and receive theory training bi-annually on paper traceability. New Blood Track kiosks have been purchased by BTHFT.	06.06.24: HTC planned for 04.06.24 was cancelled as not quorate. on 06.06.24 it was agreed by Ray Smith and Karen Dawber we could progress with the Haemobank and Blood Track TX project. Next HTC 06.08.24. 02.05.24: The business case for Haemobanks and Blood Track TX has now been submitted to ETM for consideration. Next ETM meeting on 13.5.24. 1. Roll out Haemobanks across BTHFT once the business case is approved	06 Aug 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
396	3520	08 Jan 2020		Ruth Taunton-Smith	Risk Assessment	Quality & Patient Safety Academy	There is a risk to the provision of a consistent Stroke Service due to a number of underlying issues: • Clinician and nursing vacancies, • Inconsistent delivery of the Stroke Responder Service • Nursing and AHP sickness and maternity leave on ward 6. • Cultural and behavioral issues within the ward. • Reduced provision of SALT Service due to recent vacancies (being addressed as a separate issue on the risk register.) This may have an impact on patient safety and is impacting the achievement of the Sentinel Stroke National Audit Programme (SSNAP).	01 Jun 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	15/4/24 - Risk assessment updated to reflect therapy position and SSNAP scores not improving as quickly as anticipated. Rapid Response action plan now in place (addendum to risk document). Risk score elevated to 16. 02/04/24 - Ward 9 now open but residual concern around lack of flow due to reduced therapy input. Therapy risk assessment escalated to Corporate Risk Register (score 20). Long term sickness in community nursing team also contributing to delays in 6 week reviews. Mitigation in place. 02/04/24 - Ward 9 now open but residual concern around lack of flow due to reduced therapy input. Therapy risk assessment escalated to Corporate Risk Register (score 20). Long term sickness in community nursing team also contributing to delays in 6 week reviews. Mitigation in place. 14/4/23 - Business Case approved to open a stroke rehab ward on W9. SSNAP score B for April 23 but still significant concerns around therapy input to the pathway.	15/4/24 - Rapid response action plan to address concerns specific to therapy. Actions include engaging with education to implement therapy clinical educators, secondments of staff from other areas of therapy into stroke and exploring insourcing opportunities. 05/04/2024 - SSNAP scores remain at a low 'C'. Weekly breach meetings continue. Physicians Associate, SHO and nursing team providing MDT stroke response service resulting in cover most days as opposed to frequent gaps. 2 more PAs starting in next 2 months. 15/1/24 - Ward 9 now open. Stroke response team has 1 new member plus locum SHO. Breach review meetings taking place regularly and a post-implementation review of W9 has been arranged for Feb. Appears that LoS on W9 is still a problem due to lack of therapy input. 13/10/23- SSNAP scores dipped in July/August but are predicted to come back up to a C for September. Weekly breach review meetings are taking place within the team to understand the specific pressure points and ensure there is mitigation where	01 Sep 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue

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	30 Sep 2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	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 10/4/24	30 Sep 2024	15	(5) Catastrophic	(3) May recur occasionally

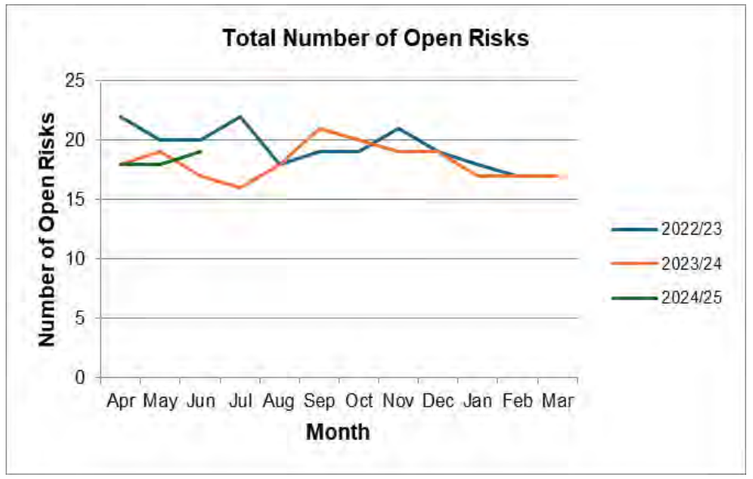
Bradford Teaching Hospitals NHS Foundation Trust

High Level Risks Report on a Page – June 2024

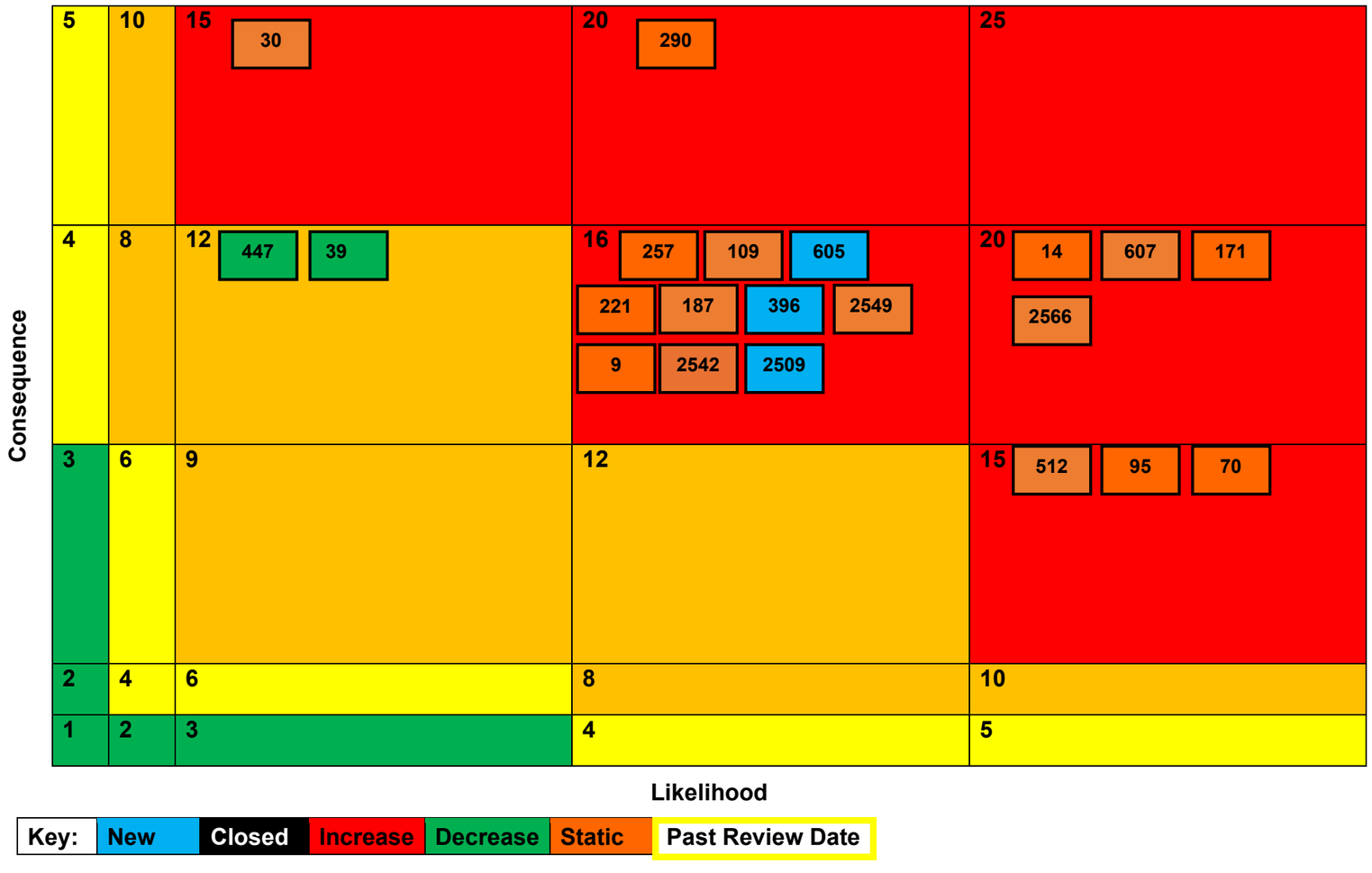
Total High Level Risks	19*
Aligned to F&PA	3
Aligned to QPSA	16
Aligned to PA	8
Aligned to Board	2

Movement of Risks	
New	3
Marked for closure	0
Risk score increased	0
Risk score static	16
Risk score decreased	2

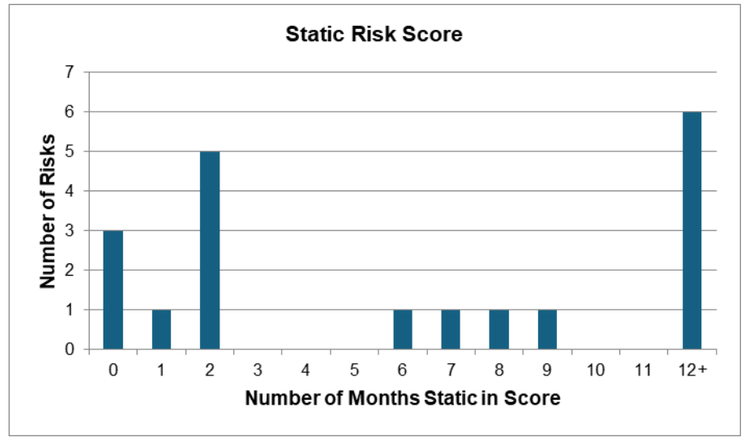
*Note some risks are aligned to more than one Academy



Risk Overview



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



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

IRIS ID	Legacy ID	Date of entry	Academy	Current Score - June 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	30/06/2024	
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	02/07/2024	
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	30/09/2024				
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									
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	20	10	30/11/2023	31/03/2024	30/09/2024												
30	3890	30/08/2023	QPSA	15	5	31/08/2024	31/05/2024	30/09/2024												
2549	N/A	05/04/2024	PA & QPSA	16	4	31/03/2025	31/05/2024													
2542	N/A	04/04/2024	F&P & QPSA	16	1	11/06/2024	05/08/2024													
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	31/05/2025													
9	3911	10/11/2023	Board	16	8	30/09/2024														
2566	N/A	12/04/2024	QPSA	16	12	30/11/2024														
2509	N/A	16/02/2024	QPSA	16	9	01/04/2024														
396	3520	08/01/2020	QPSA	16	6	01/09/2024														
605	3311	13/12/2018	PA & QPSA	16	3	31/03/2023														

Key:

Target mitigation date changed since last report

Past the target mitigation date

BO.7.24.19 - ACADEMY/COMMITTEE ANNUAL REPORTS, TERMS OF REFERENCE AND WORK PLANS

REFERENCES

Only PDFs are attached

- Bo.7.24.19 - Academy and Committee ARs - ToRs - WPlans 2023-24 (cover).pdf
- Bo.7.24.19 - Appendix 1a - Finance and Performance Annual Report 23-24.pdf
- Bo.7.24.19 - Appendix 1b - People Academy Annual Report 23-24.pdf
- Bo.7.24.19 - Appendix 1c - QPS Academy Annual Report 23-24.pdf
- Bo.7.24.19 - Appendix 1d - CFC Annual Report 23-24.pdf
- Bo.7.24.19 - Appendix 1e - AC Annual Report 23-24.pdf
- Bo.7.24.19 - Appendix 2a - FandP Academy ToR.pdf
- Bo.7.24.19 - Appendix 2b - P Academy ToR.pdf
- Bo.7.24.19 - Appendix 2c - Q Academy ToR.pdf
- Bo.7.24.19 - Appendix 2d Audit Committee ToR.pdf
- Bo.7.24.19 - Appendix 3a - FandP workplan 24-25.pdf
- Bo.7.24.19 - Appendix 3b - PA workplan 24-25.pdf
- Bo.7.24.19 - Appendix 3c - QA workplan 24-25.pdf
- Bo.7.24.19 - Appendix 3d - Audit Committee workplan 24-25.pdf

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.19

Annual Reports from Academies, Charitable Funds Committee and Audit Committee

Presented by	Jacqui Maurice, Head of Corporate Governance	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Renee Bullock, Chief People and Purpose Officer	
Purpose of the paper	This paper provides; • A summary of the work of the Academies' and Committees during 2023/24 by way of their annual reports at appendix 1 • The interim draft Terms of Reference for the Academies and the Audit Committee at appendix 2 • the Academy and Audit Committee workplans at Appendix 3.	
Key control	As sub-committees of the Board, the Academies, and Committees form a key part of the Trust's control arrangements.	
Action reported	For assurance and approval	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

The Board of Directors reviews the performance of its Committees and Academies annually to determine if they have been effective. One of the key elements of this review is the annual report provided by the Committees/Academies.

Annual Reports

The Academies and the Charitable Funds Committee considered and agreed their annual reports at the meetings held in April 2024. The reports were subsequently presented at the Audit Committee for review in May 2024. The Audit Committee derived assurance that the Academies and the Charitable Fund Committee met their terms of reference throughout 2023/24. They reports are attached as follows.

- Appendix 1a - Finance and Performance Academy
- Appendix 1b - People Academy
- Appendix 1c - Quality and Patient Safety Academy
- Appendix 1d - Charitable Funds Committee
- Appendix 1e - Audit Committee

Audit Committee

The Board is asked to note that the previous Audit Committee annual report was presented to the Board for approval in July 2023 and covered the period July 2022 to June 2023. The time frame for this current annual report (at appendix 1e) brings the Audit Committee annual reporting in line with the annual reporting schedule for other Board Committees and Academies. The report attached therefore, includes some reporting included with the previous report the Committee.

The Board is further asked to note that the Audit Committee received all other annual reports from the Academies and Charitable Funds Committee for review at its meeting in May 2024 to provide assurance

that the Academies met their terms of reference throughout 2023/24, which supported the Audit Committee in considering the assurances provided within the Annual Governance Statement.

Terms of Reference

The Board is asked to note that the Board approved the Charitable Funds Committee revised terms of reference on 9 May 2024.

The terms of reference have been considered and confirmed by the respective Academy and, the Audit Committee. With regard to the Terms of Reference for the Academies, these are presented as interim. The academies recognised that a further detailed review would be undertaken with the final versions of the Academy Terms of Reference being brought back to the Board for final approval in September 2024.

Current Amendments to the Academy Terms of Reference

- **Finance and Performance Academy**

  - Membership of the Academy to be amended to refer to the Non-Executives and the Executives. All others will be in attendance.
  - The quorum for the meeting to be at least two NEDs and one Executive Director.
  - 'Estates and Facilities' will report into Finance and Performance Academy
  - 'Environmental sustainability' will report into the Finance and Performance Academy

  The updated terms of reference are presented at **Appendix 2a.**

- **People Academy**

  - Membership of the Academy to be amended in the Terms of Reference to refer to the Non-Executives and the Executives. All others will be in attendance.
  - The quorum for the meeting to be at least two NEDs and one Executive Director.

  The updated terms of reference are presented at **Appendix 2b.**

- **Quality and Patient Safety Academy**

  - The Academy will be renamed to the 'Quality Academy.'
  - Meetings will not be split into Assurance and Learning/Improvement meetings, instead all three elements will be covered at each meeting.
  - There will be 10 Academy meetings per year and 2 CSU to Academy sessions.
  - Membership of the Academy to be amended to refer to the Non-Executives and the Executives only. All others will be 'attendees.'
  - The quorum for meetings will be 'at least two NEDs and one Executive Director.'
  - Oversight for 'Estates and Facilities' will move to the Finance and Performance Academy.

  The updated terms of reference are presented at **Appendix 2c.**

Amendments to the Audit Committee Terms of Reference

The Board is asked to note that in reviewing its terms of reference the Audit Committee present these in line with the advice and guidance included with the revised HFMA Handbook published in April 2024. The following amendments have been agreed with the Audit Committee.

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.19

- Page 1 – purpose : In the final paragraph relating to the objective of the Committee removal of reference to 'business continuity and information technology' as these elements are covered under the remit of the Finance and Performance Academy and Quality and Patient Safety Academy, respectively.
- Page 2 – duties: In the third bullet point the addition of direct reference to the self-certifications required with regard to the NHS Provider Licence, guidance on Good Governance and Collaboration, and Code of Governance for NHS Provider Trusts'.
- Page 5 – duties: Removal of the section covering 'Whistleblowing / Freedom to Speak Up' as this is covered under the remit of the People Academy.
- Page 5 – membership: Removal of reference to the NED, Deputy Chair as this role no longer exists.
- Page 6 – quorum: Amendment made to reflect that the quoracy for the meeting is now two of three independent members.
- Page 7 – reporting: Streamlining of the reporting requirement as the Board Assurance Framework is the responsibility of the whole Board.

The updated terms of reference are presented at **Appendix 2d**.

Work Plans

The work plans for the Academies have been subject to review by the Academies and subject to an interim update (in line with the interim update for the Terms of Reference). A more detailed review will take place and the final workplans will be presented for approval by the Board alongside the terms of reference in September.

- The workplan for the Finance and Performance Academy is presented at **Appendix 3a.**
- The workplan for the People Academy is presented at **Appendix 3b.**
- The workplan for the Quality and Patient Safety Academy is presented at **Appendix 3c.**

Audit Committee workplan

The work plan has been reviewed and updated in line with the Terms of Reference by the Audit Committee. The full work plan is included at **Appendix 3d.**

Recommendation

Annual Reports

The Board of Directors is asked to confirm that it derives assurance from all the annual reports presented and that the academies and committees have been effective.

Terms of Reference

The Board of Directors is asked to approve the interim changes provided to the:

- Finance and Performance Academy Terms of Reference
- Quality Academy Terms of Reference
- People Academy Terms of Reference
- Audit Committee Terms of Reference

Meeting Title	Board of Directors		
Date	11 July 2024	Agenda item	Bo.7.24.19

Academy/Audit Committee Workplans

The Board of Directors is asked to approve the workplans associated with each of the Academies and the Audit Committee.

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

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

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

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

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

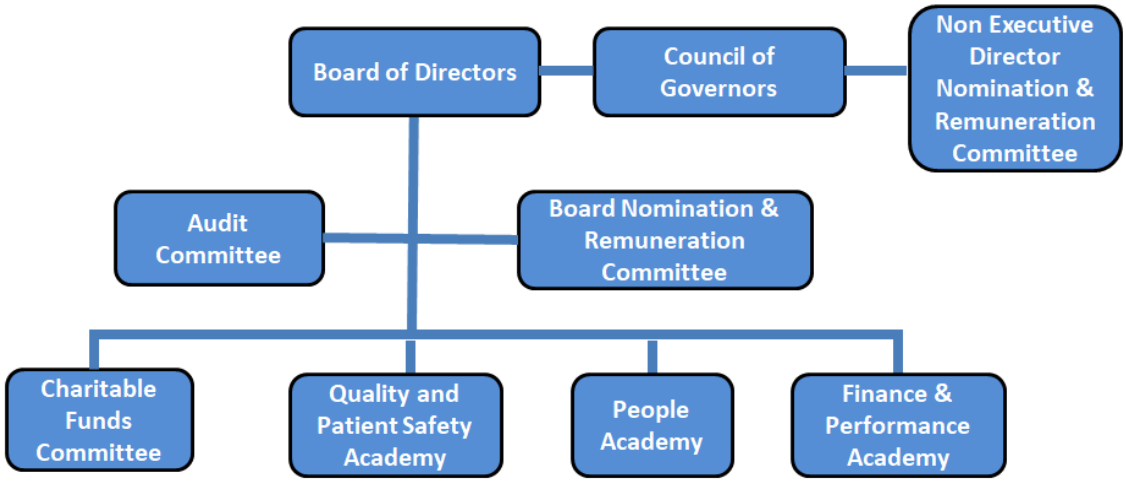
Finance & Performance (F&P) Academy Annual Report 2023/24

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees/Academies annually to determine whether they have been effective, and whether further development work is required.

1.1 Board Governance Structure

The current governance structure is outlined below:



During 2023/24, the Trust has continued to deliver its Academy governance model, which was developed and introduced in the latter half of 2020/21. Academies were introduced to focus on learning, improvement and assurance in relation to quality and patient safety; people; and finance and performance. The Terms of Reference and work plans were last approved by the Board in November 2022.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the F&P Academy in respect of 2023/24. The period reported on is from **April 2023 to March 2024.**

2. F&P Academy Terms of Reference

The F&P Academy reports directly to the Board.

The Terms of Reference of the Academy were last reviewed and approved by the Board of Directors in November 2022 and are attached at Appendix 1. The terms of reference have not been reviewed during the financial year as an external review of governance arrangements within the Trust was commissioned during Q3 2023/24. This is still ongoing, and the outcome of the review, will inform any amendments to the Terms of Reference of the Academy.

2.1 The role of the F&P Academy

The purpose of the Academy is to seek assurance, learn and drive improvement in relation to all aspects of finance and performance within the Trust.

The Academy supports the Board by actively seeking assurance of compliance with legal and regulatory requirements by actively seeking oversight and assurance through scrutiny of those areas within its remit and covered in detail in the terms of reference. These include the management of relevant risks, the development of the Trusts medium, long term and financial strategy, the review and monitoring of financial plans and their link to operational performance and, the review of the performance of the trust in achieving National Standards, Contractual Indicators (National and Local) and Trust-defined indicators. The Pathology Joint Venture Board and the Capital Strategy Group reports also report to the Finance and Performance Academy.

2.2 Reporting requirements

It is the duty of the Academy Chair to report to the Board on the Academy's activities on a timely basis.

Reports from the Academy Chair are presented at the public meetings of the Board of Directors. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action. Form March 2023, Academy Chairs have been producing more focussed Academy reports which support the delivery of greater insight on how the meetings felt and the level of assurance gained. The template introduced was developed (based on the 'Alert, Advise, Assure' model used by our partner organisations in Bradford District & Craven) and is now well embedded as part of the reporting to the Board.

The minutes from meetings of the Academy are also presented to the Board once approved, for information and assurance.

The Academy is also required to present to the Board an annual report summarising the Academy's activities and the assurance received and provided and outlining its work plan for the future year. This report will be presented to the Audit Committee in May 2024 and to the Board in July 2024.

The Chair of the Academy is satisfied that the Academy fully complied with its reporting requirements during and in respect of 2023/24.

3. Membership and attendance record during and in respect of 2023/24

During 2023/24 the Academy met 10 times.

Membership and attendance are recorded in the table below.

Name	Title	26 Apr	24 May	10 Jul	26 Jul	27 Sep	01 Nov	29 Nov	31 Jan	28 Feb	27 Mar	Total
Julie Lawreniuk	Chair / Non-Executive Director	1	1	1	1	1	1	1	1	1	1	**10/10**
Karen Walker	Non-Executive Director	1	1	1	0	1	0	1	1	1	1	**8/10**
Louise Bryant	Non-Executive Director	N/A	N/A	0	1	1	0	1	1	0	1	**5/8**
Mohammed Hussain	Non-Executive Director	1	0	1	1	0	1	N/A	N/A	N/A	N/A	**4/6**
Matthew Horner	Director of Finance	1	1	1	1	1	1	0	0	1	1	**8/10**
Sajid Azeb	Chief Operating Officer/Deputy CEO	1	1	1	0	1	1	1	1	1	1	**9/10**
Chris Smith	Deputy Director of Finance	0	1	1	1	1	1	1	1	1	1	**9/10**
Carl Stephenson	Associate Director of Performance	1	1	1	1	1	0	1	1	1	1	**9/10**
Michael Quinlan	Deputy Director of Finance	0	1	0	1	1	1	0	0	1	0	**5/10**

Name	Title	26 Apr	24 May	10 Jul	26 Jul	27 Sep	01 Nov	29 Nov	31 Jan	28 Feb	27 Mar	Total
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	1	1	1	1	1	1	1	1	1	0	**9/10**
John Bolton	Medical Director of Operations	1	1	1	1	1	0	1	1	1	0	**8/10**
James Taylor	Deputy Chief Operating Officer	1	1	1	1	0	0	1	0	1	0	**6/10**
Chris Danson	Director of Transformation	1	1	1	1	0	1	1	1	1	1	**9/10**
Neil Scott	Head of Business Intelligence	1	1	1	1	1	1	0	1	0	0	**7/10**
Terri Saunderson	Director of Operations	1	1	0	1	1	1	0	1	0	0	**6/10**
Rachel Waddington	Deputy Director of Operations - Planned Service	1	0	1	1	1	0	1	1	1	1	**8/10**
Shaun Milburn	Deputy Director of Operations - Unplanned Services	1	1	0	1	1	1	1	1	1	1	**9/10**
Ellie MacIver	Deputy Director of Operations - Cancer & Diagnostic Services	1	1	1	0	1	1	1	1	1		**8/10**
Adele Hartley-Spencer Sarah Freeman Jo Hilton	Deputy Chief Nurse/Directors of Nursing (Operations) at least one to attend each meeting	1	1	1	1	1	1	0	1	1	1	**9/10**

Key and notes	
Denotes where not a member of the Academy/attendance not required	N/A
Attended the meeting as required	1
Apologies received or Absent	0

Meetings were also attended by the Director of Strategy & Integration (until his retirement at the end of August 2023) and the Associate Director of Corporate Governance/Board Secretary. Other members of staff are invited to attend meetings when appropriate to discuss specific matters related to their roles, for example members of the 'Act as One' team.

4. Summary of the work of the Academy 2023/24

4.1 Performance

Performance report - at each meeting the Academy has received and discussed in detail the Operational Highlight Report and Performance Report, which provide assurances in relation to performance against key national and contractual indicators, and the action taken to improve and address areas of underperformance.

Performance Improvement Plan - the Academy received updates on the Trust's Performance Improvement Plan. There were significant additional challenges because of Industrial action and on occasion alerts were raised with the Board however the Trust did continue to deliver improved results through 2023/24. There are new objectives for 2024/25 and the Academy will continue to receive monthly updates.

There are three approaches to the delivery of the plan, outlined as:

- Business as usual (operational delivery)
- Proactive performance management (tactical response)
- Transformation (strategic response)

During 2023/24 the Academy received deep dives in relation to urgent and emergency care in May, September and January, and Planned care (RTT) in June, October and February, and Cancer and Diagnostics in April, July, November and March.

The discussions have been based on the delivery of the ten key standards that underpin the three areas listed above, to provide assurance to the Academy on progress.

Winter Planning - the contents of the winter plan for 2023/24 were presented on 1 November 2023 which highlighted that, in line with national and local system requirements, the Trust had developed the winter operational plan in conjunction with partner organisations. The winter plan took into consideration the requirements from NHS England (NHSE) in the letter dated 27 July 2023 in relation to next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter which related to:

- Prepare for variants of COVID-19 and respiratory challenges
- Increase capacity outside acute trusts
- Increase resilience in NHS 111 and 999 services
- Target Category 2 response times and ambulance handover delays
- Reduce crowding in A&E departments and target the longest waits in ED
- Reduce hospital occupancy
- Ensure timely discharge
- Provide better support for people at home

Nationally mandated trajectories had formed part of the winter plan. These were:

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute bed occupancy
- Percentage of beds occupied by patients who no longer meet the criteria to reside

The Command Centre continued to manage winter operational pressures.

NHSE Core Standards Self-Assessment Submission - the Board agreed to provide the Academy with delegated authority for the approval of the Trust's self-assessment against NHSE's 2023 Emergency Preparedness, Resilience and Response (EPRR) Core Standards, for submission to NHSE in December 2023.

The Trust received a non-compliant rating of 32% following the 'check and challenge' process undertaken with NHSE. The trust achieved the following in relation to the 62 standards.

- 20 standards confirmed as green (fully compliant)
- 42 standards confirmed as amber (partially compliant)
- 0 standards were confirmed as red

In the previous year the trust reported that we were 'substantially compliant'. This year has involved the introduction of more rigorous standards. Low compliance for this year has been seen across our region with Trusts either at the same compliance rating as BTHFT or scoring lower.

An action plan is in place with the objective of increasing the level of compliance. The Academy approved the request for EPRR to report directly to the F&P Academy three times yearly.

4.2 Finance

Finance report – the Academy has received assurance as to the Trust's financial position at each meeting, as well as regular updates on the capital position and the actions taken to address any

underspends. There were a number of alerts reported to Board in year regarding the risks to delivery of the 2023/24 financial plan due to the increasing costs of strike action and the slow progress in delivery the Waste Reduction Plan. However, at year end, the Trust will report a surplus of £4.4m because of non-recurrent funding received from the West Yorkshire (WY) Integrated Care Board.

As well as updates relating to the Trust, assurance has also been provided in relation to the financial position of the Bradford District & Craven Place and the West Yorkshire ICS.

The Academy received an update in May 2023 on the Pathology Joint Venture (PJV). The final financial position for the PJV is expected to be received by the Academy in May 2024.

Finance Improvement Plan - the Academy received monthly presentations on progress against the financial improvement plan which saw an overall Waste Reduction Target of 5% for 2023/24.

Treasury Management – the Academy has received six monthly updates and assurance in relation to the Trust's cash flow position and performance.

Budget Setting Process and Timetable – the draft financial forecast for 2024/25 was received during January 2024 highlighting the significant financial risk facing the Trust in 2024/25. The draft financial plan and waste reduction programme was presented to the Academy in March 2024. The situation facing the trust in 2024/25 is tougher than in previous years. The waste reduction target averaged across each CSU equates to approximately 5.6%.

The financial and operational planning submissions - The draft financial and operational planning submissions were approved by the Academy in March 2024 following agreement by the Board to provide the Academy with delegated approval to submit to the ICS. Finalised guidance from NHSE was not received until 28 March 2023.

Procurement - the Academy received a bi-annual update on procurement which included the Trust's involvement of the WYAAT wide Scan4Safety programme, review of the procurement risk register, the impact of the new inventory management and catalogue management system (in radiology). Investments in the procurement team has meant that they have gone from a historical waste reduction average value of less than £1m pa to well over £2m during 2023/24.

4.3 Act as One

The Act as One Programme Directors have attended four meetings during the year to provide an update on the Act as One Programmes, the progress being made and the impact and outcomes.

4.4 Risk

High Level Risk – the Academy has reviewed all risks within its remit scoring 15 and above, alongside an overview of the Executive Team's discussion in relation to the risks and any issues raised. The Academy has sought assurance that the risks are being managed appropriately and that the risks recorded are appropriate in the context of the information being presented.

Board Assurance Framework – During the year the Academy has reviewed the strategic risks within its remit on a bi-monthly basis. The Academy reviewed, challenged and assessed the identification and management of risks within their remit, and sought assurance that all relevant key risks had been identified and reported to the Academy, and were being managed appropriately.

4.5 Governance

Business Case Post Implementation Reviews – the Academy received bi-annual reporting (in April 2023 and in November 2023) on the post-implementation reviews (PIRs) of approved business cases. At previous meetings it was agreed that the Finance and Performance Academy would receive a paper outlining the results of a post implementation review of approved business cases on a six-monthly basis. The PIR reports are expected to provide an update of progress to date with regard to the benefits realized. Through the year there has been the impact of industrial action and operational pressures which has impacted on the completion of the templates. In year a total of 36 PRs were undertaken with the following key high-level conclusions reported to the Academy.

- 14 PIRs had all benefits realised
- 7 demonstrated benefits that were partially realised
- There was one PIR that had none of the benefits realised
- Consent had been provided to 14 of the PIRs to allow more time for the case to be fully implemented, benefits to be measured or for the PIR information to be collated and the template completed

Internal Audit Plan – the Academy has received details of the internal audit plan for the year, to provide assurance that the coverage of the plan was appropriate in terms of finance and performance related audits.

The Academy started to receive Internal Audit Reports relevant to the Academy in July 2023. Since that time the Academy has been sighted on 9 reports under the purview of the Academy. During this period one limited assurance report was received and an exception report was provided to the Audit Committee with regard to this. Two high assurance reports were received and the remaining five received significant assurance. The Academy was in receipt of one Advisory Report.

Internal Audit reports received	**Assurance Rating***
Management of patient flow – command centre – BH422023	High
Premises assurance model – BH182024	High
Demand Management – BH412023	Significant
CSU governance structures – BH432023	Significant
Payroll – BH022024	Significant
Overseas visitors – BH192024	Significant
Asset utilisation (theatres) – BH292024	Significant
Patient safety: sepsis management – BH062024	Limited
Pennine Breast Screening Unit equipment – BH452023	Advisory report

***Definitions:**
High - High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
Significant - Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
Limited - Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.

Work plan – the Academy reviews its work plan at each meeting and agrees any changes as appropriate.

Effectiveness Review – the Academy considered its effectiveness in September 2023, where Academy members were asked to consider the following:

- the effectiveness of the meetings and how meetings could be made more effective
- how engaged members were with the meetings

- whether members felt able to challenge at meetings and ways in which this could be supported
- whether the meetings included the right mix of learning, improvement and assurance
- were the right people involved in the meetings
- duration of the meetings

83% of respondents said that Finance and Performance Academy meetings had improved over the last 12 months.

A review of our governance arrangements has since been commissioned with an external consultancy. Revised terms of reference and work plan will be presented to the academy for approval early in 2024/25.

5. Conclusion

The Academy believes that during 2023/24 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Academy has reviewed all relevant items in line with its Terms of Reference and work plan.

Julie Lawreniuk
Non-Executive Director and Chair of the Finance & Performance Academy

April 2024

Finance & Performance Academy
Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to all aspects of finance and performance within the Trust.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	**Assurance:** • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Oversight and scrutiny of the development and maintenance of the Foundation Trust's medium- and long-term financial strategy. • Oversight and scrutiny of the development and delivery of the Foundation Trust's annual plan and integrated business plan. • Review and monitor financial plans and their link to operational performance. • Oversight and scrutiny of financial risk evaluation, measurement, and management. • Oversight and scrutiny of the risks and assurance associated with the impact of financial and performance pressures on the quality of care. • Scrutiny of the implementation of business cases. • Oversight of the Capital Programme. • Review the performance of the Foundation Trust in achieving National Standards, Contractual Indicators (National and Local) and Trust–defined indicators. • Receive, consider and approve the annual reference cost submission ensuring appropriate application of costing methodologies. • Approve and keep under review the Foundation Trust's

	investment policy in relation to treasury management (to include cash investments and all other elements of working capital). • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to finance and performance matters. • Consideration of relevant internal audit reports. • Oversight of the Pathology Joint Venture Board. • Oversight of the Trust's procurement activity (also relevant to the Learning and Improvement aspects of the Academy). • Oversight of the Trust's compliance with Emergency Preparedness, Resilience and Response (EPRR) requirements. • In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.
	Learning: • Review the Trust's position in line with benchmarking data including GIRFT, WYAAT and ICS data, and identify areas of learning. • Review and consider the latest innovations both nationally and internationally and identify any relevant learning for the Trust. • Consider learning from other sectors and industries, outside of the NHS. • Consider the relative strengths, weaknesses, limitations and opportunities in relation to CBUs and ensure that opportunities for learning and improvement are disseminated appropriately.
	Improvement: • Review and monitor the performance of the Bradford Improvement Programme. • Consideration of performance/finance impact assessments. • Review programme updates from WYAAT and the ICS to ensure that any related improvements are exploited within the Trust.
Sub-Groups	Pathology Joint Venture Board Capital Strategy Group
Chairing arrangements	The Academy will be chaired by a Non-Executive Director. In the absence of the Chair, the Deputy Chair (who is also a Non-Executive Director) will act as Chair.
Membership	• Chief Operating Officer • Director of Finance • Up to four Non-Executive Directors (including the Chair and Deputy Chair)

	• Deputy Directors of Finance • Associate Director of Performance • Medical Director of Operations • Deputy Chief Operating Officer • Director of Operations • Deputy Director of Operations - Planned Services • Deputy Director of Operations - Unplanned Services • Deputy Director of Operations – Diagnostics and Corporate Operational Services • Deputy Chief Nurse / Directors of Nursing (Operations) (at least one to attend each meeting) • Director of Transformation • Head of Business Intelligence Members are normally expected to attend at least 70% of meetings (7) during the year.
In attendance	• Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • The Academy may invite other employees or external advisors to attend as appropriate • Any non-member NED
Secretary	Secretarial support will be provided by the Executive Assistant or PA to the Director of Finance/Chief Operating Officer.
Quorum	A minimum of five members, including the Chair or Deputy Chair and at least one Executive Director.
Frequency of meetings	Monthly (except August and December) At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Academy will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Academy:	28 September 2022
Date approved by the Trust Board:	10 November 2022
Review date:	July 2023

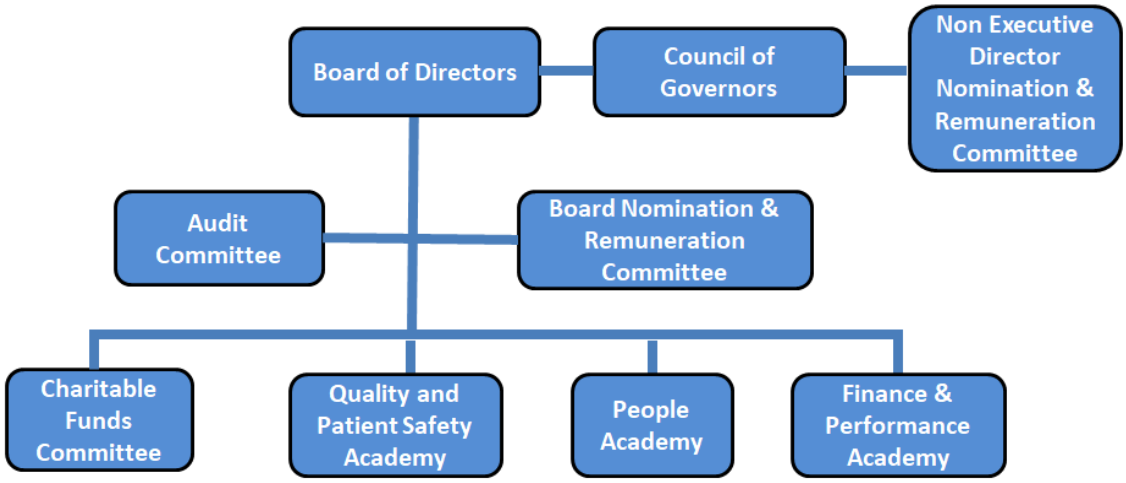
People Academy Annual Report 2023-24

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees and Academies annually to determine whether they have been effective, and whether further development work was required.

1.1 Board Governance Structure

The Board and Committee/Academy Structure is outlined below:



During 2023/24, the Trust has continued to embed its Academy governance model, which was developed and introduced in the latter half of 2020/21. Academies were introduced to focus on learning, improvement and assurance in relation to quality and patient safety; people; and finance and performance. The Terms of Reference and work plans were last approved by the Board in November 2022.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the People Academy during and in respect of 2023/24. The period reported on is from **April 2023 to March 2024.**

2. People Academy Terms of Reference

The People Academy reports directly to the Board.

The Terms of Reference of the Academy were reviewed and approved by the Board of Directors in November 2022 and are attached at Appendix 1. The terms of reference have not been reviewed during the financial year as an external review of governance arrangements within the Trust was commissioned during Q3 2023/24. This is still ongoing, and the outcome of the review will inform any amendments to the terms of reference of the academy.

2.1 The role and objectives of the People Academy

The purpose of the People Academy is to seek assurance, learn and drive improvement in relation to the people management arrangements within the Trust.

The Academy supports the Board by actively seeking assurance of compliance with legal and regulatory requirements relating to people, oversees the delivery of action plans, for example relating to the staff survey and Workforce Race Equality Standard, and monitors a range of metrics including safe staffing levels, sickness absence and turnover. Working groups have been set up to align with the commitments within the NHS People Plan, and these report to the Academy on a regular basis. The Health & Safety Committee also reports to the People Academy.

2.2 Reporting requirements

It is the duty of the Academy Chair to report to the Board on the Academy's activities on a timely basis.

Reports from the Academy Chair are presented at the public meetings of the Board of Directors. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The minutes from meetings of the Academy are also presented to the Board once approved, for information and assurance.

The Academy is also required to present an annual report to the Board summarising the Academy's activities and the assurance received and outlining its work plan for the future year. This report will be presented to the Board in May 2024.

The Chair of the Academy is satisfied that the Academy fully complied with its reporting requirements during and in respect of 2023/24.

3. Membership and attendance record during and in respect of 2023/24.

From April 2022 to March 2023 the Academy met 10 times.

Membership and attendance is recorded in the table below.

Name	Title	26/04	24/05	05/07	26/07	27/09	25/10	29/11	31/01	28/02	27/03	Total
Karen Walker	Chair & Non-Executive Director	1	1	1	0	1	1	1	1	1	1	**-9/10**
Jon Prashar	Deputy Chair & Non-Executive Director	0	1	0	0	1	1	0	0	N/A	N/A	**3/8**
Zafir Ali	Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	1	**1/2**
Altaf Sadique	Non-Executive Director in attendance	1	1	1	1	1	1	0	0	0	0	**6/10**
Sughra Nazir	Non-Executive Director	1	1	0	1	1	1	0	0	0	0	**5/10**
Karen Dawber	Chief Nurse	0	1	0	0	0	1	0	1	1	1	**5/10**
Ray Smith	Chief Medical Officer	1	1	1	0	1	0	1	1	1	0	**7/10**

Name	Title	26/04	24/05	05/07	26/07	27/09	25/10	29/11	31/01	28/02	27/03	Total
Amandeep Singh	Partnership Lead	0	0	0	0	0	1	1	1	1	1	**5/10**
Catherine Shutt	Assistant Director of HR/ Head of OD	1	1	1	1	1	1	N/A	N/A	N/A	N/A	**6/6**
David Smith	Director of Pharmacy	1	1	1	1	1	0	0	0	0	1	**6/10**
Faeem Lal	Deputy Director of HR/Interim Director of HR	1	1	0	1	1	1	1	1	1	1	**9/10**
Faye Alexander	Head of Education	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**2/2**
Jane Kingsley	Lead Allied Health Professional	1	0	1	1	1	1	1	1	1	1	**9/10**
Jo Hilton	Deputy Chief Nurse	1	1	1	1	1	1	0	0	1	0	**7/10**
Kez Hayat	Head of Equality, Diversity & Inclusion	0	1	1	1	1	1	1	1	0	1	**8/10**
Laura Parsons	Board Secretary	0	1	1	1	1	1	1	1	1	0	**8/10**
Amanda Grice	Workplace and Wellbeing Centre Manager	1	0	0	0	1	0	1	0	1	0	**4/10**
James Taylor	Deputy COO	0	0	0	0	0	0	0	0	0	0	**0/10**
Mark Holloway	Director of Estates & Facilities	1	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	**1/4**
Sara Hollins / Sarah Freeman / Adele Hartley-Spencer	Directors' of Nursing and/or Midwifery	0	1	1	1	1	1	1	1	1	1	**-9/10**
Rukeya Miah	RESIN staff network, Chair	1	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**3/3**
Abbie Wild	Chair of LGBT Network	0	1	1	0	0	0	1	1	0	0	**4/10**
Amy Ilsley	Clinical Lead for Medical Workforce	0	0	0	0	0	0	0	0	0	0	**0/10**
Adam Griffin	Deputy Chief Information Officer	N/A	N/A	N/A	N/A	0	0	0	0	N/A	N/A	**0/4**
Rachel Pyrah	General Manager CDIO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	1	**2/2**
David Robinson & Laura Gornall (covering Faye Alexander maternity leave)	Education	N/A	N/A	0	1	1	1	0	1	1	1	**6/8**
Raquel Licas	Interim Chair of RESIN	N/A	N/A	N/A	N/A	1	1	1	1	1	1	**6/6**
Samia Hussain	Associate Director of HR	N/A	1	1	1	1	1	1	1	0	1	**8/9**
Susan Parker	Co-chair of the Enable Staff Equality Network	N/A	N/A	1	1	0	0	0	0	0	0	**2/8**
Sonia Sarah	Co-chair of the Enable Staff Equality Network	N/A	N/A	N/A	N/A	N/A	0	1	0	1	0	**2/5**
Georgi Dyson	Assistant Director of HR	N/A	N/A	N/A	N/A	N/A	1	1	1	1	0	**4/5**

Other members of staff were invited to attend meetings when appropriate to discuss specific matters related to their roles.

4. Summary of the work of the Academy during and in respect of 2023/24

During the year, the Academy focused on people related items under two key headings: learning and improvement, and assurance.

4.1 Learning and Improvement

4.1.1 Staff Stories

During 2023/24 the Academy has started to receive staff stories to provide an insight into how things feel for staff throughout the Trust. This included:

- May and November 2023 – Outstanding Pharmacy Services – a great presentation in May 2023 on the launch of the programme in February 2023 and a progress update on the identified workstreams and early plans to achieve the goals. The team returned in November 2023 to provide an update of progress which saw 45% of the workforce engaged in the programme and key achievements being made within the wellbeing and culture workstreams.

- July 2023 and January 2024 – Outstanding Theatre Services – a great presentation in July 2023 on the identified workstreams of the programme, with culture being the golden thread throughout. Civility work had been undertaken as part of the programme which saw 113 theatre colleagues attend civility training during October 2022. The team returned during January 2024, on the last day of the programme, with the reins handed over to the Theatres team to continue to transform the service. The team had devised a brand 'Bradford Theatres – Moving to Outstanding' and a continuation plan along the lines of the CQC categories of well-led, safe, effective, caring and responsive.

4.1.2 Looking After Our People

The Academy received bi-monthly updates from the 'Looking After Our People' sub-group.

In June 2023, work on the outside garden space and the revamp of three other staff welfare areas were completed, providing our people with wellbeing spaces to spend time during breaks. Further funding had been secured by NHS Charities Together to create further outside spaces.

4.1.3 NHS Staff Survey

2022 NHS Staff Survey Results: During the year, the Academy received assurance on progress made against the 2021 NHS Staff Survey Results. The action plan focussed on the top priorities:

- Staff each have a voice that counts
- Staff are safe and healthy
- Staff are always learning
- Morale
- Staff engagement
- Recognition and reward

2023 NHS Staff Survey Results: The Academy received a comprehensive presentation in March 2024 detailing the results of the 2023 NHS Staff Survey. Overall, the results were positive. The Trust saw significant improvements compared to 2022 and continued to improve scores in every element of the People Promise.

4.1.4 GMC Survey Feedback

A summary of the findings from the GMC survey was presented in September 2023. 72% of postgraduate medical trainees at BTHFT had completed the survey between March-May 2023, across a range of specialties, a reduction from 80% the previous year. Some of the areas highlighted were the positive feedback received within Anaesthetics, Elderly Medicine, Neonatal Medicine and Paediatric specialities.

It was noted that the Trust ranked 226th out of 229 UK acute and mental health Trusts for workload. Summary reports for each specialty had been distributed to relevant College Tutors and Foundation Training Programme Directors to share with teams, review and develop action plans. Progress against action plans would be overseen by the Director of Education through the Foundation Steering Group and Postgraduate Medical Education Steering Group.

4.1.5 Freedom to Speak Up

During 2023/24 the Academy received quarterly reports on Freedom to Speak Up (FTSU). Through comprehensive reports, the Academy was informed of the number of concerns raised, the staff groups they were coming from and the category they aligned to.

4.1.6 Equality, Diversity and Inclusion

Belonging, Diversity and Inclusion: Throughout the year the Academy received regular updates pertaining to belonging, diversity and inclusion within the Trust.

Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) / Gender Equality Action Plans: In May 2023 the Academy reviewed the WRES and WDES data submissions and the proposed themes and actions for the 2023/24 action plans.

In October 2023 the Academy received and approved the WRES and WDES actions plans. Key progress included the launch of the Trust's first ever 3-year EDI strategy.

4.1.7 Kindness and Civility

The Academy continued to receive quarterly updates on Kindness and Civility. Progress made throughout the year included the launch of a 'Civility in the Workplace' training session, with an ambition to train all colleagues within a 12-18 month period.

The second Thrive Leadership Summit took place on 6 June 2024 which was focused on 'Finding the Leaders in Everyone' and was very well attended.

4.1.8 Recruitment and Retention

Workforce Growth and Transformation: The Academy received regular updates from the Workforce Growth and Transformation Sub-Group whose activities and action plan were linked to:

- Identifying new ways of working and delivering care.
- Identifying new ways of working and implement processes to grow our own workforce.

Nursing Recruitment and Retention Plan: The Academy received six-monthly reports on the nursing recruitment and retention plan. Staffing continued to be a challenge; however, the Academy was assured that there was a robust plan in place to tackle this. Some of the initiatives discussed include

the work with 'Just-R' to support recruitment activity for nurses, midwives and health-care assistant posts, and plans for international recruitment.

4.1.9 Training and Education

In April 2023 the Academy received the Education Annual Report on the work undertaken during 2022/23. This included an award of the National Innovation Award from HEE in July 2022 for sustainable and innovative postgraduate medical education and training recovery interventions.

4.2 Assurance

4.2.1 People Academy Dashboard

The Academy received a monthly dashboard which provides details of how the Trust is performing against a range of people related metrics. Throughout the year the Academy has noted that sickness absence and turnover rates have reduced month on month although these remain a challenge. The Academy has also noted improvements in mandatory training levels.

4.2.2 Workforce Report

The Academy received a quarterly Workforce Report which outlined the performance of the Trust in relation to the key workforce metrics and trends. These included data and the analysis against the establishment, bank and agency usage, staff turnover, recruitment, sickness absence, organisational development, pay and pensions.

4.2.3 Delivery of the NHS People Plan

In April and October 2024, the Academy received an update on progress against the actions arising from the NHS People Plan. Work had progressed well in relation to civility in the workplace with the second edition of the Civility Toolkit launched which contained support with professional behaviours such as 'what is banter' and tools for practising self-compassion.

4.2.4 Workforce Planning Submission

The Academy discussed the planning submission for 2024/25 in February 2024. The key themes built into the planning submission were reductions in temporary staffing across the year and growth developments due to the opening of the St Lukes Day Case Unit in May 2024 and the BRI Endoscopy Unit in August 2025.

4.2.5 Guardian of Safe Working Hours

As a requirement of the 2016 Junior Doctors contract, the Academy received a quarterly report, on behalf of the Board, which provided assurance that doctors and dentists in training were working safe hours.

In Quarter 3, 31 exception reports were made. 28 of these were related to hours/working patterns. In addition, 2 reports were flagged as an immediate safety concern. Assurance was provided that each exception report was carefully considered and investigated, and where appropriate and necessary action was taken to mitigate the concerns.

4.2.6 Medical Appraisals and Revalidation Annual Report

The Academy received the Annual Report on Medical Appraisal and Revalidation for 2022/23. 90.78% of the medical workforce received an outcome measure 1 (completed appraisal). 8.81% were allocated an outcomes measure 2 (approved missed appraisal), and 0.41% were recorded as outcomes measure 3 (unapproved missed appraisal).

4.2.7 Board Assurance Framework for Nurse Staffing

In line with NHSE published guidance on nursing and midwifery safer staffing, the Academy received 6 monthly updates on the Trust's ability to provide evidence against its preparedness, decision-making and its escalation process. Assurance was provided that, whilst the Trust continued to see daily nursing and midwifery staffing challenges, there were robust systems and processes in place to manage this on a daily basis.

4.2.8 Nurse Staffing Data Publication Report

The Academy receives the nurse staffing data at each meeting (since January 2023). Assurance was provided of a number of measures in place to ensure that the Trust continued to provide safe care. These include:

- daily monitoring of staffing levels
- movement of staff between departments to mitigate staffing gaps
- a clear escalation process
- oversight of risks with staffing concerns recorded via Datix
- out-of-hours on call advice and support

4.2.9 Nursing and Midwifery Staffing Review

The Academy has reviewed the six-monthly nursing and midwifery staffing reviews prior to submission to the Board for approval.

4.2.10 Health and Safety

The Academy has received updates and minutes from the Health and Safety Committee. It was noted that the internal audit review resulted in an outcome of 'significant assurance'. The updated H&S Committee Terms of Reference were reviewed and approved by the Academy.

4.2.11 Industrial Action

The Academy has received regular verbal updates to provide reassurance on the actions being taken to manage the industrial action taken during 2023/24, and details of potential and planned future strike action.

4.2.12 Review of High-Level Risks and Board Assurance Framework

High Level Risk – the Academy has reviewed all risks within its remit scoring 15 and above, alongside an overview of the Executive Team's discussion in relation to the risks and any issues raised. The Academy has sought assurance that the risks are being managed appropriately and that the risks recorded are appropriate in the context of the information being presented.

Board Assurance Framework – The Academy has reviewed the strategic risks within its remit on a bi-monthly basis. The Academy reviewed, challenged and assessed the identification and management

of risks within its remit, and sought assurance that all relevant key risks had been identified and reported to the Academy, and were being managed appropriately.

4.2.13 Bradford District and Craven (BDC) People Committee Update

The Academy has received regular updates from the Bradford District & Craven People Committee to provide insight into the work being undertaken at Place level against the four pillars of the People Plan and how each relates to the work being undertaken at Trust level.

4.2.14 Governance

Work Plan – the work plan is presented for review at each meeting to ensure that all items are covered.

Academy Effectiveness Review – the Academy considered its effectiveness on 27 September 2023, where Academy members were asked to consider the following:

- the effectiveness of the meetings and how meetings could be made more effective
- how engaged members were with the meetings
- whether members felt able to challenge at meetings and ways in which this could be supported
- whether the meetings included the right mix of learning, improvement and assurance
- were the right people involved in the meetings
- duration of the meetings

The initial outcome of the review was discussed and agreed with the Chair to Academy members in October 2023. There were plans for Academy Chairs to meet following this summary session however, that was postponed as a result of an external review of governance arrangements within the Trust was commissioned during Q3 2023/24.

4.15 Internal Audit

The Academy has received details of the internal audit plan for the year, to provide assurance that the coverage of the plan was appropriate in terms of finance and performance related audits.

The Academy was sighted on 2 reports under the purview of the Academy. One limited assurance report was received, and an exception report was provided to the Audit Committee with regard to this. One significant assurance report was received.

Audit	Assurance Rating*
Staff suspensions – BH072024	Significant
Control of Substances Hazardous to Health (COSHH) – BH172024	Limited

***Definitions:**
High - High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
Significant - Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
Limited - Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.

5. Conclusion

The Academy believes that during 2023/24 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Academy has reviewed all relevant items in line with its Terms of Reference and work plan.

Karen Walker
People Academy Chair

April 2024

Appendix 1

People Academy
Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to the people management arrangements within the Trust.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	**Assurance:** • People Dashboard and metrics to include safe staffing • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Delivery of the NHS People Plan • Ensuring compliance with relevant legislation and regulations relating to People. • Ensuring delivery of action plans to include but not restricted to the NHS Staff Survey, WRES and WDES action plans • CQC standards relating to People • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the

	Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to people matters. • Consideration of relevant internal audit reports. • In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.
	Learning: To develop good practice and recommend the consideration of innovative approaches to people practices within the Trust • To learn from other Organisations who are considered the 'best' employers in the Trust's ambition to become an outstanding Organisation • To learn from Employment Relations/Employment Tribunal cases to inform policy/practice change • System/partnership working including the Bradford District & Craven Partnership People Committee • To hear and learn from real stories from staff and patients
	Improvement: • To improve people practices • To oversee the development and implementation of action plans following the NHS Staff Survey results to drive improvement • To ensure the development of a just and compassionate culture within the Trust • To improve leadership capacity and talent management
Sub-Groups	New ways of working and delivering care Workforce Growth and Transformation Looking After Our People Health & Safety Committee Whilst not reporting to the Academy, the Academy will be mindful of the work of the Equality and Diversity Council (EDC) as it affects people management and practices. A workforce sub-group / reference groups

	will be tasked to lead pieces of work or undertake research, which will feed into the People Academy as well as the EDC as agreed.
Chairing arrangements	The Academy will be chaired by a Non Executive Director. In the absence of the Chair, the Deputy Chair (who is also a Non Executive Director) will act as Chair.
Membership	• Director of HR • Chief Medical Officer • Chief Nurse • Up to four Non-Executive Directors (including the Chair and Deputy Chair) • Director of Pharmacy • Digital representative - TBC • Assistant Director of HR/Head of OD • Deputy Director of HR • Assistant Director of HR • Workplace Health and Wellbeing Centre Manager (only when Looking After Our People is included on the agenda) • Equality, Diversity and Inclusion Manager • Deputy Chief Operating Officer, Director of Estates and Facilities • Deputy Chief Nurse • Directors of Nursing (Operations) and Director of Midwifery (at least one to attend each meeting) • Head of Education • Partnership Lead Chair – RESIN Staff Network • Chair – Enable Staff Network • Chair – LGBT Staff Network • Lead AHP

	• Clinical Lead for Medical Workforce (or Deputy) • Frontline staff (TBC – Academy to discuss) Members are normally expected to attend at least 70% of meetings (7) during the year. Deputies may attend on behalf of members subject to the agreement of the Chair.
In attendance	• Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • The Academy may invite other employees or external advisors to attend as appropriate • Any non-member NED
Secretary	Secretarial support will be provided by the Executive Assistant or PA to the Director of HR.
Quorum	A minimum of five members, including the Chair or Deputy Chair and at least one Executive Director.
Frequency of meetings	Monthly (except August and December) At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Academy will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Academy:	28 September 2022
Date approved by the Trust Board:	10 November 2022

Review date:	July 2023

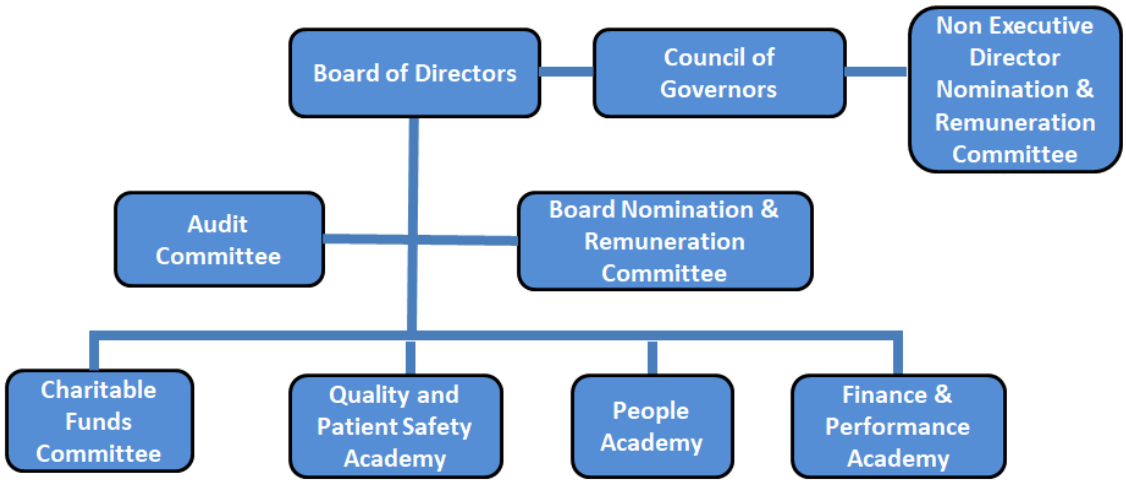
Quality & Patient Safety Academy Annual Report 2023/24

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Academies annually to determine whether they have been effective, and whether further development work is required.

1.1 Board Governance Structure

The current governance structure is outlined below:



During 2023/24, the Trust has continued to embed its Academy governance model, which was developed and introduced in the latter half of 2020/21. Academies were introduced to focus on learning, improvement and assurance in relation to quality and patient safety; people; and finance and performance. The Terms of Reference and work plans were last approved by the Board in November 2022.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the Quality and Patient Safety Academy during and in respect of 2023/24. The period reported on is from April 2023 to March 2024.

2. Quality and Patient Safety Academy Terms of Reference

The Quality and Patient Safety Academy reports directly to the Board.

The Terms of Reference of the Academy were last reviewed and approved by the Board in November 2022 and are attached at Appendix 1. The terms of reference have not been reviewed during the financial year as an external review of governance arrangements within the Trust was commissioned during Q3 2023/24. This is still ongoing, and the outcome of the review will inform any amendments to the terms of reference of the academy.

2.1 The role of the Quality and Patient Safety Academy

The purpose of the Academy is to:

- Seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards.

- Provide a space for our staff to share insight into the quality of our services and engender a culture of patient centred improvement where peer challenge and support is offered by all members.

- (In conjunction with the other Academies) oversee and review the quality, finance, performance and people metrics identified within the Clinical Service Units' Learning and Improvement Plans.

- Provide an annual opportunity for CSUs to present their achievements around quality and patient safety to a wide ranging audience. Seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards.

2.2 Reporting requirements

It is the duty of the Academy Chair to report to the Board on the Academy's activities on a timely basis.

Reports from the Academy Chair are presented at the public meetings of the Board of Directors. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The minutes from meetings of the Academy are also presented to the Board once approved, for information and assurance.

The Academy is also required to present an annual report to the Board summarising the Academy's activities and the assurance received and outlining its work plan for the future year. This report will be presented to the Board in May 2024.

The Chair of the Academy is satisfied that the Academy fully complied with its reporting requirements during and in respect of 2023/24.

3. Membership and attendance record during 2023/24

During 2023/24 the Academy met 12 times with 6 meetings focussed on Assurance and 6 meetings covering Learning and Improvement.

Membership and attendance are recorded in the table below.

Name	Designation	Apr-23 A	May-23 L&I	Jun-23 A	Jul-23 L&I	Aug-23 A	Sep-23 L&I	Nov-23 A	Nov-23 L&I	Dec-23 A	Jan-24 L&I	Feb-24 A	Mar-24 L&I	Total
Mohammed Hussain	NED, Co-Chair / NED Chair	1	0	1	1	1	1	1	n/a	n/a	n/a	n/a	n/a	**6 of 7**
Louise Bryant	NED, Co-Chair / NED Chair	n/a	n/a	1	1	1	1	1	1	1	1	1	1	**10 of 10**
Altaf Sadique	NED	1	1	0	1	1	1	1	0	0	0	0	0	**6 of 12**
Jon Prashar	NED	0	0	0	0	1	0	1	0	0	0	n/a	n/a	**2 of 10**
Zafir Ali	NED	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	1	**1 of 2**
Sughra Nazir	NED	1	1	0	1	0	1	1	0	0	0	0	0	**5 of 12**
Ray Smith	Chief Medical Officer	1	0	1	0	1	1	1	1	1	1	1	0	**9 of 12**
Karen Dawber	Chief Nurse	1	1	0	0	1	1	1	1	0	1	1	1	**9 of 12**
Paul Rice	Chief Digital and Information Officer	1	1	1	0	0	1	0	1	1	1	1	0	**8 of 12**
John Bolton	Deputy Chief Medical Officer/Operations Medical Director	1	1	1	1	0	1	0	1	0	0	1	0	**7 of 12**
Jo Hilton	Deputy Chief Nurse	0	1	1	0	1	1	1	0	1	1	1	0	**8 of 12**
Judith Connor	Associate Director of Quality	1	1	1	1	1	1	1	1	1	1	1	1	**12 of 12**
Louise Horsley	Senior Quality Governance Lead	0	1	1	0	1	0	1	1	1	1	1	0	**8 of 12**
Sara Hollins	Director of Midwifery	1	1	1	0	1	1	1	1	1	1	0	0	**9 of 12**
Yaseen Muhammad	Director of Infection Prevention and Control	0	1	0	1	0	0	1	1	0	1	0	0	**5 of 12**
David Smith	Director Of Pharmacy	1	1	0	1	1	1	1	1	0	0	0	1	**8 of 12**
Sarah Freeman	Director of Nursing – Operations	0	0	0	1	0	0	1	0	0	1	1	0	**4 of 12**
Adele Hartley-Spencer	Director of Nursing - Operations	1	0	1	0	0	0	0	1	0	0	1	0	**4 of 12**
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	1	1	1	1	1	1	1	1	1	1	1	0	**11 of 12**
Kay Pagan	Assistant Chief nurse	n/a	0	0	1	1	0	1	1	0	0	1	1	**6 of 11**
Deborah Horner	Deputy Chief Medical Officer	1	1	0	0	0	0	0	0	0	1	1	1	**5 of 12**
Faye Alexander	Head of Education	n/a	1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**1 of 1**
Benjamin McKay	Education Manager	n/a	n/a	n/a	1	n/a	1	0	1	n/a	1	n/a	0	**4 of 6**
LeeAnne Elliott	Patient Safety Specialist	1	1	n/a	1	n/a	0	n/a	1	n/a	0	n/a	1	**5 of 7**
Sally Scales	Director of Nursing: Programme Lead Magnet	n/a	1	n/a	0	n/a	1	n/a	0	n/a	1	n/a	1	**4 of 6**
Kez Hayat	Head of EDI / Assistant Director HR	n/a	1	n/a	0	n/a	1	n/a	1	n/a	1	n/a	1	**5 of 6**
Caroline Varley	General Manager, CMO Office	n/a	1	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	**1 of 6**
Liz Tomlin	Head Of QI and Clinical Outcomes	n/a	1	n/a	1	1	1	n/a	1	n/a	0	n/a	0	**5 of 7**
Leah Richardson	Patient Safety Specialist	n/a	0	n/a	1	n/a	1	n/a	1	n/a	1	n/a	0	**4 of 6**
Caroline Nicholson	Head of Non-Clinical Risk	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	**0 of 6**
Jane Kingsley	Lead Allied Health Professional	n/a	0	n/a	1	n/a	1	n/a	1	n/a	1	n/a	1	**5 of 6**
Padma Munjuluri	Associate Medical Director-Clinical Outcomes	n/a	1	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	**1 of 6**
Robert Halstead	Associate Medical Director Quality Governance	n/a	1	n/a	1	n/a	0	n/a	0	n/a	0	n/a	0	**2 of 6**
Joanna Stedman	Deputy Director of Nursing	n/a	0	n/a	1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**1 of 2**
Jill Clayton	Deputy Director of Nursing	n/a	0	n/a	1	n/a	1	n/a	0	n/a	1	n/a	1	**4 of 6**

Name	Designation	Apr-23 A	May-23 L&I	Jun-23 A	Jul-23 L&I	Aug-23 A	Sep-23 L&I	Nov-23 A	Nov-23 L&I	Dec-23 A	Jan-24 L&I	Feb-24 A	Mar-24 L&I	Total
Marianne Downey	Deputy Director of Nursing	n/a	0	n/a	0	n/a	0	n/a	0	n/a	1	n/a	1	**2 of 6**
Kay Rushforth	Associate Director of Nursing for Children and Neonatal Services	n/a	1	n/a	1	n/a	0	n/a	0	n/a	1	n/a	0	**3 of 6**
Kelly Young	Deputy Director of Nursing, Surgery and Digestive Diseases CSU	n/a	0	n/a	0	n/a	1	n/a	0	n/a	0	n/a	0	**1 of 6**
Sarah Turner	Assistant Chief Nurse Vulnerable Adults, Safeguarding Adults	n/a	0	n/a	0	n/a	0	n/a	1	n/a	0	n/a	1	**2 of 6**
Karen Bentley	Assistant Chief Nurse, Patient Experience	n/a	0	n/a	1	n/a	0	n/a	0	n/a	0	n/a	0	**1 of 6**
Sarah Wood	Quality Lead Nursing & Midwifery	n/a	0	n/a	0	n/a	1	n/a	0	n/a	n/a	n/a	n/a	**1 of 4**
Michael McCooe	Associate Medical Director, Learning from Deaths	n/a	0	n/a	0	n/a	0	n/a	0	n/a	1	n/a	0	**1 of 6**
Rebecca Kidd	Deputy Director of Nursing	n/a	n/a	n/a	n/a	n/a	0	n/a	0	n/a	0	n/a	0	**0 of 4**
Nazzar Butt	Moving to Outstanding Lead	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	**0 of 6**
Sonya Tetley	Nursing & Midwifery Quality Lead	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	**0 of 1**

Key

Attendance at 'Assurance' and 'Learning and Improvement' meetings	
Attendance at 'Learning and Improvement' meetings only	
Attendance at meetings indicated	1
Apologies received or absent from meetings	0
Not a member or, not required to attend meeting	N/A

Other members of staff were invited to attend meetings when appropriate to discuss specific matters related to their roles.

4. Summary of the work of the Academy 2023/24

4.1 Assurance

Infection Prevention and Control BAF: The IPC BAF is included as an appendix to IPC Quarterly reports. Reporting to the Academy focussed on progress with regard to the annual infection prevention and control workplan for 2023/24 and achieving compliance with:

- The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code) and;

Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maternity Services & Neonatal Updates: Detailed monthly updates have been provided on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of care. The service includes the monthly stillbirth position, learning and improvement within its reporting. The Academy is also in receipt of all Health Services Safety Investigations Body (HSSIB) reports. In January 2024, a Quality Improvement Group constituted by NHS England in response to concerns regarding historic Neonatal SIs and patient safety. The report received showed high assurance.

CQC Announced Maternity inspection of Safe and Well led domains: The inspection report was received in May 2024, following the visit on 4 January 2023. The Service received an overall rating of Good.

Quality Account: The Academy approved the Quality Account for 2022/23 at its meeting in May 2023 with the final report presented to the Board for formal sign off in June 2023. The improvement priorities approved for 2023/24 are:

- Improving the management of deteriorating patients
- Implementing Saving babies Lives Care Bundle version 3
- Improving patient experience by advancing equality, diversity and inclusion
- Implementation of the Patient Safety Response Framework including transition from the National Reporting and Learning System to the new Learning from Patient Safety Events platform.

Quality Academy Dashboard: The Academy has reviewed performance aligned to the trust strategic objectives as part of the Assurance agendas. A number of key elements remain under development. Key metrics reviewed covered:

- Summary Hospital-level Mortality Indicator,
- Hospital Readmissions,
- % of deaths scrutinised by the Medical Examiner,
- Number of Structured Judgement Reviews,
- C.Difficile performance,
- MRSA performance,
- E.coli performance,
- Pressure Ulcers Category 3 per 10,000 bed days,
- Pressure Ulcers per 10,000 bed days
- Medicine Reconciliation,
- Falls with harm per 10,000 bed days,
- Falls with severe harm,
- Stillbirths
- Cooling Babies

- Breast feeding

The dashboard metrics remain under review and are expected to be confirmed during the summer of 2024.

Quality Oversight & Assurance Profile: The model for Quality Oversight was introduced in 2019 to provide assurance that quality of care and patient safety has full oversight by the executive team which has evolved over time. It sets out a full range of safety indicators to ensure that the quality of patient care is monitored, managed, and escalated appropriately. The monthly reporting covers a range of safety indicators, to ensure that quality of patient care is monitored and managed appropriately. This includes compliance with regulators, outcomes from claims and inquests and learning to be derived from investigations. This report now includes Serious Incidents, Safety Events reported to external agencies and, the Trust response to national Patient Safety Alerts.

Safeguarding Adults and Safeguarding Children reports: Bi-annually the Academy is provided with the Safeguarding Adults and Safeguarding Children's reports. The Annual reports were received in June 2023 with further updates provided in December 2023.

Internal Audit: The Academy was sighted on all 11 reports under the purview of the Academy. Two limited assurance reports were received, and exception reports were provided to the Audit Committee with regard to these. One high assurance report was received and the remaining eight received significant assurance. The Academy continues to monitor progress in relation to these areas.

Audit	**Assurance Rating***
Infection Prevention and Control Blood Stream Infection	High
CSU Governance Structures	Significant
Complaints Handling	Significant
Data Quality	Significant
Management of To take out Medication	Significant
Safeguarding: Mental Capacity Act	Significant
Care Quality Commission Maternity Inspection Follow-up 6 March 2024	Significant
Stakeholder Engagement: Signage, Maps and Accessibility 5 March 2024	Significant
National Safety Standards for Invasive Procedures Recommendation Follow Up Review 19 March 2024	Significant
Clinical Audit Stage 1 Control Improvement Audit	Limited
Patient Safety: Sepsis Management	Limited

***Definitions:**
High - High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
Significant - Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
Limited - Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.

CLIP Report (Complaints, Litigation, Incidents, Patient Experience) The Academy was in receipt of the Patient Experience Annual Report and has received updates on the position with regard to complaints, litigation and patient experience as part of the overview report provided under the Quality Oversight & Assurance Exception Profile. The report has continued to be developed in year with the information streamlined to ensure clearer triangulation of the data to support a more effective review of themes.

High Level Risk: The Academy has reviewed all risks within its remit scoring 15 and above, alongside an overview of the Executive Team's discussion in relation to the risks and any issues raised. The

Academy has sought assurance that all relevant key risks have been identified, reported to the Academy, and were being managed appropriately. High level risks are reported monthly and are therefore presented at the Learning & Improvement meetings, as well as the Assurance meetings.

Assurance has also been derived from reports received with regard to:

- Serious Incidents Report
- Board Assurance Framework - strategic risks relevant to the Academy
- Maternity and Neonatal Services Update
- Safeguarding Adults
- Safeguarding Children
- Digital Report
- Digital & Data Transformation Committee (highlight report / minutes)
- Bradford District & Craven Quality Committee (highlight report / minutes)
- Estates & Facilities Service Report
- 15 Steps Assurance Programme
- PLACE Annual Report
- Quality Academy Work Plan
- Quality Academy Annual Report
- Freedom to Speak Up Quarterly Update (information only)
- Nursing and Midwifery Staffing Data Publication Report (information only)
- Update on Ward Accreditation
- Equality Delivery System

4.2 Learning and Improvement

At the Learning and Improvement meetings the Academy receives updates from sub-groups of the Academy. In particular the Academy has discussed how learning is devolved and how improvements are embedded. The reporting template was developed in-year and includes specific reference to Assurance, Learning and Improvement to ensure that all areas are clearly delineated and responded to. Reports are also received with regard to the Patient Safety Group, Clinical Outcomes Group, and the Patient Experience Group.

Service Presentations: The Academy has supported the delivery of three 'CSU to Academy' sessions in year and the first annual quality showcase event. The CSU to Academy events o provided CSUs with opportunities to present their learning and improvement work and their plans for continuous improvement, and reflect on how this impacts on quality, people, performance, and finance. The following CSUs took part in this first year of delivering these events. They were:

- Urgent Care, Elderly and Intermediate Care
- Childrens
- Radiology and Imaging
- MSK and Therapies
- Theatres, Critical Care and Day Case
- Women's

The Annual Quality Showcase event was delivered in November 2023. The schedule for all these activities has been put in place for 2024/25 where the expectation is that all CSUs will be provided with the opportunity to provide assurance and share their learning and improvement journeys with the members of all Academies, staff and stakeholders.

Quarterly reports received on research activity in the Trust: The report from Bradford Institute of Health Research, describes their main areas of work and progress in relation to:

- Applied Health Research Activity.
- Clinical Research Activity.

This report is also shared with the Board of Directors.

Inpatient Survey: The Academy received the report in January 2023. The survey had been conducted in January 2022 to May 2022 and included patients discharged from November 2021 when our region was still responding to the pandemic. The survey results were disappointing and as expected given the situation. The Academy discussed the outcomes in detail, the lessons learned and the accompanying action plan to secure improvements. One key area of focus was on communications and the need to look closely at whether there were any risks that should be identified and mitigated to support improvements.

Learning and improvements have also been discussed with regard to:

- Serious incidents
- Learning from Maternity Health Services Safety Investigations Body (HSSIB) reports
- Patient Safety Incident Response Framework (PSIRF)
- Bradford Nursing and Midwifery Professional Practice Model
- Children & Young People's Patient Experience Survey
- Clinical Audit Annual Report
- Clinical Audit High Priority Plan
- Clinical Outcomes Group
- GIRFT Update
- Improvement Strategy
- Infection Prevention and Control
- LD Improvement Standards
- Learning from Deaths
- Mental Health Strategy
- Mortality Review Improvement Programme
- National Patient Safety Improvement Programme Update
- Nursing and Midwifery Staffing Data Publication Report (information only)
- Outstanding Theatres Programme
- Palliative Care Annual Report
- Patient Experience - 6 monthly report
- Patient Experience Group
- Patient Safety Group
- Quality Account
- Quality Improvement Programme update
- Update on Health Inequalities
- Urgent & Emergency Care Survey
- WYAAT Quality and Safety Meeting Update

4.3 Governance

Work Plan: The Academy receives its work plan at each meeting and agrees any changes as appropriate.

The items included on the Academy work plan that have not been considered in year:

- LD Improvement Standards
- SIRO Report

- Moving to outstanding quarterly updates

Annual Effectiveness Review:

The annual effectiveness review was started in November 2023 however, following key events an external review of governance arrangements within the Trust has been commissioned during Q3 2023/24. This is still ongoing, and the outcome of the review will inform the future operation of the Academy.

5. Conclusion

The Academy believes that during 2023/24 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference.

Professor Louise Bryant
Chair of the Quality and Patient Safety Academy

April 2024

Appendix 1

Quality and Patient Safety Academy
Terms of Reference

Purpose	**Assurance Meeting:** To seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards. **Learning & Improvement Meeting:** To provide a space for our staff to share insight into the quality of our services and engender a culture of patient centred improvement where peer challenge and support is offered by all members. **CSU Health Checks:** In conjunction with the other Academies, oversee and review the quality, finance, performance and people metrics identified within the Clinical Service Units' Learning and Improvement Plans. **Annual Quality & Patient Safety Review:** An annual opportunity for CSUs to present their achievements around quality and patient safety to a wide ranging audience.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members. The Academy will receive mandated highlight reports from the clinical working groups according to the reporting structure and annual work plan.
Duties	**Assurance:** • Will receive assurance that safety, clinical outcomes, patient safety and patient experience across the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services. • Review and provide feedback on quality related submissions required by NHSE/I or other external organisations, prior to approval through the Trust Board as required. • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit, inviting the trust's appointed internal auditors as an external partner twice yearly to give an overview of progress and effective scrutiny of the risks and systems of

	internal control related to matters of quality and safety as well as the associated quality improvement plans. • Consideration of relevant internal audit reports. • Oversee the process for impact assessment (quality and equality) and receive assessments of any Trust developments and cost improvement schemes that are evaluated as high risk. • Have oversight of the Trust's objectives relating to quality priorities for inclusion in the Trust's Annual Quality Account. • Have oversight of progress towards the Trust's digital and data related objectives through regular reports from the Digital and Data Transformation Committee, and review and provide feedback on Information Governance related submissions required by legislation prior to approval through the Trust Board as required. • Oversight of the Estates & Facilities service reports (also relevant to the Learning and Improvement aspects of the Academy). • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.
	Learning & Improvement: • Work and collaborate with partner organisations to identify and share system learning. • Oversee, endorse and facilitate multi-methods of identifying, cascading and embedding learning across services. • Actively seek out learning opportunities from other healthcare providers and industries and apply research and evidence based learning which will support a culture of continuous learning and improvement. • Receive highlight reports from the Clinical Outcomes Group about compliance with internal and external quality standards including benchmarking data, learning from deaths and mortality, receive the Trusts Annual Audit Plan and have oversight of the associated improvement plans. • Receive highlight reports from the Patient Safety Group, identifying learning from patient safety incidents and have oversight of the quality improvement programmes associated with a positive patient safety culture. • Receive highlight reports from the Patient Experience Sub-Committee, identifying learning from complaints and other sources of feedback. • Support and facilitate a culture of safety and improvement in line with the NHS Patient Safety Strategy by adopting the principles of Insight, Involvement and Improvement. • Endorse and oversee the development of a basket of metrics to measure a culture of safety, quality and improvement. • Oversee and agree identified quality metrics that enable the

	development and maintenance of Quality Profiles at Clinical Service Unit level. • Oversee the development of a programme of work supporting the trust to be an outstanding provider of healthcare. • Oversee the Nursing & Midwifery Leadership Council work programmes to ensure successful accreditation for care excellence. • Agree, review and monitor the delivery of the Trust's Quality Strategy and Annual Quality Improvement Plan.
Sub-Groups	Patient Safety Group Clinical Outcomes Group Patient Experience Group Outstanding Maternity Services Programme Outstanding Theatres Programme Integrated Safeguarding Committee Digital & Data Transformation Committee Nursing & Midwifery Leadership Council
Chairing arrangements	The Academy will be chaired by a Non- Executive Director. In the absence of the Chair, Deputy Chair (who is also a Non-Executive Director) will act as Chair.
Membership	**Assurance Meeting:** • Chief Medical Officer • Chief Nurse • Chief Digital and Information Officer • Non-Executive Directors (including the Chair and Deputy Chair) • Deputy Chief Medical Officers • Deputy Chief Nurse • Directors of Nursing (Operations) • Associate Director of Quality • Senior Quality Governance Lead • Director of Midwifery • Director of Infection Prevention & Control • Director of Pharmacy • Associate Director of Corporate Governance/Board Secretary Members are normally expected to attend at least 4 meetings during the year. **Learning/Improvement Meeting:** • Chief Medical Officer • Chief Nurse • Non-Executive Directors (including the Chair and Deputy Chair) • Deputy Chief Medical Officers • Associate Medical Directors • Associate Director of Quality • Head of Education • Deputy Chief Nurse • Director of Midwifery • Directors of Nursing (Operations) • Assistant Directors of Nursing

	• Deputy Associate Directors of Nursing • Quality Lead Nursing & Midwifery • Director of Nursing – Programme Lead for Magnet • Head of Equality, Diversity & Inclusion • General Manager, Chief Medical Officer's Team • Head of Quality Improvement and Clinical Outcomes • Senior Quality Governance Lead • Patient Safety Specialist • Head of Non Clinical Risk • Lead AHP • Director of Infection Prevention and Control • Director of Pharmacy • Associate Director of Corporate Governance/Board Secretary • Identified Patient Safety Partners Members are normally expected to attend at least 4 meetings during the year. **CSU Health Checks:** • All members of Quality & Patient Safety Academy • Operational triumvirate from each CSU (three or four at each meeting). Each CSU to attend at least on an annual basis. **Annual Quality & Patient Safety Review:** • All members of Quality & Patient Safety Academy • Operational triumvirate from each CSU • NEDs • Governors • Members including staff • Patient representatives
In attendance	• CSU Quality and Patient Safety Facilitators • Associate Director of Nursing & Quality – Bradford District and Craven Health and Care Partnership • Head of Corporate Governance • The Academy may invite other employees or external advisors to attend as appropriate. • Any member of staff seeking development opportunities in relation to their role and portfolio. • Any non-member NED.
Secretary	Secretarial support will be provided by the Executive Assistant or PA to the Chief Nurse/Chief Medical Officer.
Quorum	A minimum of five members, including the Chair or Deputy Chair at least one Executive Director.
Frequency of meetings	12 times per year, alternating between assurance and learning/improvement. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.

Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Academy will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

Date agreed by the Academy:	28 September 2022
Date approved by the Trust Board:	10 November 2022
Review date:	July 2023

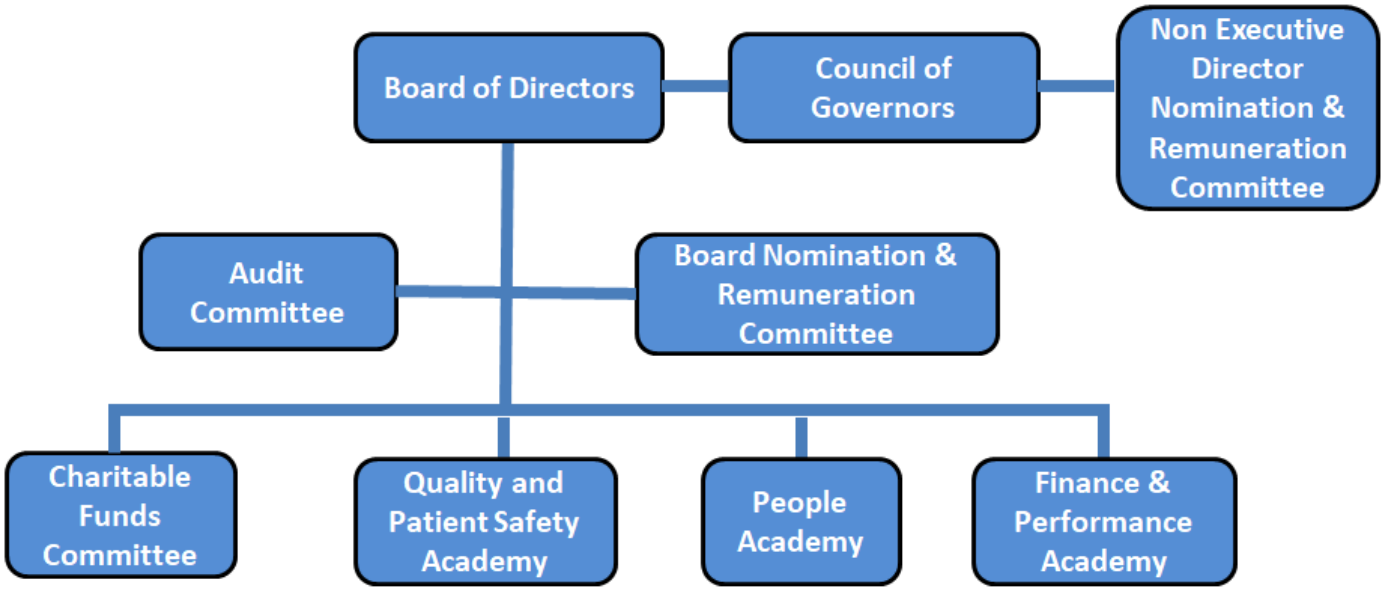
Charitable Fund Committee Annual Report 2023/24

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees/Academies annually to determine whether they have been effective, and whether further development work was required.

1.1 Board Governance Structure

The Board and Committee/Academy Structure is outlined below:



1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the Charitable Fund Committee in respect of 2023/24. The period reported on is from **April 2023 to March 2024.**

2. Charitable Fund Committee Terms of Reference

The Committee reports directly to the Board.

The Terms of Reference of the Committee were reviewed and approved by the Board of Directors in November 2023 and are attached at Appendix A.

2.1 The role and objectives of the Committee

The purpose of the Committee 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.

2.2 Reporting requirements

It is the duty of the Committee Chair to report to the Board on the Committee's activities on a timely basis. A Chair's report is presented to the Board following each meeting.

The minutes from meetings of the Committee are also presented to the Board once approved, for information and assurance.

The Committee is also required to present an annual report to the Board summarising the Committee's activities and the assurance received and outlining its work plan for the future year. This report will be presented to the Board in May 2024.

The Chair of the Committee is satisfied that the Committee fully complied with its reporting requirements during and in respect of 2023/24.

3. Membership and attendance record during and in respect of 2023/24

From April 2023 to March 2024 the Committee met four times.

Membership and attendance are recorded in the table below.

		25/04/23	04/07/23	07/11/23	07/03/24	total
Sarah Jones	Chair	N/A	N/A	N/A	1	1/1
Altaf Sadique	Non-Executive Director / Deputy Chair	1	1	1	1	4/4
Julie Lawreniuk	Non-Executive Director	0	1	1	1	3/4
Karen Walker	Non-Executive Director	1	1	1	1	4/4
Mohammed Hussain	Non-Executive Director	0	0	0	N/A	0/3
Mel Pickup	Chief Executive	1	1	1	0	3/4
Matthew Horner	Director of Finance	1	0	1	1	3/4
Sajid Azeb	Chief Operating Officer	N/A	N/A	1	1	2/2
Max Mclean	Chair	1	0	N/A	N/A	1/2
John Holden	Director of Strategy & Integration	1	1	N/A	N/A	2/2
Karen Dawber	Chief Nurse	0	N/A	N/A	N/A	0/1

Key and notes	
Denotes where not a member of the committee/attendance not required	N/A
Attended the meeting as required	1
Apologies received or absent	0

The Committee meetings were also attended by the Deputy Director of Finance and the Associate Director of Corporate Governance/Board Secretary.

4. Summary of the work of the Committee during 2023/24

4.1 Financial Position

The committee has applied particular scrutiny in year to the budget and financial reporting. It has reviewed the expected 'return on investment' which was set at an ambitious 25%. However, the investment in growing the fundraising team along with a reassessment of the neonatal fundraising appeal have led to the realisation that the Committee would not meet its financial predictions for the year. The committee does note however that an enhanced fundraising team, and other plans in train, will support the achievement of this goal in the future.

4.2 Case for Change

The most significant piece of work that began in the previous year continued in this to support the move towards independence for the charity. The due diligence work required to support the charity in moving towards independence was continuing well. Detailed update reports on progress were received at each of our meetings with the formal recommendation to support the change presented to the Board in March 2024 where it was approved. This presents an exciting opportunity for the charity and the committee will oversee the progress towards independence during 2024/25.

4.3 Investment Update

Whilst performance of the investment has remained under pressure from the higher interest rates in year; the portfolio is not operating at a loss. Benchmarking indices show that we are getting a better return than the national benchmark threshold. Up to 31 January, the portfolio saw growth of 3.6% against benchmarking of 3.2%. Since the inception of the investment portfolio in January 2020 the fund has grown by 20.6% compared to the predicted 8.5% and so overall it is performing reasonably well.

4.4 Charity Annual Report and Accounts

There was a delay in the preparation of the annual report and accounts 2022/23 which were approved by the Board in January 2024. It was good to note that they had been submitted to the Charity Commission as required by the end of January 2024. The timing of the appointment of the External Auditor was the key factor in the later than planned submission of the annual report and accounts.

4.5 Charity Operational Committee Report

Over the year the Committee received comprehensive updates on the work of the Charity Operational Committee. The topics covered included the following:

- Four Fund Summary (consolidation of the large number of individual pots of funds into smaller more manageable pots)
- The £30k development grant received from NHS Charities Together
- The launch of the '100 Club'
- Progress with the Neo Natal Unit (NNU) appeal
- Support provided to the SPaRC team's Ramadan appeal which has been well received by staff.
- A successful visit from the Sick Children's Fund in relation to the neo-natal appeal.

- The new professional and eye-catching branding for the Charity and launch of the new website. The committee was particularly delighted with the new branding which was described as 'professional and eye-catching'.

The Committee was delighted to hear of the positive outcomes from a '100 club' event providing the ability for donors to see first-hand the workings of the Da Vinci Robot which had been set up on the concourse at BRI. Four surgical specialties were present to share what this investment has meant in providing improved outcomes for patients. The event was hugely successful, and the Charity team are seeking to schedule in more activities such as this.

4.6 NNU (Neo Natal Unit) Parental Accommodation Business Case

The Committee was unanimously supportive of the business case which covered the provision of living accommodation for parents with babies on the NNU. The proposal was for the creation of five rooms in purpose-built accommodation on the BRI site. Provision of this accommodation would help to alleviate additional financial burdens on parents, help address health inequalities and, bring the Trust in line with practice in place nationally. Initial funding plans had been reviewed and were now down to £3m which makes for a more manageable fundraising campaign, with the ability to develop a more defined and realistic strategy for potential funders. This also provides the opportunity to access £1.5m from the Sick Children's Trust. The Committee approved the business case and noted that this would be the main fundraising appeal for the charity.

4.7 Bradford Hospitals Charity Strategy Development

In year the Committee has also been focussed on the work underway to support the development of a three-to-five-year strategy for the Charity, which is being supported by Gifted Philanthropy, funded by a development grant from NHS Charities Together. The committee received a comprehensive report on the work undertaken to date to inform the development of the strategy. Of note were the outcomes from meetings held with businesses and leaders within our South Asian communities who had expressed a real desire to engage with our Trust and were pleased that the Trust had reached out. This is exciting work as we are experiencing a step change as to how we run the Charity.

4.8 Governance

Committee Effectiveness Review - At the meeting held on 7 March 2024, the Committee reviewed its effectiveness via a live survey. The feedback was largely positive and it was noted that there will need to be a focus on the conversion to independence moving forward.

Terms of Reference and Work Plan Review – the Committee reviewed its Terms of Reference and Work Plan in July 2023. Minor amendments were agreed to ensure that the terms of reference remain up to date regarding references to the Charities Act and the Trust's strategic objectives. The Committee reviewed its terms of reference in July 2023. The Board approved the Charitable funds terms of reference in November 2024. The TOR have been complied with during 2023/24.

Charity Operational Committee Terms of Reference

The Committee approved minor amendments in November 2023.

Policies - The following four policies were reviewed and approved by the Committee:

- Investment and Treasury Management Policy
- Reserves Policy

- Charitable Fund Policy
- Expenditure Policy

5. Conclusion

The Committee believes that during 2023/24 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Committee has reviewed all relevant items in line with its Terms of Reference and work plan.

Altaf Sadique
Non-Executive Director
Deputy Chair of the Charitable Fund Committee

April 2024

Audit Committee Annual Report: April 2023 – March 2024

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Academies and Committees annually to determine whether they have been effective, and whether further development work is required.

The period reported on from the Audit Committee is **April 2023 to March 2024**.

The previous annual report from the Audit Committee to the Board covered the period July 2022 to June 2023. Annual reporting will now switch to reporting from 1 April to 31 March to ensure consistency with other committee annual reports.

2. Audit Committee Terms of Reference

The Audit Committee ('the Committee') is a Committee of the Board. The Committee's terms of reference were subject to minor amendments which were approved by the Board in September 2023

The Terms of Reference of the Committee are attached at Appendix 1.

2.1 The role and objectives of the Audit Committee

The purpose of the Committee is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements.

The Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

The objective of the Committee is to provide assurance on the adequacy of audit arrangements (internal and external) and on the implications of assurances provided in respect of risk and control, with a view to enabling the Board to assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls including business continuity and information technology.

The role of the Committee, in accordance with its terms of reference in effect in from 2023/24 is to:

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives
- Ensure an effective Internal Audit function
- Ensure an effective Local Counter Fraud Service function
- Review and monitor the work and findings of the External Auditors' independence and objectivity and the effectiveness of the external audit process and consider the implications of, and management's responses to, their work
- Review the Annual Report and Financial Statements before their submission to the Board for approval
- Review the findings of other significant assurance functions

- Report to the Board on the Committee's key findings

The outcomes from the previous annual assessment of the Committee, using the template checklists contained within the HFMA Audit Committee Handbook were reported to the AC in April 2022. In October 2022 the AC undertook a further review on the outcomes of the assessment. In September 2023 the AC agreed to postpone its assessment until the publication of the updated version of the HFMA Audit Committee handbook which would incorporate changes to the Health & Care that might impact the activities of the Audit Committee. Following a delay in publication, the AC was notified of the imminent publication of the revised handbook in February 2024 and determined that it would undertake its next assessment following the conclusion of the end of year reporting. Feedback on the next assessment will be included in the next annual report.

2.2 Reporting requirements

It is the duty of the Committee Chair to report, on a timely basis, to the Board on the Committee's activities by:

- Providing a written update report (including detailed commentary on the assurance received and risks identified in relation to the key controls identified within the Board Assurance Framework) following each meeting.
- Ensuring that the minutes of the Committee's meetings are formally recorded by the Secretary and submitted to the Board of Directors. The Committee Chair draws to the attention of the Board of Directors any issues that require disclosure to the full Board of Directors, or require executive action.
- Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee.
- Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive or Chairs of other relevant Academies and Committees of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives.
- Reporting to the Board of Directors annually on its work in support of the Annual Governance Statement, specifically commenting on:
  - The fitness for purpose of the assurance framework
  - The completeness and 'embeddedness' of risk management in the Trust
  - The integration of governance arrangements
  - The appropriateness of the evidence that shows the Trust is fulfilling all relevant regulatory requirements and obligations
  - The robustness of the processes behind the production of the Quality Account
- Presenting to the Board an annual report summarising the Committee's activities and the assurance received and provided.

The Audit Committee is satisfied that it fully complied with its reporting requirements during and in respect of April 2023 to March 2024.

3. Membership and attendance record during April 2023 to March 2024

From April 2023 to March 2024 the Committee met 7 times. Membership is recorded in the table below.

AC members		18/04/23	23/05/23	22/06/23	27/06/23	12/09/23	21/11/23	06/02/24	total	overall total
Barrie Senior	Chair/Non-Executive Director	0	1	1	1	1	1	N/A	5	6
Bryan Machin	Chair/Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	1	1	1
Jon Prashar	Non-Executive Director	1	0	1	0	0	0	N/A	2	6
Julie Lawreniuk	Non-Executive Director	1	1	1	1	0	1	1	6	7
Sughra Nazir	Non-Executive Director	1	1	1	1	1	1	0	6	7
Zafir Ali	Deputy Chair/Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	1	1	1

Key and notes	
Denotes where not a member of the Academy/attendance not required	N/A
Attended the meeting as required	1
Apologies received or Absent	0

Audit Committee meetings are attended by the Director of Finance, an Assistant Director of Finance, the Associate Director of Corporate Governance/Board Secretary and the Head of Corporate Governance. Other senior Executives and Directors are invited to attend meetings when appropriate to discuss specific matters related to their roles. In addition the majority of the meetings of the Audit Committee were also attended by an Executive Director on a rotational basis. In year these included:

- Chief Operating Officer - 18 April 2023
- Chief Medical Officer - 23 May 2023
- Faeem Lal, Interim Director of HR – 12 September 2023
- Paul Rice, Chief Digital and Information Officer – 21 February 2024

The Chief Executive, as the Trust's Accountable Officer, attends at least one meeting per year and she attended the meeting on 18 April 2023 to present the Annual Governance Statement. Representatives of both Internal and External Audit and Counter Fraud also routinely attended the meetings.

In-year, the Audit Committee members also held private meetings with Internal Audit (Audit Yorkshire) and the External Auditor (Deloitte).

4. Summary of the work of the Committee during and in respect of April 2023 to March 2024

4.1 Integrated Governance, Risk Management and Internal Control

During the reporting period the Committee's work plan sought to ensure the acquisition of adequate assurance regarding integrated governance, risk management and internal control. Supplemented by the consideration of assurance provided by internal audit's work to deliver the agreed internal audit plan, counter fraud and external audit, the Committee gained assurance from and in respect of:

- Annual Governance Statement 2022/23

- Annual Report 2022/23
- Annual Reports from Academies & Charitable Funds Committee (2022/23)
- Annual Review of Audit Committee Terms of Reference and submission to Board
- Appropriateness of Single Source Tenders
- Assurance regarding compliance with Risk Management Strategy
- Assurance: Data Quality
- Assurance: Key IT systems progress report
- Assurances regarding all relevant third parties that deliver key functions to the Trust
- Audit Committee Annual Report
- Audit Committee Annual Self-Assessment (proposal)
- Service specific, thematic benchmark reports produced by Audit Yorkshire
- Charitable Funds Annual Report and Accounts 2022/23
- Clinical Audit High Priority Workplan / Clinical Audit annual report
- Compliance with NHS Provider Licence and FT Code of Governance
- Conflicts of Interest Annual report
- Corporate Governance Statement
- Cyber security
- Effectiveness of Quality Management System in protecting patient and staff interests
- Estates Project Management Quality Manual Assurance
- Exception reports: Schedule of Losses & Special Payments and Appropriateness of Single Source Tenders
- Final Annual Accounts 2022/23 and Draft Letter of Representation 2022/23
- Freedom to Speak Up annual report and Effectiveness of Whistleblowing/FTSU Arrangements
- IFRS 16 Accounting for Leases – Deemed Lives
- Impact of climate change on public sector bodies
- Monitoring compliance with the 'Policy for the Development and Management of Trust Policies' and compliance with Trust Policies
- Partnership arrangements: implications for the Audit Committee
- Pennine Breast Screening Unit (PBSU) Mammography equipment replacement programme
- Policies and procedures for ensuring acceptable data quality for all key Trust data
- Production of the Quality Account 2022/23
- Changes to Standing Orders/Scheme of Delegation/Standing Financial Instruction
- Schedule of high-value approvals under the scheme of delegation
- UK Corporate Governance Code publication
- Update on delivery of the Emergency Preparedness Resilience & Response (EPRR) 21/22 workplan and NHSE core standards

4.2 Internal Audit (IA) and Local Counter Fraud Services

Internal Audit and Local Counter Fraud Services are provided to the Trust by Audit Yorkshire. The Director of Finance is a member of the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level.

4.2.1 Internal Audit

In respect of the reporting period, the Committee considered and reviewed the following reporting from Internal Audit and Local Counter Fraud:

- Annual Internal Audit performance review
- Draft Head of Internal Audit Opinion

- Draft Annual Internal Audit Plan 2023/24
- Follow up of Internal Audit Recommendations
- Head of Internal Audit Opinion 2022/23
- Internal Audit Annual Report 2022/23
- Internal Audit Reports
- Internal Audit Effectiveness Review
- Internal Audit Quarterly Progress Reports
- Internal Audit Progress Report covering 2022/23

Audit Committee members and regular attendees were also in receipt of the monthly insight reports from the Internal Audit Network (TIAN)

The Committee approved the planning methodology to be used by Internal Audit to create the three-year strategic Internal Audit Plan covering 2022 to 2025 in April 2022. The Internal Audit programme of work includes resources allocated to management requests and a contingency to capture areas of risk that may arise during 2022-2025. The reviews deferred from the 2022/23 plan were risk assessed by Internal Audit and the Audit Sponsor to determine whether they should feature in 2023/24 or be replaced by higher priority auditable areas. Revisions to the plan were reviewed and approved by the Audit Committee in April 2023 for the period 2023/24.

The conclusions, as well as the findings and recommendations, of all Internal Audit reports finalised during 2023/24 were shared with the Committee. The Committee challenged Internal Audit on assurances provided and, where appropriate, requested additional information, clarification and follow-up work if considered necessary. The system whereby all Internal Audit recommendations are followed-up on a quarterly basis was scrutinised. Progress towards the implementation of agreed recommendations was reported (including full details of all outstanding recommendations) to the Executive Team. The Committee reviewed and was satisfied by the quarterly progress reports but has sought improvement in the assurances given about the completion of management actions.

4.2.2 Head of Internal Audit Opinion

The Head of Internal Audit is required to provide an annual opinion, based upon and limited to the internal audit work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. (i.e. the Trust's system of internal control). The 2022/23 opinion was received by the Committee in June 2023. The overall opinion was as follows:

> *"The overall opinion for the 2022/23 reporting period provides Significant Assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."*

The Head of Internal Audit Opinion contributed to the Committee's and to the Board's assessment of the effectiveness of the Trust's system of internal control and to the completion of the Annual Governance Statement 2022/23.

For 2023/24 the Head of Internal Audit Opinion is expected for review by the Committee in May 2024. Executive Directors and or their representatives have attended the Audit Committee and provided updates (where required) on the mitigations and action plans to address areas where limited assurance was provided.

4.3 Local Counter Fraud Service (LCFS)

In respect of the reporting period, the Committee considered and reviewed the following reporting from the Local Counter Fraud representatives:

- Counter Fraud Annual Report 2022/23
- Counter Fraud Functional Standards Return
- Counter Fraud Quarterly Progress Reports
- Draft Counter Fraud Annual Plan 2023/24
- Policies and procedures for all work related to counter fraud, bribery and corruption

The Local Counter Fraud Specialist presented regular reports detailing progress towards achievement of the 2023/24 LCFS Plan, as well as summaries of investigations undertaken. The Committee has ensured that the LCFS has received all the necessary support to enable them to perform their role efficiently, effectively and promptly.

All NHS organisations are required to provide assurance against the NHS Counter Fraud Functional Standard. The NHS Counter Fraud Functional Standard (CFFSR) has been produced by the NHSCFA to align with the Government Functional Standard GovS 013: Counter Fraud. The CFFSR accurately reflects how the Trust has performed against the new functional standards across 2022/23. The CFFSR is divided into 13 individual “NHS Requirements”. All NHS organisations are required to assess themselves against these requirements annually, and to produce a CFFSR return which is submitted to the NHSCFA for review.

With regard to Green, Amber and Red compliance; the Trust achieved 12 Green ratings, and 1 Amber rating. The Green standards reflect accurately the work of the Trust and the LCFS over the course of 2022/23. The amber rating relates to the identification of further work required in relation to ensuring Fraud Risk Descriptors are aligned to the registers. The results for 2023/24 are expected to be reviewed by the Audit Committee in May 2024.

4.4 External Audit / Financial Reporting

4.4.1 Appointment of External Auditor

Deloitte LLP was appointed as the Trust’s External Auditor from 1 June 2020 to 31 May 2023 (with an option to extend for a maximum of two years) in June 2020 by the Council of Governors in line with a recommendation from the Audit Committee.

In January 2023 the Council of Governors approved a recommendation presented by the Audit Committee to change the contract in place with Deloitte LLP to ensure continuity of supply of external audit services and taking into consideration the benchmarking against other “traditional style” external auditors on the procurement framework; risks highlighted within the market; and time that would be needed to undertake a tender exercise. The revised contract - effective from 1 June 2023 runs for a period of 2+1 years and was awarded via the NHS SBS Internal and External Audit, Counter Fraud & Financial Assurance Services framework.

The original appointment of Deloitte LLP was reported to the Board at the time andwas made in accordance with the Code of Audit Practice for NHS Foundation Trusts, issued by the National Audit Office on behalf of the Comptroller and Auditor General.

4.4.2 Key reports from External Audit

During and in respect of the reporting period, the Committee considered and reviewed the following reporting from the External Auditors:

- Accounts delivery and external audit improvement plan
- Annual External Audit performance review
- Annual Policy review – use of external audit for non-audit purposes
- Auditor's Annual Report 2022/23 and certificate of completion
- Draft Annual Accounts 2022/23
- Draft ISA260 – Foundation Trust
- External Audit Annual Plan 2023/24
- ISA 260 - Charitable Funds
- ISA 260 - Foundation Trust
- ISA 260 - Response to Sector Development recommendations
- Sector update and benchmarking report

External Audit Annual Plan 2022/23 and 2023/24

The Audit Committee received and approved an External Audit Plan for 2023/24. The Plan identified significant inherent audit risks related to:

- Property valuation
- Capital expenditure
- Management override of controls

The ISA 260 was received on 11 July 2023 (following its expected delivery date of 27 June 2023). The report confirmed that, based on the audit work of the External Auditor (Deloitte LLP), they envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.

The Audit Committee made recommendations to the Board in June 2023 to approve the Annual Report and Annual Governance Statement for 2022/23. The final audited accounts were approved by a sub-set of Board members (including the Audit Committee Chair) via e-mail on 12 July 2023, following the receipt of the final ISA 260.

The Audit Committee did advise the External Auditor (Deloitte LLP) that this delay in receipt of the final ISA 260 was of great concern to the Audit Committee as it had caused the Trust to miss the deadline imposed by the regulator for the submission of the Annual Report and Accounts (the first time the Trust has had to do this). The Audit Committee did seek assurances from the External Auditor (Deloitte LLP) that this situation would not happen again. The Value for Money audit and Audit Certificate from the External Auditor was received on 7 September 2023, reviewed by the Audit Committee, and approved by Board on 14 September 2023.

For 2023/24 a verbal External Audit Plan was presented to the Committee from Deloitte LLP at the meeting held in February 2024.

4.4.3 Financial Reporting

During and in respect of the year, the Committee reviewed, gained assurance and approved the following:

- Annual Accounts 2022/23
- Annual Report 2022/23
- Letter of Representation 2022/23

4.4.4 Use of External Audit to provide non-audit services

Any proposal for the use of the External Auditors to provide non-audit services is required to be reported to the Audit Committee. Dependent upon the nature and/or cost of the services then Audit Committee approval is required.

The Audit Committee can confirm that there were no such engagements in 2023/24.

4.5 Other significant assurance functions

During 2023/24, in addition to the assurances provided by Internal Audit, Counter Fraud and External Audit, the Committee has also been sighted on the progress made with regard to the development of partnership arrangements and any implications for the Audit Committee.

5 Conclusion

The Committee believes that during the period of reporting it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference.

Bryan Machin
Audit Committee Chairman

May 2024

Appendix 1

Audit Committee

Terms of Reference

Purpose	The purpose of the Audit Committee ('the Committee') is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance. The objective of the Committee is to provide assurance on the adequacy of audit arrangements (internal and external) and on the implications of assurances provided in respect of risk and control, with a view to enabling the Board to assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls including business continuity and information technology.
Responsible to	Board of Directors
Delegated authority	The Committee is a non-executive committee of the Trust's Board ('the Board') and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to act and investigate any activity within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions The Committee shall embed the Foundation Trust's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business. The requirements for the conduct of business as set out in the Foundation Trust Board's Standing Orders are equally applicable to the operation of the Committee.
Duties	**Integrated governance, risk management and internal control** The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement),together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors
- The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statement
- The policies and procedures for ensuring compliance with all relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA.

The Committee will review, challenge and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy, and provide assurance to the Board in that respect.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, other Board Committees and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages.

Internal Audit
The Committee shall ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by:

- Considering the provision of the Internal Audit service and the costs involved.
- Reviewing and approving the strategic and annual Internal Audit plan, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of Internal Audit work (and management's responses), and ensuring coordination between the Internal and External Auditors to optimise the Trust's use of audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.
- Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the External Auditors' independence and objectivity and the effectiveness of the external audit process. In particular, the Committee

will review the work and findings of the External Auditors and consider the implications and management's responses to, their work. This will be achieved by:

- Considering the appointment and performance of the External Auditors, as far as the rules governing the appointment permit (and make recommendations to the Board of Directors when appropriate).
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the External Audit annual plan.
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside of the annual External Audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear and appropriate policy for the engagement of External Auditors to supply non-audit services.

Other assurance functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors - for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions - for example, Royal Colleges, accreditation bodies, etc.

The Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's areas of responsibility.

The Committee will have oversight of and receive assurances in relation to compliance with Trust policies.

Counter fraud
The Committee shall satisfy itself that the Trust has adequate arrangements in place for the prevention and detection of fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas. The Committee shall refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Agency.

The Committee shall receive and consider reports arising from quality inspections by the NHSCFA.

Management
The Committee shall request and review reports, evidence and assurances from Board Committees and Academies, directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the Trust.

Financial reporting and control
The Committee shall monitor the integrity of the financial statements of the Trust and any

<table>
<tr><td></td><td>formal announcements relating to its financial performance. The Committee will ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

• The Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
• The quality of financial reports
• Changes in, and compliance with, accounting policies, practices and estimation techniques
• Explanations for significant variances
• Unadjusted misstatements in the financial statements
• Significant judgements in preparation of the financial statements
• Significant adjustments resulting from the audit
• The letter of management representation

As regards Standing Orders and Standing Financial Instructions, the Committee shall:

• Seek assurance regarding the Trust's compliance with Standing Orders and Standing Financial Instructions.
• Consider any proposed changes to Standing Orders and Standing Financial Instructions and, as appropriate, make recommendations to the Board.

The Committee shall review schedules of losses and special payments, and review single source tenders.

The Committee shall receive, consider and derive assurance from reports relating to the Trust Charitable Funds Committee with regard to governance, risk management, control, audit and financial reporting.

Whistleblowing / Freedom to Speak Up
The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial control and reporting, clinical quality, or patient or staff safety or other matters and ensure that any such concerns are investigated proportionately and independently.</td></tr>
<tr><td>Chairing arrangements</td><td>The Chair of the Committee ('the Chair') shall be appointed by the Board of Directors from amongst its independent Non-Executive Directors. The Chair must have recent and relevant financial experience.</td></tr>
<tr><td>Membership</td><td>
<table>
<tr><th>Title</th><th>Role</th></tr>
<tr><td>Non-Executive Director</td><td>Chair
To ensure the Committee functions properly, that there is full participation during meetings, that all relevant matters are discussed and that effective decisions are made and carried out.</td></tr>
</table>
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</table>

Non-Executive Director	Deputy Chair. To provide independent oversight and challenge
Non-Executive Director X2	To provide independent oversight and challenge
Attendees	
Director of Finance	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
Associate Director of Corporate Governance/Board Secretary	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan To support the Chair of the Committee in ensuring that the Committee functions properly
Accountable Officer	To discuss annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she shall also attend when the Committee considers the draft Annual Governance Statement and, the Annual Report and Accounts
Representative(s) from Internal audit	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
Representative(s) from external audit	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
Assigned Local Counter Fraud Specialist	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan. The assigned Local Counter Fraud Specialist will attend a minimum of two Committee meetings a year.
Other Executive Directors/Directors	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan as required by the Committee

	The Head of Internal Audit and lead representative of External Audit shall have a right of direct access to the Chair of the Committee. The Chairperson of the Trust shall not be a member of the Committee.
Secretary	Secretarial support will be provided by the Corporate Governance Team.
Quorum	A quorum shall consist of two of the four Independent members. Members should attend at least 75% of meetings within any calendar year. Attendance will be monitored and addressed by the Chair. Should any member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair. The Committee may ask any of those who are in attendance but who are not members to withdraw to enable a full and frank discussion of particular matters. Where the Committee is not quorate, the meeting should be rearranged within 2 weeks.
Frequency of meetings	The Committee will meet at least five times per annum and shall agree a schedule of meetings at least 12 months in advance. The Committee will consider and keep under consideration the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Board of Directors, Accountable Officer, External Auditors or Head of Internal Audit may request of the Committee Chair an additional meeting if they consider that one is necessary. At least once a year the Committee shall meet privately with the external and with the internal auditors. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to the functioning of such a meeting. These meetings will be deemed as standard meetings of the Committee and shall be documented accordingly.
Circulation of papers	The Associate Director of Corporate Governance/Board Secretary will hold an agenda setting meeting with the Chair and/or the Deputy Chair at least 3 weeks before the meeting date. The agenda will be based around the Committee's work plan, matters arising and requests from the Board of Directors or other Board Academies and Committees to consider specific issues. Following approval, the agenda and timetable for papers will be circulated to all Committee members. Agenda items along with accompanying papers to be submitted to the Committee secretary one week prior to meeting dates. The agenda and papers for meetings will be distributed five working days in advance of the meeting. The minutes, highlight report and action log will be circulated to members within

	seven working days of the meeting to check the accuracy. Members must forward amendments to the Committee secretary within the next seven days.
Reporting	The Committee Chair shall report formally, regularly and on a timely basis to the Board of Directors on the Committee's activities by: • Providing a written update report (including detailed commentary on the assurance received and risks identified in relation to the key controls identified within the Board Assurance Framework) following each meeting and the presentation of an annual report for each of its operational duties. • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board of Directors. The Chairperson of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board of Directors, or require executive action. • Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee. • Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives. Reporting to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on: • The fitness for purpose of the assurance framework • The completeness and 'embeddedness' of risk management in the Trust • The integration of governance arrangements • The appropriateness of the evidence that shows the Trust is fulfilling all relevant regulatory requirements and obligations • The robustness of the processes behind production of the Quality Accounts. This Audit Committee Annual Report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered and how they were addressed. If, through the course of Committee business an issue is raised which needs immediate escalation, or action taken, which is outside of the remit of the Committee this should be escalated to the appropriate Executive meeting, via the Chair, for discussion and action. The Committee shall undertake an annual self-assessment. It will report thereon to the Board of Directors. These terms of reference and operating arrangements shall be

	reviewed on at least an annual basis by the Committee for approval by the Board of Directors.
Date agreed by the Audit Committee:	12 September 2023
Date approved by the Trust Board:	21 September 2023
Review date:	September 2024

Bradford Teaching Hospitals
NHS Foundation Trust

Finance & Performance Academy

Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to all aspects of finance and performance within the Trust.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	**Assurance:** • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Oversight and scrutiny of the development and maintenance of the Foundation Trust's medium- and long-term financial strategy. • Oversight and scrutiny of the development and delivery of the Foundation Trust's annual plan and integrated business plan. • Review and monitor financial plans and their link to operational performance. • Oversight and scrutiny of financial risk evaluation, measurement, and management. • Oversight and scrutiny of the risks and assurance associated with the impact of financial and performance pressures on the quality of care. • Scrutiny of the implementation of business cases. • Oversight of the Capital Programme. • Review the performance of the Foundation Trust in

	achieving National Standards, Contractual Indicators (National and Local) and Trust–defined indicators. • Receive, consider and approve the annual reference cost submission ensuring appropriate application of costing methodologies. • Approve and keep under review the Foundation Trust's investment policy in relation to treasury management (to include cash investments and all other elements of working capital). • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to finance and performance matters. • Consideration of relevant internal audit reports. • Oversight of the Pathology Joint Venture Board. • Oversight of the Trust's procurement activity (also relevant to the Learning and Improvement aspects of the Academy). • Oversight of the Trust's compliance with Emergency Preparedness, Resilience and Response (EPRR) requirements. • Oversight of the Estates and Facilities function • Oversight with regard to Environmental ~~S~~sustainability • In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.
	Learning: • Review the Trust's position in line with benchmarking data including GIRFT, WYAAT and ICS data, and identify areas of learning. • Review and consider the latest innovations both nationally and internationally and identify any relevant learning for the Trust. • Consider learning from other sectors and industries, outside of the NHS. • Consider the relative strengths, weaknesses, limitations and opportunities in relation to CBUs and ensure that opportunities for learning and improvement are disseminated appropriately.
	Improvement:

	• Review and monitor the performance of the Bradford Improvement Programme. • Consideration of performance/finance impact assessments. • Review programme updates from WYAAT and the ICS to ensure that any related improvements are exploited within the Trust.
Sub-Groups	Pathology Joint Venture Board (in relation to the financial position only) Capital Strategy Group Cancer Board
Chairing arrangements	The Academy will be chaired by a Non-Executive Director. ~~In the absence of the Chair, the Deputy Chair (who is also a Non-Executive Director) will act as Chair.~~
Membership	• Up to three Non-Executive Directors (including the Chair) • Chief Operating Officer • Director of Finance • Director of Strategy and Transformation • ~~Up to four Non-Executive Directors (including the Chair and Deputy Chair)~~ • ~~Deputy Directors of Finance~~ • ~~Associate Director of Performance~~ • ~~Medical Director of Operations~~ • ~~Deputy Chief Operating Officer~~ • ~~Director of Operations~~ • ~~Deputy Director of Operations - Planned Services~~ • ~~Deputy Director of Operations - Unplanned Services~~ • ~~Deputy Director of Operations – Diagnostics and Corporate Operational Services~~ • ~~Deputy Chief Nurse / Directors of Nursing (Operations) (at least one to attend each meeting)~~ • ~~Director of Transformation~~ • ~~Head of Business Intelligence~~ Members are normally expected to attend at least 70% of meetings (7) during the year.

In attendance	• Deputy Directors of Finance • Associate Director of Performance • Medical Director of Operations • Deputy Chief Operating Officer • Director of Operations • Deputy Director of Operations - Planned Services • Deputy Director of Operations - Unplanned Services • Deputy Director of Operations – Diagnostics and Corporate Operational Services • Deputy Chief Nurse / Directors of Nursing (Operations) (at least one to attend each meeting) • Director of Transformation • Head of Business Intelligence • Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • The Academy may invite other employees or external advisors to attend as appropriate • Any non-member NED
Secretary	Secretarial support will be provided by the Executive Assistant or PA to the Director of Finance/Chief Operating Officer.
Quorum	A minimum of ~~five~~ three members, including two NEDs and ~~the Chair or Deputy Chair and~~ at least one Executive Director.
Frequency of meetings	Monthly (except August and December) At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The

	Academy will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Academy:	~~28 September 2022~~4 July 2024
Date approved by the Trust Board:	~~10 November 2022~~11 July 2024
Review date:	~~July 2023~~September 2024

Bradford Teaching Hospitals
NHS Foundation Trust

People Academy
Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to the people management arrangements within the Trust.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	**Assurance:** • People Dashboard and metrics to include safe staffing • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Delivery of the NHS People Plan • Ensuring compliance with relevant legislation and regulations relating to People. • Ensuring delivery of action plans to include but not restricted to the NHS Staff Survey, WRES and WDES action plans • CQC standards relating to People • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and

	systems of internal control related to people matters. • Consideration of relevant internal audit reports. • In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.
	Learning: To develop good practice and recommend the consideration of innovative approaches to people practices within the Trust • To learn from other Organisations who are considered the 'best' employers in the Trust's ambition to become an outstanding Organisation • To learn from Employment Relations/Employment Tribunal cases to inform policy/practice change • System/partnership working including the Bradford District & Craven Partnership People Committee • To hear and learn from real stories from staff and patients
	Improvement: • To improve people practices • To oversee the development and implementation of action plans following the NHS Staff Survey results to drive improvement • To ensure the development of a just and compassionate culture within the Trust • To improve leadership capacity and talent management
Sub-Groups	~~New ways of working and delivering care~~ Workforce Growth and Transformation ~~Looking After Our People~~ Health & Safety Committee Civility Programme Board Freedom to Speak Up Whilst not reporting to the Academy, the Academy will be mindful of the

	work of the Equality and Diversity Council (EDC) as it affects people management and practices. A workforce sub-group / reference groups will be tasked to lead pieces of work or undertake research, which will feed into the People Academy as well as the EDC as agreed.
Chairing arrangements	The Academy will be chaired by a Non Executive Director. ~~In the absence of the Chair, the Deputy Chair (who is also a Non Executive Director) will act as Chair.~~
Membership	• ~~Director of HR~~ Up to three Non-Executive Directors (including the Chair) • Chief People and Purpose Officer • Chief Medical Officer • Chief Nurse • ~~Up to four Non-Executive Directors (including the Chair and Deputy Chair)~~ • ~~Director of Pharmacy~~ • ~~Digital representative - TBC~~ • ~~Assistant Director of HR/Head of OD~~ • ~~Deputy Director of HR~~ • ~~Assistant Director of HR~~ • ~~Workplace Health and Wellbeing Centre Manager (only when Looking After Our People is included on the agenda)~~ • ~~Equality, Diversity and Inclusion Manager~~ • ~~Deputy Chief Operating Officer~~ • ~~Director of Estates and Facilities~~ • ~~Deputy Chief Nurse~~ • ~~Directors of Nursing (Operations) and Director of Midwifery (at least one to attend each meeting)~~ • ~~Head of Education~~ • ~~Partnership Lead~~ • ~~Chair – RESIN Staff Network~~ • ~~Chair – Enable Staff Network~~ • ~~Chair – LGBT Staff Network~~ • ~~Lead AHP~~ • ~~Clinical Lead for Medical Workforce (or Deputy)~~ • ~~Frontline staff (TBC – Academy to discuss)~~ Members are normally expected to attend at least 70% of meetings (7)

	during the year. Deputies may attend on behalf of members subject to the agreement of the Chair.
In attendance	• Director of HR • Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • Director of Pharmacy • Digital representative ~~- TBC~~ • Assistant Director of HR/Head of OD • Deputy Director of HR • Assistant Director of HR • Workplace Health and Wellbeing Centre Manager (only when Looking After Our People is included on the agenda) • Equality, Diversity and Inclusion Manager • Deputy Chief Operating Officer • Director of Estates and Facilities • Deputy Chief Nurse • Directors of Nursing (Operations) and Director of Midwifery (at least one to attend each meeting) • Head of Education • Partnership Lead • Chair – RESIN Staff Network • Chair – Enable Staff Network • Chair – LGBT Staff Network • Lead AHP • Clinical Lead for Medical Workforce (or Deputy) • Frontline staff (TBC – Academy to discuss) • The Academy may invite other employees or external advisors to attend as appropriate • Any non-member NED
Secretary	Secretarial support will be provided by the Executive Assistant ~~or PA~~ to the Chief People and Purpose Officer~~Director of HR~~.
Quorum	A minimum of ~~five members~~three members, including at least two NEDs and ~~the Chair or Deputy Chair and~~ at least one Executive Director.
Frequency of meetings	Monthly (except August and December) At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to

	quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Academy will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Academy:	~~28 September 2022~~4 July 2024
Date approved by the Trust Board:	~~10 November 2022~~11 July 2024
Review date:	~~July 2023~~XX September 2024

Bradford Teaching Hospitals
NHS Foundation Trust

Quality ~~and Patient Safety~~ Academy

Terms of Reference

Purpose	**~~Assurance~~ Academy Meetings:** To seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards. ~~**Learning & Improvement Meeting:**~~ To provide a space for our staff to share insight into the quality of our services and engender a culture of patient centred improvement where peer challenge and support is offered by all members. **CSU ~~Health Checks~~to Academy meetings:** In conjunction with the other Academies, oversee and review the quality, finance, performance and people metrics identified within the Clinical Service Units' Learning and Improvement Plans. **Annual Quality & Patient Safety Review:** An annual opportunity for CSUs to present their achievements around quality and patient safety to a wide ranging audience.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members. The Academy will receive mandated highlight reports from the clinical working groups according to the reporting structure and annual work plan.
Duties	**Assurance:** • Will receive assurance that safety, clinical outcomes, patient

	safety and patient experience across the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services. • Review and provide feedback on quality related submissions required by NHSE~~/I~~ or other external organisations, prior to approval through the Trust Board as required. • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit, inviting the trust's appointed internal auditors as an external partner twice yearly to give an overview of progress and effective scrutiny of the risks and systems of internal control related to matters of quality and safety as well as the associated quality improvement plans. • Consideration of relevant internal audit reports. • Oversee the process for impact assessment (quality and equality) and receive assessments of any Trust developments and cost improvement schemes that are evaluated as high risk. • Have oversight of the Trust's objectives relating to quality priorities for inclusion in the Trust's Annual Quality Account. • Have oversight of progress towards the Trust's digital and data related objectives through regular reports from the Digital and Data Transformation Committee, and review and provide feedback on Information Governance related submissions required by legislation prior to approval through the -Trust Board as required. • ~~Oversight of the Estates & Facilities service reports (also relevant to the Learning and Improvement aspects of the Academy).~~ • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • In reviewing the assurances received, the Academy will

	take into consideration the quality of data presented and any associated issues.
	Learning & Improvement: • Work and collaborate with partner organisations to identify and share system learning. • Oversee, endorse and facilitate multi-methods of identifying, cascading and embedding learning across services. • Actively seek out learning opportunities from other healthcare providers and industries and apply research and evidence based learning which will support a culture of continuous learning and improvement. • Receive highlight reports from the Clinical Outcomes Group about compliance with internal and external quality standards including benchmarking data, learning from deaths and mortality, receive the Trusts Annual Audit Plan and have oversight of the associated improvement plans. • Receive highlight reports from the Patient Safety Group, identifying learning from patient safety incidents and have oversight of the quality improvement programmes associated with a positive patient safety culture. • Receive highlight reports from the Patient Experience Sub-Committee, identifying learning from complaints and other sources of feedback. • Support and facilitate a culture of safety and improvement in line with the NHS Patient Safety Strategy by adopting the principles of Insight, Involvement and Improvement. • Endorse and oversee the development of a basket of metrics to measure a culture of safety, quality and improvement. • Oversee and agree identified quality metrics that enable the development and maintenance of Quality Profiles at Clinical Service Unit level. • Oversee the development of a programme of work supporting

	the trust to be an outstanding provider of healthcare. • Oversee the Nursing & Midwifery Leadership Council work programmes to ensure successful accreditation for care excellence. • Agree, review and monitor the delivery of the Trust's Quality Strategy and Annual Quality Improvement Plan.
Sub-Groups	Patient Safety Group Clinical Outcomes Group Patient Experience Group ~~Outstanding Maternity Services Programme~~ ~~Outstanding Theatres Programme~~ Integrated Safeguarding Committee Digital & Data Transformation Committee Nursing & Midwifery Leadership Council
Chairing arrangements	The Academy will be chaired by a Non- Executive Director. ~~In the absence of the Chair, Deputy Chair (who is also a Non-Executive Director) will act as Chair.~~
Academy Membership	• Four Non-Executive Directors • Chief Medical Officer • Chief Nurse Members are normally expected to attend at least 8 meetings during the year.
In attendance	• Deputy Chief Medical Officers • Associate Medical Directors • Associate Director of Quality • Head of Education • Deputy Chief Nurse • Director of Midwifery • Directors of Nursing (Operations) • Assistant Directors of Nursing • Deputy Associate Directors of Nursing • Quality Lead Nursing & Midwifery • Director of Nursing – Programme Lead for Magnet • Head of Equality, Diversity & Inclusion

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	• General Manager, Chief Medical Officer's Team • Head of Quality Improvement and Clinical Outcomes • Senior Quality Governance Lead • Patient Safety Specialist • Head of Non Clinical Risk • Lead AHP • Director of Infection Prevention and Control • Director of Pharmacy • Associate Director of Corporate Governance/Board Secretary • Identified Patient Safety Partners • CSU Quality and Patient Safety Facilitators • Associate Director of Nursing & Quality – Bradford District and Craven Health and Care Partnership • Head of Corporate Governance • The Academy may invite other employees or external advisors to attend as appropriate. • Any member of staff seeking development opportunities in relation to their role and portfolio. • Any non-member NED.
~~**Membership**~~	~~**Assurance Meeting:**~~ ~~• Chief Medical Officer~~ ~~• Chief Nurse~~ ~~• Chief Digital and Information Officer~~ ~~• Non Executive Directors (including the Chair and Deputy Chair)~~ ~~• Deputy Chief Medical Officers~~ ~~• Deputy Chief Nurse~~ ~~• Directors of Nursing (Operations)~~ ~~• Associate Director of Quality~~ ~~• Senior Quality Governance Lead~~ ~~• Director of Midwifery~~ ~~• Director of Infection Prevention & Control~~ ~~• Director of Pharmacy~~ ~~• Associate Director of Corporate Governance/Board Secretary~~ ~~Members are normally expected to attend at least 4 meetings during the year.~~

	~~**Learning/Improvement Meeting:**~~ • ~~Chief Medical Officer~~ • ~~Chief Nurse~~ • ~~Non-Executive Directors (including the Chair and Deputy Chair)~~ • ~~Deputy Chief Medical Officers~~ • ~~Associate Medical Directors~~ • ~~Associate Director of Quality~~ • ~~Head of Education~~ • ~~Deputy Chief Nurse~~ • ~~Director of Midwifery~~ • ~~Directors of Nursing (Operations)~~ • ~~Assistant Directors of Nursing~~ • ~~Deputy Associate Directors of Nursing~~ • ~~Quality Lead Nursing & Midwifery~~ • ~~Director of Nursing – Programme Lead for Magnet~~ • ~~Head of Equality, Diversity & Inclusion~~ • ~~General Manager, Chief Medical Officer's Team~~ • ~~Head of Quality Improvement and Clinical Outcomes~~ • ~~Senior Quality Governance Lead~~ • ~~Patient Safety Specialist~~ • ~~Head of Non-Clinical Risk~~ • ~~Lead AHP~~ • ~~Director of Infection Prevention and Control~~ • ~~Director of Pharmacy~~ • ~~Associate Director of Corporate Governance/Board Secretary~~ • ~~Identified Patient Safety Partners~~ ~~Members are normally expected to attend at least 4 meetings during the year.~~ **CSU ~~Health Checks~~to Academy meetings:** • All members of Quality ~~& Patient Safety~~ Academy • Operational triumvirate from each CSU (three or four at each meeting). Each CSU to attend at least on an annual basis. **Annual Quality ~~& Patient Safety~~ Review:** • All members of Quality ~~& Patient Safety~~ Academy

	• Operational triumvirate from each CSU • NEDs • Governors • Members including staff • Patient representatives
~~**In attendance**~~	~~• CSU Quality and Patient Safety Facilitators~~ ~~• Associate Director of Nursing & Quality – Bradford District and Craven Health and Care Partnership~~ ~~• Head of Corporate Governance~~ ~~• The Academy may invite other employees or external advisors to attend as appropriate.~~ ~~• Any member of staff seeking development opportunities in relation to their role and portfolio.~~ ~~• Any non-member NED.~~
Secretary	Secretarial support will be provided by the Executive Assistant ~~or PA~~ to the Chief Nurse/Chief Medical Officer.
Quorum	A minimum of three members, including at least two NEDs and at least one Executive Director.~~A minimum of five members, including the Chair or Deputy Chair at least one Executive Director.~~
Frequency of meetings	~~12~~ 10 times per year~~, alternating between assurance and learning/improvement~~. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Academy will present a written annual report to the Trust Board

	summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Academy:	~~28 September 2022~~2 July 2024
Date approved by the Trust Board:	~~10 November 2022~~11 July 2024
Review date:	~~July 2023~~September 2024

Bradford Teaching Hospitals
NHS Foundation Trust

Audit Committee

Terms of Reference

Purpose	The purpose of the Audit Committee ('the Committee') is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance. The objective of the Committee is to provide assurance on the adequacy of audit arrangements (internal and external) and on the implications of assurances provided in respect of risk and control, with a view to enabling the Board to assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls. ~~including business continuity and information technology.~~
Responsible to	Board of Directors
Delegated authority	The Committee is a non-executive committee of the Trust's Board ('the Board') and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to act and investigate any activity within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions The Committee shall embed the Foundation Trust's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business. The requirements for the conduct of business as set out in the Foundation Trust Board's Standing Orders are equally applicable to the operation of the Committee.

Duties	**~~Integrated~~ Gg~~overnance~~, risk management and internal control** The Committee will review the establishment and maintenance of an effective system of ~~integrated~~ governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of: • All risk and control related disclosure statements (in particular the Annual Governance Statement),together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors • The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statement • The policies and procedures for ensuring compliance with all relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications including the NHS Provider Licence, guidance on Good Governance and Collaboration, and the Code of Governance for NHS Provider Trusts • The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA. The Committee will review, challenge and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy, and provide assurance to the Board in that respect. In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, other Board Committees and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. **Internal Audit** The Committee shall ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by: • Considering the provision of the Internal Audit service and the costs involved. • Reviewing and approving the strategic and annual Internal Audit plan,

ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.

- Considering the major findings of Internal Audit work (and management's responses), and ensuring coordination between the Internal and External Auditors to optimise the Trust's use of audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.
- Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the External Auditors' independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to, their work. This will be achieved by:

- Considering the appointment and performance of the External Auditors, as far as the rules governing the appointment permit (and make recommendations to the Board of Directors when appropriate).
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the External Audit annual plan.
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside of the annual External Audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear and appropriate policy for the engagement of External Auditors to supply non-audit services.

Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors - for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions - for example, Royal Colleges, accreditation bodies, etc.

The Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's areas of responsibility.

The Committee will have oversight of and receive assurances in relation to compliance with Trust policies.

Counter fraud
The Committee shall satisfy itself that the Trust has adequate arrangements in place for the prevention and detection of fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas. The Committee shall refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Agency.

The Committee shall receive and consider reports arising from quality inspections by the NHSCFA.

Management
The Committee shall request and review reports, evidence and assurances from Board Committees and Academies, directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the Trust.

Financial reporting and control
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance. The Committee will ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

- The Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- The quality of financial reports
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Explanations for significant variances
- Unadjusted misstatements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of management representation

As regards Standing Orders and Standing Financial Instructions, the Committee shall:

- Seek assurance regarding the Trust's compliance with Standing Orders and Standing Financial Instructions.
- Consider any proposed changes to Standing Orders and Standing Financial

<table>
<tr><td></td><td>Instructions and, as appropriate, make recommendations to the Board.

The Committee shall review schedules of losses and special payments, and review single source tenders.

The Committee shall receive, consider and derive assurance from reports relating to the Trust Charitable Funds Committee with regard to governance, risk management, control, audit and financial reporting.

<s>Whistleblowing / Freedom to Speak Up</s>
<s>The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial control and reporting, clinical quality, or patient or staff safety or other matters and ensure that any such concerns are investigated proportionately and independently.</s></td></tr>
<tr><td>Chairing arrangements</td><td>The Chair of the Committee (‘the Chair’) shall be appointed by the Board of Directors from amongst its independent Non-Executive Directors. The Chair must have recent and relevant financial experience.</td></tr>
<tr><td>Membership</td><td>
<table>
<tr><th>Title</th><th>Role</th></tr>
<tr><td>Non-Executive Director</td><td>Chair
To ensure the Committee functions properly, that there is full participation during meetings, that all relevant matters are discussed and that effective decisions are made and carried out.</td></tr>
<tr><td><s>Non-Executive Director</s></td><td><s>Deputy Chair.
To provide independent oversight and challenge</s></td></tr>
<tr><td>Non-Executive Director X2</td><td>To provide independent oversight and challenge</td></tr>
<tr><td colspan="2">Attendees</td></tr>
<tr><td>Director of Finance</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan</td></tr>
<tr><td>Associate Director of Corporate Governance/Board Secretary</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan

To support the Chair of the Committee in ensuring that the Committee functions properly</td></tr>
<tr><td>Accountable</td><td>To discuss annually with the Committee the process for assurance that supports the Annual Governance Statement. He</td></tr>
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<tr><td>Officer</td><td>or she shall also attend when the Committee considers the draft Annual Governance Statement and~~,~~ the Annual Report and Accounts</td></tr>
<tr><td>Representative(s) from Internal audit</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan</td></tr>
<tr><td>Representative(s) from external audit</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan</td></tr>
<tr><td>Assigned Local Counter Fraud Specialist</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan. The assigned Local Counter Fraud Specialist will attend a minimum of two Committee meetings a year.</td></tr>
<tr><td>Other Executive Directors/Directors</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan as required by the Committee</td></tr>
</table>

The Head of Internal Audit and lead representative of External Audit shall have a right of direct access to the Chair of the Committee.

The Chairperson of the Trust shall not be a member of the Committee.</td></tr>
<tr><td>Secretary</td><td>Secretarial support will be provided by the Corporate Governance Team.</td></tr>
<tr><td>Quorum</td><td>A quorum shall consist of two of the ~~four~~ three Independent members.

Members should attend at least 75% of meetings within any calendar year. Attendance will be monitored and addressed by the Chair.

Should any member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.

The Committee may ask any of those who are in attendance but who are not members to withdraw to enable a full and frank discussion of particular matters.

Where the Committee is not quorate, the meeting should be rearranged within 2 weeks.</td></tr>
<tr><td>Frequency of</td><td>The Committee will meet at least five times per annum and shall agree a schedule of meetings at least 12 months in advance. The Committee will</td></tr>
</table>

meetings	consider and keep under consideration the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Board of Directors, Accountable Officer, External Auditors or Head of Internal Audit may request of the Committee Chair an additional meeting if they consider that one is necessary. At least once a year the Committee shall meet privately with the external and with the internal auditors. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to the functioning of such a meeting. These meetings will be deemed as standard meetings of the Committee and shall be documented accordingly.
Circulation of papers	The Associate Director of Corporate Governance/Board Secretary will hold an agenda setting meeting with the Chair and/or the Deputy Chair at least 3 weeks before the meeting date. The agenda will be based around the Committee's work plan, matters arising and requests from the Board of Directors or other Board Academies and Committees to consider specific issues. Following approval, the agenda and timetable for papers will be circulated to all Committee members. Agenda items along with accompanying papers to be submitted to the Committee secretary one week prior to meeting dates. The agenda and papers for meetings will be distributed five working days in advance of the meeting. The minutes, highlight report and action log will be circulated to members within seven working days of the meeting to check the accuracy. Members must forward amendments to the Committee secretary within the next seven days.
Reporting	The Committee Chair shall report formally, regularly and on a timely basis to the Board of Directors on the Committee's activities by: • Reporting to the Trust Board on those matters covered by these terms of reference through a regular written report ~~Providing a written update report (including detailed commentary on the assurance received and risks identified in relation to the key controls identified within the Board Assurance Framework)~~ following each meeting, and the presentation of an annual report for each of its operational duties. • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board of Directors. The Chairperson of the Committee shall draw to the attention of the Board of Directors

	any issues that require disclosure to the full Board of Directors, or require executive action. • Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee. • Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives. Reporting to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on: • The fitness for purpose of the assurance framework • The completeness and 'embeddedness' of risk management in the Trust • The integration of governance arrangements • The appropriateness of the evidence that shows the Trust is fulfilling all relevant regulatory requirements and obligations • The robustness of the processes behind production of the Quality Accounts. This Audit Committee Annual Report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered and how they were addressed. If, through the course of Committee business an issue is raised which needs immediate escalation, or action taken, which is outside of the remit of the Committee this should be escalated to the appropriate Executive meeting, via the Chair, for discussion and action. The Committee shall undertake an annual self-assessment. It will report thereon to the Board of Directors. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board of Directors.
Date agreed by the Audit Committee:	~~12 September 2023~~21 May 2024
Date approved by the Trust Board:	~~21 September 2023~~11 July 2024
Review date:	~~September 2024~~July 2025

FINANCE AND PERFORMANCE ACADEMY WORK PLAN 2024-25

Item	Lead	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jul-24	Jul-24	Sep-24	Oct-24	Nov-24	Jan-25	Feb-25	Mar-25	Notes	Relevant Strategic Commitments
Finance and Performance Academy Dashboard	DoF/COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Monthly Finance Report	DoF	x	x	x	x	x	x	x	x	x	x	x	x	x		
Bradford Place and ICS System Financial Update	DoF	x			x			x			x	x			To include key updates on work programmes (by way of exception).	
Capital Update	DoF	x			x			x		x		x				
Capital Programme	DoF		x										x			
Contract Update	DoF				x					x						
Treasury Management Update	DoF					x					x					
Procurement Update	DoF			x					x					x		
Pathology Joint Venture - Financial Position	DoF					x					x					
Budgetary Management Framework	DoF					x										
Budget Setting Process and Timetable	DoF	x	x							x		x	x			
Financial Plan / NHSE Operational Plan Submission	DoF / COO	x										x				Pat6a
Internal Audit - Audit Plan	DoF		x										x			
High Level Risks	DoF/COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary		x		x		x			x			x		NB updates in August and December to be circulated via e-mail	
Operational Highlight Report	COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Performance Report	COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
F&P Academy Terms of Reference Review & Effectiveness Review	Board Secretary								x							
F&P Academy Annual Report	Board Secretary				x											
F&P Academy Work Plan	DoF/COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Closing The Gap Update	DoS&T	x	x	x	x	x	x	x	x	x	x	x	x	x		
Operational Improvement Plan	COO	x	x	x	x	x	x	x	x	x	x	x	x	x	Urgent & Emergency Care, RTT, Cancer & Diagnostic Performance (one per month in this order)	Pat4a, Pat4b, Pat6a, Pat 6b, Pat6c
Service Development Post Implementation Reviews	DoF					x					x					
CIP Methodology	DoF														Date TBC	
Winter Planning	COO									x						
Winter Review	COO														Date TBC	
Act As One Programme Update	Act As One Programme Director	x		x			x			x		x		x	Quarterly	Pat6b, Pl1b
EPRR Update	COO	x		x			x								Date TBC	
EPRR Submission	COO									x					Date TBC	
Health Inequalities & Waiting List Analysis	COO/CDIO		x	x				x					x			
Internal Audit Reports relevant to the Academy (for information only)	Chair	x	x	x	x	x	x	x	x	x	x	x	x	x	Standing item - as an annex for information only, except for limited assurance reports which will be for discussion	
Cancer Board minutes (for information only)	COO			x	x	x	x	x	x	x	x	x	x	x		
Environmental Sustainability	Director of Strategy and Transformation															
Estates & Facilities Service Report	Dir Estates & Facilities				x Q3&4			x Q1&2								Pl4a, Pl4b

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

PEOPLE ACADEMY WORK PLAN 2024-25

Item	Lead	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Jan-25	Feb-25	Mar-25	Notes	Relevant Strategic Commitments
Act as One Programme Updates - People Perspective	Act as One Programme Directors														Quarterly - dates TBC	Pe3f
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary		x		x		x			x			x		NB updates in August and December to be circulated via e-mail	
Board Assurance Framework for Nurse Staffing	Chief Nurse			x					x					x		
Bradford District & Craven People Committee Updates	Director of HR	x	x	x	x	x		x		x		x		x	Bi-monthly	Pe3f, Pe4b
Education Annual Report	Chief Medical Officer				x											Pe4b, Pe4c,Pe4d, Pe4e
Equality Delivery System 2- workforce elements	Director of HR		x													
Equality Update (WRES/WDES)	Director of HR					x									Annual report, date subject to change pending availability of data	Pe2a, Pe2b, Pe2c, Pe2d
FTSU Quarterly Report	Chief Nurse		x			xAR		x		x			x			Pe1b
Gender Pay Gap	Director of HR			x										x		Pe2a
Guardian of Safe Working Hours / Quarterly / Annual Report	Chief Medical Officer		x		xQ4	xAR		x		x			x			Pe1c
Healthcare Worker Flu Vaccination Best Practice Assurance	Director of HR										x					
High Level Operational Risks	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x		
Industrial Action	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x	Standing item - verbal	
Internal Audit Reports relevant to the Academy (information only unless there are exceptions to report)	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x		
Looking After Our People	Director of HR		x												Looking after our people now subsumed within civility - report no longer required	Pe1a, Pe1c, Pe1d
Medical Appraisal and Revalidation Annual Report	Chief Medical Officer						x									Pe1c
NHS EDI Improvement Plan	Director of HR														Frequency/timing TBC	
NHS Long Term Workforce Plan	Director of HR														Frequency/timing TBC	
NHS Staff Survey Action Plan Updates	Director of HR				x		x			x						Pe2a, Pe2b
NHS Staff Survey Results & Action Plan	Director of HR		x	x									x		Debbie Jackson & Julie Snellgrove to present	Pe2a, Pe2b
Nursing & Midwifery Staffing Establishment Review	Chief Nurse				x	x	x			x						Pat1c, Pe3g, Pe4a, Pe4b
Nursing and Midwifery Staffing Data Publication Report	Chief Nurse	x	x	x	x	x	x	x	x	x	x	x	x	x		
Nursing Recruitment and Retention Plan	Chief Nurse		x						x				x			Pat1c, Pe3f, Pe3g, Pe4a, Pe4b, Pe4e
Organisational Culture	Director of HR			x					x					x		
Outstanding Pharmacy Services	Director of S&I			x			x				x			x	3x per year	
People Academy Annual Effectiveness Review	Director of HR	x		x	x				x							
People Academy Annual Report to Board	Director of HR				x											
People Academy Dashboard	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x		Pe2a
People Academy Work Plan	Director of HR / Academy Chair	x	x	x	x	x	x	x	x	x	x	x	x	x		
People Plan/Strategy workplan	Director of HR				x		x			x						Pat1c, Pe1a, Pe2a, Pe2b, Pe3d, Pe3f, Pe3g, Pe4b, Pe4c
Report / Minutes from Health & Safety Committee	Director of Estates & Facilities	x		x		x		x		x		x		x	Bi-monthly	
Review of GMC Survey Feedback	Chief Medical Officer/Director of Education								x							
Review of National Education & Training Survey (NETS) Feedback	Chief Medical Officer				x											Pe4c
Review of People Academy ToRs	Director of HR	x		x	x				x							
Staff Story	Director of HR	x		x		x		x		x		x		x	Jan - Outstanding Theatre Services	Pe1c
Violence Prevention & Reduction Standard	Director of Estates & Facilities	x						x				x			2024 - January and July (inc Annual Security Report)	
Workforce Civility Update	Director of HR	x		x	x		x		x			x		x	Quarterly	Pat2a, Pe1b
Workforce Growth and Transformation	Associate Chief Nurse – Quality & Workforce	x		x		x		x		x		x		x	Bi-monthly - Jan/Mar/May/Jul/Oct	Pat1c, Pe3d, Pe3e, Pe3f, Pe3g, Pe4a, Pe4b, Pe4c, Pe4d, Pe4e
Workforce Planning Submission	Director of HR	x	x									x				Pe3f, Pe4a, Pe4b
Workforce Report	Director of HR	x			x			x			x	x			Quarterly	Pe2a

Action from Board: Plan for reduction of the sickness absence target to be brought to People Academy for oversight and for consideration as to how to influence to achieve this. People Academy to confirm when the first report required and reporting frequency.

Key:
Planned item
Planned item deferred to future meeting

Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

QUALITY ACADEMY - 2024-25 ASSURANCE WORK PLAN

Item	Lead	28/02/2024	24/04/2024	26/06/2024	04/09/2024	23/10/2024	18/12/2024	26/02/2025	Notes	Relevant Strategic Commitments
Infection Prevention and Control BAF	CN								*IPC BAF included as appendix to IPC quarterly reports*	Pat1a
Quality & Patient Safety Academy Dashboard	CN/CMO	x	x	x	x	x	x	x		
Quality Oversight & Assurance Profile	CMO	x	x	x	x	x	x	x		
Serious Incidents Report	CMO	x	x	x	x	x	x	x		
CLIP Report (Complaints, Litigation, Incidents, Patient Experience)	CMO	x Q3		x Q3 & Q4 AR	x Q1		x Q2	x Q3	Quarterly Report, Q4 is annual report	
High Level Risks	CN/CMO	x	x	x	x	x	x	x	As Assuring Academy	
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary	x	x	x	x	x	x	x		
Maternity and Neonatal Services Update	CN	x	x	x	x	x	x	x		
Safeguarding Adults	CN			x			x		Annual report in June & 6 monthly update in Dec (Dec report to include external feedback on annual report). June report to include update on Right Care, Right Person.	
Safeguarding Children	CN			x			x		Annual report in June & 6 monthly update in Dec (Dec report to include external feedback on annual report)	
Digital Report	CDIO		x		x		x		Three reports per year April report to include plan re: SHMI/depth of coding	Pat5a, Pat5b, Pat5c, Pl2a, Pl2b, Pl3a
Digital & Data Transformation Committee (highlight report / minutes)	CDIO		x		x		x			Pat5a, Pat5b, Pat5c, Pe3e, Pl2a, Pl2b, Pl3a
SIRO Report	CDIO								Date TBC	Pat5a, Pat5b, Pat5c
Bradford District & Craven Quality Committee (highlight report / minutes)	CN/CMO	x	x	x	x	x	x	x		
~~Estates & Facilities Service Report~~	~~Dir Estates & Facilities~~		~~x Q3&4~~			~~x Q1&2~~				~~Pl4a, Pl4b~~
15 Steps Assurance Programme	CMO	x		x		x		x	Quarterly	
PLACE Annual Report	CN			x					2024 results reported within the PLACE annual report so not required at the June meeting. Move to May 2025	Pat2b, Pat2c
Quality Academy Work Plan	Chair	x	x	x	x	x	x	x		
Quality Academy Annual Report	Chair		x							
Internal Audit Reports relevant to the Academy (information only unless there are exceptions to report)	Chair	x	x	x	x	x	x	x		
Moving to Outstanding Quarterly Update TBC	CN								TBC	
Freedom to Speak Up Quarterly Update (information only)	CN	x		x	x	x		x		
Nursing and Midwifery Staffing Data Publication Report (information only)	CN	x	x	x		x		x		
Update on Ward Accreditation	CN		x							
Equality Delivery System	Head of Equality	x								

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

QUALITY ACADEMY - 2024-25 LEARNING/IMPROVEMENT WORK PLAN

Item	Lead	Jan-24	Mar-24	May-24	Jul-24	Sep-24	Nov-24	Jan-25	Mar-25	Notes	Relevant Strategic Commitments
Improvement Strategy	CMO/CN						x			Annual	Pat3a
Palliative Care Annual Report	CN	x						x			
Quality Account	CMO/CN		x	x		x	x		x	Quarterly progress updates Annual Quality Account for sign off in May	
Review of Quality Academy ToRs / Effectiveness Review	Chair					x					
High Level Risks	CN/CMO	x	x	x	x	x	x	x	x	As Assuring Academy	
Infection Prevention and Contol	CN	x		x	x		x	x		Quarterly Report IPC BAF to be included as an appendix	Pat1a
Research activity in the Trust - Update (Month/Year) - This paper then to be submitted to Board of Directors	CMO		x		x		x		x		Pat3c, Pl3a, Pl3b, Pl3c
Patient Safety Group	CMO	x	x	x	x	x	x	x	x		
Clinical Outcomes Group	CMO	x	x	x	x	x	x	x	x		
Patient Experience Group	CN (Joanne Hilton)	x	x	x	x	x	x	x	x		Pat2a, Pat2b, Pat2c
Patient Experience - 6 monthly report	CN	x		x			x			May - Annual report	Pat2a, Pat2b, Pat2c
Serious Incidents Report (focus on learning)	CMO	x	x	x	x	x	x	x	x		
Inpatient Survey	CN						x			Annual	Pat2b, Pat2c
Children & Young People's Patient Experience Survey	CN							x		Every 2 years - date TBC	Pat2b, Pat 2c
Urgent & Emergency Care Survey	CN							x		Every 2 years - date TBC	Pat2b, Pat2c
National Patient Safety Improvement Programme Update	CMO	x			x			x		Bi-annual	
Learning from Deaths	CMO	x		x		x		x		3 times per year co-ordinated with Mortality review	
Maternity and Neonatal Services Update	CN	x	x	x	x	x	x	x	x		
Clinical Audit High Priority Plan	CMO			x							
Clinical Audit Annual Report	CMO			x	x						
Bradford Nursing and Midwifery Professional Practice Model	CN		x		x		x		x		Pat 1a, Pat 1b, Pat3c
Quality Improvement Programme update	CMO	x		x		x		x			
Mortality Review Improvement Programme	CMO	x		x		x		x		Co-ordinated with Learning from Deaths	
LD Improvement Standards	CN									Dates TBC	
Mental Health Strategy	CN		x	x		x			x		
Outstanding Theatres Programme	CMO	x								Programme ends Jan 2024	Pat1b, Pat3b
GIRFT Update	CMO			x							Pat3b
Update on Health Inequalities	Dir Strategy & Integration			x			x				
WY system quality group meeting update	CN		x			x			x	Bi-annual	
WY system quality group meeting minutes	CN				x	x	x	x	x		
Patient Safety Incident Response Framework	CMO	x	x	x	x	x	x	x	x		
Outstanding Pharmacy Programme (quality impacts)	TBC									Date TBC	
Nursing and Midwifery Staffing Data Publication Report (information only)	CN	x	x	x	x	x	x	x	x		

Key:
Planned item
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Item discussed at the meeting

Source	Purpose	Assurance / Approval / Information	Lead	16 April 2024	21 May 2024	20 June 2024 accounts sign off	10 September 2024	19 November 2024	11 February 2025
INTEGRATED GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL				**April**	**May**	**June**	**September**	**November**	**February**
Annual Governance Statement	To decide if : • The AGS contains all of the elements required by relevant guidance • The AGS contains no inconsistencies between the statements made and the reports that the Committee has received from auditors or other sources of assurance • Any and all significant control issues and gaps in control or assurance recorded in the AGS are consistent with the reports that the Committee has received • The AGS gives a balanced view of the Trust's governance arrangements throughout the year • The AGS is appropriately consistent with the Annual Head of Internal Audit opinion	For approval	Chief Executive		**X (Draft)**	**X(Approve)**			
Trust's Annual Self - Certification as to the compliance with the conditions of the NHS Provider Licence, guidance on Good Governance and Collaboration and Code of Governance for NHS Provider Trusts	To decide if the Trust is justified in its self-certification as to the compliance with the conditions of the NHS provider licence, guidance on good governance and collaboration and code of governance. To decide if the Trust has effective and reliable policies, procedures and controls in place to ensure compliance with its Licence Conditions, including all relevant regulatory, legal and code of conduct requirements and any related reporting requirements	For assurance	Associate Director of Corporate Governance/Board Secretary	**X**					
INTERNAL AUDIT				**April**	**May**	**June**	**September**	**November**	**February**
Annual Internal Audit Performance Review	To form a judgement regarding the effectiveness and efficiency of the Trust's Internal Audit service and its compliance with Public Sector Internal Audit Standards	For assurance	Director of Finance / Internal Audit / Audit Committee				**X**		
Annual Internal Audit Plan	To decide if the Annual Internal Audit Plan is appropriately derived from a complete and risk-profiled audit universe, and that the purpose, scope and limitation of scope of individual planned audit reviews is appropriate.	For approval	Internal Audit	**X**					
Annual Internal Audit Report 2022/23		For approval	Internal Audit				**X**		
Annual Internal Audit Charter	The Internal Audit Charter establishes the Internal Audit activity's position within the organisation; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of Internal Audit activities. Approval of the Internal Audit Charter resides with the Member Organisation Audit Committees and is reviewed at least annually.	For approval	Internal Audit				**X**		
Internal Audit Progress Reports	To receive Internal Audit Reports, assess progress by reference to the Internal Audit Annual Plan, and derive assurance from Internal Audit findings and recommendations	For assurance	Internal Audit	**X**	**X**		**X**	**X**	**X**
Internal Audit follow-up reports	To decide if the response from management has been effective and timely with regard to greed Internal Audit findings and recommendations	For assurance	Internal Audit	**X**	**X**		**X**	**X**	**X**
Annual Head of Internal Audit Opinion	To decide if the Annual Head of Internal Audit Opinion covers all key Internal Audit activities during the year and is consistent with detailed audit reports issued during or in respect of the year.	For assurance	Internal Audit		**X**	**X**			
Private meeting(s) with Internal Audit	To decide if: • Internal Audit has the necessary resources to provide the assurance required by the Committee • Internal Audit has received all necessary cooperation from Trust management and staff • Internal Audit was not restricted in the execution of its duties • any key issues and/or disagreements with management were satisfactorily resolved and/or brought to the attention of the Committee	For assurance	Internal Audit / Audit Committee						**X**
EXTERNAL AUDIT				**April**	**May**	**June**	**September**	**November**	**February**
Annual External Audit performance review	To form a judgement on the External Auditors' independence, objectivity and effectiveness in executing their duties	For assurance	Director of Finance/Audit Committee/External Audit				**X**		
External Audit annual plan 2022/23	To consider and, if appropriate, approve the External Audit annual plan, paying particular attention to identified key audit risks and planning materiality	For approval	External Auditor						**X**
External Audit Sector Development Report	To note and, as appropriate, make decisions in respect of the report.	For information	External Auditor	**X**	**X**		**X**	**X**	**X**
ISA 260 – Foundation Trust	To consider, discuss and form a judgement with regard tothe External Auditors' ISA260 report	For assurance	External Auditor		**X**	**X**			
ISA 260 – Charitable Funds	To consider, discuss and form a judgement with regard to the External Auditors' ISA260 report regarding the Charitable Fund	For assurance	External Auditor					**X**	
Use of External Audit to provide non-audit services	To decide on the suitability of and compliance with the Trust's policy regarding non-audit services provided by the Trust's External Auditors	For approval	Director of Finance / External Auditor	**X**	**X**		**X**	**X**	**X**
Annual policy review - use of external audit for non audit purposes	Policy review	For approval	Director of Finance / External Auditor					**X**	
Private meeting(s) with External Audit	To decide if: • External Audit has the necessary resources to provide the assurance required by the Committee • External Audit has received all necessary cooperation from Trust management and staff • External Audit was not restricted in the execution of its duties • any key issues and/or disagreements with management were satisfactorily resolved, and/or brought to the attention of the Committee	For assurance	External Auditor / Audit Committee		**X**				
OTHER BOARD COMMITTEES				**April**	**May**	**June**	**September**	**November**	**February**
Annual Report: Charitable Funds Committee	The Committee shall receive, consider and derive assurance from an annual report relating to the Trust Charitable Funds Committee with regard to governance, risk management, control, audit and financial reporting.	For assurance	Charitable Funds Committee Chair		**X**				

Annual Report: Finance and Performance Academy	The Committee shall receive, consider and derive assurance from an annual report relating to the Academy role to seek assurance, learn and drive improvement in relation to all aspects of finance and performance within the Trust.	For assurance	F&P Academy Chair		X				
Annual Report: Quality and Patient Safety Academy	The Committee shall receive, consider and derive assurance from an annual report relating to the Academy role to seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards.	For assurance	Q&PS Academy Chair		X				
Annual Report: People Academy	The Committee shall receive, consider and derive assurance from an annual report relating to the Academy role to seek assurance, learn and drive improvement in relation to the people management arrangements within the Trust.	For assurance	People Academy Chair		X				
OTHER ASSURANCE FUNCTIONS				**April**	**May**	**June**	**September**	**November**	**February**
Assurance regarding compliance with Risk Management Strategy	To provide assurance as to the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy,	For assurance	Associate Director of Corporate Governance/Board Secretary / Associate Director of Quality				X		X
Partnership Arrangements: Implications for the Audit Committee	To decide if there are any considerations needed to be made by the Audit Committee with regard to the Trusts Partnership Arrangements.	For information	Associate Director of Corproate Governance / Board Secretary	X	X		X	X	X
Annual report - Conflict of interest (declare)	To receive assurance as to compliance with the Trust's Managing Conflicts of Interest Policy	For assurance	Associate Director of Corproate Governance / Board Secretary				X		
Review of External Regulatory Visits register	Where there are potential implications for the governance of the Trust, the AC should receive any final reports following receipt and review by the Executive Management Team (ETM) with any recommendations to the AC.	For assurance	Associate Director of Quality / Associate Director of Corporate Governance/Board Secretary	X	X		X	X	X
Monitoring compliance with regard to the 'Policy for the Development and Management of Trust Policies' and, compliance with Trust Policies	To seek assurance on comliance with the Policy for the development and management of trust policies and compliance with Trust Policies	For assurance	Associate Director of Corporate Governance/Board Secretary					X	
COUNTER FRAUD				**April**	**May**	**June**	**September**	**November**	**February**
Policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA	To form a judgement as to the appropriateness, effectiveness and reliability of the Trust's Counter Fraud, Bribery and Corruption policies and procedures	For assurance	Local Counter Fraud Service		X				
Counter Fraud Annual Plan	To review and, if appropriate, approve the Counter Fraud Annual Plan	For approval	Local Counter Fraud Service		X				
Counter Fraud Self Review Tool	To receive the outcome of the assessment against the Self Review Tool	For assurance	Local Counter Fraud Service		x				
Counter Fraud Updates (progress report)	To consider and form a judgement with regard to from Counter Fraud Updates	For assurance	Local Counter Fraud Service	X	X		X	X	X
Counter Fraud Annual Report	To review and, if appropriate, approve the Counter Fraud Annual Report	For assurance	Local Counter Fraud Service		X				
FINANCIAL REPORTING AND CONTROL				**April**	**May**	**June**	**September**	**November**	**February**
Annual Report and Financial Statements	To review the Annual Report and Financial Statements, paying particular attention to: • key audit risks • compliance with relevant requirements • going concern assessment • changes in accounting standards • changes in accounting policies • changes in accounting practice • changes in estimation techniques • significant judgements made in preparing the financial statements • significant adjustments resulting for the audit • any unadjusted misstatements in the financial statements • explanation for significant variances by comparison with management accounts • letter(s) of representation and, as and when appropriate, to recommend approval to the Board	For assurance	Director of Finance / External Auditor		X	X			
Trust compliance with Standing Orders / Standing Financial Instructions/Scheme of Delegation	To form a judgement with regard to on-going compliance with Standing Orders, Standing Financial Instructions and Scheme of Delegation	For assurance	Director of Finance	X	X		X	X	X
Proposed changes to Standing Orders / Standing Financial Instructions/Scheme of Delegation	To review and, if appropriate, approve changes to SOs/SFIs	For approval	Associate Director of Corporate Governance/Board Secretary / Director of Finance	X	X		X	X	X
Suspension of Standing Orders / Standing Financial Instructions	To review the reasons for, and implications of, suspension of SOs/SFIs	For assurance	Associate Director of Corporate Governance/Board Secretary / Director of Finance	X	X		X	X	X
Exception reports - Schedules of losses and special payments	To note and, as appropriate, question the exception reports regarding losses and special payments	For assurance	Director of Finance	X			X	X	X
Appropriateness of single source tenders	To decide if the Committee is sufficiently assured that all single source tenders/waivers since the last Committee meeting have been executed fully in compliance with regulations	For assurance	Strategic Head of Procurement	X			X	X	X
Charitable Funds Annual Report and Accounts	To review the Annual Report and Accounts, paying particular attention to: • key audit risks • compliance with relevant requirements • going concern assessment • changes in accounting standards • changes in accounting policies • changes in accounting practice • changes in estimation techniques • significant judgements made in preparing the accounts • significant adjustments resulting for the audit • any unadjusted misstatements in the accounts • explanation for significant variances by comparison with management accounts • letter(s) of representation and, as and when appropriate, to recommend approval to the Board	For assurance	Director of Finance					X	
REPORTING				**April**	**May**	**June**	**September**	**November**	**February**
Audit Committee Annual Report to Board	To provide an annual summary of the activities of the Committee, the key matters arising and the assurance obtained	For approval	Chair of Audit Committee	X	X				
MONITORING AND REVIEW				**April**	**May**	**June**	**September**	**November**	**February**

Annual Audit Committee Annual Self-Assessment	To assess the Committee's processes and its effectiveness and to identify and implement possible improvements	For assurance	Chair of Audit Committee	**X**	**X**				
Annual review of terms of reference and submission to Board	To review the Committee's terms of reference and, in the light of events and of the results of the Annual Self-Assessment, identify and recommend to Board any appropriate enhancements	For assurance	Chair of Audit Committee	**X**	**X**				
Audit Committee Work Plan	To develop, consider and approve the Audit Committee Annual Workplan	For approval	Chair of Audit Committee		**X**	**X**		**X**	**X**

BO.7.24.20 - ANY OTHER BUSINESS

BO.7.24.21 - ISSUES TO REFER TO BOARD COMMITTEES OR ELSEWHERE

BO.7.24.22 - REVIEW OF MEETING

BO.7.24.23 - DATE AND TIME OF NEXT MEETING

BO.7.24.24 - BOARD WORK PLAN

REFERENCES

Only PDFs are attached

Bo.7.24.24 - Board Open Work Plan 2024-25 - v8.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		x		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				x	
Freedom to Speak Up Annual Report	Chief Nurse					x					
Nursing & Midwifery Staffing Establishment Review	Chief Nurse			x		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	x				
Self Certification of Provider Licence	Chief People & Purpose Officer			x							Closed Board
NED Independence Test	Chief People & Purpose Officer			x							Closed Board
Compliance with NHS Code of Governance	Chief People & Purpose Officer			x							Closed Board
Well Led Review & Board Self Assessment	Chief People & Purpose Officer										Date TBC
Annual Report from Academies	Academy Chairs			x	x						
Annual Report from Audit Committee	Chair of Audit Committee			x	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	x				
Violence Prevention & Reduction Standard	Director of Estates & Facilities		x				x			x	Sept - part of Annual Security Report
Membership Plan	Chief People & Purpose Officer										Reported through COG only
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	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 *(see notes)	Director of Finance	x	x	x		x	x	x	x	x	Chair requested document needs to go to alternate closed board
Performance Report *(see notes)	Chief Operating Officer	x	x	x		x	x	x	x	x	Chair requested document needs to go to alternate closed board
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	x	x		
ITEMS FOR INFORMATION ONLY											
Confirmed Charitable Funds Committee minutes	Chair	x	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.7.24.25 - CONFIRMED ACADEMY MINUTES

REFERENCES

Only PDFs are attached

- Bo.7.24.25 - Confirmed Minutes FP Academy 24 April 2024.pdf
- Bo.7.24.25 - Confirmed Minutes FP Academy 22 May 2024.pdf
- Bo.7.24.25 - Confirmed People Academy minutes 24 April 2024.pdf
- Bo.7.24.25 - Confirmed People Academy minutes 22nd May2024.pdf
- Bo.7.24.25 - Confirmed QPS Academy.Minutes 24 April 2024.pdf
- Bo.7.24.25 - Confirmed QPS Academy - Minutes 22 May 2024.pdf

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	24 April 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) - Louise Bryant, Non-Executive Director (LB) - Chris Danson, Director of Transformation (CD) - Sarah Freeman, Deputy Chief Nurse (SF) - Joanne Hilton, Director of Nursing/Deputy Chief Nurse (JH) - 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) - Michael Quinlan, Deputy Director of Finance (MQ) - Terri Saunderson, Director of Operations (TS) - Neil Scott, Head of Business Intelligence (NS) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - Rachel Waddington, Deputy Director of Operations Planned Care (RW) - Karen Walker Non-Executive Director (KW)		
In Attendance:	- Laura Parsons, Board Secretary/Associate Director of Corporate Governance (LP) - Katie Shepherd, Corporate Governance Manager (KS) - Leah Pollard, Service Improvement Lead (LPo) for agenda item FA.4.24.11		
Observing			

No.		**Action**
FA.4.24.1	**Apologies for Absence**	
	The following apologies were noted: - Mohammed Hussain, Non-Executive Director (MHu)	
FA.4.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.4.24.3	**Unconfirmed Minutes of the Meeting held 27 March 2024**	
	The minutes of the meeting held on the 27 March 2024 were approved as an accurate record.	
FA.4.24.4	**Matters Arising**	
	JL advised that today will be KW and LB's last attendance at the F&P Academy as members as they will be moving to another Academy from May. JL thanked both KW and LB for their contributions to the Academy. The Academy reviewed the action log and the following actions were closed: - FA230037: **Finance & Performance Academy Effectiveness Review:** LP would review all responses and bring a more detailed update on	

No.		Action
	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. Item covered under the Assurance section of the agenda. Action closed. - FA24007: **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 has shared details via email on 3/4/24. Action closed: - FA24007: **Operational Improvement Plan – RTT:** 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. 24/04/24: SA advised this will be picked up through the Access to Care workstream of the Act as One Programme. Action closed. - FA24008: **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. Agenda item on April F&P Meeting & Dedicated Board Development Session on 18.4.24. Action closed.	
	Assurance	
FA.4.24.5	**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 advised that a refresh of the dashboard has been undertaken to align it to data which are reflective of the metrics. This will continue to be refined as the strategic objectives are refreshed but the new format does flow much better.	
FA.4.24.6	**Finance & Performance Academy Work Plan**	
	LP confirmed that no changes had been made to the workplan since it was previously presented to the Academy.	

No.		Action
FA.4.24.7	**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 15 April 2024 in relation to high level risks. JL noted that one new risk has been added to the register in relation to delayed discharges into social care which has been discussed in detail at previous meetings. One risk has been closed in relation to incorrect/missing information on EPR. SA advised that a lot of work has been undertaken on the Prevent, Correct and Clear model which supported clearance of the backlog that was a result of data quality issues. A team is in place which is helping maintain data quality to reduce further errors but there is still some further work to do therefore Paul Rice, Chief Digital and Data Officer will be opening a new risk to cover all aspects of data quality including EPR optimisation, coding and counting changes. No risks have changed in score since the last report. The Academy was assured by the update.	
FA.4.24.8	**Board Assurance Framework – Strategic Risks Relevant to the Academy**	
	LP advised that the terms of refence (ToR), workplans and agendas for the Board and Academy Meetings are currently undergoing a review to streamline them to ensure the right items are being presented to the right academies. Academies will be aligned to the Trust Strategy including the four P's: People, Patients, Partners and Place. The Board Assurance Framework is also undergoing a review with support from an external consultant to ensure that also aligns to the four P's. LP is working with the Trust Chair to formulate a plan to agree the approval process of the reviews with Academy Chairs and Lead Executives following which it will likely be presented at a Board Development session in June. This will be followed by approval from the Academies and final sign off at a Board meeting, most likely to be in July. MH drew attention to the finance risk which is included in the BAF and advised that the rating which was 16 for the previous financial year will be changed to 20 or 25 for the current financial year. This will also impact the rating of the Capital risk which will also be updated. The Academy noted the update.	

FA.4.24.9	**F&P Academy Annual Report – Proposed Changes to ToRs and Workplans**	
	JL presented the item and explained that the Board of Directors reviews the performance of its Committees and Academies annually to determine if they have been effective, and whether further development work is required. One of the key elements of this review is the annual report provided by the Committees and Academies. The draft Finance and Performance Academy annual report is attached at Appendix 1. The period reported on is from April 2023 to March 2024. JL advised that the Academy annual report will be presented to the Audit Committee on 21 May 2024 as part of the suite of assurances supporting the Annual Governance Statement. The Academy approved the report.	
	Learning & Improvement	
FA.4.24.10	**Finance Improvement Plan**	
	This item was covered as part of the Finance section of the agenda later in the meeting.	
FA.4.24.11	**Operational Improvement Plan – Cancer & Diagnostic Performance**	
	SA introduced the item and explained that the presentation provides an update on the operational improvement plan in relation to cancer and diagnostic performance. SA invited EM to provide an overview of the presentation. EM talked through the presentation circulated to colleagues and highlighted the following key points: - Cancer 2 Week Wait: there was a deterioration to the standard due to the Christmas period and as a result of the industrial action but this has now improved and the standard now remains static. - Cancer 28 Day Faster Diagnosis Standard: this standard has improved slightly over the last three months. - Cancer 31 Day General Treatment: this standard has plateaued but work is underway to improve this. - Cancer 62 Day First Treatment: this standard continues to improve following the work that has taken place to clear the backlog. The backlog position was 40 against the required 42 for the end of the year and although there is a slight spike at the moment the team understand the reason for this and are working on reducing this. - DMO1 Position: the position continues to improve and further improvement is expected due to the opening of the Community Diagnostic Centre (CDC) and Echo recovery plan. - EM reported that the new Cancer IT System was installed during March 2024 and will be delivered via a phased roll out throughout the current year. The new system is a real enabler which provides better oversight of patients, understand where blockers are within pathways and reduces the need to use spreadsheets to track patients. The system	

	has a digital remote monitoring system which will support clinical teams to implement personalised follow up pathways which means that patients will not need to come back for follow-up appointments unnecessarily but will be able to contact their clinical teams and come back for help if needed. - There are currently a number of Pathway Navigator and Cancer Co-Ordinator roles in place on a fixed term basis but this is not across all tumour sites. The Cancer Alliance funding for 2024/25 will have a strong focus on expansion of these roles. The current risk is that patients may not receive CNS support at the time they are given a cancer diagnosis due to insufficient numbers of CNSs to meet patient demand and compounding multiple clinic location issues. A review has been undertaken by the Lead Cancer Nurse with a view to developing a business case to address this capacity gap. - A new weekly One Stop Clinic for palpable neck lumps has been implemented. Revised referral forms to ensure correct patients are referred to the clinics is currently with Primary Care for approval prior to go-live. - The monthly Cancer Board has been re-established from April with appropriate clinical engagement and a cancer timeout session is scheduled to take place in June 2024 to develop a shared clinical vision for the Trust's Cancer Strategy. - Digital Histopathology went live on 3 April and this provides the ability to report from digital slides anywhere at any time and enables improved information sharing with rapid access to second opinion and expert review. The next step is to validate the consultants to enable them to report from the digital slides. - The CDC was officially opened on 27 February but the majority of services actually went live from September 2023 onwards. Activity up to the end of March 2024 has included: Radiology modalities 4789 at Place, 4593 BTHFT activity, Endoscopy, Cystoscopy, Hysteroscopy & Colposcopy 3447 at Place, 2277 BTHFT activity and Cardio-respiratory tests 501 BTHFT activity. - EM talked through the waiting list for non-obstetric ultrasound (NOUS) and the challenges over recent years. The CDC now provides additional NOUS capacity 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. - EM handed over to Leah Pollard, Service Improvement Lead (LPo) to talk through the HISTO Programme. LPo provided a brief overview of the HISTO Programme as detailed within the presentation. LPo explained Histopathology is a highly specialised department which has seen an increase in demand that does not meet current capacity. A structured improvement programme has been put in place to provide clarity, governance and accountability to help improve Turnaround Time (TAT). The scope of the three workstreams People, Place and Process has now been agreed based on team and patient feedback. LPo talked through the current TAT data and reported that the Trust is significantly lower than the national target of 80% for 7 day (the Trust is mid 20%-30%) and 90% for 10 day (the Trust is 35%). In order to improve this priority actions are being taken such as ensuring validation of cases and reviewing the outsourcing to ensure earlier allocation of work.	

	There are other areas of improvement which will take longer to implement such as recruitment into key roles. LPo talked through the challenges and explained that the next month will focus on validation of fast track requests, outsourcing allocation, escalation to consultants for reporting and a review of capacity and demand to help identify the Laboratory staff workforce development. JL expressed her concern at the performance data in relation to Histopathology TAT and asked what the target is to improve the TAT and by when. SA explained that the aim is to meet the national target and in order to achieve this there is a lot of work that needs to be undertaken to improve the data. EM explained that recruitment is underway but there is a national shortage of Histopathologists which adds to the challenge. EM could not provide a definitive answer in relation to timescales but provided assurance that the challenge is being addressed as best as possible. CSm asked whether the issue is a recent one or something that was of concern previously. EM explained that as vacancies have arisen due to staff leaving the situation has worsened and the increase in the number of fast track referrals has compounded this further. The service needs to be modernised and the Trust is behind others in recruiting to the relevant roles to help meet demand. KW asked what we can do to attract people to the roles and create a campaign that drives a longer term pipeline. EM referred to digital pathology processes that could be implemented which would be an attractive proposition for trainees. She also recognised the challenges with the current estate which can be off-putting to prospective registrars. LB queried the impact of the histopathology challenges in relation to patient safety incidents, complaints and delays in diagnoses. SA confirmed that operational colleagues maintain a close watch on pathways and the length of times that patients are waiting, and whilst the metrics within the report indicate the general health of the service and currently indicate compliance, there are still improvements to be made and therefore the implementation of the HISTO improvement programme. The Academy was assured by the update.	
	Performance	
FA.4.24.12	**Operational Highlight Report**	
	SA introduced the item and invited CSt to present the report. CSt highlighted the following key points: - With regards to inpatients, the plan is very stretched in accordance with full recovery and despite not meeting plan last year, there has been an increase of 5% in previous years. This was not surprising given challenges such as the industrial action. Part of the exploration with services was to identify if it was possible to return to pre-covid activity given changes in case mix. - In relation to outpatient services, there has been some success and there is a lot of work ongoing to improve further such as the Go Further, Faster programme. The plan for this year remains stretched with	

	significant improvement needed. - Long wait RTT performance remains strong, with the one challenging area being trauma and orthopaedics which remains the area of focus. The Trust is comparatively strong against other organisations. Efforts remain to have zero 65 week waits by end-August 2024. - Cancer performance had been covered under previous agenda items but CSt noted the significant improvements made and performance is now tracking back towards upper quartile. - There are ongoing challenges with ambulance handover data and colleagues continue to work with YAS to increase data accuracy to reflect the true position. - A&E metrics remain strong and the biggest urgent and emergency care challenge within the hospital is flow, with bed occupancy rates high and delays to discharge to intermediate care. This has now been added to the risk register and discussions with local authority partners are underway to identify solutions. - Work remains ongoing to improve stroke performance and this is happening within expected pace. JL congratulated colleagues for their efforts, particularly within A&E and the improvements made to A&E performance which makes a big difference to the population. SA highlighted the significant reduction on Medinet insourcing which is now almost non-existent, the usage of which has previously resulted in large amounts of expenditure. From a financial perspective, this was welcomed. He referred back to CSt's comments on the challenges faced by trauma and orthopaedics in reducing their waiting list and whilst this still does require improvement, all other specialities have reduced the wait list as expected which was promising. KW commented on the clear improvements that can be seen throughout the A&E department, whilst recognising the evident overcrowding in the ambulance handover areas. She referred to PIFU and whether there was any data available on the patients that don't initiate follow up. CSt advised that PIFU is not just used to discharge patients at the end of a specified time frame, it is used as a means for patients to flag if they need to be reviewed sooner than planned. There wasn't any data available to share as yet as this is a new initiative. TS referred to a survey undertaken last year at St Luke's Hospital and upon talking to patients in the waiting area found that some patients enjoy the experience of attending the hospital. For the younger population, they welcomed the introduction of PIFU as it was much more convenient. This demonstrates the work still required to engage areas of the population. JL recognised the importance of continuing to consider the needs of patients who may not benefit from a PIFU pathway. The Academy was assured by the update.	
FA.4.24.13	**Performance Report**	
	The performance report was noted.	

	Finance	
FA.4.24.14	**Monthly Finance Report**	
	CSm presented the report and highlighted the following: - The report is very basic with limited detail available as the finance team have been focused on other areas and have not had the opportunity to populate the report. - The year end position has not yet been audited but is positive from an income and expenditure perspective in that the Trust has exceeded a plan with a posted surplus of £4.6m (subject to audit). Whilst the original plan was a breakeven position, the Integrated Care Board (ICB) had recently provided £4.4m of non-recurrent monies on the condition that it would result in a surplus position. The focus was now on delivery of the plan for 2024/25. - CSm noted that 2023/24 plan had been delivered with over £20m of non-recurrent flexibility. JL noted her thanks to all finance colleagues for their hard work in completing the accounts and ensuring delivery of a surplus to plan position in 2023/24. MH highlighted to the Academy that in terms of staff survey results, BTHFT finance department is the most improved in the country in the National Staff Survey this year. This was a massive achievement and MH was very proud of the efforts of all colleagues within the team for their dedication and embracing of the improvement works undertaken. He advised that they have been asked to showcase as a best practice team as a result of this. JL congratulated the team and commented that the team would continue to thrive as a result of the embedded improvement works. The Academy was assured by the update.	
FA.4.24.15	**Bradford Place and ICS System Financial Update**	
	MH shared a brief presentational update and reported that the headline position is that the system gap across the ICS is £140m, and the vast majority of this is across acute providers, with all acute Trusts in a very challenged position (with the exception of Leeds). BTHFT had originally reported a deficit gap of £26.3m, which had now reduced to £22.6m, and this equates to approximately 3.9% of our turnover. Other organisations were similarly challenged. Bradford Place continues to be an outlier across the ICS with a gap of around £64m, and there has been a peer place review scheduled for 26 April for colleagues across the place to meet with West Yorkshire senior leads to share how this gap is being addressed. MH highlighted that this would be the first such review meeting and therefore there was limited understanding as to how this would be approached although it was hoped it would be a supportive process. JL commented that it would be helpful to hear from Simon Worthington at Leeds at the peer place review to see if there is any learning that we can	

	undertake as an organisation to improve our financial plan, whilst recognising that a plan was no indication of delivery. MH confirmed that he believed the plan for the Trust to be plausible and credible based on realistic assumptions and expected productivity improvements. He noted the possibility of external intervention and increased external scrutiny if there is no demonstrable continued improvement. MH also explained that an implication of being a deficit Trust is that NHS England have applied a range of actions they expect to see to address financial position, split into 'rapid actions' and 'governance actions'. MH had populated the list of actions and identified those that he believed were being taken. He had shared this with executive colleagues at the weekly executive team meeting and would share this back to the Academy once complete which would demonstrate some of the actions being taken. He highlighted the need for a rigorous impact assessment process to ensure provision of services is not destabilised. There may also be a need to consider unpalatable options. The Academy noted the update.	**Director of Finance** (FA24010)
FA.4.24.16	**Capital Update**	
	MQ presented the report and highlighted the following: - West Yorkshire Integrated Care System (WY ICS) and the Trust are planning to report that it has spent its capital allocation in line with agreed overall fundings allocations during 2023/24. To deliver the capital allocated by WY ICS the Trust had to invest £8.6m more on internal funded schemes (operational) to mitigate the risk reporting a material underspend against overall budget. This has meant that £8.6m of external funded schemes will need to be completed in future periods using operational budget. In order to fund this the Trust will need to re-prioritise its operational capital programme in 2024/25 and 2025/26. - The Trust is planning to spend £134.7m over the next five years which includes the endoscopy transformation programme, address the estates and facilities rolling backlog and critical infrastructure risk, outstanding maternity services, replacement of medical equipment at St Luke's Day Case Unit. - Slippage and commitments from 2023/24 need to be confirmed (approx. £11m) and may impact on the 2024/25 capital budget. - Total WY ICS allocation for capital £134.7m is £28.6m more than the Trusts internal capital CDEL allocation. To deliver the indicative capital programme the Trust will need to use its own cash headroom which will have a significant impact on cash for the next five years. - MQ highlighted a number of assumptions have been made to project the cash impact for the next five financial years including: o The Trust will report a deficit position in 2024/25 of £26.6m (this includes delivering a challenging £26.1m waste reduction programme) and a break-even position from 2025/26. The papers are based on the original deficit and not the recently revised £22.6m o The Trust plans to allocate £40.7m towards capital investment in 2024/25 and £23.5m each year from 2025/26. Total allocation of capital agreed by WY ICS (£106.1m) is £28.6m more than the	

	total Internal and External CDEL (£134.7m). Therefore, the Trust is forecast a decline in cash of approx. £6.1m per annum over the next five financial years. - Opening cash at the end of the last financial year was £64.2m and we are expecting to report a reduction to £10.9m in this financial year. From March 2026 onwards, it is anticipated a continued reduction of cash. This could potentially cause liquidity issues from March 2026 onwards. The Trust could decide to reduce capital investment but first there needs to be an understanding on the ICB capital allocation for future years. MH provided some further context, noting that the assumptions of capital allocations from the ICB are unlikely to continue and there will be a need to realign back to internally generated cash. He also referred to the emergency board meeting planned for 26 April and the need to consider all factors at play, one being the cash position for the organisation. This would limit ability to invest in anything else in 2025/26 other than the maternity programme (which is already committed to) and the normal replacement process. However, it is believed that there may be a national pot of monies available for maternity investment which would make a big difference to the cash position if allocated to the Trust. JL recognised the need for some strategic discussions on the limited cash position and the wider impact on services. The Academy was assured by the update.	
FA.4.24.17	**Contract Update**	
	MH presented the report and highlighted the following: - There have been a number of changes to the NHS standard contract, none of which suggest a material risk to the organisation, and the consultation has been responded to. - There were several areas of challenge, particularly within the diagnostic centre, and in relation to the issuing of electronic FIT notes. However, there was no areas of significance to escalate at this stage. The Academy was assured by the update and noted the changes to the contract.	
FA.4.24.18	**Operational and Financial Plan Update**	
	SA and MH presented the operational and financial plan and made the following key points: - This had been brought to the Academy following the Board decision to delegate authority to the Academy to approve the final plan. - CSt highlighted there was one area where it is not likely we will achieve the ask contained within the planning guidance and that is diagnostics achievement of 95% however a complaint plan was submitted for the ICS. - There have been no changes to the financial plan since presented at the Board meeting and the Academy was asked to ratify the Board's	

	decision to proceed with the £22.6m deficit submission. Given that there were no material changes to the plan that was shared with the Board previously, the Finance and Performance Academy ratified the decision to submit the operational and financial plan for 2024/25 with a deficit of £22.3m.	
FA.4.24.19	**Any Other Business**	
	JL noted that this was CDs last meeting before he leaves to undertake a secondment at another organisation. She thanked CD for the work he has completed for the Academy and hoped to see him back in the organisation following the end of his secondment.	
FA.4.24.20	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.4.24.21	**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**	
	22 May 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 24 April 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FA24010	24/04/24	**FA.4.24.15**	**Bradford Place and ICS System Financial Update:** MH explained that an implication of being a deficit Trust is that NHS England have applied a range of actions they expect to see to address financial position, split into 'rapid actions' and 'governance actions'. MH will share these with the Academy.	Director of Finance	22/05/24	Verbal update to be provided at the May meeting
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	
FA24011						

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	22 May 2024	**Time:**	08:30-10.30
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director (JL)
Present:	- Zafir Ali, Non-Executive Director (ZA) - Sarah Freeman, Deputy Chief Nurse (SF) - Joanne Hilton, Director of Nursing/Deputy Chief Nurse (JH) - Mark Hindmarsh, Director of Strategy & Transformation (MHi) - Matthew Horner, Director of Finance (MH) from 9am - Matthew Howson, Head of Service & Business Development (MHow) - Ellie MacIver, Deputy Director of Operations for Cancer and Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations – Unplanned Care (SM) - Michael Quinlan, Deputy Director of Finance (MQ) - Terri Saunderson, Director of Operations (TS) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - Rachel Waddington, Deputy Director of Operations Planned Care (RW)		
In Attendance:	- Jacqui Maurice, Head of Corporate Governance (JM) - Laura Parsons, Board Secretary/Associate Director of Corporate Governance (LP)		
Observing:			

No.		**Action**
FA.5.24.1	**Apologies for Absence**	
	The following apologies were noted: - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - John Bolton, Deputy Chief Medical Officer & Medical Director - Ops (JB) Absent: - Sughra Nazir Non-Executive Director (SN) - Neil Scott, Head of Business Intelligence (NS)	
FA.5.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.5.24.3	**Unconfirmed Minutes of the Meeting held 24 April 2024**	
	The minutes of the meeting held on the 24 April 2024 were approved as an accurate record.	
FA.5.24.4	**Matters Arising**	
	The Academy reviewed the action log and the following actions were updated: - FA24010: **Bradford Place and ICS System Financial Update:** MH explained that an implication of being a deficit Trust is that NHS England (NHSE) have applied a range of actions they expect to see to address financial position, split into 'rapid actions' and 'governance actions'. MH will share these with the Academy. 22/05/24: MH explained this is still	

No.		Action
	evolving and will be shared once available, action timescale changed to 26 June.	
	Assurance	
FA.5.24.5	**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. TS and MH confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting. JL commented that the refreshed dashboard now aligns to data that is reflective of the metrics and flows much better. The dashboard will continue to be refined as the strategic objectives are refreshed.	
FA.5.24.6	**Finance & Performance Academy Work Plan**	
	LP confirmed that no changes had been made to the workplan since it was previously presented to the Academy. LP advised that the Academy Terms of Reference and Workplan are due to be reviewed and an update will be presented at next month's meeting for approval. MHi referred to the Closing the Gap item on the workplan and the frequency of reporting. JL suggested that the item is reported monthly and this will be agreed as part of the workplan review for approval.	
FA.5.24.7	**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 13 May 2024 in relation to high level risks. JL noted that no new risks have been added to the register, no risks have been closed and no risks have changed in score since the last report. The Academy was assured by the update.	
	Learning & Improvement	
FA.5.24.8	**Closing the Gap**	
	MHi presented the item and explained that the Trust is required to find savings in 2024/25 of £38.9m. This is a challenging target and exceeds any waste reduction or cost improvement target achieved at the Trust previously. The Closing the Gap (CTG) programme, with MHi as the lead executive director, has been charged with leading this work. MHi	

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	emphasised that some difficult decisions will need to be made in order to achieve the savings but the focus will be on working with teams to generate ideas and empower and support staff to deliver efficiencies. The proposed approach detailed in the paper aims to build on existing governance processes and embeds a new Trust-wide focus on reducing costs and improving efficiency, whilst maintaining quality and performance. The Academy supported the vision and ethos of delivering the programme. MHi talked through the governance structure as detailed within the paper and explained the aim of the CTG Board, the list of workstreams and the proposed reporting cycle. MHi advised that the financial challenge is not just being applied to Clinical Service Units (CSUs) but will also apply to corporate departments who will also have a financial challenge to address. MHi explained the engagement that has taken place to date with CSUs in the form of letters explaining the challenge and the ask as well as face to face meetings to go through the detail and address any concerns and issues at this point. ZA referred to the suite of finance papers with references to the Efficiency Programme, Waste Reduction Programme and the newly formed CTG Programme and asked if these have been correlated. CSm explained that there is one overall efficiency target and the various programmes referred to are in a transitional phase. The Waste Reduction Programme was developed last year to align it to other partner organisations within West Yorkshire but the Trust has now moved away from that and the focus is on one overall efficiency target and CTG is the means by which the financial challenge will be addressed. ZA made reference to the governance of the CTG programme and felt that although governance is good we need to ensure it is lean and the programme is not over governed with too many hurdles in place for people. ZA felt it was imperative that actions are completed therefore it was important to monitor the process to ensure it was effective and lean. MHi explained that although it may seem like there are a lot of meetings in place it was important to get the balance right in order to provide the right level of executive support for the CSUs. A judgement was therefore made based on how colleagues across other WYAAT organisations are running similar programmes alongside the cycle aligning to reports being generated to support the delivery of the programme. It was also important to note that the Trust is likely to be scrutinised on the internal processes that have been put in place to deliver the efficiency target. ZA asked how risks such as the impact on staff morale will be managed particularly with high workloads, managing backlogs and the impact Covid has left alongside the financial challenge. MHi referred to the vision statement which highlights the importance of maintaining quality and performance through the risk assessment and equality impact assessment process. The process and governance that has been suggested will provide support to colleagues and help manage such risks. MH also emphasised the importance of the impact assessment process which will be taken for any potential decisions to reduce costs but CSUs have had a very clear message in terms of the scale of the challenge that is faced which will inevitably result in some very difficult decisions all of which will	

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	be made in an informed and balanced way once all the necessary risks and impact assessments have been undertaken. MH talked about the expected external scrutiny and explained that a piece of work has been commissioned across WYAAT to look at a number of areas including organisational and cultural readiness to deliver a program of this scale. This is to determine that the Trust has taken a proportionate response in trying to deliver the challenge. The second key area is to ensure that the right performance, management, reporting, forecasting and governance arrangements are in place. The final element of the work is to look at cross cutting opportunities across all WYAAT organisations and whether there is any best practice that can be shared. MH shared his nervousness in relation to the capacity and capability of teams to switch their minds to delivering such a large-scale programme at a quick pace as the challenge is huge but he felt confident that the structure and governance that has been set up is the right approach and will support teams and deliver what is required. CSm was in agreement with the ethos of the programme and supporting the CSUs to design their own solutions but said it was important to note that at Month 1 the Trust was already £700k behind plan therefore some decisions will need to be taken soon in relation to financial controls to bridge the gap. All decisions will be subject to impact assessments. CSt reflected on the strength in the holistic approach taken with CSUs across various programmes and was complimentary of the way the Trust has undertaken the planning process for this year which has demonstrated connectivity between quality objectives, workforce goals, the financial position and performance targets. JL asked if the Comms teams has been involved in relation to the messaging and communication across the Trust. MHi said this was in the process of being finalised as there are a number of ideas on how to engage and communicate with staff. MHi advised that the first CTG Programme Board is expected to take place in June and a report will be presented to the Academy the following month. The Academy approved the recommendations detailed within the report.	
FA.5.24.9	**Operational Improvement Plan – Urgent & Emergency Care**	
	JL welcomed SM to present the update on the operational improvement plan in relation to urgent and emergency care performance. SM referred colleagues to the presentation and took this is as read but wished to highlight that the plans detailed within the presentation were developed at an away day session in September 2023 and although there was awareness at the time of the potential financial challenges the Trust was facing the significance of how large these challenges are was realised in March this year.	

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	SM referred to the workstreams detailed within the presentation and noted that some of the transformational and proactive management schemes are dependent on full realisation of business cases and investment. SM has recently been working closely with the teams to see what can be done differently in the event that a business case for specific plans cannot be approved due to the need to reduce spend. SM wished to share some positive news and referred colleagues to the benchmarking data and graphs on the final couple of slides which demonstrates the strong performance position of the Trust against peers. Trusts have been mandated with achieving a performance of 78% on the Emergency Care Standard (ECS) which is the top-level figure that Trusts will be measured against in the current financial year. SM was pleased to report that the Trust is already at 83% therefore there is already a built-in tolerance which will be valuable as it is predicted that a dip in ECS performance is expected due to the challenges that the local authority faces in relation to health and social care in the next two years. SM felt assured that the current performance alongside doing what we can in terms of the transformational and proactive management work the Trust will achieve the 78% ECS performance for the current year. SM referred to the RAG rating against the various schemes and explained this is the first time this is being presented in this format for the 2023-25 improvement plan therefore many are currently either Amber or Red rated as they are currently in the early stages. SM reported that he is working closely with Yorkshire Ambulance Service (YAS) to look at ambulance turnaround times and a key piece of work has been started to map the whole process from ambulance arrival to departing. The Trust is taking the lead on this work on behalf of WYAAT which will mean that we will lead on some of the improvement work ahead of other Trusts. JL was pleased to note the ECS performance of 83% particularly with the challenges that the local authority faces for intermediate care and the impact this is having on the ECS standard. MHi was happy to support some of the transformational work if this was required and also keen to speak to SM and CSt in relation to length of stay and share good practice from another Trust he has previously supported in relation to this. TS referred to the challenges faced by partners in the Place and how this may impact the Trust's financial position as the impact is based on all Trusts achieving 78% ECS performance. CSm agreed this does present a challenge and if the Trust is judged as part of the Place then the overall performance of the Trust will be impacted but the priority for the Trust currently should be to focus on the internal financial challenge and deliver the waste reduction target as best as possible. The Academy was assured by the update.	
	Finance	

No.		Action
FA.5.24.10	**Monthly Finance Report**	
	CSm presented the report and highlighted the following: - The plan is currently at a deficit of £14m with a £39m waste reduction target. The plan is more benignly spread during the earlier months of the year to provide the opportunity to get the efficiency programme off the ground but this becomes more challenging as the year progresses. - The planned deficit for Month 1 was £2.3m and the Trust has actually delivered a deficit of £3m therefore this is already behind plan by £700k. There are no non recurrent measures available to deploy against the deficit to achieve a break-even position. - CSm referred to a slight discrepancy in the efficiency programme summary section of the report that was originally submitted which showed a year-to-date target of more than £2m but it was actually an efficiency target of £1.4m therefore the efficiency programme is £800k behind that plan at Month 1 which explains the overall £700k shortfall. - The planned monthly deficit becomes increasingly challenging as the year progresses. The improvement from Month 8 onward reflects the proposed phasing of the additional £5m stretch efficiency target. - CSm explained that in a scenario where the Month 1 Income & Expenditure (I&E) position was to be repeated for the remainder of the financial year, the year-end deficit would be £35.9m, which would be £21.9m below plan. The CTG programme and increased focus and governance around cost control is intended to mitigate and prevent this scenario. This highlights the need to embed the CTG programme as quickly as possible and consider putting some additional financial controls in place in the coming weeks such as vacancy freezes, controls on temporary staffing and discretionary non pay spend. The Academy was assured by the update.	
FA.5.24.11a	**Treasury Management Update**	
	MQ presented the report and explained that the purpose of the paper is to describe the impact of the I&E position, the deficit, the waste reduction target and the impact of capital on the cash position. MQ stressed the importance of holding sufficient cash in the bank to be able to deliver operations and pay bills and salaries. The paper highlights whether there is sufficient cash in the bank this financial year in order to deliver operations and the capital programme as well as looking ahead over the next five years in terms of cash and liquidity. MQ highlighted the following: - Since 2019/20 the Trust reported a significant increase in its closing cash balance reaching the peak of £81.1m in 2021/22 which is a healthy picture. However, since 2021/22 the Trust has been reporting a reduction in cash balances with a planned closing cash position of £18.5m in 2024/25. Between 2019/20 and 2023/24 the Trust has invested over £154.6m in capital which is a substantial investment. MQ asked the Academy to note that since the presentation was prepared the figure has improved slightly to a cash balance of £23.5m due to a stretched waste reduction target of £5m this financial year. - MQ talked through the 2024/25 cash plan as detailed within the slides.	

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	The Trust is reporting an opening cash position of £64.2m with the Trust planning to report a reduction of £45.7m during 2024/25 with a closing cash position of £23.5m. - In terms of the capital position MQ explained capital expenditure is in line with the West Yorkshire ICS allocation of £40.7m which is funded by £19.9m depreciation and £17.2m PDC. There is £19.0m movement in capital payables to pay for 2023/24 accrued capital expenditure and a loan repayment of £3.1m for both New Hospitals Wing and EPR and £1.4m payment for existing leases. - Looking forward at the five-year cash plan MQ reported that the Cash could breach its treasury policy by the end of 2028/29. The 2024/25 forecast cash (£23.5m) is £5.0m higher than plan due to an improved I&E forecast. The forecast assumes a breakeven I&E position from 2025/26 and the Trust spends its capital allocation in line with WY ICS capital budget allocation. The five-year cash flow assumes that the Trust will deliver the 2024/25 waste reduction programme of £38.9m and report a deficit of £14.4m. From 2025/26 it has been assumed that the Trust will deliver a breakeven I&E position. The main reason for the recurrent reduction in cash from 2025/26 onwards is that the ICS has currently allocated £5.4m more CDEL to the Trust than cash generated from its operations. It was important to note that future West Yorkshire ICS allocations are indicative. Should the Trust not deliver the 2024/25 waste reduction programme then the worst case scenario highlights that cash could breach the treasury policy by the end of March 2025. The worst case also assumes a break-even I&E position from 2025/26. Should the Trust require external cash support then the Department of Health and NHSE will consider what other financial or non-financial interventions are required. - MQ referred to Appendix 1 of the slides which describes the debt recovery process and assured the Academy that the Trust is recovering debt in line with expectations. Debtor days is an indication of how quickly the Trust is turning debt into cash. The average debtor days for the Trust has increased from 17 days in 2022/23 to 19 days in 2023/24 and this increase is partly due to accrued funding in April and May relating to the back dated pay award for 2022/23. The average aged debt has fallen from £6.8m in 2022/23 to £5.5m in 2023/24. MQ also explained the better payment practice code and the Trusts position in relation to this. If the Trust requires any revenue support through the year then NHSE will look at both these metrics as indications of cash flow problems therefore it was important to keep them in line with NHSE expectations. JL thanked MQ for the detailed presentation and asked whether it was worth considering having a more regular update from six monthly to quarterly to the Academy on the cash position due to the current financial challenge. This will be discussed and agreed at the Academy review meeting the following day. The Academy was assured by the update.	
FA.5.24.11b	**Treasury Management Policy**	

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	MQ presented the item and explained that the purpose of the paper is to set the target for the minimum level of cash that needs to be held in the Trust bank account. Currently that is the equivalent to eleven days of operational expenses which is approximately £56m. The policy also includes guidance on how surplus cash is invested i.e. with approved counter parties, the national loan fund or held with the bank. An updated version of the Treasury Management policy is included for approval. The policy has been reviewed in line with the 2024/25 financial plan and there are three changes to the document. The first change is to include a 13 week cash flow section in the F&P Academy paper which will pinpoint any cash flow issues that will need to be discussed and highlighted and whether revenue support cash to support operations. The updates also include changes to the position on foreign exchange management and a slight increase to deposit limits for approved counter parties from £10m to £12m should there be surplus cash and the main reason for that increase is to maximise interest received for the Trust. The Academy approved the changes to the policy.	
FA.5.24.12	**Pathology Joint Venture – Financial Position**	
	MH asked the Academy to note that the report highlights the financial position for Integration Pathology Solutions (IPS) & Integrated Laboratory Solutions (ILS), the two companies that form the Pathology Joint Venture (JV) for the year ending 31 March 24. The two limited liability partnerships now have a turnover £33m in total which is a significant amount of money. The three partners are Bradford, Airedale and Harrogate Trusts. MH was pleased to report the position at the end of the financial year of £0.5m profit which will be distributed evenly across the three partners. The JV has set a plan of another £0.5m profit for 2024/25 which is going to be a challenge in the current financial climate but a good stretch target. MH explained that the JV has been running for a number of years and the JV Board is now in a position to start to look at some of the process improvement work for a few areas where issues have arisen recently such as histopathology and neonatology where representatives have come along to the JV Board and issues may get escalated to the Quality and Safety Academy. In order to receive further reassurance the Managing Director of the JV will attend the Board meeting periodically to articulate from his perspective the operational and financial position as well as to provide the clinical input. This will enable the Board to be fully sighted on the issues that are faced by the JV. MH referred to some misunderstanding over the last twelve months in relation to the contractual relationship with the JV which has resulted in a number of frustrations but there are issues that do need to be addressed between specific services and the output from the JV in terms of the turnaround times of the laboratory. EM said it was helpful to receive the financial report in respect of the JV but asked if a performance report could also be provided in the future which includes the detail in relation to turnaround times in order to have clear oversight. EM referred to the vacancies that are currently being held by the	

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	JV which has an impact on performance. MH agreed that this would be useful and explained that the Medical Directors report that is presented to the JV Board which meets three or four times a year and does include performance reporting. MH said it was important to determine whether this is the right Academy to present the performance of the JV. It was agreed that the next report will include the performance aspect of the JV. To be presented to the F&P Academy initially and if it felt appropriate it would be transferred to another Academy. The Academy noted the update.	**Director of Finance FA24011**
FA.5.24.13	**2024/25 Budget Setting Process**	
	MH introduced the item and explained that the paper will be discussed by the Executive Management Team (ETM) for an in-depth discussion of the recommendations in May 2024. MH invited CSm to present the report. CSm highlighted the following: - The paper describes the allocation of internal expenditure budgets and efficiency targets for 2024/25 to the Trust's CSUs and other operational and corporate departments. The process translates the overall annual financial plan into operational budgetary envelopes which each department is required to deliver for their services in 2024/25. The proposed budget allocations, inclusive of efficiency targets have been shared with the CSUs and form the basis of Month 1 reporting. - CSm explained that the high level annual financial plan submitted to NHSE is derived from an extrapolation of 2023/24 outturn income and expenditure run rates. This extrapolation is then adjusted for non-recurrent items in the baseline period, the full year effects of developments and pressures, inflation, planned investments and known new cost pressures in 2024/25. These adjustments are informed by a combination of national guidance, local intelligence, Executive Team or Board decisions and information provided by the CSUs and their Finance leads in the bottom up budget setting process. - As the basis for the annual plan is extrapolated run rates from the previous financial year, it necessarily diverges from the internal CSU budgets that were set for 2023/24. Many departments underspent or overspent substantially against their budget allocations in 2023/24 and delivered minimal recurrent savings against their efficiency targets. Rolling forward existing budgets unamended would result in CSU budget plans that were materially misaligned with both the overall annual plan and their own income and expenditure run rates. A structured and transparent process must therefore be carried out each year to realign internal budgets to the overall financial plan while maintaining the link with historic allocations and expenditure patterns. - CSm explained that the paper and its appendices set out the process in detail for each CSU and ETM will be requested to approve the internal budgets for 2024/25 on this basis. - A number of options are highlighted within the paper for the ETM to consider in relation to: o The funding of specific pressures flagged by CSUs in their budget setting proposals. o Renewal of funding for approved business cases that have not yet	

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	commenced to incur costs. o The allocation of non-recurrent budgets for in/outsourcing to CSUs. o The treatment of unplanned non-recurrent income received in 2024/25. o The allocation of negative vacancy factor pay budgets to CSUs. o The treatment of ongoing pay overspends within some CSUs. o The allocation of efficiency targets to CSUs. JL thanked CSm for explaining the detailed process which was helpful to understand. It was clear to see that there is a real financial challenge for the Trust to address. The Academy noted the content of the report and the actions to be discussed by the Executive Management Team.	
FA.5.24.14	**Service Development Post Implementation Reviews**	
	MH presented the report and explained that this review is an evolving process and thanked MHow and his team for collating the information which provides a really good report as it demonstrates that a good mechanism is now in place to track the benefits, some of which are exceeding what was detailed in the business case. MH reported that of the 15 Post Implementation Reviews (PIR) undertaken 11 have been returned with all benefits realised, 1 has been returned with benefits partially realised. 0 have been returned where none of the benefits have been realised and 3 PIRs have been deferred to allow more time for the case to be fully implemented, benefits to be measured or for the PIR information to be collated and the template completed. MH referred to the procurement PIR whereby £300k was invested for what would appear to be a £2.8m return which will be an absolute cost reduction but also a cost avoidance exercise and an 800% return. JL asked if such benefits are being captured as sometimes it was important to invest to save. MH confirmed that CSUs would be expected to include this information on their trackers. The Academy noted the update.	
	Performance	
FA.5.24.15	**Operational Highlight Report**	
	CSt presented the report and explained that the format of the report has been updated and although it follows the same headline KPIs it also includes sub metrics aligned to the framework and the planning guidance for the current financial year. CSt explained that some changes continue to be made to bring the metrics in line with the changing financial position. CSt highlighted the following key points: - The number of ambulances arriving daily at the Trust continues to remain high and ambulance handovers continue to be recorded on the YAS Ambulance Mobile Device Terminal (AMDT) only. Whilst this has	

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	reduced duplication for YAS colleagues, there are still discrepancies with data accuracy and significant internal validation remains in place with a c.49% discrepancy in handover clock stops. - Emergency Care Standard (ECS) performance for Type 1, 2 & 3 attendances was 83.48% for April 2024 and is currently forecast at 82.65% for May 2024. The position is in the upper decile of Acute Trusts in England. Adult bed occupancy is high at 96.11% in April 2024 with high acuity and issues within the social care sector continuing to impact the timely discharge of patients. Although this figure is high it was important to note that this is lower than neighbouring trusts. Work is ongoing to make further improvements. - Inpatient activity reduced slightly and delivered below plan in April 2024 and is projected to increase but remain below plan in May 2024. Outpatient activity delivered above plan in April 2024 and is expected to remain in line with plan in May 2024. The work on reviewing Outpatient and Theatre sessions against job plan capacity, activity run rates and waiting list profiles is near completion and identified improvement opportunities. The Day Case Unit (DCU) at St. Lukes Hospital (SLH) will support an increase in sessions and an uplift in session productivity with the ability to run high volume low complexity lists. - Outpatient and elective transformation schemes are being brought together within the umbrella of GIRFT further faster. This is a clinically led approach to understand opportunities presented by variation in data compared to peers. Each CSU will be supported to interpret the available data and then implement and track associated improvement. - In terms of RTT there has been a growth in the waiting list which is putting pressure on the long wait position. There is a particular pressure within Trauma and Orthopaedics and some intense work is underway with the CSU to help stabilise and recover the position in order to achieve recovery towards a zero 65-week position by September. However, it should be acknowledged that this is a risk as a Trust and there is the chance that there may be some patients at 65 weeks going into September. 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. - CSt talked through the overall plans and explained the work underway in relation to further, faster, health inequalities, continuing to work with networks to reduce DNA rates and optimising both pathways and systems. Data quality work to ensure clean data has now started on non RTT following the success of the RTT PTL. - In terms of diagnostics the improvement that was seen in the previous month has continued but there are some emerging challenges with MRI and endoscopy. The MRI challenge relates to downtime with the equipment which always creates an immense challenge. However, once the scanner is back online the service does recover quickly. For endoscopy the challenge is due to capacity due to staff leave and patient availability but CSt was hopeful that this position will recover during May with the CDC capacity. - The cancer position remains positive and the 28-day faster diagnosis standard (FDS) performance was above target at 85.23% in March and is expected to improve further in April. Weekly oversight and targeted improvements have helped maintain delivery at a high level. There has been significant focus on fast-track diagnostic turnaround times and a	

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	HISTO programme has been launched to improve histopathology processes. 31-day general treatment is forecast to improve in May following a dip during holidays. Treatment numbers have reduced slightly which has added to the 62-day backlog so improvements into June will support the overall position. The number of patients waiting over 62 days reduced in March 2024 but is now increasing. There is no single cause for this with tumour groups experiencing increased complexity, reduced treatment, diagnostic delays and patient-initiated delays. A Cancer 'Time-Out' is taking place in June to develop a shared clinical vision for the Trust's Cancer Strategy. JL asked what is causing the challenges within Trauma and Orthopaedics. CSt explained that the overall operating lists for the Trust for a lot of services is lower than it was previously in terms of the number of lists that are run. This is being reviewed to understand why it is the case but some of this relates to allocation and the acute or trauma commitment. Also the number of patients being admitted onto the waiting list is the same as that in 2018/19 but the amount of operating hours required has increased by about 30% which impacts the capacity of the lists. The reason for the increase of the operating time required is being reviewed i.e. is it due to a change in equipment or a change in process. RW added that work is underway with the CSU to support them longer term and all opportunities will be explored to help improve the position. The Academy was assured by the update.	
FA.5.24.16	**Performance Report**	
	The performance report was noted. CSt proposed that going forward the Operational Highlight Report is provided with a cover sheet with no need to provide the Performance Report as the dashboard is now more strengthened and includes additional narrative. JL agreed to discuss this at the Academy Review meeting the following day but did feel that this was a good proposal as it reduces duplicate reports.	
FA.5.24.17	**Any Other Business**	
	There were no further items of business to discuss.	
FA.5.24.18	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.5.24.19	**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.1.24.20	**Date and Time of the Next Meeting**	
	26 June 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 22 May 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FA24010	24/04/24	**FA.4.24.15**	**Bradford Place and ICS System Financial Update:** MH explained that an implication of being a deficit Trust is that NHS England have applied a range of actions they expect to see to address financial position, split into 'rapid actions' and 'governance actions'. MH will share these with the Academy.	Director of Finance	26/06/24	Verbal update to be provided at the May meeting. 22/05/24: MH explained this is still evolving and will be shared once available.
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	
FA24011	22/05/24	**FA.5.24.12**	**Pathology Joint Venture – Financial Position:** The next report to include the performance aspect of the JV. To be presented to the F&P Academy initially and if it felt appropriate it would be transferred to another Academy.	Director of Finance	27/11/24	
FA24012						

Bradford Teaching Hospitals NHS Foundation Trust

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 27 April 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) - Renee' Bullock, Chief People and Purpose Officer (RB) - Karen Dawber, Chief Nurse (KD) - Ray Smith, Chief Medical Officer (RS) - Joanne Hilton, Deputy Chief Nurse (JH) - Jane Kingsley, Lead Allied Health Professional (JK) - Sarah Freeman, Director of Nursing (Operations) (SF) - 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) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Faye Alexander, Head of Education (FA) - Amanda Grice, Workplace and Wellbeing Centre Manager (AG) - Sara Hollins, Director Midwifery (SH) - Sonia Sarah, Co-Chair of the Enable Staff Equality Network (SS)		
In Attendance:	- Sarah Turner, Assistant Chief Nurse (ST) for agenda item - Debbie Jackson, OD Manager (DJ) for item PA.4.24.6 only - Amanda Nicholson, HR Business Partner (AN) - Katie Shepherd, Corporate Governance Manager (KS) - Georgi Dyson, Assistant Director of HR (GD) - Amanda Limbert, Head of Service for workforce information and flexible workforce (AL) - Sehra Hasan, Executive Assistant (SHa) as secretariat		
Observers	- Helen Wilson, Staff Governor (HW)		

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 - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) - Sean Wills, Associate Chief Nurse – Quality and Workforce (SW) Absent: - James Taylor, Deputy Chief Operating Officer - Amy Ilsley, Clinical Lead for Medical Workforce - Raquel Licas, Deputy Chair, RESIN (RL)	

PA.4.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.4.24.3	**Draft minutes of the meeting held on 27 March 2024**	
	The minutes of the meeting held on 27 March 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: FL informed members due to low attendance at the previous meeting, the meeting has been re-arranged for May where the triangulation of data will be discussed and an update will be provided at June's meeting. • PA24006 – PA1.24.13 – Report/Minutes from the Health and Safety committee: LP has discussed this with the Chair and there is a view not to have a NED representative at that meeting. Action Closed • PA24011 – PA2.24.9 – Nursing and Midwifery recruitment and retention data: JH agreed to pick this up with AHS and will feedback response virtually. • PA24012 – PA.3.24.9 – Outstanding Pharmacy Services: the workplace related incidents in Pharmacy are reported through InPhase. Action Closed • PA24013 – PA3.24.20 – Any other Business: Email communication sent out by Executive leads reminding of the deadline for papers. Action Closed	
PA.4.24.4	**Matters arising**	
	There were no mattes arising.	
Assurance		
PA.4.24.5	**People Academy Dashboard**	
	FL presented an updated version of the dashboard and shared the following highlights: • Staff turnover – there has been a slight increase in turnover to 9.81% from 9.73%. • Sickness absence rate – the current rate is at 5.77%. • Saff in post – the current rate is 6454. • Staff advocacy information will be presented next month. • Mandatory Training – compliance is currently above the 85% target rate. • Appraisals – compliance rates are currently below the targeted 85% rate, there is a plan in place for to improve appraisals rates, where the process and paperwork will be simplified. FL asked colleagues to share their feedback on the new revised dashboard and mentioned that further changes need to be made, to understand the data better. FL agreed to meet with the Business Intelligence team and will feedback the changes that need to be made to the dashboard. RS highlighted that there was no unapproved missed medical appraisal in the last financial year, 97% of medical staff had a	

	completed appraisal in the last year and suggested whether learning can be shared between medical and non-medical appraisal to increase compliance with appraisals. The academy noted the update.	
PA.4.24.6	**Workforce Report**	
	FL introduced the Workforce Report and highlighted that sickness absence has reduced, although our sickness levels are high compared to other organisations in the region. FL advised that he will be working with the HR Business Partners, to understand why sickness level is high in some areas of the trust and to delve into options of reducing sickness absence. FL drew members attention to the work that has undergone in the Nursing and Midwifery directorate, which highlights all the interventions that have taken place to increase recruitment in Nursing and HCA roles. ZA asked whether there is a plan in place to ensure we are on track with bank and agency spend? FL commented that there is a programme of work relating to efficiencies, which will be led by the Director of Strategy and Transformation, who will lead and oversee this area of work. AS queried whether we can showcase our wellbeing offers and revisit some of the offerings that were available previously to staff, FL advised that he is working with the HR and Health and wellbeing teams and will be reviewing the programme of work and offerings that are available to staff and will also discuss this with AS, in their next one to one. The academy noted the update.	
PA.4.24.7	**High level operational risk**	
	LP highlighted the following risks from the report, for the attention of the People Academy: Two new risks were identified which are: • 2549 – this risk relates to 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. RS is the Exec lead for this risk. • 2566 – this relates to delayed discharges to Adult Social Care The following risk has reduced in score: • 111 – Industrial action this has reduced from 20 to 8, where Consultants have confirmed they have accepted the pay offer, therefore there is no more risk of industrial action in the immediate future. The academy noted the update.	
PA.4.24.8	**Board Assurance Framework - strategic risks relevant to the Academy**	
	LP informed members that an annual review was undertaken of the Board Assurance Framework, ensuring the risks are relevant to this	

	academy. Support has been offered by an external Consultant to review our governance arrangements, work plans etc. The board assurance framework has also been reviewed and a revised format has been suggested, focusing on a smaller number of risks overall. The Corporate Goverannce team are currently working through the new changes and this will further be discussed at a Board Development session in June. The proposed changes will be presented to academies at June's meeting and will be presented to the Board of Directors in July for final sign off. There is a proposal that the BAF is presented quarterly as appose to bi-monthly. The academy noted the update.	
PA.4.24.9	**Nursing and Midwifery staffing establishment review**	
	This item was deferred to the next meeting.	
PA.4.24.10	**Nursing and Midwifery staffing data publication report**	
	JH took the paper as read and highlighted the following key points: • There has been a slight increase in the fill rates for March, this has been due to the increase in recruitment for Nursing and HCA roles. • Staffing is still on the Corporate Risk Register and is under monthly review. • All wards and departments are on the standard pay rate in terms of bank pay rates. • Overall vacancy position has highlighted a gap of 70. • The NHS England quality mark has been given to the trust for international recruitment. • 12.6% vacancy position. • The trust is waiting to hear back from NHSE, whether there will be additional funding support for international recruitment this year. • Work is continuing with recruitment, retention and recognition. • Approval has been given to fund the falls lead post. FL added that the workforce plan does not include any international nurse's recruitment for the current financial year. The academy noted the update.	
PA.4.24.11	**Sexual Safety Charter**	
	ST joined to the meeting to provide an update on the presentation which was circulated with the papers and highlighted the following: • NHS England in June outlined their intention to develop a Sexual Safety Charter. The intention of this Charter is to ensure that every part of the NHS takes a systematic zero tolerance approach to sexual misconduct and violence. The charter was launched on the 4 September 2023. • The charter outlines 10 standards and the Trust has signed up to fulfilling these standards. • The priority standards have been RAG rated and the organisation has reporting mechanism on some of the standards. • The 'training, capturing and sharing data principles' needs to be	

	developed further. • We scored low in a question relating to Staff survey results and this requires further work. • We scored low in the section relating to 'staff who been targeted of unwanted behaviour of a sexual nature in the workplace from patients/service users', and this requires development around this area. • The presentation highlighted the current support mechanisms that is in place for staff and managers. • Further meetings have taken place to develop an awareness to raise the campaign around this charter. • Resources and training will become available, to ensure staff have the correct tools to support colleagues and appropriately react to sexual safety of staff, in the workplace. • There is, evidence within the Trust, that the Sexual Safety Charter is required, work needs to be undertaken to strengthen existing processes and develop support, where there may be gaps. The academy noted the update.	
PA.4.24.12	**Guardian of safe working hours quarterly report**	
	RS presented the quarterly report, the Guardian of Safe Working Hours was created following concerns over the 2016 junior doctors contract and the impact this had on junior doctors training and work load. 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, all safety concerns are reviewed individually by the guardian, the 2 reports which were flagged were from the same junior doctor who raised concerns about working beyond their contracted hours to care for a sick patient. All incidents are investigated independently. In total 41.75 additional hours were reported across the Trust. The trust is currently under resourced with junior doctors and the allocation is received from NHSE. There are currently 67 unfilled training posts, but local employed doctors post foundation fellow fill the gaps, in theory all the training posts are filled. There were 3000 bank/agency locum request for the 4th quarter of the year, which has seen an increase of 54% from the previous year and this puts pressure on the junior doctor workforce. The academy noted the update.	
PA.4.24.13	**Workforce Civility update**	
	This item was discussed earlier at the meeting.	
PA.4.24.14	**Bradford District and Craven People Committee update**	
	FL updated members that a staff survey results discussion took place at the previous meeting, where the efficiency plans, proposals and risks across place were discussed. Due to the governance review and re-structure, the frequency of the People committee meetings will change, as there is a workforce programme board at place and the effectiveness of the group will	

	be discussed. The academy noted the update.	
PA.4.24.15	**Industrial Action update**	
	There was no update to report.	
PA.4.24.16	**Education Annual Report**	
	FA introduced the paper which provided an overview of the education service annual report and highlighted the following: • The external recognition Education has received over the last year, including several awards for the Apprenticeship Team, achievement of the Interim Quality Mark for Preceptorship and Clinical Teaching Excellence Award from Leeds Medical School. • Education have significantly expanded, using innovative roles, to support the development of the workforce. These roles include investment in Mandatory and Statutory Training, a Locally Employed Doctor tutor, significant expansion of Clinical Fellows. • Within 2023/2024 the team has increased the amount of training places for undergraduate students (Nursing/Midwifery/AHP) alongside medical students, T-level placements, and work experience students. Feedback from learners is positive overall and hoping that the investment into these learners will translate into future recruitment. • Declining of education estate and facilities. The estate is aging and in places not conducive to facilitating and maintaining an outstanding learning environment. Post-pandemic the education and training service has expanded to meet the educational needs of the workforce, but this has meant current facilities are now stretched to maximum capacity. Investment is required to ensure education and training can adapt to future workforce needs, especially when considering the implications of the NHS Long-Term Workforce Plan. • Budgets will be concerning going forward, last year the regional NHSE budget for Workforce Development commissioned courses was cut by 80% and this will continue to cause challenges. • Workload is continually becoming challenging. The results of the GMC survey 2023, showcased Bradford ranking 217/229 for workload in the UK. These challenges are being supported through use of other workforce roles including the link medics pilot, increased numbers of expansion posts and adopting and embedding other roles including ACP's. • The current education plan expires at the end of this year, the team will be developing an education strategy for the next five years, which will involve stakeholders to be part of the plan. RS asked if the education team will deliver supporting the apprenticeship programme with limited resources and funding. FA stated that she is not confident that the team will be able to achieve it's outcome, but FA will be reviewing this and this will be given priority.	

	ZA asked if the education plan is monitored and asked if an education dashboard can be shared going forward, which shows achievements against the plan and progress. FA mentioned that the education plan is reported to the Quality and Patient Safety Academy and she will discussing with RS, whether a report can be drawn up which shows the achievement against the education plan. An education dashboard was circulated with the papers, but FA mentioned that she will include progress in the next update. The academy noted the update.	
PA.4.24.17	**People Academy Annual Report to the Board.**	
	KW introduced the paper which sought approval of the People Academy Annual report. KW highlighted the following: • 10 meetings took place over the year, which focused on the trust people, learning, improvement, and assurance. • Learning and improvement has been evidenced through staff stories – Outstanding Theatre services, Outstanding Pharmacy Services • Significant improvements across wellbeing, in the culture workstreams. • Looked after our People – new wellbeing spaces offered, i.e. outdoor areas and is still being developed. • Staff Survey results has increased in each category annually. • GMC survey feedback – highlighted positive feedback within Anaesthetics, Elderly Medicine, Neonatal Medicine and Paediatric specialities. It was noted that we have been ranked 226th out of 229 UK acute and mental health Trusts for workload. • There has been a strong focus on Equality, Diversity and Inclusion. In October 2023 the Academy received and approved the WRES and WDES actions plans. Diversity and Equality scored at 82.6% and inclusion at 72.7%. • Kindness and civility has progressed. The second Thrive Leadership Summit took place on 6 June 2024 which was focused on 'Finding the Leaders in Everyone' and was very well attended. • Recruitment and retention have seen monthly reduction in turnover since 2022. • Assurance has been taken from the dashboard, workforce report, delivery of the people plan, workforce planning submission, guarding of safe working hours, Medical Appraisals and revalidation annual report, Board assurance Framework for nurse staffing, Nurse staffing data publication report, Nursing and Midwifery Staffing review, health and safety, Industrial action. • The challenges between attendees have been constructive and valuable, everybody who attends the meetings have made a significance difference to our people and patients. • KW thanked all members for their contribution and in particular thanked FL for his leadership, in the absence of the Chief People and Purpose Officer and AS, for his support, contribution and his fair challenges.	

	The academy approved the People Academy Annual Report to be presented to the Board.	
PA.4.24.18	**People Academy Terms of Reference**	
	LP informed members that the terms or reference are currently under review, for all academies and the Board of Directors. The Corporate Governance team will be working through these with leads Executives, as well as the Chair's of the Academies. A proposal will be shared with the Board of Directors in June and will also be shared with Academies in late June.	
PA.4.24.19	**People Academy work plan**	
	The workplan was noted.	
	Learning and Improvement	
PA.4.24.20	**NHS Staff Survey Action plan updates**	
	DJ joined the meeting and shared a presentation with the academy which outlined the staff survey action plan for 2024. DJ shared the following: • Increased staff survey response rate, the OD team are analysing the results and have pulled together a draft action plan for 2024, which has been aligned with the NHS People Plan. • The draft action plan has been created for consideration and discussion following analysis of the 2023 results. This will be shared with Governors, staff networks, and JNCC before it is due to be presented to Board for ratification, and agreement on accountability and timelines in May. • The first pillar of the survey is 'looking after our people'. A question which was asked related to how the trust provides nutritious/affordable food to staff and we scored 49%, results showed that staff find it difficult to find food that is affordable and food offerings should be available 24 hours. • The 'reward and recognition' offerings are currently under review, there is currently a lot of offerings such as Greatix, Daisy awards, department awards, etc, but more recognition needs to be rewarded to staff and to make the awards more instant, accessible, and inclusive, which the OD are working on this currently and giving it some thought. • The 'belonging' pillar covered communication across the Trust and some colleagues stated that communication can be difficult, due to not having access to IT. Consideration is being given to this to ensure that staff are communicated with, in several different methods, ensuring all staff feel included. • With regards to the 'Growing our future' pillar, feedback needs to be shared and received from academies, trade unions, networks in order to build on this. Conversations that have taken place suggest how do we build an environment which is supportive, which encourages individuals to work across the organisation, where they aspire to and how to support and approach leaders to review flexible working, wellbeing and support colleagues to carry out these conversations. • Feedback relating to 'new ways of working' pillar, showed that	

	staff who were raising concerns were not always receiving feedback, the OD team will be reviewing the mechanism for this as feedback should be shared in a timely manner. • The FTSU process will potentially be reviewed, to create a trusted and multi-channel speaking up culture, where staff feel safe to raise concerns. The results showed that staff are in fear of speaking up due to fear of retribution. JK advised that she chairs the nutrition steering committee, the trust food and drink strategy is due to be published imminently, which contains information about work which is ongoing and will address some off the issues relating to food offerings available to staff. The trust is not compliant with the national food standards on provision of food availability for 24 hours, but the estates and facilities team along with the catering team, are working on the provision of a hot vending machine. AS commented, that out of hours home cooked nutritious food should be minimum requirement for an organisation of our size. With regards to communicating wider with our staff members he suggested whilst staff are on long term absence, maternity leave etc, that their accounts should be not frozen during these periods. The academy noted the update.	
PA.4.24.21	**Review of National Education & Training Survey (NETS) Feeback**	
	FA and LG introduced the paper which sought to report on the review of the national education and training survey (NETS). The survey is open to all undergraduate learners, as well as doctors in training. The data was collected throughout October and November 2023, which had the most responders and this was an increase by 40% from the previous year. The results were seen very positive for our trust, four quality domains were assessed and the trust over achieved against local and national benchmark figures. High scoring results were seen amongst ODPs in theatres, this will be explored further to identify if good practice can be shared from this. Low scoring outliers included foundation training in surgery, this has routinely been reported as low and will be looked at further. Participants were asked if they would recommend us a training place, where 79% said they would and 79% also recommended BTHFT as a place of care for family and friends and this has seen an increase from previous years results. Nursing students were asked whether they would apply for a job here, upon completion of their course, results showed that 49% would, 28% said no and 23% said they were unsure. Challenges persist with learners stating financial difficulties as reasons for leaving programmes of study, showing an increase	

	from the previous year. Furthermore, opportunities for quality improvement (QI) and leadership development were underutilised among Allied Health Professionals (AHPs), midwives, and nurses, indicating areas for targeted intervention. LG mentioned that provision for undergraduate student midwives, feedback indicated that supervision was not at the level they hoped, and this scored as a low scoring outlier nationally, but work needs to be done to explore whether this is a consistent issue, or if there was a small number of unhappy students at the time. Students also highlighted that they were not given the opportunity to take part in QI projects, research and innovation, which an action plan will be drawn up to address the issue. RS further added with regards to the four quality domains, our trust scored well across WYAAT and scored higher than the national average. Medical and surgery have struggled from a foundation year doctors perspective, but this is a national issue. The NETS survey is out of date as it arrived later than expected, but changes have been made since the results have been issued and the benefits will be seen in future surveys. KD asked if results can be shared from students at other universities and FA agreed to bring some data from other trusts and agreed to share results at a future meeting. **Action**: FA to share NETS survey feedback from students at other trusts, at a future meeting. The Academy was assured by the update.	
PA.4.24.22	**Any other business**	
	There was no other business discussed.	
PA.4.24.23	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.4.24.24	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.4.24.25	**Date and time of next meeting**	
	27th May 2024, 11.00 – 13.00	
PA.4.24.26	**Internal Audit Reports relevant to the Academy** **BH362024 – Nursing recruitment - Just R and overseas**	
	A review was carried out on the Just R and overseas recruitment, KW referenced the significant assurance which was received. The trust has the effective nurse recruitment and retention processes in place through the utilisation of Just R and international recruitment. The Academy was assured by the update.	

ACTIONS FROM PEOPLE ACADEMY – 24 April 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
PA24001	31.01.2024	PA.1.24.5	**Staff Story – Outstanding Theatre Services -** JS to share a copy of the review undertaken in theatres for the leadership protected time.	Matron – Theatres, Critical care and day case.	22.05.2024	A copy of the review is provided for information under item PA.5.24.23. Action closed
PA23008	22.02.2023	PA.2.23.13	**Gender Pay Gap:** LP to arrange an exceptional People Academy session on EDI and Gender Pay Gap.	Associate Director of Corporate Governance / Board Secretary	22.05.2024	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.
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	26.06.2024	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. **24.04** – due the workforce civility meeting not taking place, FL agreed to provide an update at June's meeting.
PA24014	27.04.2024	**PA.4.24.21**	**Review of National Education & Training Survey (NETS) Feeback:** FA to share NETS survey feedback from students at other trusts, at a future meeting.	Head of Education	26.06.2024	

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.	Matron, Theatres, Critical care and day case	26.06.2024	JH agreed to pick this up with AHS and will feedback response verbally. May 2024. Agreed to agenda this item for June's meeting & for JS to present this item.
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.	Director of HR	27.11.2024	

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 22 May 2024	**Time:**	11:00-13:00
Venue:	MS Teams meeting	**Chair:**	Karen Walker, Non-Executive Director
Present:	- Karen Walker, Non-Executive Director, Chair (KW) - Louise Bryant, Non-Executive Director (LB) - Renee' Bullock, Chief People and Purpose Officer - Faeem Lal, Director of HR (FL) - Karen Dawber, Chief Nurse (KD) - Ray Smith, Chief Medical Officer (RS) - Joanne Hilton, Deputy Chief Nurse (JH) - Jane Kingsley, Lead Allied Health Professional (JK) - Sarah Freeman, Director of Nursing (Operations) (SF) - Samia Hussain, Associate Director of HR (SH) - Faye Alexander, Head of Education (FA) - Raquel Licas, Deputy Chair, RESIN (RL) - Georgi Dyson, Assistant Director of HR (GD) - Kez Hayat, Equality, Diversity and Inclusion Manager (KH) - Amanda Limbert, Head of Service for workforce information and flexible workforce (AL) - Jacqui Maurice, Head of Corporate Governance (JM)		
In Attendance:	- Justine Carroll, HR Business Partner (JC) - Ruth Haigh, Equality Diversity and Inclusion Manager (RH) - Tabitha Lawreniuk, Personal Business Manager (TL) as secretariat - Susan Franklin, Associate Chief Nurse (SF) for agenda item PA.5.24.7 only - Daniel Lane, Organisational Development Officer (DL) and Lisa Falkingham, Senior Organisational Development Manager (LF) for agenda item PA.5.24.9 only - Chris Davies, Deputy Director of Estates and Facilities (CD) and Darren Mitchell, Fire Safety Manager (DM) for agenda item PA.5.24.16 only		
Observers	- Farideh Javid, Governor - Ripal Kaur, WY ICB Fellowship Participant		

Agenda Ref	Agenda Item	Actions
PA.5.24.1	**Apologies for Absence**	
	- Amandeep Singh, Partnership Lead - Rachel Pyrah, General Manager to CDIO office - Zafir Ali, Non-Executive Director Absent: - James Taylor, Deputy Chief Operating Officer - Amy Ilsley, Clinical Lead for Medical Workforce - Altaf Sadique, Non-Executive Director - Catherine Shutt, Assistant Director of HR/Head of OD - Laura Parsons, Associate Director of Corporate Governance/Board Secretary - Abbie Wild, Chair of LGBTQ staff network	

	- Susan Parker, Co-chair of the Enable Staff Equality Network	
PA.5.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.5.24.3	**Minutes of the meeting held on 24 April 2024**	
	The minutes of the meeting held on 27 March 2024 were approved as an accurate record. The Academy noted that the outcomes regarding the following actions: • PA24011 – PA.1.24.5 – Staff Story – Outstanding Theatre Services: AHS has shared a copy of the review undertaken in theatres for the leadership protected time under item PA.5.24.23. Action closed. • PA23008 – PA .2.23.13 - Gender Pay Gap – LP to liaise with KW and KH to agree a suitable timescale for this action. Action deferred to July.	
PA.5.24.4	**Matters arising**	
	There were no mattes arising.	
Learning and Improvement		
PA.5.24.5	**Therapies Workforce plan**	
	JK introduced the therapies workforce plan presentation, noting that the AHP workforce plan has been in place since 2022 with key priorities for development identified including the apprentice programme and staff retention. The purpose of the presentation was to provide an update specifically in relation to the theatres strand of AHP, around several key themes (train, retain, reform). As part of the 'train' element of the plan, the team hoped to increase apprenticeships and double the number of starters per year from 3 to 6 by 2026/27. This was ambitious as there are already large numbers of undergraduate student placements each year. The plan also included more work to develop career pathways and increase career promotion. The 'retain' element of the plan included a refresh of the retention plan from 2023, a plan to continue the AHP legacy mentors project (funded to end April 2024), and to support workforce engagement and development including an event planned with the AHP faculty in June 2024. In relation to 'reform' the plan was to develop career development pathways and new roles including enhanced roles, legacy mentors, and development posts (mainly band 5 to band 6). There was also a plan to over-recruit to maximise recruitment of university graduates to band 5 posts at specific times of the year.	

	RS recognised the need to be proactive at recruiting apprentices to substantive posts following the end of their apprenticeship, particularly in areas of challenged recruitment such as physiotherapists. JK noted that there were several apprentices coming to the end of their experience with the Trust and she would update on the number of apprentices taking up permanent posts within the Trust at a future Academy. **Action**: JK to update on the number of apprentices taking up permanent posts within the Trust at a future Academy. The presentation referred to lack of interest in the support worker apprenticeships and KW queried why this might be the case. JK believed this was due to circumstances at the time of them being offered, staff being content in their current roles and a lack of engagement in the service. She hoped that increasing engagement and involving staff in conversations about the future of the service would encourage more uptake. KW questioned whether any support was needed to deliver the plan, and JK reported on delays in approval to over-recruit to posts following a discussion at the Executive Team meeting in February however, she did confirm that there was sufficient support in place to deliver the plan. The Academy was assured by the update.	PA24015 Lead AHP
PA.5.24.6	**Equality update (WRES/WDES)**	
	KH introduced the WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standard) update review of the previous 12 months data. He was pleased to report some overall improvements, both in terms of race and disability equality, however there were still areas of improvement based on captured data. The presentation provided a detailed update on progression against WRES indicators and RH and KH provided some additional comments: • There has been an increase in overall workforce representation to 40.5% which exceeds the 35% target, and although ethnic minority staff remain underrepresented at bands 8A and above, this does show an increasing trend. Emphasis is needed on promotion and progression for staff up to senior manager levels, as benchmarking data shows inequity in progression. • The data shows no change to Board representation in Voting Board membership, and a 5.6% increase in Executive membership of the Trust Board. However, upon analysis, this is due to several white members leaving and therefore not reflective of an improvement in actual representation. • There were several areas for further improvement, including ethnic minority representation at senior levels, improved staff experience in relation to discrimination, harassment, and bullying, and embedding the EDI strategy.	

The presentation also gave a detailed update on progression against WDES indicators and RH and KH provided the following additional comments:

- Overall representation of disabled staff has increased to 4.9%. There has been a 7.2% reduction in disabled representation for voting members of the Trust Board, but at 7.1% remains higher than the organisation, and higher than the national benchmark of 5.6%.
- Areas of improvement include:
  - improving disability declaration rates,
  - ensure a fair and inclusive approach to recruitment and selection.
  - continue to improve provision of reasonable adjustments, continue developing the work on Civility in the workplace, and improve engagement with the Enable Staff Equality Network.

The Academy was advised that the revised WRES/WDES action plans for 2024/25 will be aligned with the national people plan, EDI improvement plan, and other local and regional priorities with a focus on 'inclusion and creating a sense of belonging'. These plans will be developed through engagement and consultation with staff equality networks and other key stakeholders.

KH put on record his thanks to colleagues in the workforce information team for working hard to supply the relevant data.

The People Academy was asked to note the content of the report and the WRES/WDES data submissions for 2024 and consider whether there are any gaps in the proposed areas for further action. The Academy would receive the final action plans for approval and continue to receive regular updates on the wider equality, diversity and inclusion agenda.

RS acknowledged the progress made in the organisation because of KH and RHs efforts and thanked them for this. He queried whether consultants were represented in the senior leader category and suggested that they should be if not already. KH responded that NHS England will be introducing mandatory medical WRES data from 2025/26 which he anticipated would be very favourable for the Trust. RS also recognised the importance of cultural competency training, particularly for colleagues that were involved in recruitment and selection processes.

FL commented that previous action plans to increase representation at senior levels have not demonstrated an improvement and so there would be a need to consider how this can be responded to differently over the next 12 months. KW echoed this and the need to consider using positive action in a careful manner in the areas that it may have the most impact. KH recognised the need for focus on what a positive action approach would look like which would be informed by discussions with senior managers, with various practices that could be explored further.

	The Academy was assured by the update and welcomed the action plans back to a future Academy meeting.	
PA.5.24.7	**FTSU Annual Report**	
	SF joined the meeting to present the FTSU Annual Report for 2023/24 which sought to provide assurance in relation to the management of the FTSU arrangements in the Trust. SF highlighted the Too Hot to Handle report which has been shared via other routes and noted that because of this, the annual refresher for FTSU guardians now includes a three-hour session on equality, diversity and inclusion. SF thanked KW for the work she has done in relation to FTSU and advised that the NGO recently asked for Guardians to contact them to 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 met with the NGO, and they have developed 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. This year, 101 concerns have been raised which is the highest in any one year. Staff are also able to report anonymous concerns via an app, and there is now a route for feedback through this app to continue communication whilst ensuring anonymity. The highest reporting category is 'inappropriate attitudes and behaviours.' In relation to staff survey results, there has been a slight dip in score for the question around 'confidence that safety concerns would be addressed,' but the other three questions relating to FTSU have all increased slightly. The FTSU team is working to increase FTSU ambassadors via the staff networks. KD advised that Sarah Jones, Trust Chair, was keen for SF to join a Trust Board meeting to present an FTSU update directly to the Board. SF was content to do this. The Academy thanked SF for joining the meeting and confirmed they were assured by the update.	
PA.5.24.8	**Workforce Growth and Transformation**	
	JHi referred to the report which was taken as read. She highlighted those key areas of focus for the group included access to education and training, and support for preceptorship and beyond. There have also been some issues raised around the difficulty of international staff access to university courses, and KD and JHi would be meeting with colleagues at the University of Bradford to explore improving access for BTHFT staff. The Academy noted the update.	

PA.5.24.9	**Thrive Hive**	
	DL and FL provided an overview of the Thrive Hive presentation. Having a 'sense of belonging' is a core element of the NHS People Plan, and here in BTHFT, the feeling of belonging in the workplace is very much valued, and results in benefits such as increased levels of engagement, greater job satisfaction, and an overall increase in wellbeing. The Thrive Hive would be a central hub for colleagues to access a wide variety of activities, clubs and events, and would be inclusive and accessible to all colleagues, led by colleagues and not owned by a specific team, and the Trust at all levels would encourage all staff to partake in activities. Some initial themes for launch of the hub included physical activity, wellbeing activities, board game clubs, music activities, and cultural activities. The measurement for success would be to monitor engagement and attendance at these activities, and periodically run focus groups to ask questions about the offerings. There would also be the opportunity to look at future staff survey results to see if the level of belonging has increased. RS was very supportive of the initiative but suggested that the launch be reduced to several key themes to encourage engagement and provide a chance for staff to embrace the initiative before expanding more widely. The Academy noted the update and were supportive of the initiative.	
Assurance		
PA.5.24.10	**Nursing & Midwifery Staffing Establishment Review**	
	This item was deferred to the following meeting.	
PA.5.24.11	**Nursing and Midwifery Staffing Data Publication Report**	
	JHi introduced the report and highlighted the following points: • There has been positive improvement in the increase in fill rates which are now consistently above 80% and are reflective of the work to improve recruitment and retention. • Bank pay has remained as standard with no surge or super surge paid during March and April. • There is a monthly cycle of recruitment for health care support workers, and 59 newly qualified nurses have been appointed to start in September. • The funding from NHS England for internal recruitment has ceased, and so the Trust is working around the process for colleagues already working in BTHFT who hold registration in another country to apply to the Nursing and Midwifery Council. • An updated retention toolkit will be released in June, following which a benchmarking exercise will be undertaken and the outcomes reported back to the Academy. • However, to maintain the current position, there was a need to continue to recruit an average of 130 nurses and 40 midwives	

	per year. The Academy was assured by the update.	
PA.5.24.12	**Guardian of safe working hours – annual report**	
	In presenting the report, RS highlighted the following points: • During 2023/24, there was 119 exception reports raised, 93 of which were for extra hours worked (to a total of 93.25 hours), 26 with missed educational opportunities. • The Trust actively encouraged reports to be completed if warranted, and promoted as part of the junior doctor induction process. • Of the 119 exception reports raised, 75% were from three specialities (general medicine, general surgery, and ops and gynaecology). • Of the 93 raised in relation to extra hours worked, 63 were raised by foundation year doctors which are known to be particularly challenged with a number of unfilled gaps resulting in a high demand for locum cover. • There remains a very precariously challenge and continued tension around keeping things safe in terms of staffing numbers but also ensure staffing is affordable. • There has been a significant reduction in the number of reports flagged as an immediate safety concern (13 this year in comparison to 49 in the previous year). The Academy was assured by the update.	
PA.5.24.13	**Bradford District and Craven People Committee updates**	
	FL advised that there has not been a Bradford District and Craven People Committee since the last Academy, but there have been developments with the Workforce Programme Board which focuses on more immediate issues. The most recent meeting focused on pathways into healthcare, and the workforce hub website and where this should sit in terms of oversight. FL commented that there was more recognition at the meeting of a place-based approach rather than focusing on individual organisational levels, including discussions on a place-based response to introducing a single point of entry for entry level roles. The Academy was assured by the update.	
PA.5.24.14	**People Academy dashboard**	
	FL introduced the Dashboard, noting that the bullying and harassment outcomes have been updated (as they are on a twice-yearly basis), so the data is live and relevant. The data shows low numbers of staff in bullying and harassment disciplinary processes. There has also been a slight increase in non-medical appraisals which is a positive trend, and a slight decrease in sickness absence levels. There were no areas of concern for the Academy to be aware of and no areas for escalation to the Board.	

	The Academy was assured by the update.	
PA.5.24.15	**High level operational risks**	
	FL advised that there was one new risk accepted on to the high-level risk register relating to blood storage fridges at the end of life, and this would be monitored via the Quality and Patient Safety Academy. He further advised that there were no other issues of note regarding the risks assigned to the People Academy. The Academy was assured by the update.	
PA.5.24.16	**Annual Fire Report**	
	CD and DM introduced the report on the last calendar year which was taken as read. DM highlighted the following statistic from the report: • Five fires in 2023 compared to two in 2022. Four of the five fires were in relation to smoking, including a patient who smoked whilst on oxygen. The fifth fire was in relation to electrical safety. West Yorkshire fire and rescue service are in contact with the Trust to ensure actions are in place to address the issue of smoking on Trust premises. KD and FL reflected that current actions in place are not addressing the problem, with verbal abuse encountered when challenging people who are smoking. This would need careful consideration to address, and the Academy acknowledged this was a significant issue. The Academy was assured by the update.	
PA.5.24.17	**Report/Minutes from Health and Safety Committee**	
	The Academy noted that there were no reports or minutes for consideration.	
PA.5.24.18	**Industrial action update**	
	FL advised that there has been a national offer from the government to the BMA relating to SAS doctors, which is a positive sign of movement to resolve this pay dispute. Dialogue between the junior doctor committee and the government continues, and we are not expecting further industrial action currently. However, there was also feedback from agenda for pay unions about disgruntlement regarding the AFC pay deal and there may be impacts on this for nursing and non-medical support staff. The Academy noted the update.	
PA.5.24.19	**People Academy work plan**	
	JM advised that she would review the regularity of reporting to the Academy for the 'nursing and midwifery establishment review'	

	following receipt of a revised timetable from JHi. There were no other changes to the workplan to note. JM further advised of an upcoming meeting for KW, Executive Leads and the Board Secretary to review the Academy meetings. The outcomes from the meeting would be presented to the Academy for review at the end of June and then shared with the Board for approval in July. The Academy noted the update provided.	
PA.5.24.20	**Any other business**	
	Thriving Together Programme KW asked the Academy to note that the Thriving Together programme was about to launch their Cultural Leadership Survey, focused specifically on leadership behaviours, and highlighted the importance of hearing from leaders across the Trust around areas of good practice and areas to improve. Further information was available from Carly Wilson, Recruitment and Onboarding Lead and Claire Bancroft, Voluntary Services Lead, if required.	
PA.5.24.21	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.5.24.22	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.5.24.23	**Date and time of next meeting**	
	26 June 2024 – 11.00 – 13:00 (rescheduled to 3 July, 9 to 11)	
Items for Information		
PA.5.24.24	**Internal audit reports relevant to the Academy**	

ACTIONS FROM PEOPLE ACADEMY – 22 May 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
PA24008	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	03.07.2024	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. May 2024 – LP to meet with KH & KW to discuss this, therefore deadline extended. Action to remain open.
PA24014	27.04.2024	PA.4.24.21	**Review of National Education & Training Survey (NETS) Feeback:** FA to share NETS survey feedback from students at other trusts.	Head of Education	24.07.2024	
PA24015	22.05.2024	PA.5.24.5	**Therapies Workforce Plan:** JK to update on the number of apprentices taking up permanent posts within the Trust.	Lead AHP	24.07.2024	
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.	Director of HR	27.11.2024	

Bradford Teaching Hospitals NHS Foundation Trust

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) ASSURANCE MEETING MINUTES

Date:	Wednesday, 24 April 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 - Mr Zafir Ali (ZA), 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 - Ms Judith Connor (JC), Associate Director of Quality - Ms Louise Horsley (LH), Senior Quality Governance Lead - Mrs Sara Hollins (SH), Director of Midwifery - Mr David Smith (DS), Director of Pharmacy - Mrs Sarah Freeman (SF), Director of Operations (Nursing) - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary		
In Attendance	- Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District Care Health and Care Partnership - Ms Leah Richardson (LR), Patient Safety Specialist - Ms Jacqui Maurice (JM), Head of Corporate Governance - Ms Elizabeth Brooks (EB), Quality and Patient Safety Facilitator - Ms J Kitching, Minute taker		
Observers	- Mr Alastair Goldman, Governor		

Agenda Ref	Agenda Item	Actions
QA.4.24.1	**Apologies for Absence**	
	- Ms Adele Hartley-Spencer (AHS), Director of Operations (Nursing) - Mr Mohammed Hussain (MH), Non-Executive Director/Co-Chair (Authorized absence) - Mr Sean Willis (SW), Associate Chief Nurse, Quality and Workforce **Absent** - Mr Altaf Sadique (AS), Non-Executive Director - Ms Sughra Nazir (SN), Non-Executive Director - Mr John Bolton (JB), Deputy Chief Medical Officer/ Operations Medical Director	

	- Dr Debbie Horner (DH), Deputy Chief Medical Officer - Dr Yaseen Muhammad (YM), Nurse Consultant/Director of Infection, Prevention and Control - Ms Kay Pagan (KP), Assistant Chief Nurse for Informatics	
QA.4.24.2	**Declarations of Interest**	
	PR confirmed his position as the Chief Digital Information Officer for both Bradford and Airedale Trusts regarding agenda item QA.4.24.13 on the basis that this agenda item covers the go-live Electronic Patient Record (EPR) at Airedale.	
QA.4.24.3	**Minutes of the meeting held on 27 March 2024**	
	The minutes of the meeting held on 27 March 2024 were approved as a correct record. The following four actions on the log were closed: • **QA24005** – QA.2.24.13 (28.02.24) – 15 Steps Assurance Programme - KD noted that as part of the Care Quality Commission (CQC) preparation some additional communications were undertaken around the interpreter service and referenced in the CQC booklet, Moving to Outstanding. • **QA23030** – QA.7.23.9 (26.07.23) – 2022 Urgent and Emergency Care Survey – Pre-Publication Results - New screens have been commissioned incorporating technology to alert the team as to when the screens are not operating via a remote action facility. • **QA24006** – QA.3.24.8 (27.03.24) – Maternity and Neonatal Services Update – Jamie Steele, Matron for Neonatal Services and team, provided the feedback that contrary to suggestions there had been a decrease in drug errors. An in-depth discussion took place with regard to the following action: • **QA24004** - QA.2.24.7 (28.02.24) - Quality and Patient Safety Academy Dashboard whereby PR agreed to provide a full update to the April QPSA Assurance meeting (on SHMI). PR discussed the format of the SHMI data having been recorded internally and then reflected in the Health Evaluation Data published externally. Much work undertaken in the run up to the April 2024 CQC inspection to confirm that in relation to what that data might have indicated in terms of unexpected deaths, quality of care, patient safety and other issues from the deaths' programme providing assurance there were other issues in relation to SHMI. It has now been ascertained this is due to a combination of factors. A paper is due to be submitted to the Executive team imminently. A combination of the way information is recorded on EPR and how the Coding team calculate to inform the SHMI score will be addressed. Both issues are part of an improvement programme framework going forward. The QPSA and the Board of Directors will receive further details generating the appropriate level of assurance. RS noted SHMI has the highest level metric on the dashboard	

	as of a cause for concern and work is ongoing considering the content and metrics. The SHMI work has taken a step forward over the last few weeks, however, the dashboard remains work in progress. PR apologised that the latest version of the dashboard has only recently become available for discussion at the QPSA on 24 April 2024, remaining work in progress using statistical process charts to inform SHMI. Detailed conversations have ensued with the metric owners to provide confidence that the Statistical Process Control chart is the correct method of presenting the data. All data points are accurate. LB raised the transition from the existing dashboard to the new version, accepting that this is not quite finalized. RS noted the dashboard would not be discussed in any great detail in its current form. SHMI has been discussed on numerous occasions and the QPSA are fully aware of the information shared by PR regarding the background. This is a gap in assurance for the QPSA on 24 April 2024. LB asked the Exec Directors present if in light of this there were any changes to the data not apparent in the current version of the dashboard that were of concern, or that needed discussion. It was confirmed there were not. KD commented the improved dashboard looks very professional to date and requested the text be enlarged. ZA noted the acceptable presentation of the People Academy dashboard on 24 April 2024. Raising dashboards as the way forward for the presentation of data, however, there was confusion over the key performance variation assurance cycle. A request was made for the information to be displayed more simply. If assurance is being taken from the dashboard the QPSA is required to understand the meanings of the variation and assurance icons. PR reflected a discussion at a Board Development and the question regarding making data count and icons. Forward progress has been demonstrated since that time, however, the correct metric and correct way of visualising each metric is required. A programme of work will be undertaken to ensure all colleagues are aware of the information ensuring correct metrics are selected. Unfortunately this was not possible for April QPSA. PR assured the Academy the team would engage, persist and produce an improved version and welcomed the Non-Executive Director feedback. LB noted this recognised transition point with the move from the old SI framework to PSIRF and the QPSA being aware of this transition period. In the new dashboard the analysis will produce additional insight into the data. PR noted all colleagues are aware of the items relating to their portfolios and should raise any concerning issues. The Academy noted that a further update will be provided. <u>Action to remain open.</u>	

QA.4.24.4	**Matters Arising**	
	LB highlighted an issue to note concerning the Histopathology department risk and turnaround times (Risk 607). On 24 April 2024 at the Finance and Performance Academy, an update had been provided regarding the new Histopathology programme with three workstreams, which is now underway to consider a long-term sustainable action. This is not, however, a quick turnaround due to issues relating to recruitment difficulties, a national issue, and the increase in demand for the service, reduced capacity and difficulties in training. RS noted the site remains busy with significant attendances through the Accident and Emergency Department. Recent incidents were highlighted within the Trust around violence and aggression with Police involvement. KD discussed the headlines from the 16 to 18 April 2024 Care Quality Commission (CQC) Well Led inspection noting the Trust remains in inspection phase until the final interview is completed around the end of April 2024. Further information requests are not expected after 25 April 2024 and the Trust is in the process of collating and returning the evidence requested. Feedback received was very positive from the CQC feeling welcomed. Staff were noted to be caring and friendly with an overwhelming impression received that every single person who was spoken to was concerned about Bradford, the people of Bradford and the Trust's work for the people of Bradford. KD noted the concerns previously raised around allegations of racism and islamophobia, how the Trust responds to incidents and people feeling safe to respond to incidents. Ongoing work continues to ensure staff feel safe and welcome attending the workplace. The CQC report should be available within two months, however, the Trust is the first to be inspected in the new format, under the new CQC Well-Led inspection process under the single assessment framework and the Trust has been advised the report may take longer than the usual length of time due to this factor. On receipt of the initial report the Trust will have two weeks to undertake a factual accuracy check. On return to the CQC a further two weeks will allow the CQC response prior to the finalized report being issued. Taking into account this process the finalized report is expected to be received by the Trust around August/September 2024. To date, following the visit, the Trust has positively not received any urgent escalations in relation to the recent inspection, indicating no concerns have been raised during the visit around immediate patient safety. PR wished to record and thank KD and her team for the incredible depth of input and leadership during the last few weeks of this process, both prior to and during the inspection, on behalf of the organisation and the QPSA, noting the number of colleagues at this Academy meeting involved. LB also thanked the team for the CQC packs and regular updates provided to the Non-Executive Directors during the inspection.	

	There were no additional matters arising or further issues to escalate.	
QA.4.24.5	**Quality and Patient Safety Academy Annual Report 2023/24**	
	• Proposed changes to the Terms of Reference and Workplans. LB noted the QPSA Annual report circulated to the QPSA, requesting any comments on the business of the QPSA over the last twelve months. No comments were received and the Annual Report was approved by the QPSA. LP discussed the Board Assurance Framework (BAF), the QPSA Terms of Reference and workplans which are all under review, noting support to this exercise from an external governance consultant with the Trust looking to streamline processes to ensure efficiency, everything is reported correctly and aligned with the Strategy and the four Ps of Patients, People, Partners and Place. Discussions will continue for development with the Board of Directors throughout May and June 2024. A proposal will be brought back to the QPSA with the revised Terms of Reference and workplans in late June 2024 for sign off at the Board of Directors in July 2024. LP welcomed any comments to be submitted to herself. The Terms of Reference and workplan will be discussed at the June 2024 meeting.	QA24007 Associate Director of Corporate Governance/ Board Secretary (LP)
QA.4.24.6	**Quality and Patient Safety Academy Dashboard**	
	RS referred to the earlier discussions reflected in the action log QA24004, noting the updated professional looking dashboard of metrics, currently work in progress and noted the major improvements. Summary Hospital-level Mortality Index (SHMI) has been discussed extensively by the QPSA and will remain a metric, however, Hospital Standardised Mortality Ratio (HSMR) is now an outdated metric; SHMI and Crude Mortality are likely to remain in order to provide a triangulation around death statistics. For assurance purposes, RS highlighted the CQC inspection recognised and complimented the Trust's learning from deaths and mortality processes. The metrics noted to not have a narrative in terms of for example, the analysis and risk mitigations in the timescale provided, RS confirmed would be updated for the next version. ZA reiterated the dashboard is the way forward for statistics across the Trust and in reference to the Board Assurance Framework (BAF) appreciated this focuses on providing assurance against risk, however, noted the assurance framework at Board level should be considered as to how this links back to the dashboards provided to the different Academies, and referenced an assurance framework is much broader than risk but concerns the organisation's performance	

	and delivery, and noting that level of detail is now being demonstrated within these dashboards. ZA requested when developing the BAF consideration needs to be given to whether assurance is broader than risk. ZA queried whether the three Academy dashboards had any pertinent significant items which should be feeding into the dashboard even if by exception, in order that the Board receives the collective assurance from all Academies. ZA noted he was very happy to have a separate conversation outside of the meeting and this observation was welcomed by LB and PR. PR noted it would also be helpful to include, Michael Rooney, Business Intelligence Manager, in these discussions noting his specialist skills and the majority of his work surrounding dashboards. LB questioned whether any member of the QPSA had any issues around assurance that they would wish to raise in relation to the dashboard. RS noted no particular concern in relation to any metric, with the exception of SHMI as discussed, noting the majority of the metrics are fairly consistent producing normal cause variation around the baseline. The Academy noted there were no items for escalation to the Board of Directors' meeting on 9 May 2024 and was assured following the discussions.	
QA.4.24.7	**High Level Risks**	
	RS noted the papers circulated referencing any risk scoring 15 or above is discussed monthly at the Executive team meeting with changes agreed prior to the documentation being submitted to the QPSA. Risks scoring 12 and above are discussed at the Executive to Clinical Service Unit (CSU) meetings. In terms of the high-level risks scoring 15 or greater, no risks at this stage are past their target date for completion of mitigation and there are no risks beyond the review date. Some risks have changed in scoring with three new risks since the last report, one allocated to closed Board with a score of 16 at present, and two others added to the High-Level Risk Register. Risk 2549 – Non-Surgical Oncology (NSO) workforce – NSO is a pressured area nationally with difficulties in the recruitment of medical staff and a shared service with Airedale, also currently experiencing vacancy issues and, therefore, unable to share the on-call duties at present with Bradford. Discussions are underway at Place level and locum staff are assisting with the rota. A wider piece of work is ongoing at West Yorkshire Association of Acute Trust (WYAAT) level looking at a different model for managing Oncology services, however, this is a long-term project and may be another one to two years before it is completed. A small minority of oncology patients require in-patient services and due to the challenged workforce across the Integrated Care System (ICS) consideration is being given to an alternative model of in-patient facility.	

	Risk 2566 scores 16 and is related to delayed discharges to adult social care. There has been significant closures of social care beds across the district having a significant impact on the Trust's ability to discharge patients. The Multi-agency Integrated Discharge Team (MAIDT) undertakes this work but the current position is significantly impacting. Risk 448 has been closed relating to staff not following or being able to follow the correct process for recording activity or patient pathway steps on the Electronic Patient Record (EPR) accurately to reflect the work underway. A risk assessment will be completed and considered for escalation as appropriate. Three risks have changed in score: Risk 607 – Harm to patients and the organisation from delays in processing histopathology samples, with the potential of having an impact on delayed diagnosis and treatment pathways, and as referred to earlier by LB, under QA.4.24.4. Previously scoring 16, this risk has now been elevated to a score of 20 due to a number of issues in Histopathology services, including workforce vacancies. Mitigations are being worked on to resolve the issues and other matters outside of the workforce including processes between laboratories within the joint venture (Bradford, Harrogate and Airedale). All laboratories will be situated on the Airedale site with transportation and BTH samples under consideration. A Histopathology quality programme with appropriate workstreams is being developed to discuss all aspects of, for example, equipment, people/workforce, relationships, culture and cancer. On 24 April 2024 it was agreed a weekly oversight meeting, chaired by either Sajid Azeb, Chief Operating Officer, or RS will commence to ensure the service is micromanaged as escalations of concern have been received from clinical teams. Risk 111 concerning Industrial action has reduced in score from 20 to 8, with agreement of the consultant pay offer. The junior doctor situation remains unresolved with no further notification of any proposed forthcoming industrial action at present suggested to date. Two weeks' notice is required of any new industrial action period, however, other actions are currently under consideration which could be significant. Going forward the risk rating is likely to fluctuate. Risk 35 concerning the risk to patients, staff and visitors across the Trust due to a lack of supervision of a 24/7 operational security team/service has reduced from 15 to 9. The risk has been mitigated due to successful recruitment. This risk is allocated to the People Academy. KD noted the risk in relation to the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy around the electronic proforma on EPR with the system going live on 24 April 2024. KD thanked PR and his team for resolving and for finalizing this risk.	

	LB noted there were no comments, however, the Histopathology risk will be brought to attention of the Board of Directors. The Academy were assured that all the relevant key risks have been identified and reported and are being managed appropriately.	
QA.4.24.8	**Board Assurance Framework (BAF) – Strategic Risks relevant to the Academy**	
	This item was discussed by LP in agenda item QA.4.28.5.	
QA.4.24.9	**Quality Oversight and Assurance Profile**	
	LH presented the Quality Oversight and Assurance Profile report and eight appendices for the period 1 February 2024 to 31 March 2024. LH highlighted the Academy aim and the Quality Oversight system including the process of safety incident escalation. Safety incidents are discussed within CSUs at daily safety huddles. Where an incident links to the Trust's agreed Patient Safety Incident Response Plan priorities, meets the national response requirements or where a potential theme or trend is identified linked to the Trust's improvement priorities these are escalated to the Safety Escalation Group (SEG) which is the new name of the group and this will be amended in the next report and where indicated to the Quality of Care Panel (QuOC) to agree the level of learning response, the method to be used to conduct the review and the reviewer that would undertake it. Any additional themes or risks would also be identified. There has not been a dip in incident reporting since the Trust transitioned from Datix to IRIS (Integrated Reporting Learning and Improvement System) providing assurance that incidents continue to be appropriately reported. The key highlights during the reporting period were noted: • Ten safety incidents were escalated from the CSU to SEG. • Ten safety incidents discussed at SEG were escalated to QuOC. • Three safety incidents occurred in January and were declared as Patient Safety Incident Investigations (PSIIs) in February due to issues with the national system and the Trust's inability to log these, however, the problems have now been resolved. • No PSIIs declared in the reporting period. • Escalations to SEG and QuOC currently being monitored within the CSU and relevant team were noted and the emerging risks identified are either under review or have been reviewed. • Externally reported incidents between 1 February 2024 and 31 March 2024 were noted. • CQC enquiries – No monthly enquiries in February or March 2024 received from the Trust's new CQC Inspector. Seven ad hoc enquiries received one of which remains ongoing. • Cancellation of the CQC's planned engagement meeting of 9 April 2024 in view of the CQC Well-Led inspection undertaken from 16 to 18 April 2024. • Patient Safety Investigations – On 31 March there were eight	

	ongoing, with two being Patient Safety Incident Investigations, two Maternity and Newborn Safety Incidents (MNSI) and four legacy Serious Incidents (SIs) at the time of writing the report. As of 24 April 2024 there are four open investigations in total and not three as noted in the PSII/SI legacy report presented. LH will amend the report accordingly. • Ten alerts issued were highlighted to QuOC. • There have been eight new alerts and two alerts have been updated, with one requiring a Trust response, however, the Trust is already compliant with this alert within obstetrics and anaesthetics and consideration is being given to other areas in the Trust to ensure full compliance. • Detailed claims and inquest information provided noting four inquests had been attended during the period, two concluded as of natural causes, one as an accidental death and one a narrative conclusion. • Organisational learning described as received from both internal and external sources. LB noted the thorough report provided by LH requesting clarification of a narrative conclusion for a death. LH suggested the narrative conclusion is sometimes issued by H M Coroner (HMC) in conjunction with the family and may be as a result of a discussion, a short narrative which accompanies the outcome or the provision of some additional information to support the outcome. RS discussed a number of options open to HMC and explained if one of the overriding categories does not cover the verdict, then HMC has the option of producing a narrative verdict which is a few sentences rather than a two-word verdict. As part of the CQC information requested, KD queried the length of time taken to close some incidents further noting the length of time taken for some reports to be identified as a safety incident, the date it is reported on StEIS (Strategic Executive Information System), some incidents reported within a week and some having taken up to between 6 to 8 weeks to report. LH noted the initial prolonged discussions around some incidents with further information then identified confirming the incident meets the criteria. A further factor for delay noted those cases requiring consent from family, prior to discussion at QuOC, once MNSI have agreed to take on. LH discussed the process from the occurrence of an incident, the various escalation processes and the review. LR noted the technical point raised that some of the delay for reporting onto StEIS was due to problems with the StEIS system itself and being unable to input data. The new Learning from Patient Safety Event (LFPSE) taxonomy an NHS platform should avoid these issues once this is available for use. The Academy noted the content and was assured following the discussions.	QA24008 Senior Quality Governance Lead (LH)

QA.4.24.10	**Patient Safety Incident Investigations (PSII) and Legacy Serious Incident (SI) Report**	
	LH provided an oversight of the PSIIs declared and PSII or SI investigations completed between 1 and 31 March 2024. Following the go-live of IRIS on 17 January 2024 and the live reporting of PSIIs to the LFPSE platform, there continues to be a small number of bounce backs on a daily basis and these are reviewed and rectified. The majority of bounce backs are not accepted and there appears to be some technical issues with the national system, for example in relation to drug names having been incorrectly recognised by the LFPSE system as patient names. Once rejected these are escalated for review and confirmed by the Trust. LR noted the StEIS reporting system historically used to log confirmed SIs, however, once NHS England confirm the move to the LFPSE platform, StEIS will cease. There were no PSIIs in March 2024 that were identified for reporting or as meeting local or national criteria. The Trust continues to meet Duty of Candour requirements; no breaches having occurred since 2016. The last declaration of an SI under the old framework took place on 29 November 2023 and the trajectory for those incidents to be submitted was 21 February 2024, however, four investigations remain ongoing, two Trust cases (expected to be completed by 4 May 2024) and two currently with the Maternity and Newborn Safety Investigations team (MNSI). The learning from the two SIs was noted. There are four ongoing PSIIs, SIs and MNSIs in total with an error noted in this number on page 8 of the report. The reports that have been signed off have been shared with the QPSA to demonstrate the early learning and improvement to indicate no delay. JC discussed the length of time taken to investigate incidents comparing the old SI framework and noting the new methodology provided for the investigations under PSIRF which has made a huge difference in bringing colleagues together to look at incidents and identify the learning. LB queried how colleagues were experiencing the change to the new process with JC noting colleagues are looking at this very positively, SF confirming the new technology is fundamentally much improved and is being embraced by the team as a much simpler system to negotiate. JC noted herself and LR are registered Patient Safety Specialists with NHS England, who attended the Trust following a patient safety incident, and they are both currently completing an education programme being delivered in both on-line and in face-to-face settings. At this point JC highlighted the on-line training modules are having to be undertaken at home due to the Trust's firewall, however, IT are fully aware. A significant number of staff have also been trained using different methodologies focused on learning. LB thanked JC for the insight and update.	QA24009 Senior Quality Governance Lead (LH)

	LR noted there is no national guidance on the metrics around Patient Safety Incident Response Framework (PSIRF). The national patient safety team is very small following the changes and the Trust is working on the metrics taking into account the qualitative work with the Quality Improvement team built around the four key aims of PSIRF and the metrics to ensure these reflect what the CQC may ask around the patient safety standards. ZA queried Appendix 1 of the report in relation to SI 2023/21514 and SI 2023/17239, stating these have yet to commence in the status column, however, they have agreed extensions with new submission dates. LH noted that this was an error on the spreadsheet and that the first one has commenced and the second is now concluded and these will be updated accordingly. Further training continues to ensure staff have the expertise to respond to patient safety incidents under PSIRF. The QPSA noted the current position of the legacy SIs and the PSIIs with the confirmed assurance processes in place to identify, investigate and learn from patient safety investigations.	
QA.4.24.11	**Maternity and Neonatal Services Update**	
	SH presented the March update and key highlights of the Maternity and Neonatal (Perinatal) Services update to the QPSA: • Yorkshire Internal Audit rated progress and management against the Maternity CQC action plan as Significant Assurance. The service did not receive the top level of assurance due to some timescales, however, when reviewed it was apparent of the difficulties to put short turnaround timescales on some of the actions as these are reliant on significant building work or recruitment plans, so the Unit is confident there has not been a lapse on the part of the service. • Still birth position – Nil. • No cases of Hypoxic-ischaemic encephalopathy (HIE) reported. • Two neonatal deaths reported. • One late maternal death. • Perinatal Mortality Review tool – Quarterly report and associated action plan noted required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme. Cases of harm and opportunities for improvement noted. The Academy were reassured all the standards have already been met or are within the trajectory to be completed in the required timeframe. From the learning actions identified following the reviews within the reporting period no actions identified contributed to the deaths of those babies in the time period, however, areas for improvement were identified within the antenatal period, for example improved documentation regarding previous pregnancy issues to inform the appropriate community and antenatal clinic	

	midwives who book patients in for their pregnancy. One issue raised concerned a missed opportunity for carbon monoxide screening around faulty equipment, this did not impact on the outcome for the baby, however, could potentially have been an issue for another woman. Discussions have taken place with community teams around equipment checks and labelling of blood samples. • The slight lapse in the Maternity dashboard data which is still not 100% complete was noted. This has now been updated by the Deputy Head of Midwifery, who has brought data up-to-date with validation in the absence of the Digital Midwife. • The Digital Midwife post has recently been appointed to with a candidate who has previous experience. This is very reassuring as the new employee will be familiar with the role. • Homebirth numbers are decreasing due to two birthing partners now being allowed to attend hospital births, post-pandemic and visiting restrictions having been lifted. The Homebirth team are actively trying to explore the reasons and promote homebirths. • One to one care in labour remained just below the 90% threshold whilst this might not impact harm to women, patients feel less secure and often vulnerable. • Vacancy rates have improved, however, staffing challenges continue due to sickness and releasing midwives for study. The situation is under continual monitoring. • The Birthrate+ acuity App is now being rolled out and training for this will commence in May with rollout expected in June/July 2024, enabling labour ward co-ordinators and shift leaders to better assess the acuity of women in their areas and assist with the allocation of staff in a different way. If required, escalation processes will also become more apparent enabling timely management. SH noted a conflict with LH's earlier report, but there were no completed internal or external reports in March, however, this could be a time lag in that these have already been reported to the QPSA; SH will cross-reference with LH following the meeting and if anything has been omitted, will ensure it is included in the next report. ***Post-meeting note:*** *SH confirmed that the report referenced by LH has been shared with the QPSA in a previous Maternity and Neonatal Service update. No further action required.* LB noted the clear set of papers. The Academy noted the information provided and was assured that timely information was being received on perinatal quality and safety issues, learning and improvement, following the presentation.	
QA.4.24.12	**Update on Ward Accreditation**	
	JH highlighted the key information to the Academy in the absence of SW, around the Ward Accreditation Scheme referred to as the Bradford Accreditation Scheme, as this not only covers	

	ward areas but covers departments and out-patient areas. JH outlined a suite of ten documents are used with one document covering in-patient areas, the other nine documents having been developed over time with ten different standards. A team of senior nurses assess the areas to identify a rating and this rating determines the date of the next scheduled visit. Since the last update provided to the QPSA, there has been a change in personnel with Sonya Tetley having joined the team in February 2024 as the Nursing and Midwifery Quality Lead, who supports this process. This Scheme is documented on the local risk register, scoring 8, around the delay in accreditation visits affected by such factors as the availability of staff to conduct assessments following winter pressures and industrial action. Standard Operating Procedures will be revised following agreement with the CN and Quality team to align the process to the CQC Framework. Subsequent to the recent CQC inspection, there is learning to introduce and be factored into the recent process around the assessment for the medicine core service as well as Well-Led. Monthly assurance and a shared governance approach to improve will be established to identify how the accreditation visits will be supported. Consideration is being given to stretched targets for Bronze (two areas), Silver and Gold. Further personal targets are issued in clinical areas in order to raise a Bronze rating to Silver and Gold which are awarded following a panel meeting, which includes the CN. The work around nursing excellence supports ward leaders to understand their data and take appropriate action. The information provided to Ward and Departmental Managers includes patient and student nurse feedback. Patient measurement of safety is a key element which is built into audit systems and can be used in terms of the patient voice regarding experience and safety. JH clarified this scheme is for the clinical teams only and not for display purposes. The current status for each area was illustrated to the QPSA. If an area receives a red accreditation then support for improvement is provided to identify the area(s) of concern with this triggering a repeat process. Celebrations are also recognised. JH noted staff are incredibly proud to receive successful ratings in recognition of the work undertaken and an annual review of the accreditation process is undertaken in order new developments and guidance can be incorporated.	

	LB noted the importance of the accreditations regarding quality and safety checking and staff satisfaction. JH noted work is underway to make this a less stand-alone process and link into the broader quality improvement work and to link and develop the clinical areas to improve in all elements under consideration. Once an area is achieving a green status consistently then the area can focus on achieving a higher rating. On behalf of the QPSA, LB thanked JH and SW for the work around this scheme.	
QA.4.24.13	**Digital Report**	
	PR presented the Digital report discussing the enhanced governance and assurance model maintaining pace and equity with the continuing changing dynamics of digital, aligned to the objectives of the organisation and the necessary and appropriate requirements of colleagues. The key enhancements were highlighted: • A range of new contact points introduced in relation to People experience and customer service metrics. • Resources introduced through external third parties. • Workforce and apprenticeship schemes in discussion with the University of Bradford and local Colleges. • Challenges of coding and SHMI viewed through assurance to ensure the Trust recognises the areas of challenge. • Skilled talented workforce continues to be developed. • Cyber Security. • Information Governance. • Electronic Patient Record (EPR) Optimisation and Clinical Developments – Completion of ReSPECT. • Continued deployment of the Theatres, Anaesthesia and Critical Care Cerner module, in conjunction with colleagues in Airedale, with completion expected by the end of September 2024. Some qualitative changes are already visible in the way the system operates due to the involvement of the three-way partnership – Bradford Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust and Calderdale and Huddersfield NHS Foundation Trust. PR noted the continued input into the Informatics function to ensure that the Trust is well-led in digital matters and that leadership is focused on continually striving to improve its service to ensure it delivers digital and change services in a safe, effective and efficient manner. LB thanked PR for the interesting report querying when the Trust could expect to view an improvement in the SHMI data input and the improvements from the coding point-of-view. PR noted that some improvements had already been made, that additional technical steps would be taken and that a programme of wider engagement with those colleagues responsible for capturing data at the point of care was also being developed. As the SHMI	

	calculation is undertaken on a rolling average annual basis it will take time before all of these improvements are reflected in the published "score". LB highlighted the previous research on SHMI undertaken by Dr Mike McCooe, Consultant Anaesthetist, and that the organisation remains confident via its well-developed learning from deaths process and other indicators such as standard mortality rations that there is nothing to currently raise concern. RS noted SHMI is a rolling twelve-month position and is currently approximately four months out-of-date. Some immediate changes have been made and further ongoing improvements will be necessary. The QPSA should begin to see a difference in six months' time and further improvement in figures is expected. LB thanked PR for the update provided.	
QA.4.24.14	**Any Other Business**	
QA.4.24.14.1	RS referenced the submitted evidence to the UK Covid Inquiry noting this has now responded requesting approximately nine queries and seven clarifications, for final submission. The draft responses to these queries/clarifications are currently with the Trust's Legal Advisor and will be submitted by 26 April 2024. Redactions where necessary have been undertaken following agreement with the Inquiry. The Trust will then await further information as to whether evidence in person will be required to be provided in September/October 2024.	
QA.4.24.14.2	LB thanked ZA for his attendance and contributions to the QSPA meetings recently noting some of the Non-Executive Directors are being reassigned to other Trust Academies and this would be his last QPSA.	
QA.4.24.14.3	KD noted DS was leaving the Trust and, therefore, his final QPSA. KD thanked DS for all his work undertaken and contributions over his many years at the Trust.	
QA.4.24.14.4	JC noted and thanked LH as this would be her last QPSA as she is moving into a different role within the Quality team, in the Trust.	
QA.4.24.15	**Matters to share with Other Academies**	
	There were no matters to share with the other Academies.	
QA.4.24.16	**Matters to escalate to the Board of Directors**	
	Histopathology Services – Risk 607 to be highlighted in the Board QPS Academy report.	
QA.4.24.17	**Date and time of next meeting**	
	Wednesday, 22 May 2024, 2 pm to 4.30 pm	

	Annexes for the Quality and Patient Safety Academy **Annex 1 – Documents for Information**	
QA.4.24.18	**Bradford District and Craven Quality Committee (Highlight Report/Minutes)**	
	Noted for information.	
QA.4.24.19	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.4.24.20	**Estates and Facilities Service Report Quarter 4**	
	Noted for information.	
QA.4.24.21	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.4.24.22	**Internal Audit Reports relevant to the Academy**	
	Noted for information: • BH/32/2024 Clinical Coding – 27 March 2024 • BH/33/2024 Business Continuity of Key IT Systems • BH/38/2024 – Medical Records – Deletion and destruction of electronic patient records	

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 24 APRIL 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	May 2024	Post-meeting note: 10.05.24: Update on Summary Hospital-level Mortality Indicator (SHMI) data – Item deferred from the April 2024 QPSA meeting; removed from the May QPSA agenda following PR's discussion with the meeting Chair LB and presentation of a paper to the Board of Directors' meeting on 9 May 2024 (Bo.5.24.4), Matters Arising – Depth of Coding. Completed. **CLOSED.**
QA24008	24.04.24	QA.4.24.9	**Quality Oversight and Assurance Profile** As of 24 April 2024 there are four open investigations in total and not three as noted in the PSII/SI legacy report presented. LH will amend the report accordingly.	Senior Quality Governance Lead	May 2024	10.05.24: LH confirmed the report had been amended and sent to Jacqui Maurice on 24 April 2024. Completed. **CLOSED.**
QA24009	24.04.24	QA.4.24.10	**Patient Safety Incident Investigations (PSII) and Legacy Serious Incident (SI) Report** There are four ongoing PSIIs, SIs and MNSIs in total with an error noted in this number on page 8 of the report.	Senior Quality Governance Lead	May 2024	10.05.24: LH confirmed the report had been amended and sent to Jacqui Maurice on 24 April 2024. Completed. **CLOSED.**

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23017	26.03.23	QA.3.23.6	**Serious Incidents Report (Focus on learning)** ST to do some work with the local police on how the Trust can make improvements to their communication regarding vulnerable patients, bringing a report to the Academy in four months' time.	Assistant Chief Nurse Vulnerable Adults	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 suggested she provides an update on the work being undertaken at the next safeguarding update in June 2024.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						24.04.24: LB noted confirmation that this update will be provided in June 2024.
QA24007	24.04.24	QA.4.24.5	**Quality and Patient Safety Academy Annual Report 2023/24** • Proposed changes to the Terms of Reference and Workplans Terms of Reference and Workplan will be discussed at the June 2024 meeting.	Associate Director of Corporate Governance/ Board Secretary	June 2024	
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	September 2024	Action held over from March meeting. Update to be provided by PR at the April meeting. 24.02.24: PR – Different Laboratory Information Manager Systems (LIMS) are in place across the West Yorkshire Association of Acute Trusts. Multi-year programme now in place to replace the systems. Four systems are to be migrated. Blood science workflows and microbiology workflows have Leeds as a critical partner in the delivery chain, however, Leeds' scheduled go-live has slipped on numerous occasions and BTH is linked to this. Leeds now have a June date and in early August 2024 are working to deploy Clinicist. BTH will follow and it is anticipated to link this with the go-live of the Electronic Patient Record (EPR) in Airedale in late September 2024. Full consideration will be given

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						to this, however, BTH is in the hands of Leeds' colleagues. Assurance was provided through the Finance Directors' network that Leeds has committed £1.5 million of additional resource into meeting this timeline with the programme having been escalated to Chief Executive level. The joint venture in relation to Pathology services with both Harrogate and Airedale is embedded. Further update to be provided.
QA24010						

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) - LEARNING AND IMPROVEMENT MINUTES

Date:	Wednesday, 22 May 2024	**Time:**	14:00-16:50
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 - Ms Julie Lawreniuk (JL), Non-Executive Director **Executive Directors:** - Professor Karen Dawber (KD), Chief Nurse - Dr Ray Smith (RS), Chief Medical Officer		
Attendees:	- Ms Jill Clayton (JC), Deputy Associate Director of Nursing - Mr Kez Hayat (KH), Head of Equality, Diversity and Inclusion - Dr LeeAnne Elliott (LAE), Consultant Paediatric Radiologist/Patient Safety Specialist - Ms Leah Richardson (LR), Patient Safety Specialist - Mrs Sarah Freeman (SF), Director of Nursing (Operations) - Ms Faye Alexander (FA), Head of Education - Ms Caroline Varley (CV), General Manager, Chief Medical Officer's Office - Mrs Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing (Left the meeting at 3.30 pm) - Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes - Dr Yaseen Muhammad (YM), Nurse Consultant/Director of Infection, Prevention and Control - Ms Jane Kingsley (JK), Lead Allied Health Professional		
In Attendance	- Mr Nick Rushton (NR), Patient Safety Manager, Learning from Deaths, for agenda item QA.5.24.5 and QA.5.24.6 - Ms Carly Stott (CS), Head of Midwifery, representing Sara Hollins (SH), Head of Nursing, Midwifery, for agenda item QA.5.24.13 - Ms Ruth Tolley (RT), Quality Lead for Patient Experience, for agenda item QA.5.24.16 - Mr Mark Hindmarsh (MH), Director of Strategy and Transformation, and Mr Naveed Siddique (NS), Service and Business Development Manager, for agenda item QA.5.24.21 - Dr Daniel Cummings (DC), Anaesthetic Registrar, for agenda item QA.5.24.22 - Mr Adam Griffin (AG), Deputy Chief Digital and Information Officer, representing Paul Rice, Chief Digital and Information Officer - 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 J Kitching, Minute taker		

Observers	- Ms Ripaljeet Kaur, West Yorkshire Integrated Care Board Fellowship Participant - Ms Louise Middleton, Transformation Facilitator

Agenda Ref	Agenda Item	Actions
QA.5.24.1	**Apologies for Absence**	
	Mr Mohammed Hussain (MH), Non-Executive Director/Co-Chair (Authorised absence) Dr Paul Rice (PR), Chief Digital and Information Officer Ms Sara Hollins (SH), Director of Midwifery Dr Michael McCooe (MMc), Consultant in Anaesthesia / Associate Medical Director Ms Karen Bentley (KB), Assistant Chief Nurse, Patient Experience Ms Sonya Tetley (STe), Nursing and Midwifery Quality Lead Dr Robert Halstead (RH), Consultant in Emergency Medicine/Associate Medical Director Ms Judith Connor (JC), Associate Director of Quality Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary **Absent:** Ms Sughra Nazir (SN), Non-Executive Director Mr Altaf Sadique (AS), Non-Executive Director Dr Debbie Horner (DH), Deputy Chief Medical Officer/Consultant Anaesthetist Ms Kay Pagan (KP), Assistant Chief Nurse, Informatics Mrs Sally Scales (SS), Director of Nursing/Programme Lead for Magnet Mrs Adele Hartley-Spencer (AHS), Director of Nursing (Operations) Mrs Kay Rushforth (KR), Associate Director of Nursing for Children and Neonatal Services Ms Marianne Downey (MD), Deputy Associate Director of Nursing Mrs Sarah Turner (ST), Assistant Chief Nurse, Safeguarding Ms Caroline Nicholson (CN), Head of Non-Clinical Risk Ms Kelly Young (KY), Deputy Associate Director of Nursing 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 Ms Kavitha Nadesalingam (KN), Rheumatology Consultant/Honorary Senior Lecturer Mr Sean Willis (SW), Associate Chief Nurse, Quality and Workforce Ms Anila Zaman (AZ), Quality and Patient Safety Facilitator	
QA.5.24.2	**Declarations of Interest**	
	There were no declarations of interest.	

QA.5.24.3	**Minutes of the meeting held on 24 April 2024**	
	The minutes of the meeting held on 24 April 2024 were approved as a correct record. Verbal updates were provided at the meeting on the outstanding actions and these are reflected in the action log. The following actions were closed: **QA24004** – QA.2.24.7 (28.02.34) - Post-meeting note: 10.05.24: Update on Summary Hospital-level Mortality Indicator (SHMI) data – Item deferred from the April 2024 QPSA meeting; removed from the May QPSA agenda following PR's discussion with the meeting Chair LB and presentation of a paper to the Board of Directors' meeting on 9 May 2024 (Bo.5.24.4), Matters Arising – Depth of Coding. **QA24008** – QA.4.24.9 (24.04.24) – Quality Oversight and Assurance Profile – Louise Horsley, Senior Quality Governance Lead, confirmed the report had been amended and sent to Jacqui Maurice on 24 April 2024. **QA24009** – QA.4.24.10 (24.04.24) – Patient Safety Incident Investigations (PSII) and Legacy Serious Incident (SI) Report – Louise Horsley confirmed the report had been amended and sent to Jacqui Maurice on 24 April 2024.	
QA.5.24.4	**Matters Arising**	
	Items to escalate from the Chief Nurse/Chief Medical Officer. • Infected Blood Inquiry - RS discussed the recent Government publication, external Infected Blood Inquiry which occurred approximately 40 years' ago criticising historical issues. The Trust had been made aware of the issues prior to publication and had responded appropriately. BTHFT (Bradford Teaching Hospitals NHS Foundation Trust) with Airedale NHS Foundation Trust (ANHSFT) has issued, on 22 May 2024, a joint statement at the request and with approval of NHS England (NHSE). RS did not believe any enquiries/concerns in relation to infected blood had been received, however, noted these may be forthcoming noting those directly affected by the Inquiry have already been contacted by BTHFT. • Covid Inquiry – Following a number of required clarifications received from the first submission, the Trust's final submission to the Covid Inquiry has been made and the Trust will now await to be informed whether a physical presence will be required at the Inquiry in the future. • Unannounced Care Quality Commission (CQC) – KD provided an update following the unannounced CQC Inspection to Maternity and Neonates on 15 and 16 May 2024. Early indications note the CQC seem content with all the areas visited, reporting the CQC felt welcomed to the Trust. A full inspection of all five domains for Neonates and a Safety and Well-led inspection for Maternity had been carried out. No urgent escalations were received at the time. Further enquiries in relation to one open Serious Incident (SI) regarding induction of labour delay, from November 2023, and a historical maternity	

	incident (reviewed at the time by the QPSA), where a lady had received joint antenatal care at both BTHFT and Leeds, subsequently giving birth to a stillborn baby, had been requested and the further information provided. Regarding the latter Healthcare Safety Investigation Branch (HSIB) recommendations were received regarding shared sharing of notes and scans. The Trust is hoping to receive a closure letter this week, informing this part of the inspection is now closed. The CQC report may take up to 70 working days to be received by the Trust, thus indicating this report should be expected around September/October 2024. KD referred to the fact that no urgent escalations had been received following any recent CQC visits to Medicines, Neonates or Maternity. The CQC have reported back to the Trust following the two day visit to Maternity and Neonates, speaking to different staff on shift on both occasions that they had not identified any issues with the culture and had indeed noted a positive culture within the Unit. RS and KD were thanked for the update provided.	
QA.5.24.5	**Mortality Review Improvement Programme**	
	This programme going forward will be incorporated into the Learning from Deaths report, agenda item QA.5.24.6.	
QA.5.24.6	**Learning from Deaths**	
	NR highlighted the annual Learning from Deaths report noting the Mortality Review Improvement Programme had been combined into one document. NR reported the contributions made to both the recent Quality Account and the Annual Report to Parliament. The report was taken as read. LB noted during the CQC Well-led inspection in April 2024 that the Inspectors had conveyed that they felt Mortality Governance and the Learning from Deaths Structured Judgement Review (SJR) programme at Bradford was the best they had seen during their inspections and LB thanked the team and all those involved working in that area. RS reported there has now been a decision made that the Medical Examiner service will become statutory across the country on 9 September 2024. The Trust is currently in a good position, being led by Dr Harry Ashurst, Lead Medical Examiner, well-staffed and well-functioning and the service is again out to advert for Medical Examiners. The QPSA noted the report.	
QA.5.24.7	**Quality Account Improvement Priorities: Quarterly progress update**	
	LT provided an update on the Quality Account Improvement Priorities referencing the four priorities for the reporting year of 2023/24: • Improving the management of deteriorating patients – This is a	

	key metric relating to sepsis screening. On average across all wards approximately 47% of patients are screened. Approximately 64% of patients attending the Accident and Emergency Department are screened once an alert is triggered. The importance of treatment for patients with potential sepsis was highlighted. Data around treatment and time to treatment was recorded as good with a target of 90% for patients with suspected severe sepsis and 86% of patients receiving antibiotics within the one hour time period. Outcome journeys have been followed for the remaining 14% resulting in the findings that the majority of patients did not have sepsis or that treatment was received without completion of sepsis screening. This target is picked up as part of the continued learning and improvement around addressing treatment for deteriorating patients. Deterioration work around the NHSE Worries and Concern pilot is a national initiative and BTHFT is working with NHSE and several other NHS organisations to explore the various ways to encourage patients and their families to get involved in their wellness and illness trajectory. For uncomplicated sepsis 84% receive antibiotics within a three hour period. The Trust is working with Cerner to ensure a more sensitive trigger tool, however, monthly audits confirmed delivery of treatment to patients with suspected sepsis is timely and audits to check for any adverse events relating to delays have also been recorded as good. Sepsis treatment is delivered to patients often prior to the digital alerts being triggered due to good clinical judgement. Confidence was provided that patients are receiving treatment in a timely fashion. A sepsis dashboard is easily accessible to all staff and work underway around the further education of staff to use the available data to drive learning and improvement. • Implementing the three-year delivery plan for Maternity and Neonatal services – Four themes are being introduced: o Listening to and working with women and families with compassion: At this point, KD referenced the work underway, previously undertaken during the Outstanding Maternity Services project with the Maternity and Neonatal Voices Partnership (MNVP) commissioning only three hours a week of time. Following escalation to the Integrated Care Board (ICB), both from MNVP and from the Trust, notification has been received indicating monies will be forthcoming into the West Yorkshire ICB. o Growing, retaining and supporting our workforce. o Developing and sustaining a culture of safety, learning and support. o Standards and structures that underpin safer, more personalised and more equitable care. • Improving patient experience by advancing Equality, Diversity and Inclusion (EDI) – KH noted BTHFT had implemented NHS Equality Delivery System 2 (EDS2) between November 2023 and February 2024, a key equality framework. Domain 1 references provider and commissioner services, Domains 2 and 3 are more organisational around workforce, health, wellbeing and leadership. KH discussed the work around respiratory services also aligned to the CORE20PLUS5 approach to	

	reducing health inequalities and the services considered were lung cancer, sleep services and asthma. A range of Task and Finish groups were developed to consider evidence, requirements and prevention measures. An engagement event had been held in February 2024 with neighbouring Trusts and evidence presented at a community engagement event. The overall score achieved from EDS2 was 'Achieving'. This had previously been discussed at the QPSA in February 2024. This is an annual process and three further service areas will be selected. KH noted this information was shared with CQC colleagues at the recent inspection. • Implementation of the Patient Safety Incident Response Framework (PSIRF). LT noted the EDI programme and the information around advances and progress made. KH highlighted one of the key areas to focus on is working with the Clinical Service Units (CSU) and Directorates in terms of developing local EDI plans with alignment to the Trust's EDI Strategy which provides a clear focus on EDI priorities and encourages the formalisation of local action plans. KH highlighted the importance of linking EDI priorities to the Quality Agenda. KD, KH and LT were thanked by LB for the informative updates.	
QA.5.24.8	**Quality Improvement (QI) Programme Update**	
	LT referenced the Quality Improvement (QI) plan for 2023/24 of prioritised improvement programmes under: • Quality Account Priority – Deteriorating Patient Workstream. • Quality Governance support. • QI Capacity and Capability Building work. Assistance from the Transformation team was noted and the five elements of the Improvement Strategy, Our Journey of Continuous Learning and Improvement 2023/28. An in-depth discussion was held and the following highlighted: • Access to improvement, training and support for all. • Developing QI capacity and capability. • NHSE Worries and Concerns Pilot with the two aims of developing, testing, implementing and evaluating reliable methods for patients/families/carers to escalate concerns about acute illness and deterioration when standard care does not meet their needs, and to routinely input their views regarding their wellness/illness/trajectory and any concerns into the health record with evidence these are acted upon. A Patient Wellness Questionnaire has been adapted for use with staff to gather a patient-reported measure about how well/ill they are feeling. Small tests of change using an improvement approach have been conducted on three ward areas. This has been a fantastic opportunity, well embraced and led by ward staff and clinical teams. The National collaboration has now been completed with the Trust applying an expression of interest	

	and being accepted by NHSE to take part in the first phase of implementation around Martha's rule with 143 other organisations. LB thanked LT for the thought-provoking presentation and noted the importance of the benefits being obtained from the useful tools provided. RS noted this exciting work and the inspiring work undertaken by team Bradford led by LT. RS questioned regarding Martha's rule and the Trust not having the facility of a Paediatric Critical Care Unit (PCCU) and the previous concerns raised by the Adult Critical Care Specialists. This has been recognised and is being considered. Dr Brian Wilkinson, Consultant Anaesthetist, has become involved and is keen to voice and address any issues at national level. JL questioned the patient wellness tool, following its success, whether this tool could be encouraged for use across all wards. LT noted the tool received different views when commenced and this was used in alternative ways. The work is currently being considered by both KD and JH, working with Cerner, Airedale and Calderdale and Huddersfield, in order this will become part of the Electronic Patient Record (EPR). JL noted the discussion around the Improvement Strategy and questioned the approach to delivering improvements and quality and whether this would be an audience for all Academies and Board or whether there would be one focus. MH noted further thought is required as to which Academy would report on the Improvement Strategy with discussions underway - Closing the Gap is being launched on 23 May 2024. LT has been working with Louise Middleton, Transformation Facilitator, in order to identify how colleagues will be supported. Further QI work across the organisation is required around implementation and the reporting issue remains to be decided. KD stressed the importance of testing prior to implementation. LB thanked the team and the report was noted by the QPSA.	
QA.5.24.9	**Serious Incident (SI) Report (Focus on Learning) – Patient Safety Incident Investigations (PSII) and Legacy Serious Incident (SI) Report**	
	LR presented the April 2024 report and appendices highlighting the following: • Four Trust Patient Safety Incident Investigations (PSII) have been concluded between 1 and 30 April 2024: o SI 2023/17239 – Unexpected death of a patient. o SI 2023/19818 – Fractured hip during transfer. o SI 2023/2208 – Delayed diagnosis of intracranial haemorrhage. o SI 2023/2214 – Potential cross-contamination between a haemodialysis patient with Hepatitis B and other haemodialysis patients. • Two outstanding legacy Serious Incidents (SI) have extensions	

	in place and two Maternity and Newborn Safety Incidents (MNSI). • There has been one newly reported MNSI case. The report was taken as read. KD referenced the suite of papers and the depth of information within highlighting the importance of this documentation with the extraction of the learning and saliant points. LT welcomed any feedback from colleagues on this report. Extraction of particular data will also assist when collecting the evidence for the CQC, as recently experienced. Information requested by the CQC on policies and procedures has been readily available, however, the actions and evidence from previous SIs has been more difficult to access and consideration needs to be given as to how this can be undertaken differently. KD proposed at the Executive Team meeting on 20 May 2024, a document entitled, 'Moving to Outstanding Improvement Group' which discussed the current Moving to Outstanding meeting currently referencing all things CQC. The new group would be a more operational assurance group focusing on learning, grouping themes in order information is reported in a way that is more saliant and understandable. LB noted the volume of information provided and the difficulties previously experienced when referring back to legacy SIs and welcomed this consideration, thought and insight. The Academy noted the current position and was assured that the Trust has processes in place to identify, investigate and learn from patient safety incidents meeting national and local reporting requirements.	QA24010 All
QA.5.24.10	**Patient Safety Incident Response Framework (PSIRF)**	
	LR noted the aspirations of PSIRF over the next twelve months for the Trust, around transition and embedding of the framework to demonstrate learning and insights. PSIRF metrics are currently being developed with the QI team. No steer for this has been provided nationally and upon completion the metrics will be presented to the QPSA. There is now one Patient Safety Partner in post, sitting on the Patient Safety Group, and thanks were expressed to the Volunteer Service for supporting this appointment which has taken time to appoint to. LR highlighted the key points of the report: • PSIRF screensaver has been launched and an event for World Patient Safety Day is planned for September. • Discussions underway with psychology colleagues in terms of staff support to link to the Integrated Reporting Learning and Improvement System (IRIS). An appendix will be added to the PSIRF Policy around compassionate engagement, civility and support of those involved in incidents. • Development of a review learning response guide and templates.	

	• Positive staff feedback received regarding open and honest conversations following incidents - An appendix will be added to the Policy around compassionate engagement. • Reporting/escalation structure reviewed as an assurance measure for Patient Safety Incidents (PSII). The Safety Escalation Group (SEG) will reflect in the Terms of Reference PSIRF and the Quality of Care Panel (QuOC). • Assurance provided to the QPSA around PSIRF training. Evidence was recently requested by the CQC to demonstrate staff had been trained appropriately in line with the standards. Training plans are in place for the coming year with support from colleagues at the Improvement Academy and legal partners. • LR and JC are currently completing the nationally mandated Patient Safety Specialist Training, knowledge being shared with teams. • Three PSIIs declared since the Trust went live with PSIRF on 1 December 2023: o 2024/2208 – Delayed Diagnosis of intracranial haemorrhage. o 2024/2214 – Potential cross-contamination between haemodialysis patient with Hepatitis B and other haemodialysis patients. Learning has been received but does not meet the PSII category, this involves an outside agency, therefore, has been declared due to there being no SI framework. The learning is regional/nationwide. o 2024/2217 – Never Event – Patient referred for left renal tumour biopsy with surveillance of the right renal tumour. The right renal tumour was biopsied in error. Learning from the Never Event has been received from the West Yorkshire Association of Acute Trusts (WYAAT) and will be shared across the Trust's CSU groups through quality and safety meetings. • Local priority areas discussed. • Between 17 January and 18 April 2024, 206 incidents were reported, five of which were graded as moderate harm or above, learning will be shared. • Patient Safety System updated provided – The Strategic Executive Information System (StEIS) continues to be used until the Trust is upgraded to taxonomy 6 for learning from patient safety events. Patient safety dashboards are under-development and reporting numbers remain consistent. Safety dashboard in the IRIS system is being developed in order for data to be useable across the organisation. A CQC and action module will be developed within the system. • 30 day and over position for all incidents is being managed. Concerns were expressed due to losing the opportunity for immediate learning or highlighting immediate risks. The team will ensure feedback to teams and provide support where required. • Patient Safety Incident reporting remains consistent – IRIS system to be made more user-friendly. KD noted the recent increase in the number of 30 day and older patient safety incidents. As discussed earlier in the Academy the	

	Moving to Outstanding meeting will consider this data in the future and it was referenced that many of those incidents relate to Estates and Facilities, therefore, a robust plan is required for support from this area. A position report is submitted to QuOC on a weekly basis where a report from Estates and Facilities should be presented. LR noted the 206 incidents reported on slide 9 are separate to those reported on slide 11. The 206 incidents relate to those reported by individuals where they are able to select one of the priority areas from the plan and are categorised. Following the presentation the QPSA noted the update on the current position of PSIRF implementation, the next steps and the Trust's new IRIS and Learning from Patient Safety Events (LFPSE) compliance, noting this is currently work in progress, that the Trust has processes in place to identify, investigate and learn and the Academy was assured.	
QA.5.24.11	**Patient Safety Group (PSG) – Terms of Reference**	
	LAE noted the previously reviewed and subsequently updated Terms of Reference for the PSG reviewed in light of the Trust's transition from the SI framework to PSIRF ensuring the ethos around PSIRF and the National Patient Safety Strategy (NPSS). LAE noted some terminology had changed following the Trust's transition to PSIRF in order to ensure this covers the priority areas and the learning from the priority areas within the plan. The revised Terms of Reference document was approved by the QPSA.	
QA.5.24.12	**National Patient Safety Improvement Programme Update (Removal from workplan)**	
	LT noted the plan to retire this particular item in the next QPSA workplan. The National Patient Safety Improvement Programme is part of national NHSE's approach to understand and support on system level, the work required to be undertaken. There are currently four areas within the National Safety Improvement Programme which includes Managing deterioration and safety, this work being picked up within the Recognition and Response Working Group and through the QI workstream, the Maternity and Neonatal Safety Improvement Group and the Medicine Safety Improvement Programme. A monthly update is provided from QuOC and is also submitted to the Patent Safety Group. Any learning received will continue to be actioned. LB noted the revised QPSA workplan has not yet been compiled, however, thanked LT for the information in advance, acknowledging there are mechanisms in place to ensure the work is picked up and embedded. LT was thanked for the explanation.	

QA.5.24.13	**Maternity and Neonatal Services Update**	
	CS presented the April update of the Maternity and Neonatal Services report in SH's absence. The key highlights were noted: • The contents of the April 2024 report were noted. • The Maternity and Perinatal Incentive Scheme, Year 6, standards were published in April, the service has noted the content and is working towards compliance; the ten safety action titles remain unchanged with a few minor amendments to the required standards. Year 6 includes an option tracker which will be used to update the Board and support submission of evidence. There are no initial concerns regarding ability to achieve the standards at this time, however, monitoring will continue and any risks escalated to the QPSA and the Board of Directors as required. The aim is to continue to reduce the number of stillbirths, neonatal and maternal deaths and brain injuries by 50% by the end of 2025. • Four stillbirths in the month of April were discussed noting any learning identified was shared as appropriate. • There was one case of Hypoxic-ischaemic encephalopathy (HIE) reported, an MNSI reportable incident. Any identified learning will follow and be shared. • Three neonatal deaths noted in April – The cases were discussed noting all outcomes were anticipated. • No maternal deaths in April. • Six ongoing maternity SIs/Level 1 investigations – 3 MNSIs and 3 Trust-level investigations. • No new neonatal SIs or ongoing neonatal SIs. • No completed MNSI or internal SI reports to share with the QPSA during the month of April or to share at closed Board • There was one MNSI case reported and this has been declared as an SI. • No unit closures and there were no occasions where the unit was assessed as needing to divert women to other organisations. • The MNVP Leads have had a number of escalations of concerns from staff during April, re issues around their capacity to undertake their role to the required standard within the current resource arrangements. Two members of staff have raised safety concerns for which unfortunately the forthcoming information has been limited, the staff wishing to remain anonymous, thus affecting the ability to ascertain their concerns and to ensure robust plans are in place to resolve the issues. The capacity of the MNVP leads has been escalated to the ICB who receive funding for these posts. If capacity is not increased a local solution to address will be considered. The MNVP Leads are liaising with staff members who have raised concerns to try and ascertain whether further information can be provide by speaking confidentially to a member of the Midwifery team or anyone in the Trust. The positive culture around escalation of concern will be further explore.	

	LB requested clarification of the table on page 12 of the report illustrating the neonatal death position, referencing the number of expected deaths. LB noted this suggests it appears three neonatal deaths may have been expected, however, the report suggests two. ***Post-meeting note*** **-** *There were three neonatal deaths in April. Two babies had known congenital abnormalities and were, therefore, expected deaths. The third baby was born at 24 weeks with medical complexities which gave a high probability of mortality.* JL noted the recent CQC visit and the report raising concerns in Maternity and queried whether there was any known concern regarding the culture in Maternity. KD referenced her monthly drop-in with staff, two Freedom to Speak Up (FTSU) Guardians in Maternity and the Maternity Champion meeting attended by a Non-Executive Director (last meeting held on 14 May 2024). During the recent CQC inspection MNVP raised issues directly to the CQC all of which had been discussed. One case related to a lady who had sadly died and one case reported was an allegation that a member of midwifery staff was intoxicated whilst on duty. The Trust has no clue as to whom this allegation refers to. This latter message has been passed to the MNVP stating if the person who has reported this concern is a registrant, then the registrant has a duty to inform the Trust of the name of the intoxicated individual. Another concern raised regarding 'time' was also difficult to substantiate without further information. As noted previously the Trust has no way of identifying who has made these claims, reporters may be current staff members from Maternity or elsewhere in the Trust, whether the staff member is in post or a past member of staff. In response to these issues the FTSU Guardian has set up her own meeting to look at Black, Asian and Minority Ethnic (BAME) staff progression. Following issues and safety concerns raised around the birth centre/labour ward staffing it has recently been reported that birth centre staff are overwhelmingly satisfied to carry on with the current staffing model with continued support. KD noted Maternity is probably the most scrutinised area in the entire Trust, following frequent walk-rounds with the slightest errors reported. Systems continue to be designed as flawlessly as possible and staff are encouraged to inform managers of any concerns and be open in order improvements, where necessary, can be made. The Trust reports externally on certain criteria around stillbirths and cases of HIE, however, this does not necessarily apportion blame; the service is stringent on how it reports. JL thanked KD for this informative information. The QPSA was assured by the information and detail provided with concerns raised via the various routes being taken extremely seriously and addressed. Those who do speak up are listened to and issues are followed up. No concerns were noted by the Academy and the QPSA were fully assured. CS was thanked.	

QA.5.24.14	**Infection Prevention and Control (IPC) Quarterly Report**	
	YM presented the Quarter 4 IPC progress report, January to March 2024 and highlighted the following: • BTHFT position in relation to National and Regional data described with twelve months of rolling data discussed and comparison noted against other Trusts in the region for MRSA, MSSA, E coli, pseudomonas and Klebsiella, with the only concern being around MSSA, the figures being slightly higher than average. • Covid-19 and influenza cases for England were noted with the peak for influenza being in February 2024. The flu season is now officially over which is assuring. Over 150 cases of influenza identified in February at BTHFT. • The new Covid-19 Omicron JN.1 demonstrated there is no evidence that this illness is causing more severe disease. • Targets highlighted for the mandatory organisms reported at BTHFT. In summary the Trust equalled the target number of C difficile cases. Nine cases were identified in April 2023, however, eleven months later the Trust broke even. The Trust, however, exceeded the targets for E coli bacteraemia by 8 cases and Klebsiella bacteraemia by 12 cases. No target was provided for MSSA bacteraemia, there being no national objective for MSSA. It was noted regionally Trusts struggled with C difficile targets. • Mandatory organisms – Targets were discussed with comparisons made to the previous years of 2022/23. C difficile and E coli were below the 2022/23 target. MSSA and Klebsiella cases were slightly increased on the number of cases in 2022/23. The cases are being scrutinised for consideration of interventions for improvement. • The IPC Board Assurance Framework (BAF) was discussed, consisting of 54 standards in total, noting full compliance of 50 standards with only two elements partially compliant and following mitigation and where appropriate actions have been taken. The Water Safety plan should be approved at the next Water Safety group meeting and a plan is in place for more side rooms in Ward 1. A business case has been written for another Pharmacist with antimicrobial stewardship responsibilities. • Hydration improvement plan project is underway regarding E coli. • Bacteraemia reduction measures noted – Comprehensive improvement plan updated regularly with immediate review of cases for quick learning and triangulation of cases using PSIRF. • Audits of Octenisan currently non-compliant on IRIS – A tool has been applied regarding Octenisan baths for patients. • C difficile reduction measures. LB thanked YM for the comprehensive report and the detail noted and enquired how the team had adjusted to the changes to PSIRF from post-infection reviews. YM noted satisfaction in the system improvement with the new process regarding post-infection reviews being undertaken for each individual case in order to identify immediate learning and route cause.	

	The QPSA was assured by the Quarter 4 report noting monitoring of the activity by IPC and the annual work programme. The actions arising and recommendations in the report were approved.	
QA.5.24.15	**High Level Risks**	
	RS presented the report noting the discussion of the high-level risks at the Executive team (ET) meeting held on 13 May 2024. • The risks scoring 15 or above are escalated to the relevant Academy with 15 risks currently aligned to the QPSA. These risks have all been previously discussed at the Executive team meeting. • Risk 447 - Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is currently past its target mitigation date as the system is now live on the Electronic Patient Record (EPR). The detailed overview of all current high-level risks and the number of changes made to the target mitigation dates were noted. • One new risk has been elevated to the high level risk register – Risk 2542, currently storing 16, Haemonetics Blood Track Kiosks relating to a Blood tracking system for blood transfusions, track and trace storage and safe transfusion of blood to patients. The Trust's system is relatively old with one of the Kiosks in Maternity linked to the blood fridges, requiring patient details to be scanned prior to fridge opening to obtain the correct patient's blood is broken and unrepairable or replaceable. Mitigating actions are in place. Unfortunately the whole system will require replacement, a software upgrade and a change required as to how the Trust's blood products are managed. There is concern regarding the server for which blood products have to be retained and information tracked. Further details have been required and any replacement will be high cost. • No risks have been closed during the period. • No risks have changed in score since the last report. • Three appendices were noted, the list of risks relevant to the QPSA, plan on a page and two outliers, Risk 3660 and Risk 3404 are not easily solvable, one being around maternity staffing and one around pressure on paediatric services. These are expected to remain on the list for sometime. Regarding Risk 2542, LB noted both patient safety and the financial concerns. JL requested an updated on the blood fridge risk timescales noting this concerning risk. RS reported some equipment has already been received, however, prior to use a software upgrade is required to allow full function of the system and the need for staff training. RS confirmed the appropriate controls and mitigations are in place of which the Board is fully aware. The Academy confirmed there was sufficient assurance that all relevant key risks had been identified and reported and are being managed appropriately. Risk 2542 will be highlighted to the Board of Directors.	QA24011 Head of Corporate Governance (JM)
QA.5.24.16	**Patient Experience Annual Report**	

	RT presented the report on behalf of KB, noting that the report included information on complaints and the Patient Led Assessment of the Care Environment (PLACE) noting the aims of the Patient Experience Engagement team and those teams within the Patient Experience and Involvement umbrella who provide the work involving patients across the Trust. The key highlights were noted: • Patient Experience and Engagement Strategy 2023-2028 – Kindness at every step – no decision about you without you, has been well received by nursing teams. • Patient representation on the Patient Experience Group. Teams are encouraged to attend the Patient Experience Group within the Trust. • Community Engagement Group working with Equality Diversity and Inclusion (EDI) colleagues to recruit volunteers to assist providing their voice. • Friends and Family Test (FFT) feedback. • Areas demonstrating learning, for example patient stories from different arenas with different themes. Extremely valuable asset for learning purposes leading to service improvement. • Listening events. • Liaison with Healthwatch. • Veteran work over the last twelve months linked to the EPR. • Revised Visiting Policy – Audits undertaken with patients, visitors and staff. • Availability of real-time feedback. • Patient and Public Involvement projects – Pennine Breast Screening Service following an increase in DNA rates identified due to non-availability of childcare facilities, solutions being considered. • PLACE visits continue to be planned. • Patient Information Communication and Accessibility – Accessible information standard training is now delivered at Trust induction and via the Electronic Staff Record (ESR), flagging patients with communication difficulties and enabling additional support to this group of patients. • A-Z index for patient information leaflets using smart technology and QR codes under discussion. • New project underway with Accessible 360 digital plan of Bradford Royal Infirmary (BRI) to be made available. • Commissioned the use of Electronic Import Delivery Order (EIDO) leaflets – Suite of procedure leaflets available for patients in different languages, for printing, if required. Leaflets also available in Easy Read. • CardMedic App implemented, an addition in the toolkit for staff, to use in an emergency for interpreting services. • Assurance was provided via a number of routes and services demonstrating improvement. High assurance had been received on external audits (PLACE, complaints and visiting) in recent months. • National and local awards had been received recognising the patient experience work.	

	The QPSA were assured of continued commitment and the future steps were noted: • Shared learning repository for complaints under consideration. • Implementing new Parliamentary Health Service Ombudsman standards around early resolution. • Development of the patient experience dashboard providing a quick and easy update of work underway. • Service improvements. • The amount of work submitted to the Annual Report from the Patient Experience and Involvement teams and teams at operational level demonstrates full commitment to patient experience. JL congratulated the team on an 87% score for the FFT, rating the service good/very good. RT noted the Trust's score is above national average. LB thanked the team for all the work and the QPSA was assured by the report presented.	
QA.5.24.17	**Clinical Audit High Priority Plan**	
	LT presented the programme of work of the Clinical Outcomes Group referencing the national clinical audit and patient outcome programme. This plan is informed from a list of audits from the Quality Accounts for 2024/25 published annually by NHSE and is an NHS Standard Contract requirement the Trust is contractually obliged to undertake. The work this year will ensure closer engagement with the CSUs working alongside QPS Facilitators. An away day was held in May 2024 to identify improvement priorities with part of that work to understand the opportunities of learning from both national and local clinical audits and recruitment has been made to the team to identify and support the national programme. There are 59 out of a total of 74 audits where the Trust is eligible to take part, to be completed in 2024/25. Some support will be provided as appropriate by the Quality team, particularly to those areas with a disproportionate number of national clinical audits. Clinical leads will present their findings at the Clinical Outcomes Group sharing any learning and improvements, not just from national recommendations but also from a local point-of-view and this will be led by PM. Recent challenges around a cardiology audit were noted, however, the audit is now on track and will hit the deadline. Data quality checks are essential in order demonstration can be made if requested to, for example, the CQC, around delivering care to patients according to best practice. LB noted the huge amount of work required for some audits. RS noted the clinical teams will report through the Clinical Outcomes Group their learning, driving learning and improvements which are sometimes difficult to demonstrate.	

	The plan was noted by the QPSA.	
QA.5.24.18	**Clinical Audit Annual Report**	
	This item was deferred until the July 2024 QPSA, as the report has not, as yet, been shared and signed off at a Clinical Outcomes Group meeting.	QA24012 Head of Quality Improvement and Clinical Outcomes (LT)
QA.5.24.19	**Mental Health Strategy**	
	KD informed the Academy that due to unforeseen circumstances unfortunately this item has had to be deferred. ***Post-Meeting Note*** *– KD agreed this item would be deferred until the Learning and Improvement QPSA scheduled to take place on Wednesday, 25 September 2024. This item will be added to the agenda.*	QA24013 Assistant Chief Nurse Safeguarding and Vulnerable Adults (ST)
QA.5.24.20	**Getting It Right First Time (GIRFT) Update**	
	CV presented the GIRFT update, GIRFT being a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting data driven evidence-base to support change. 32 GIRFT deep dives have taken place at the Trust since 2016 with all specialities having had a deep dive and five peer review meetings having taken place. As part of the peer review meetings other Trusts in WYAAT in the local region were included and the recent meetings included an Ophthalmology Gateway Review: West Yorkshire Integrated Care System Peer Review meeting held in November 2023 and a Pancreatic Cancer Peer Review meeting held in March 2024. Four further peer review meetings will be scheduled to take place this year. A GIRFT page on the intranet is now available to access local/ national resources, reports, speciality packs and best practice guides. The main priority nationally and also for the Trust in 2024/2025, is the 'Further Faster' programme described, as a key priority for 2024/25. This programme aims to bring together clinicians and operational teams with the challenge of how collectively the programme can transform pathways taking into account elective waiting lists and backlogs, using GIRFT methodology to rapidly adopt best practice across a range of clinical pathways. 'Further Faster' work has been undertaken nationally for a number of months and the Trust will partake in Cohort 3. Work has been ongoing for a number of months and undertaken in relation to this, focusing on outpatient transformation and building upon and extending from the GIRFT work that has originally been undertaken. GIRFT outpatient recommendations are already in circulation and 'Further Faster' will build on the existing work.	

	'Further Faster' focuses on 16 specialties and there are plans for this to extend into additional specialties that have not already been covered. The approach was described with significant quality and patient outcome benefits for the specialties and a number of conversations have been held regionally as part of GIRFT meetings with specialities and senior colleagues. The themes to be covered were described which all have a huge impact on services. The 'Further Faster' work is being led by Dr Kavitha Nadesalingam, GIRFT Clinical Lead, and Terri Saunderson, Director of Operations, to identify how these recommendations can be embedded into local services. National clinical specialty meetings and national webinars are arranged to share best practice and learning. Details of the Pancreatic Cancer Peer Review held in March 2024 at the Trust were discussed with this being a review of pancreatic cancer services in England. The review is ongoing and focuses on improvement at Network level with the aim of achieving excellent clinical outcomes for patients with pancreatic ductal adenocarcinoma. A number of recommendations have been listed following concerns raised recently on the back of Peer Review meetings around workload within the specialty and under-resource of the Clinical Nurse Specialist (CNS) team. These highlighted concerns raised link to an existing risk on the Risk Register - Risk 2549 (Workforce constraints within Non-Surgical Oncology (NSO)) currently scoring 16, with the principle risk being failure to maintain the quality of patient services. There is also a risk that the current NSO workforce within both BTH and WYAAT cannot continue to support the current NSO model of care within the region which will cause harm to patients. The significant challenges over the years and the control measures in place were described, with local monitoring of waiting times and additional sessions delivered where possible. A locum consultant has been approved and Executive sponsored involvement in the NSO programme was noted. The actions going forward were noted, with the NSO programme tasked by WYAAT to develop a robust and sustainable model for delivering NSO services in West Yorkshire and Harrogate. A meeting is due to take place with the national GIRFT team and Professor Tim Briggs, Chair of the national GIRFT programme, and RS, on 24 May 2024 to look at the concerns raised from the pancreatic peer review and discuss the join service between BTHFT and ANHSFT. RS noted the challenges regarding sickness, recruitment and retention between the two organisations, referencing the ongoing work at Place with the NSO programme and also WYAAT Non-Surgical oncology programme considering new opportunities.	

	Each sector will develop their own Target Operating Model and will work to implement this model over the duration of the NSO Programme. GIRFT has changed with a traditional GIRFT and a 'Further Faster' GIRFT, both under the GIRFT banner. Traditional GIRFT concerned quality first and was quality led, 'Further Faster' concerns productivity only. LB Noted the helpful insight of the work underway behind the high-level risk. JL queried the testing behind the review. CV noted the Trust has been involved in the deep dive visits made available to the organisation in collaboration with the national team and amounting to 32 in total. The shift is now to peer review meetings with four planned to be scheduled this year and these meetings will include representation from Bradford, Leeds, Calderdale and Huddersfield, Airedale and Mid-Yorkshire coming together to consider clinical specialties at system level and the approach to adopt going forward. The QPSA was assured following the presentation.	
QA.5.24.21	**Update on Health Inequalities (HI)**	
	MH noted the recently published useful national documents, one of which the Trust has recently benchmarked itself against and which forms the foundation of the Trust's plan around HI for the remainder of the year. NS as Trust Lead for HI noted in early April NHS Providers published the guidance, 'What Good Looks Like', discussing how HI can be considered across the organisation including Board, Human Resources, clinical and operational areas with a core purpose of the guidance to demonstrate how addressing inequality should be a Trust-wide priority. Guidance was informed by NHSE's policy and publications for example, CORE20PLUS5, describing some of the best practice observed by NHS Providers. Within the guidance a self-assessment tool is included to understand where an organisation is in terms of addressing HI, NS noted the Trust has used the tool to self-assess, to understand the Trust's HI level and whether there are areas to improve or strengthen, for example clinical services, HI data and the Trust's role as an anchor organisation. The self-assessment covers four domains individually rated after responses were provided and each domain received a maturity rating ranging from 'not started' to 'thriving' and these were discussed: • Building public health capacity and capability rated as Emerging - Understanding the needs of the local population, availability of HI training and support provided to operational clinical teams around inequalities. • Data, insight, evidence and evaluation, concerned data engagement and research, performance and business intelligence and rated as Maturing.	

	• Strategic leadership and accountability considered leadership, existing reporting arrangements, commitment and CORE20PLUS5 and rated as Developing. • System Partnership – Place level work, rated as Maturing. NS discussed the areas for improvement with the QPSA which included HI training for both the Board of Directors and staff, the use of population health data and focusing on outcomes and equality of experiences. The next steps were noted including utilisation of the expertise available from the Bradford Institute for Health Research Improvement Academy, as this is one of the Trust's top priorities. Some intelligence has been published recently to highlighted some inequalities and how these can be addressed through the secondary care sector and a meeting has been convened to discuss. An action plan is in development to be aligned to the NHS Providers guidance, the CORE20PLUS5 HI statement and the Trust's own priorities and these will involve colleagues from across the Trust in order to increase involvement and raise the profile of HI. LB noted this significant ambition noting Bradford has huge challenges and huge opportunities to make a difference. MH thanked NS and his colleagues for the work undertaken referencing the work currently underway across the organisation highlighted at the May Board of Directors meeting, that links and relates to the HI work. The national prominence around HI work locally and involvement of some partners in the wider health and care partnership will further strengthen these initiatives. LB noted the ask to consider all things HI and the QPSA were assured noting the detail of the paper and the intended actions.	
QA.5.24.22	**Hospital at Night Safety Huddle Update**	
	DC, Trust Chief Registrar, was welcomed to the meeting to present Critical Care Without Walls – Implementation of a Nightly Safety Huddle, a QI project set up with colleague Dr Alex Small, Anaesthetic ICU Registrar. The Safety Huddle meeting attended by representatives from outreach, critical care, medicine and the Command Centre, takes place nightly in the Command Centre, and has been running since November 2023. Attendance was reported as very good. The Huddle is open to other areas for example surgery and paediatrics to discuss in-patients of concern and includes review of the GE deteriorating patient tile to identify in-patients who are at risk of deterioration overnight. Over half of the meetings have detected a patient who was at risk of deterioration who the group was not previously aware of ensuring appropriate care, overnight management and escalation as necessary. Capacity and enhanced care areas of Intensive Care Unit (ICU), High Dependency Unit (HDU), Hyper-acute Stroke Unit (HASU), Coronary Care Unit (CCU) and Acute Respiratory Care Unit	

	(ARCU) are also reviewed allowing contingency plans to be made. This also enables the downstream of patients appropriately to safe places ensuring prompt unplanned admission of patients if required. Pre- and post-implementation questionnaires were circulated and as a result the Huddles have improved confidence in knowing colleagues on shift, those working as part of the Crash team improving communication and function during emergencies and better role allocation, identifying learning needs for junior staff allowing development in leadership and educational skills during the situation and improving confidence of junior doctors in escalating to their seniors, to ICU or to the outreach nurses. DC noted the reduction in the number of Crash calls for cardiac arrests per month since the inception of the Huddle. Where appropriate patients on wards are visited avoiding patient deterioration ceilings of care and resuscitation orders put in place thus avoiding inappropriate cardiac arrest calls due to patient palliation. Clare Nandha, Lead Sepsis Nurse, investigated the recording of, and response to NEWS2 score for unplanned critical care admissions which demonstrated a marked improvement in ICU CQUIN performance and results were discussed highlighting unplanned admissions to ICU, predominantly out-of-hours, never scored a NEWS score of greater than five at any point during their admission confirming involvement with these patients earlier, either by timely admission or improved ward management avoids patient deterioration. Length of stay for all unplanned ICU admissions from 1 January 2023 to 30 April 2024 was highlighted, noting a decrease in the average length of stay for unplanned ICU admissions dropping from seven to five days on average. Qualitative feedback from colleagues for both pre- and post-implementation surveys of areas involved noted. LB thanked DC noting this perfect example for the Learning and Improvement agenda for the QPSA. RS thanked DC for this work, noting the unmeasurable benefits and relationships between the different teams and referencing the confidence that people have articulated in terms of their willingness to escalate, knowing how to escalate and having the confidence to escalate. This relates to the concerns pilot discussed in agenda item QA.5.24.8 around Martha's rule. MH noted the impressive work and the difficulties to undertake this across the entire organisation bringing colleagues into the Huddle, ensuring full engagement and noting the impact on the effective relationships across the Trust.	

	SF noted this Huddle has been really well received in terms of nursing staff on wards, being particularly useful when issues have arisen with vapotherms. The evening Huddle links in with the morning Trust Safety Huddle and the operational meetings to ensure continuous oversight of risks. DC noted the goals set to try to improve the lives of junior doctors working overnight, ensuring full support. The metrics demonstrate unmeasured improvements and determining causality is difficult. DC thanked Dr Small for their huge amount of input into this project, DH and Sarah Buckley, Clinical Lead for Patient Flow and Command Centre, who have also championed this throughout. LB noted this positive work and the QPSA were assured by the findings.	
QA.5.24.23	**Any Other Business**	
	There was no other business to discuss.	
QA.5.24.24	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
QA.5.24.25	**Matters to Escalate to the Board of Directors**	
	Risk 2542 - Haemonetics Blood Track Kiosks to be highlighted in the Board QPS Academy report.	
QA.5.24.26	**Date and Time of Next Meeting**	
	Wednesday, 26 June 2024, 2 pm to 4.30 pm.	
	Annexes for the Quality and Patient Safety Academy	
	Annex 1 – Documents for Information	
QA.5.24.27	**Patient Safety Group Minutes**	
	Noted for information.	
QA.5.24.28	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.5.24.29	**Clinical Outcomes Group Minutes**	
	Noted for information.	
QA.5.24.30	**Patient Experience Group Minutes**	
	Noted for information.	
QA.5.24.31	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.5.24.32	**Internal Audit Reports relevant to the Academy**	
	Noted for information: BH/39/2024 VTE Assessment – 15 April 2024. BH/40/2024 Risk Management Framework and Strategy.	

Bradford Teaching Hospitals NHS Foundation Trust

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 22 MAY 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23017	26.03.23	QA.3.23.6	**Serious Incidents Report (Focus on learning)** ST to do some work with the local police on how the Trust can make improvements to their communication regarding vulnerable patients, bringing a report to the Academy in four months' time.	Assistant Chief Nurse Vulnerable Adults	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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						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. 24.04.24: LB noted confirmation that this update will be provided in June 2024.
QA24007	24.04.24	QA.4.24.5	**Quality and Patient Safety Academy Annual Report 2023/24** • Proposed changes to the Terms of Reference and Workplans Terms of Reference and Workplan will be discussed at the June 2024 meeting.	Associate Director of Corporate Governance/ Board Secretary	June 2024	18.06.24: Item added to the 22 July 2024 (was 26 June 2024) QPSA agenda. Completed. **CLOSED.**
QA24010	22.05.24	QA.5.24.9	**Serious Incident (SI) Report (Focus on Learning) – Patient Safety Incident Investigations (PSII) and Legacy Serious Incident (SI) Report** KD referenced the suite of papers and the depth of information within highlighting the importance of this documentation with the extraction of the learning and saliant points. LT welcomed any feedback from colleagues on this report.	All	July 2024	
QA24011	22.05.24	QA.5.24.15	**High Level Risks** Risk 2542 will be highlighted to the Board of Directors.	Head of Corporate Governance	July 2024	

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24012	22.05.24	QA.5.24.18	**Clinical Audit Annual Report** This item was deferred until the July 2024 QPSA, as the report has not, as yet, been shared and signed off at a Clinical Outcomes Group meeting.	Head of Quality Improvement and Clinical Outcomes	July 2024	12.06.24: Item added to the 24 July 2024 QPSA agenda. Completed. **CLOSED.**
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	September 2024	Action held over from March meeting. Update to be provided by PR at the April meeting. 24.02.24: PR – Different Laboratory Information Manager Systems (LIMS) are in place across the West Yorkshire Association of Acute Trusts. Multi-year programme now in place to replace the systems. Four systems are to be migrated. Blood science workflows and microbiology workflows have Leeds as a critical partner in the delivery chain, however, Leeds' scheduled go-live has slipped on numerous occasions and BTH is linked to this. Leeds now have a June date and in early August 2024 are working to deploy Clinicist. BTH will follow and it is anticipated to link this with the go-live of the Electronic Patient Record (EPR) in Airedale in late September 2024. Full consideration will be given to this, however, BTH is in the hands of Leeds' colleagues. Assurance was provided through the Finance Directors' network that Leeds has committed £1.5 million of additional

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						resource into meeting this timeline with the programme having been escalated to Chief Executive level. The joint venture in relation to Pathology services with both Harrogate and Airedale is embedded. Further update to be provided.
QA24013	22.05.24	QA.5.24.19	**Mental Health Strategy** KD informed the Academy that due to unforeseen circumstances unfortunately this item has had to be deferred. ***Post-Meeting Note*** *– KD agreed this item would be deferred until the Learning and Improvement QPSA scheduled to take place on Wednesday, 25 September 2024. This item will be added to the agenda.*	Assistant Chief Nurse for Safeguarding and Vulnerable Adults	September 2024	12.06.24: Item added to the 25 September 2024 QPSA agenda. Completed. **CLOSED.**
QA24014						

BO.7.24.26 - CONFIRMED AUDIT COMMITTEE MINUTES

REFERENCES

Only PDFs are attached

Bo.7.24.26 - confirmed Audit Committee minutes 22.4.24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

DRAFT AUDIT COMMITTEE MEETING MINUTES

Date	Monday, 22 April 2024	**Time**	14:00 – 16:20
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) • Karina Edwards, Internal Audit, Audit Yorkshire (KE) • Chris Boyne, Deputy Director, Internal Audit (CB) • 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.4.24.20, A.4.24.21, A.4.24.22

No.	Agenda Item	Action
-	**Private meeting with Audit Committee members, Internal and External Audit**	
A.4.24.1	**Apologies for absence** • Helen Higgs, Internal Audit, Audit Yorkshire (HH) **Absent** • Sughra Nazir, Non-Executive Director (SN)	
A.4.24.2	**Declarations of interest** No interests were declared.	
A.4.24.3	**Minutes of the meeting held 21 February 2024** The minutes of the meeting held on 21 February 2024 were approved as a correct record.	
A.4.24.4	**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. • A24001 – Internal audit progress report – action closed • A24002 – Internal audit progress report – data warehouse – action closed • A24003 – Internal audit progress report – action closed	

	• A24004 – Follow up of internal audit recommendations – action closed • A24005 – Follow up of internal audit recommendations – action closed • A24006 – Internal audit report (limited assurance) BH262024 – action closed **Updates were provided at the meeting as follows:** • A24007 - 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. LP & BM will review the AC handbook and the changes to the TOR, workplans and agendas prior to providing an update to the AC – action to remain open. • A23025 - Partnership arrangements: implications for the Audit Committee - JH noted that an update to the public sector internal audit standards is due imminently which will be shared once it is received – action to remain open.	
A.4.24.5	**Sector update and benchmarking report** PH advised this item is included within agenda item A.4.24.6	
A.4.24.6	**External Audit Annual Plan 2023/24** PH and NR provided an overview of the external audit plan which sets out the assessment of the significant risks for the forthcoming audit of the accounts ended 31 March 2024. NR drew attention to the following key items within the paper: **Capital expenditure** A significant audit risk was identified due to the Trust having a large capital programme, which is consistent within the sector. A sample of items will be tested to ensure they have been correctly accounted for along with any associated revenue. An additional part of the testing is around the use of vesting certificates and ensuring they are used in line with managing public money rules. **Management override of controls** A requirement of the financial statements is to consider the management override of controls risk around posting of journals. A testing of samples will be undertaken based on fraud characteristics identified by the software. **Quality indicators** A number of areas of the Trust's financial reporting and accounts close process were identified as "mature" and needing only limited improvements but there were also areas which were identified as "developing" or "lagging" with improvements needed. **Determined materiality** A materiality level of £11.3m will be used for the Trust in planning the audit. This decreased slightly when we calculated this at planning for the forecast position. This will be recalculated once the updated year end information is received, although it is not expected to change significantly. The scope is based on the level of overall materiality, but tests are undertaken to a lower materiality which is forecast around £8.5m.	

	Misstatements Any misstatements above £300k will be reported in the audit.. **Planned timing of the audit** Planning and interim work has been completed. Work will commence on the year end field work over the next couple of months. **Scope of work and approach** There are three key areas of responsibility under the Audit Code which are Financial Statements, Annual Governance Statement and Value for Money (VFM). In relation to the Value for Money work, unlike last year, this must be signed off before signing off the financial statements, so this work has been brought forward in line with the work on the financial statements. **Value for Money:** • **Risk of significant weakness** - a significant weakness in the governance arrangements of the Trust due to the resignation of the former Chair and subsequent issues raised by NEDs has been identified. JL raised the issue around the detail contained within the risk description on page 2. It was agreed that JL, on behalf of the AC, would speak with PH outside of the meeting to discuss the wording. PH requested that the CQC inspection report is made available to them prior to completion of the audit. • **Areas of focus – Financial sustainability/CIPs -** As the Trust is forecasting a small deficit in 2023/24 the financial performance and achievement of CIP targets as well as the governance structures in place to meet its control total will be reviewed via the VFM work. **Property valuation** Additional work has been ongoing to address the two recommendations raised at last year's audit. A risk assessment is being undertaken to consider if there is a risk of a significant misstatement in relation to the property valuation for the current year, although it was not envisaged that a significant risk will be included as part of this year's audit. Due to the Trust changing their underlying assumptions it is expected that this will be a significant risk this year and included in the final report. MQ confirmed that following a file review at Deloitte a significant amount of work has been undertaken to ensure that the Trusts audit working papers meet the requirement of the Deloitte's file review. BM felt that if there is a significant risk and it becomes a major issue of interpretation in the accounts then committee members may need an explanation offline so that they fully understand the issues under discussion. **IFRS 16** Due to the recommendations made last year, IFRS 16 remains an area of focus but is not a significant risk. It is envisaged that over time this item will become a silent part of the report as business as usual. **Other issues**	Board Secretary A24008 Non-Executive Director (JL) A24009

	Remuneration disclosures will remain an area of focus to ensure that the disclosures are correct as the requirements change regularly. BM asked for clarification on the statement on page 46 which reads '*If the provision is released in the current year, expenditure will be understated by £1.2m'* and if there was any perceived risk to the Trust's reported financial position in 2023/24. MQ confirmed that, for the annual leave accrual, we have taken steps and are in line with the accounting standards although there are some new accruals included within the accounts. It was noted that arrangements have been put in place to improve the working relationship between the finance team and Deloitte to avoid the delays seen last year. The Committee noted the report and the assurance provided.	
A.4.24.7	**Use of External Audit to provide non-audit services (standing item)** There was nothing to report on this item.	
A.4.24.8	**Internal Audit progress report** KE provided an overview of the paper which details the progress made towards the delivery of the 2023/24 Internal Audit Plan. Thirteen reports have been issued since the last meeting. Two have high assurance, ten have significant assurance and one has low assurance. One management change to the plan is the request to cancel the cyber security audit due to insufficient Audit Yorkshire clients participating to facilitate a benchmarking exercise. KE noted that the data security and protection toolkit is changing next year to become the Cyber Assessment Framework (CAF) which we understand will have a bigger focus on cyber security. The CAF will be covered by internal audit in 2024/25. 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 87%. ZA asked for clarity on the Head of Internal Audit Opinion and the work for 2023/24 that isn't completed by year end. KE confirmed that the Head of Internal Audit Opinion report would be presented to the May AC which will be a snapshot of the current position and the work completed to date. She was optimistic that all the IA reports would be finalised but there may be a possibility that 2 or 3 remain in draft form although a significant amount of field work will have been completed to enable a meaningful Head of Internal Audit Opinion and the Annual Report. Reporting in May allows IA to continue testing to year end and all field work is due to be completed by 30 April, however BM was keen to ensure that all audits are completed in advance of the Head of Internal Audit Opinion. KE drew attention to the executive summaries for each of the finalised reports. In relation to audit ref. BH332024 – Business Continuity of Key IT Systems, this was raised historically by the Audit Committee for PR to identify the key IT systems and the business continuity of those said	

	systems. BM questioned which academy or committee had oversight of business continuity and disaster recovery for IT systems or did this fall under the remit of the Emergency Preparedness Resilience & Response (EPRR) policy. MH agreed to explore further and provide a response back to the May AC. ZA referred to audit ref. BH362024 - Just R & Overseas Recruitment and the figures of 1 in 8 candidates not having the required validation in relation to employment history and references for international candidates. He queried if the checks had since taken place and if there were any risks to patients if they were employed by the Trust prior to references being validated. KE agreed to provide further detail to ZA on the broader risks to the organisation. ZA queried management's response to the lack of a policy in relation to audit ref. BH382024 – Medical Records deletion and destruction of electronic patient records. KE confirmed that full copies of all internal audits are uploaded to the board portal, Team Engine, and the details can be found there. Discussion took place around the significant assurance ratings relating to follow up recommendations as BM felt that these shouldn't be included within the overall ratings scores at year end. CB agreed to review this process. JL asked whether any of the draft reports listed were low assurance. KE noted that it was likely that a couple of the draft internal audits may receive a rating of 'limited assurance'. The Committee noted the report and the assurance provided.	Director of Finance A24010 Internal Audit (KE) A24011 Internal Audit (CB) A24012
A.4.24.9	**Follow up of Internal Audit recommendations** KE provided an overview of the current position in relation to internal audit recommendations and the progress made. Discussion took place around the timescales for reporting on outdated recommendations. BM confirmed that where the AC had previously accepted a change in the timetable, then that is the timetable which should be used for reporting. BM requested that updates are sought from management on all outstanding recommendations which would be include in the next report to the May AC meeting. The Committee noted the report and the assurance provided.	Director of Finance A24013
A.4.24.10	**Audit recommendations assurance and evidence** Following recent discussions at the AC it was proposed that the process to close and conclude audit recommendations is strengthened. The evidence collation and consolidation process proposed will assure the Trust and the Audit Committee that internal audit recommendations are appropriately addressed. It will also provide Internal Audit with the evidence required	

	when undertaking their periodic review of closed audit recommendations. MH confirmed that his Executive Assistant will collate the evidence that supports the closure of internal audit recommendations supported by the new audit software. The system requires organisation leads to be identified and the suggestion is for all Executive Assistants to be granted access who will be responsible for actions that fall within their area. A periodic report will be provided to ETM for assurance along with an in year additional follow up audit to be undertaken by Audit Yorkshire. The Committee noted the report and the assurance provided.	Director of Finance/Head of Corp Governance A24014
A.4.24.11	**Draft Internal Audit plan 2024/25** KE provided an overview of the paper and highlighted the following key points and headlines: • A robust planning exercise has been undertaken with key stakeholders throughout the Trust, specifically Executive Directors and ETM and academy input. • The number of audit days remains at 542. • The number of audits covered in year has been reduced from 52 to 35 which gives scope for deep dives to take place where needed. Discussion took place around the mapping of the plan specifically the strategic risk/alternative source column and text linking to the strategic objectives. ZA felt that this could be better populated, and CB agreed to review this. ZA asked for clarification on the choice and rationale on the cycle of audits. CB confirmed that work is undertaken to ensure that there is an even selection and there are no duplicates. Audit Yorkshire have moved away from the traditional 3 year plan to a yearly plan and BM queried the danger of not undertaking a payroll audit periodically. After discussion CB agreed to provide, at the May meeting, a 3 year historic look back of audits that have previously taken place to provide assurance that there are no missed audits or duplications. The Committee agreed that work could commence on the plan with final approval being sought at the May meeting.	Internal Audit (CB) A24015 Internal Audit (CB) A24016
A.4.24.12	**Counter Fraud progress report** RM provided an update on the position to date for the Counter Fraud Functional Standards return and the Counter Fraud Annual Plan. He envisaged that we 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 reaching the green standard. BM referred to fraud report INV/24/00061 - Working Elsewhere Whilst Absent Without Leave, and queried what disciplinary action had been taken. RM confirmed that the relevant staff member had left the Trust, although the	

	money had been recovered from them. BM requested that more detailed information, specifically around disciplinary action, is included within the outcome section for each relevant investigation which would provide further assurance to the AC. The Committee noted the report and the assurance provided.	Counter Fraud (RM) A24017
A.4.24.13	**Exception reports: Schedules of losses and special payments** **Schedule of losses and special payments** MQ presented an overview of the Losses and Special Payments and the Tender Waiver Report. He noted that the majority of the write offs related to overseas visitors who are taken off the system but are not removed from the debt collection process and procedures. Work continues to chase the debt, with the assistance of the UK border force, in the event that individuals may re-enter the country. JL asked how the Trust benchmarks against other trusts in terms of reducing the debt. MQ confirmed that the Overseas Manager follows guidance and takes all the appropriate steps to recover the debt along with external debt collectors with the debt written off after 12 months, and agreed to provide some benchmarking data from other trusts to the May AC meeting. KE noted that the strengthened overseas visitors team are proactively identifying non paying overseas visitors which could account for the high write off figures recorded. BM proposed that Julie Ward, Overseas Manager is invited to the September meeting to provide the AC with an overview of the role of the Overseas team. **Single Source Tenders** MQ highlighted the increase in the number of waivers in Q4 which is due in part to ensuring they are included in the year end figures. MQ provide assurance to the AC that these are in line with the Standing Financial Instructions and Scheme of Delegation. No instances of standing financial instructions being waived have been reported. BM queried if the Trust makes every effort to search for a reasonably satisfactory alternative supplier when needed. MH confirmed that the Trust has a robust process in place for approving waivers. ZA queried the last time an audit of single source tenders had taken place. KE believed this formed part of the financial transactions annual audit but agreed to verify with ZA. The Committee noted the report and the assurance provided.	Assistant Director of Finance A24018 Board Secretary A24019 Internal Audit (KE) A24020
A.4.24.14	**Appropriateness of Single Source Tenders** Item addressed as part of A.4.24.13.	
A.4.24.15	**2023/24 Annual accounts update** MQ provided an overview of the paper which set out the timetable for the production of the Trust's annual accounts and the items to be considered in preparing them. Once the draft accounts have been submitted to External Audit and NHSE, they will be shared with the AC along with an analytical	

	review paper detailing the key movements and issues raised in the audit. A closure meeting is planned with Deloitte on or around 10 June which will provide a view of the ISA 260 and any changes that may be recommended from the audit undertaken by Deloitte. The final accounts are subject to approval from the AC and the Board of Directors prior to submission to NHSE on 28 June. MQ also confirmed that no changes have been made to the accounting standards for this year. The key issues raised within the report have previously been highlighted at A.4.24.6. The Committee noted the report and the assurance provided.	
A.4.24.16	**Trust compliance with Standing Orders, Standing Financial Instructions/Scheme of Delegation (standing item)** There was nothing to report on this item.	
A.4.24.17	**Suspension of Standing Orders/Standing Financial Instructions (standing item)** There was nothing to report on this item.	
A.4.24.18	**Other assurance functions (standing item)** There was nothing to report on this item.	
A.4.24.19	**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.	
A.4.24.20	**Policies and procedures for ensuring acceptable data quality for all key Trust data** PR provided an overview of the paper 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. BM drew attention to the poor scores in Summary Hospital-level Mortality Indicator (SHMI) data and felt that this led to a lack of assurance for the AC and didn't reconcile with the data contained within the paper. PR noted that there is a particular blend of elements that form the SHMI calculations, and these have been an issue over the last period of reporting. PR 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. JL suggested that when the governance arrangements for academies are reviewed, we ensure a clear reporting route for the Trust wide data quality improvement plan. Discussion took place around the specific elements that the AC is responsible for overseeing (even though they might report through	

	the academies also), and those items specifically reference in the Audit Committee handbook. However, the role of the AC is to ensure that the academies perform their role appropriately in those areas and not to repeat the work of the academies. BM and LP agreed to review the reporting route in their review of the Audit Committee handbook and the Trust's committee/academy terms of reference. The Committee noted the report and the recommendation that a further updated is presented in relation to data quality in 6 months and that a cycle of updates at 6 monthly intervals continues going forward. LP agreed to update the workplan accordingly.	Chair/Board Secretary A240007 Board Secretary A24021
A.4.24.21	**Interna audit report - BH262024 - IT systems and software management follow up update** PR provided an update which noted that since the initial internal audit, the outstanding documentation has been provided and shows an improved position. The Trust will be engaging with a third party to perform a complete review of our service and support arrangements to seek opportunities for enhancement and refinement. The Committee noted the report and the assurance provided.	
A.4.24.22	**Internal audit report - BH382024 – Medical Records deletion and destruction of electronic patient records - low assurance** PR referred to the medical records deletion and destruction of electronic patient records audit that took place recently which had received a low assurance rating. He noted 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. 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. Discussions are ongoing internally with the Central Patient Booking Service (CPBS) and the informatics team to produce a policy and commence the piece of work. He confirmed he will continue to work with IA and external colleagues on areas of good practice and the positive steps being taken by other organisations. He confirmed that after inquiry and investigation we may still conclude that it is entirely reasonable for the organisation to maintain the digital footprint for longer which would require us to provide a rationale to GDPR. PR noted that the Task and Finish Group being implemented will report directly to the Board. However, BM felt that it was important, as part of the assurance process, that the Quality & Patient Safety Academy and the AC are provided with an update on progress in 3 months' time, prior to the report being presented at the Board in September. The Committee noted the report and the assurance provided.	Chief Digital & Information Officer A24022
A.4.24.23	**Audit Committee annual report to board** BM confirmed the initial draft has been prepared and this will be submitted to the May AC for approval.	Board Secretary A24023

A.4.24.24	**Compliance with NHS provider licence and, code of governance** **Provider Licence and guidance on Good Governance and Collaboration** LP provided an overview of the paper which was reviewed by the executive team in April 2024. A revised provider licence was published by NHSE in March 2023 in line with the publication of the Health and Care Act. The licence now includes an assessment of our compliance with the guidance on good governance and collaboration which was published last year. The proposal is to declare full compliance against the provider licence. **Code of Governance for NHS Provider Trusts** LP noted that given the resignation of the Chair, part way through the year, this has led to more partially compliant areas this year than normal. ZA queried the impact on the Trust of the areas that were not met or partially met in relation to the code of governance. LP confirmed that the Trust is required to either 'comply' or 'explain' with the requirements of the code of governance. The AC felt assured with the explanations provided for the amber areas of partial compliance. A final position paper will be presented to the May Board. The Committee agreed to recommend that: 1. The Board approves the compliance statements in relation to the Provider Licence Conditions, and the guidance on Good Governance and Collaboration; and 2. In relation to the Code of Governance, the Board confirms the findings with regard to each provision and approves those areas deemed compliant and those deemed partially/non compliant.	
A.4.24.25	**Any other business** MH stated that if a Trust is posting a deficit plan, it must complete a template that reviews a number of rapid actions and governance actions which the AC or Chair of the AC have to review prior to submission. MH agreed to circulate this to the AC for review once completed. There are proposed changes to the Non-Executive Director membership of the AC from May 2024. JL and SN will leave, and Mohammed Hussain will join the membership. The Chair, on behalf of the AC, thanked JL for her contribution to the AC over the past 4 and a half years.	Director of Finance A24024
A.4.24.26	**Matters to share with other committees** **A.4.24.22 - IA report BH382024 – Medical Records - low assurance** – A progress report is to be provided to the Quality & Patient Safety Academy in 3 months' time, prior to the report being presented at the Board in September.	
A.4.24.27	**Matters to escalate to the Risk Register** There were no matters identified to escalate to the high-level operational risk register.	

A.4.24.28	**Matters to escalate to the Board of Directors** There were no matters identified to escalate to the Board of Directors.	
A.4.24.29	**Items deferred to subsequent meetings** A.4.24.23 – AC annual report to Board	
A.4.24.30	**Attendees for subsequent audit committee meeting** • The AC would continue with the practice of Executive attendance on a rotational basis. • September - Paul Rice, CDIO – data quality • September - Julie Ward, Senior Healthcare Contracts & Overseas Manager – overseas visitors presentation	
A.4.24.31	**Review of meeting** BM and LP agreed to discuss the ordering of the agenda to make this more fluid.	Chair/Board Secretary A24025
A.4.24.32	**Date and time of next virtual meetings:** • 21 May 2024 • 20 June 2024 (extraordinary meeting accounts sign off) • 10 September 2024 • 19 November 2024	

Action log from the Audit Committee Meeting held 22 April 2024

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
22.4.24	A.4.24.26	**Review of meeting** BM and LP agreed to discuss the ordering of the agenda to make this more fluid.	**Chair and Board Secretary A24025**	May 2024	Session scheduled for 14 May. Action closed.
22.4.24	A.4.24.25	**Any other business** MH stated that if a Trust is posting a deficit plan, they have to complete a template that reviews a number of rapid actions and governance actions which the AC or Chair of the AC have to review prior to submission. MH agreed to circulate this to the AC for review once completed.	**Director of Finance A24024**	May 2024	Two documents require signature of AC Chair in relation to HFMA sustainability exercise. MH to arrange for this to take place.
22.4.24	A.4.24.23	**Audit Committee annual report to Board** BM confirmed the initial draft has been prepared and this will be submitted to the May AC for approval	**Board Secretary A24023**	May 2024	Added to May AC agenda. Action closed
22.4.24	A.4.24.22	**IA report BH382024 – Medical Records deletion and destruction of electronic patient records - low assurance** PR noted that the Task and Finish Group being implemented will report directly to the Board. However, BM felt that it was important, as part of the assurance process, that the Quality & Patient Safety Academy and the AC are provided with an update on progress in 3 months' time, prior to the report being presented at the Board in September.	**Chief Digital & Information Officer A24022**	May 2024	Action forwarded to QPS Academy for July agenda and to the AC for September agenda. Action closed.
22.4.24	A.4.24.20	**Policies and procedures for ensuring acceptable data quality for all key Trust data** The Committee noted the report and the recommendation that a further updated is presented in 6 months and that a cycle of updates at 6 monthly	**Board Secretary A24021**	May 2024	Work plan updated. Action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		intervals continues going forward. LP agreed to update the workplan accordingly.			
22.4.24	A.4.24.13	**Single Source Tenders** ZA queried the last time an audit of single source tenders had taken place. KE believed this formed part of the financial transactions annual audit but agreed to verify with ZA.	**Internal Audit (KE) A24020**	May 2024	This forms part of our procurement reviews. It has been included in the Estates procurement review recently covered. Action closed.
22.4.24	A.4.24.12	**Counter fraud progress report** BM requested that more detailed information, specifically around disciplinary action, is included within the outcome section for each relevant investigation which would provide further assurance to the AC.	**Counter Fraud (RM) A24017**	May 2024	The LCFS will endeavour to include non-prosecution outcomes in future Progress Reports. The LCFS will link in with HR re: disciplinary action and keep an open dialogue with professional bodies (GMC, NMC, HCPC etc.) when required for updates. Action closed.
22.4.24	A.4.24.11	**Draft Internal Audit plan 2024/25** After discussion CB agreed to provide, at the May meeting, a 3 year historic look back of audits that have previously taken place to provide assurance that there are no missed audits or duplications.	**Internal Audit (CB) A24016**	May 2024	Document provided for review under item A.5.24.10. Action closed.
22.4.24	A.4.24.11	**Draft Internal Audit plan 2024/25** Discussion took place around the mapping of the plan specifically the strategic risk/alternative source column and text linking to the strategic objectives. ZE felt that this could be better populated, and CB agreed to review this.	**Internal Audit (CB) A24015**	May 2024	Reviewed by CB. Action closed.
22.4.24	A.4.24.10	**Audit recommendations assurance and evidence** The system requires organisation leads to be identified and the suggestion is for all Executive Assistants to be granted access who will be responsible for actions that fall within their area. A periodic report will be provided to ETM for assurance	**Director of Finance A24014**	May 2024	Paper provided to May meeting to describe process. Action closed.

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		along with an in year additional follow up audit to be undertaken by Audit Yorkshire.			
22.4.24	A.4.24.9	**Follow up of Internal Audit recommendations** BM requested that updates are sought from management on all outstanding recommendations and KE agreed to include those in her next report to the May AC meeting.	**Internal Audit (KE) A24013**	May 2024	To be included in May report – action closed
22.4.24	A.4.24.8	**Internal Audit progress report** Discussion took place around the significant assurance ratings relating to follow up recommendations as BM felt that these shouldn't be included within the overall ratings scores at year end. CB agreed to review this process.	**Internal Audit (CB) A24012**	May 2024	This has been factored into the rationale when developing the Annual Report and HoIAO. Action closed.
22.4.24	A.4.24.8	**Internal Audit progress report** ZA referred to the BH362024 -Just R & Overseas Recruitment audit and the figures of 1 in 8 candidates not having the required validation in relation to employment history and references for international candidates. H KE agreed to provide further detail to ZA on the broader risks to the organisation.	**Internal Audit (KE) A24011**	May 2024	Email sent to ZA 9.5.24 which provided an update/clarification on the issue raised– action closed
22.4.24	A.4.24.8	**Internal Audit progress report** BM questioned which academy or committee had oversight of business continuity and disaster recovery for IT systems or did this fall under the remit of the Emergency Preparedness Resilience & Response (EPRR) policy. MH agreed to explore further and provide a response back to the May AC.	**Director of Finance A24010**	May 2024	MH has requested info from PR. update to be provided from MH – action to remain open
22.4.24	A.4.24.6	**External audit annual plan 2023/24** Value for money – significant weakness - JL raised the issue around the level of detail contained within the	**Non-Executive Director (JL) A24009**	May 2024	MH has discussed with Deloitte. They are taking amended wording through their governance panel for sign off. JL is also

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		risk description on page 21, first paragraph, as it doesn't feel accurate, and she felt it was misleading. It was agreed that JL, on behalf of the AC, would speak with PH outside of the meeting to agree a form of words that were appropriate for both parties.			comfortable with the revised wording. 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**	May 2024	LP & BM will review the AC handbook and the changes to the TOR, workplans and agendas prior to providing an update to the AC. Review scheduled for 14 May. Action closed.
22.4.24	A.4.24.6	**External audit annual plan 2023/24** **V**alue for money – significant weakness **-** PH requested that the CQC inspection report is made available to them prior to completion of the audit	**Board Secretary A24008**	September 2024	As and when the CQC report becomes available it will be provided to Deloitte. An update will also be provided to the AC in September.
22.4.24	A.4.24.13	**Schedule of losses and special payments** MQ agreed to provide some benchmarking data from other Trusts to the May AC meeting. KE noted that the strengthened overseas visitors team are proactively identifying non-paying overseas visitors which could account for the high write off figures recorded.	**Assistant Director of Finance A24018**	September 2024	AC to note: Following a review of actions by AC chair at agenda review meeting in May, this to be addressed in the reporting from the Senior Healthcare Contracts and Overseas Manager whose attendance has been confirmed at the September AC meeting. Action to remain open until September.
22.4.24	A.4.24.13	**Schedule of losses and special payments** BM proposed that Julie Ward, Overseas Manager is invited to the September meeting to provide the AC with an overview of the role of the Overseas team.	**Board Secretary A24019**	September 2024	Julie Ward, Senior Healthcare Contracts and Overseas Manager has been invited to the September meeting. Action closed.
23.5.23	A.5.23.22	**Partnership arrangements: implications for the Audit Committee** JH noted that an update to the public sector internal	**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

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		audit standards is due imminently which will be shared once it is received.			standards. Once issued they will be shared with the Committee. Action to remain open.