Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS OPEN

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25 September 2024

09:30 GMT+1 Europe/London

Conference room, Field House, BRI

AGENDA

AGENDA -25.9.24

REFERENCES

Only PDFs are attached

Bo.9.24.0 - Open Board Agenda 25.9.24 - v9.pdf

Bradford Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	Wednesday 25 September 2024	**Time:**	09:30 – 12:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair

Observers
- Farideh Javid, Governor
- Molly Tate, Zainab Rasheed & Yaqub Ibrahim, Graduate Management Trainees

In attendance
- 09.35 – 09:55 – Ruth Tolley, Quality Lead for Patient Experience and Shaheen Kauser, Patient & Public Engagement Officer – Bo.9.24.5 – Patient Story
- 10:00-10:15 - Sara Hollins, Director of Midwifery & Sam Wallis, Consultant Neonatologist– Bo.9.24.7 - Maternity and Neonatal Services update

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.9.24.1	Apologies for absence • Mohammed Hussain, NED • Karen Walker, NED • Altaf Sadique, NED • Louise Bryant, NED	Chair	For information	Verbal
Bo.9.24.2	Declarations of interest	Chair	For information	Bo.9.24.2
Bo.9.24.3	Minutes of the meeting held on 11 July 2024	Chair	For approval	Bo.9.24.3
Bo.9.24.4	Matters arising	Chair	For information	Verbal
09:35 Section 2: Patient Care				
Bo.9.24.5	Patient story	Chief Nurse	For information	Bo.9.24.5
Bo.9.24.6	Report from the Chair of the Quality and Patient Safety Academy - August and September 2024	Chair of the Quality and Patient Safety Academy	For assurance	Bo.9.24.6
Bo.9.24.7	Maternity and neonatal services update	Chief Nurse	For assurance	Bo.9.24.7
Bo.9.24.8	Research activity in the Trust	Chief Medical Officer	For assurance	Bo.9.24.8
10:30 Section 3: People				
Bo.9.24.9	Report from the Chair of the People Academy: - August and September 2024 - Workforce report - Medical appraisal & revalidation annual statement of compliance - 2024 Training and Education self-assessment report	Chair of the People Academy	For assurance	Bo.9.24.9
Bo.9.24.10	Equality & Diversity Council update	Chief Executive	For assurance	Bo.9.24.10

BREAK 10:55 – 11.05

11:05 5 Section 4: Finance and Performance				
Bo.9.24.11	Report from the Chair of the Finance and Performance Academy – July and September 2024 – Closing the Gap – Integrated Dashboard – Finance Report – Performance Report	Chair of the Finance and Performance Academy	For assurance	Bo.9.24.11

11:35 Section 5: Audit & Assurance				
Bo.9.24.12	Report from the Chair of the Audit Committee – 10 September 2024	Chair of the Audit Committee	For assurance	Bo.9.24.12
Bo.9.24.13	Report from the Chair of the Charitable Funds Committee – 22 July 2024	Chair of the Charitable Funds Committee	For assurance	Bo.9.24.13

11:40 Section 6: Business Reports				
Bo.9.24.14	Report from the Chair	Chair	For information	Bo.9.24.14
Bo.9.24.15	Report from the Chief Executive	Chief Executive	For information	Bo.9.24.15

12:00 Section 7: Governance				
Bo.9.24.16	Board Assurance Framework and high-level risks	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.9.24.16
Bo.9.24.17	Board, Committee and Academy Terms of Reference and work plans	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.9.24.17
Bo.9.24.18	Premises Assurance Model (PAM) progress report	Director of Estates & Facilities	For assurance	Bo.9.24.18
Bo.9.24.19	Annual security report (inc. Violence Prevention and Reduction Standard)	Director of Estates & Facilities	For assurance	Bo.9.24.19
Bo.9.24.20	Annual Data Protection Officer report	Data Protection Officer	For assurance	Bo.9.24.20
Bo.9.24.21	Use of the Trust seal	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.9.24.21

12:25 Section 8: Board Meeting Outcomes				
Bo.9.24.22	Any other business	Chair	For information	Verbal
Bo.9.24.23	Issues to refer to Committees/Academies or elsewhere	Chair	For approval	Verbal
Bo.9.24.24	Review of meeting	Chair	For information	Verbal
Bo.9.24.25	Date and time of next meeting: • 14 November 2024 – 9.30am	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 25 September 2024

Annex 1: For Information: Board Committee/Academy Governance				
Bo.9.24.26	Confirmed Academy minutes: • Quality & Patient Safety Academy – 2 July 2024 and 14 August 2024 • People Academy – 3 July 2024 and 9 August 2024 • Finance & Performance Academy – 4 July 2024 and 24 July 2024	Chairs of Academies	For information	Bo.9.24.26
Bo.9.24.27	Confirmed Audit Committee minutes – 21 May 2024	Chair of the Audit Committee	For information	Bo.9.24.27

BO.9.24.1 - APOLOGIES FOR ABSENCE

BO.9.24.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.9.24.2 - Declarations of Intestest.pdf

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21,2021/22,2022/23,2023/24	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/23,2023/24	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency. Key customers NGH NHS Trust, NHSD, NHSHSA & Helios. Partners Telefonica, GS1, Zebra & Patient Source.	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08/12/2021	2021/22,2022/23,2023/24	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01/09/2022	2022/23,2023/24	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	04/05/2023	2023/24	Gifts		Free course; Creating Safe Systems including Human Factors	HC-UK Conferences	300
Ben Roberts	**Chief Finance Officer**	**01/09/2006**	**2024/25**	**Loyalty Interests**		**professional membership - Fellow of Chartered Institute of Management Accounts**	**Fellow of Chartered Institute of Management Accounts**	**0**
Ben Roberts	**Chief Finance Officer**	**02/09/2006**	**2024/26**	**Loyalty Interests**		**member of the HfMA (Healthcare Financial Management Association) and sit on their Digital Council**	**HfMA**	**0**
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
David Moss	Director of Estates	01/12/2022	2022/23	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01/12/2022	2022/23	Loyalty Interests		National Chair of HEFMA	HEFMA	0
Dorothy Bryant	Non-Executive Director	01/09/2023	2023/24	Nil Declaration				0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/22,2022/23,2023/24,2024/25	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/22,2022/23,2023/24,2024/25	Loyalty Interests		wife is employee of Rotherham Doncaster and South Humber NHS Trust	Rotherham Doncaster and South Humber NHS Trust	0
James Rice	Chief Digital & Information Officer	01/06/2019	2019/20,2020/21,2021/22,2022/23,2023/24,2024/25	Loyalty Interests		member of the strategic advisory board	Strategic Advisory Board of the Yorkshire & Humber AHSN	0
James Rice	Chief Digital & Information Officer	01/07/2020	2020/21,2021/22,2022/23,2023/24,2024/25	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/23,2023/24,2024/25	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Netwwork nationally	0
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/24,2024/25	Loyalty Interests		Son is now an employee of Yorkshire Ambulance Services.	Bradford Teaching Hospitals NHS Foundation Trust	0
James Rice	Chief Digital & Information Officer	13/09/2023	2023/24	Hospitality		Meal at Tattu, Leeds, following a CIO roundtable event.	Credera Healthcare	45
James Rice	Chief Digital & Information Officer	13/12/2023	2023/24	Hospitality		Meal paid for by company following a visit to AFT and BTHFT.	Luscii	40
James Rice	Chief Digital & Information Officer	28/02/2024	2023/24	Hospitality		Meal for NHS Trusts Chairs, CEOs and CDIOs following an learning event in Manchester.	Agilisys	45
James Rice	Chief Digital & Information Officer	12/03/2024	2023/24	Hospitality		Meal at Rewired event.	Penpole Consulting	27.5
James Rice	Chief Digital & Information Officer	11/03/2024	2023/24	Hospitality		Meal at Rewired event.	Meditech	27.5
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	2020/21,2021/22,2022/23,2023/24	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23,2023/24	Outside Employment		board member	Incommunities housing association	0
Julie Lawreniuk	Non-Executive Director	31/03/2021	2020/21	Change to existing declarations				0
Julie Lawreniuk	Non-Executive Director	01/07/2022	2022/23,2023/24	Outside Employment		Board member and chair of system finance and performance committee	Bradford District and Craven Partnership	0
Karen Dawber	Chief Nurse	01/09/2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12/11/2022	2022/23	Loyalty Interests		Member of Professional Body	Member of the Royal College of Nursing	0
Karen Dawber	Chief Nurse	01/11/2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the PPE hub	Ellie Dawber	0
Karen Dawber	Chief Nurse	10/09/2023	2023/24	Hospitality		Due to my role as Honorary Professor at the University of Bradford and as my role of Chief Nurse at BTHFT, I was invited to visit Pakistan on a shared learning journey to see how the healthcare system is operating in Lahore. The trip was also part of ongoing ideas for the Universities to team up with our Trust to host a junior nursing programme, for students to study two years in Lahore and two years in Bradford and would involve placements at our hospitals. Return flights to Pakistan.	University of Bradford	4362.73
Karen 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	2022/23,2023/24	Outside Employment		Deputy Chair, People Committee	Bradford District and Craven Health Care Partnership	0
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	04/05/2023	2023/24	Nil Declaration				0

Mark Hindmarsh	Director of Strategy and Integration	09/08/2024	2024/25	Nil Declaration			0
Melany Pickup	Chief Executive	01/06/2020	2020/21,2021/22,2022/23,2023/24,2024/25	Loyalty Interests	Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	10/07/2023	2023/24	Hospitality	Bradford Curry Awards	Asian Standard	40
Melany Pickup	Chief Executive	22/06/2023	2023/24	Hospitality	Lit Fest Launch Dinner Midland Hotel Bradford	Bradford Literary Festival	40
Melany Pickup	Chief Executive	18/12/2023	2023/24	Gifts	A small christmas hamper containing a christmas cake and several other goods, including chocolate, syrup, sauce, brownies and mince pies.	The Storyt Team	15
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/23	Outside Employment	Trustee of a charity which is a nil remuneration post.	Pharmacist Support (Charity)	0
Mohammed Hussain	Non-Executive Director	24/04/2023	2023/24	Hospitality	Offered a london marathon running place with lunch at the finish line	Tata consultancy services	20
Mohammed Hussain	Non-Executive Director	26/07/2023	2023/24	Outside Employment	Digital therapeutics lead for Viatris	Viatris	0
Raymond Smith	Medical Director	10/10/2018	2018/19,2019/20,2020/21,2021/22,2022/23,2023/24,2024/25	Clinical Private Practice	Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/21,2021/22,2022/23,2023/24,2024/25	Clinical Private Practice	Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	01/12/2019	2019/20,2020/21,2021/22,2022/23,2023/24,2024/25	Clinical Private Practice	Anaesthetics within scope of normal clinical practice	Ray Smith Anaesthetic Services Ltd	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests	Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests	Brother a GP and Primary Care Clinical Lead for Calderdale CCG	Calderdale CCG / Calderdale PCN	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment	Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment	MBA Industry Advisory Board Chair	Bradford University	0
Sajid Azeb	Chief Operating Officer	16/05/2023	2023/24	Hospitality	Eid Milan Event - Invited and attending as part of BTHFT Charity representative	Yorkshire Cricket Club (Hilcrest)	25
Sarah Jones	Chair	01/10/2020	2020/21	Outside Employment	Chair of Realise Education & Training	Realise Education & Training	0
Sarah Jones	Chair	04/03/2024	2023/24	Loyalty Interests	Brother MD of the Cheshire & Merseyside Cancer Alliance	Cheshire & Merseyside Cancer Alliance	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/23	Outside Employment	Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/23	Loyalty Interests	Parish councillor Sandy Lane Parish Council	Sandy Lane Parish Council	0
Sughra Nazir	Non-Executive Director	01/10/2023	2023/24	Outside Employment	associate with Social Care Institute of Excellence	Social Care Institute of Excellence	0
Zafir Ali	Non-Executive Director	01/11/2016	2016/17,2017/18,2018/19,2019/20,2020/21,2021/22,2022/23.2023/24	Outside Employment	Various roles including: Deputy Head of Internal Audit – Department of Health & Social Care Head of Internal audit for the NHS Counter Fraud Authority Head of Internal audit for the NHS Health Research Authority	Government Internal Audit Agency	0

BO.9.24.3 - MINUTES OF THE MEETING HELD ON 11 JULY 2024

REFERENCES

Only PDFs are attached

Bo.9.24.3 - Unconfirmed Minutes of the meeting held on 11 July 2024.pdf

Bradford Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday 11 July 2024	**Time:**	09:30 – 12:20
Venue:	Meeting Room, Listening for Life Centre, BRI	**Chair:**	Sarah Jones, Chair
Present:	**Non-Executive Directors:** - Sarah Jones (SJ) - Bryan Machin (BM) - Julie Lawreniuk (JL) - Karen Walker (KW) - Louise Bryant (LB) - Zafir Ali (ZA) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - Professor Karen Dawber, Chief Nurse (KD) - Dr Ray Smith, Chief Medical Officer RS) - Chris Smith, Interim Director of Finance (CS) - Mark Hindmarsh, Director of Strategy and Transformation (MHi)		
In Attendance:	- Adam Griffin, Deputy Chief Digital and Information Officer (AG) - Renee Bullock, Chief People and Purpose Officer (RB) - Jacqui Maurice, Head of Corporate Governance (JM) Carly Stott, Head of Midwifery (CS) for item Bo.7.24.6 only Ruth Tolley, Quality Lead for Patient Experience (RT) for item Bo.7.24.7 only - Yaseen Muhammed, Director of Infection, Prevention and Control (YM) for item Bo.7.24.8 only - Cat Shutt, Head of OD (CS) for item Bo.7.24.12 only - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- Katie Shepherd, Corporate Governance Manager - Helen Wilson, Governor - John Waterhouse, Governor - Rob Hickling, Business Development manager – BT Health		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.7.24.1	**Apologies for Absence** Apologies were received as follows: - Mohammed Hussain (authorised absence), Non-Executive Director - Sughra Nazir, Non-Executive Director - Altaf Sadique, Non-Executive Director - Paul Rice, Chief Digital and Information Officer	

No.	Agenda Item	Action
	- Laura Parsons, Associate Director of Corporate Governance / Board Secretary	
Bo.7.24.2	**Declarations of Interest** There were no further declarations of interest.	
Bo.7.24.3	**Minutes of the Meeting held on 9 May 2024** The minutes of the meeting held on 9 May 2024 were approved as a true and accurate record.	
Bo.7.24.4	**Matters Arising** The following actions were reviewed, and the outcomes confirmed. • Bo24009 EDI Strategy annual update / Equality, Diversity & Inclusion update (WRES, WDES): NED objectives have been reviewed and agreed. Action completed. • Bo23003 Health Inequalities & Waiting List Analysis – A new Board development programme is being developed. Action completed. • Bo24010 Staff Survey Results: 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 completed. • Bo24004 Performance Report: An update in relation to stroke has been circulated to Board members via email. There were no further comments during the meeting. Action completed. • Bo24013 Report from the Chair of the Quality and Patient Safety Academy – March and April 2024: KD to provide a more detailed update on PSIRF incidents via the QPSA.. Action completed. • Bo24014 Report from the Chair of the Quality and Patient Safety Academy – March and April 2024: Sue Franklin is planned to attend the Board meeting today to update on FTSU. Action completed.	
Section 2: Patient Care		
Bo.7.24.5	**Report from the Chair of the Quality and Patient Safety Academy – May and July 2024** LB gave an overview of the reports which provided an update of the Quality and Patient Safety Academy (QPSA) meetings held in May and July 2024. The report was largely taken as read, however LB alerted the Board to the new high level risk in relation to a broken	

No.	Agenda Item	Action
	Haemonetics Blood Track Kiosk in Maternity linked to the blood fridges which 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 to ensure safety of the system, but 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 (in excess of £1m). The Board would be kept updated on this as appropriate via the QPSA. The Board was assured by the update. **Adults & Children Safeguarding Annual Report** LB gave an overview of the highlights from the Adults and Children Safeguarding Annual report. The report was noted by the Board.	
Bo.7.24.6	**Maternity and Neonatal Services Update** KD welcomed CS to the meeting to provide an update on maternity and neonatal services. KD highlighted that the task and finish group (as discussed at the last Board meeting) is in development and would report to the Maternity Oversight Group. CS gave an overview of the presentation relating to maternity and neonatal services which included details on four additional issues that had not yet been received by QPSA: • A review of the All Party Parliamentary Report on Birth Trauma • Information regarding a formal 'escalations of concern' letter received from MNSI regarding Maternity 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 two maternal deaths in June – one by suicide and one antenatal community death of which cause of death is not yet ascertained. CS noted that the number of maternal deaths in the last 6 months is four in comparison to the previous years average of 3 in 12 months. Initial review suggests there are no emerging trends or themes of concern, but it is suggested a thematic review is undertaken to confirm this. There are still areas of learning from these that the service will respond to. CS also advised of a further escalations of concern letter received last week in relation to Consultant Obstetrician response time, attendance, and labour ward cover during the case of a maternal death in January. The service was investigating this and would respond in due course.	

No.	Agenda Item	Action
	The Board thanked CS for the update and was assured by the report.	
Bo.7.24.7	**Engagement Strategy Annual update** RT joined the meeting to present the engagement strategy annual update. The presentation detailed the model of feedback, examples of engagement and involvement with both internal and external partners (e.g. Healthwatch, CQC, PHSO), and provided detail of the joint work with the Citizen Voice Forum network across Bradford, District and Craven. RT noted the importance of recognising and responding to concerns, and advised of work ongoing to streamline the complaints process including movement to an electronic system which ensures more rapid response. There has been an increase in complaints in Q3 and Q4 of last year, and a deep dive will be undertaken to identify any key themes. The Board was assured by the update.	
Bo.7.24.8	**Infection Prevention and Control Annual Report 2023/24** YM joined the meeting to prevent the Infection Prevention and Control (IPC) Annual Report for 2023/24. The presentation demonstrated improvement from 2022/23 to 2023/24, with the exception of two organisms: MSSA bacteraemia and Klebsiella bacteraemia. YM also highlighted a reduction in E-coli over the last four months which he believed was attributed to the hydration improvement project. MP queried the drivers behind the klebsiella increase, and YM advised that there has been an increase in community acquired cases, and due to the 28 incubation period for klebsiella some of these patients are classified as hospital acquired cases if they return within that time. YM highlighted that other organisations are also seeing similar increases, and that in comparison with other Trusts, BTHFT is below the average benchmarking figure. The IPC team continue to review how practices can be improved to limit the number of klebsiella incidents. The Board thanked YM for his work in relation to IPC and was assured by the update.	
Section 3: People		
Bo.7.24.9	**Report from the Chair of the People Academy – May and July 2024** KW gave an overview of the reports which provided an update of the People Academy meetings held in May and June 2024. There were a number of issues to alert to the Board including the increase in the	

No.	Agenda Item	Action
	number of on-site fires as highlighting in the annual fire safety report, primarily as a result of smoking. A task and finish group has been set up to look at how to address this. The Board was also alerted to the most recent period of industrial action in late June – early July, but KW highlighted that the Trust is now experienced in handling this and mitigating the effects. The Academy had also heard an update in relation to Closing the Gap and the impacts this was having on staff, however the Academy were assured that the people impacts of the programme were understood and being mitigated. The Board was assured by the update. **Workforce report** The report was noted by the Board. **Medical Appraisal & Revalidation annual report** The report was noted by the Board. **Annual Fire Safety report** The report was noted by the Board.	
Bo.7.24.10	**Freedom to Speak up Annual Report** KD introduced the report, highlighting that there is an increasing trend in freedom to speak up concerns for the Trust, but this is also happening nationally. The majority of concerns were in relation to inappropriate attitudes / behaviours and bullying and harassment. ZA queried if there were any specific trends in concerns, and KD advised there were no major themes or trends of concern. KD also confirmed that presently, there are 11 FTSU Ambassadors within the Trust. Of these, four were men, four were from an ethnic minority, and they were across all bands from 3 – 8d, so very representative of the workforce. There is an ambition to increase the number of ambassadors in the estates and facilities service recognising that this is a large and encompassing area. SJ noted the desire to ensure the service is adequately resourced to ensure that all concerns can be appropriately managed and responded to. The Board was assured by the update.	
Bo.7.24.11	**Nursing & Midwifery Staffing Establishment Review** KD gave an overview of the paper which provided the outcome and recommendation of the Chief Nurse 6 month strategic staffing review for June 2024. The paper provided detail of the review for each area and KD highlighted the following recommendations of which she sought Board support:	

No.	Agenda Item	Action
	• 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. Where additional establishment requests were not supported, KD had provided a detailed plan for addressing this. KD recognised the step change response this year to the establishment review in light of the current financial constraints faced by the Trust, which has led to difficult decisions. However, the Board was assured that the establishment levels remained at safe levels for patients. MP recognised that whilst there has been no financial investment in nursing, there has been recent decision making at ETM to invest in medical support overnight in A&E to help respond to the concerns around long waits in the A&E department to help more rapid turn around of patients by an increase in senior decision makers at the front door. JL noted the impact on People as a result of decisions such as this being made and so there was real importance to continue discussion of Closing the Gap at People Academy. KW echoed this and the need for transparency around decisions being made. The Board was assured by the update and supported the recommendations contained in the paper.	
Bo.7.24.12	**Looking after our People – Staff Survey Action Plan** CS joined the meeting to provide an update on the action plan reduced as an outcome for the 2023 Staff Survey. 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 focuses on the top priorities that have been identified through engagement and after intensive analysis of the results. CS noted that progress would be reported via the People Academy with the Board kept updated via the Chair's report. The Board was assured by the update.	

No.	Agenda Item	Action
Bo.7.24.13	**Equality & Diversity Council update** MP advised that there had been no council meeting since the last Board meeting, with the next meeting to be held 17th July. The Board noted the update.	
Section 4: Finance and Performance		
Bo.7.24.14	**Report from the Chair of the Finance and Performance Academy – May and July 2024** JL gave an overview of the reports which provided an update of the Finance and Performance Academy meetings held in May and June 2024. She alerted the Board to the risks to the financial position, noting that 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. MHi gave some headlines relating to Closing the Gap (CTG): • The CTG programme has an overall £38.9m savings target, and at present there are 206 schemes identified amounting to approximately £46m (but £25m risk adjusted - 65% of the target and there are caveats around deliverability, risk etc) and this continues to rise week on week. This is encouraging process. • The CTG Programme Board in place and met for the second time this week. CSUs are meeting with the entire Executive Team on a monthly basis, with CSU sponsor meetings held in between these. • High level impact assessments are being undertaken for each scheme and if schemes surpass a set score, deeper assessments will be undertaken. • A monthly CTG bulletin will be produced with video highlights of showcased areas. The intranet site launched at the end of June with >1000 hits in the first three days. Colleagues are working on developing a simple totaliser to display on the main page so that colleagues are aware of progress against target. • CTG will be included as a standing item on future Board agendas. CS also gave a quick update on the financial position for month 3, noting that the trends were significantly improved on month two. At a headline level: • The revised plan targeted a deficit at month 3 of £8.1m. The Trust has posted a deficit of £7.9m which is marginally lower than projected. However this includes £200k industrial action costs and we are unsure if this will be reimbursed. There is also a risk around the reported ERF position which is currently neutral as the baseline has not yet been issued from NHSE.	

No.	Agenda Item	Action
	• There has been an improvement in the month 3 run rate of around £1.8m which is very substantial. • There is a variable pay panel in place which seems to demonstrate improvement in agency, bank and surge rates spend. • The non-clinical vacancy freeze remains in place, with any exceptions approved via ETM. • A non-pay review group is also in place to review non-clinical supplies beyond a set threshold, and decide whether to approve or reject requests. • Good progress has led to a better mid-case forecast of approximately £27m. However, CS highlighted we cannot lose pace on this and need to continue focus on delivering this. MP made reference to the external cost review commissioned by WYAAT, led by PWC. The outcome report was not yet available but there would likely be shared learning that the Trust could implement and the Board would be kept updated as appropriate. The Board thanked colleagues across the Trust for their work in identifying opportunities for delivering the savings target. The Board was assured by the report.	
Section 5: Audit & Assurance		
Bo.7.24.15	**Report from the Chair of the Audit Committee** The report was noted by the Board.	
Section 6: Business Reports		
Bo.7.24.16	**Report from the Chair** SJ introduced the report which was shared with the Board for information. The Board noted the report.	
Bo.7.24.17	**Report from the Chief Executive** MP introduced the report which was shared with the Board for information. She made the following highlights: • The most recent period of industrial action took place in late June – early July, and the BMA had provided slightly more notice than the statutory two weeks which had resulted in less impact on elective procedures as there was not as many planned electives to cancel. The new Secretary of State has already commenced negotiations with the BMA as a first	

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	order of priority following Labour party election into government which is positive progress. • The performance standards for urgent and emergency care (UEC) are very binary metrics, and do not demonstrate patient experience. MP referred to the Channel 4 Dispatches programme aired on 24th June highlighting the findings of an undercover journalist that showcased horrific experiences for patients attending a hospital in the Midlands. Following this, all Trusts have received a letter from Sarah-Jane Marsh and other senior Leaders in NHSE instructing that we are to assure ourselves that those same experiences are not prevalent in our own organisations. Work on this has commenced and the QPSA will receive an assessment against this which will then report to Board. SA will also take a detailed report to Finance and Performance Academy in relation to UEC, but initial comparison data was that BTHFT was significantly better in terms of performance than the hospital in the Dispatches programme. There are also a number of control measures processes in place at BTHFT to ensure oversight and escalation of concerns e.g. safety huddle, executive huddle etc. • SJ had visited A&E recently and saw exceptional service with no areas of concern. The pressure point appears to be in relation to section 136 patients (those with mental health needs) as the emergency department does not have the appropriate structure to be able to deal with this. The Board noted the update. **Integrated Dashboard** The report was noted by the Board. **Finance Report** The report was noted by the Board. **Performance Report** The report was noted by the Board.	
Section 7: Governance		
Bo.7.24.18	**Board Assurance Framework, risk appetite review and High-Level Risks** JM 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 risk was discussed in more detail: • Risk 2509 (autism and ADHD waiting times) – KD highlighted this was not a solo BTHFT problem / risk and she was	

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	working with the place to identify how to address this at place level. Notwithstanding, she was looking at what mitigations could be put in place at Trust level to address this. 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. KD advised of the change in the Moving to Outstanding Meeting to an Oversight Governance Assurance meeting which ensures oversight of risks ahead of these being presented to ETM and the Board. 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.7.24.19	**Academy/Committee annual reports, terms of reference and work plans** JM introduced the paper which provided updates on the Academy / Committee annual reports, terms of reference, and workplans. JM highlighted that the Audit Committee has received and approved all annual reports and interim terms of reference. The Board confirmed that that it derives assurance from all the annual reports presented and that the academies and committees have been effective. The Board also approved the interim terms of reference and the proposed Academy / Committee interim work plans. The final Terms of Reference and Work Plans would be brought back to Board in September for approval.	
Section 8: Board Meeting Outcomes		
Bo.7.24.20	**Any Other Business** No other business was discussed.	
Bo.7.24.21	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no particular issues to refer elsewhere.	
Bo.7.24.22	**Review of Meeting** There were no comments noted.	

No.	Agenda Item	Action
Bo.7.24.23	**Date and Time of Next Meeting** 19 September 2024 – 09:30am	

ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 11 July 2024

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	September 2024	Discussions have taken place as agreed. **Action closed.**
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 Trustee's'.	Associate Director of Corporate Governance and Board Secretary	November 2024	Amended TOR to be presented to Charitable Funds Committee and Board in November 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	A key has been added to the document (logic model). **Action closed.**
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.9.24.4 - MATTERS ARISING

BO.9.24.5 - PATIENT STORY

REFERENCES

Only PDFs are attached

Bo.9.24.5 - Patient story link.pdf

Patient story 20082024-10092024

https://vimeo.com/1008793734/7994282ad4?share=copy

Talking through the eyes of a carer

BO.9.24.6 - REPORT FROM THE CHAIR OF THE QUALITY & PATIENT SAFETY ACADEMY

REFERENCES

Only PDFs are attached

- Bo.9.24.6 - Report from the Chair of Quality and Patient Safety Academy - August 2024.pdf
- Bo.9.24.6 - Report from the Chair of the Quality Committee - September 2024.pdf

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Date	25 September 2024	Agenda item	Bo.9.24.6

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Academy

Date of meeting: 14th August 2024 (July meeting delayed)

Key escalation and discussion points from the meeting

Alert:

A new risk 2605 scoring 25 was added to the High-Level Risk Register in June.

Due to lack of chairs and skilled nursing capacity to meet demand, a number of patients requiring regular chemotherapy were unable to have their treatment when it was due. The patients were held on a reserve list and slotted in when slots were available. Mitigations were put in place including moving some iron infusion treatments out of the Meadows to BRI (Bradford Royal Infirmary), a daily check of cancellations and improved access to chemotherapy drugs. The situation had improved by the time the Academy met and no patients were now on reserve lists. The score will be reduced appropriately but will remain on the HLRR (High Level Risk Register). Discussions at ICB (Integrated Care Board) level are taking place in relation to increasing demand in this and some other specialties. The Academy was assured that the risk was being managed appropriately at this time.

Advise:

The Academy was updated on potential disruption in view of GPs collective action. It was felt that relationships between primary and secondary care were strong and BTHFT had not experienced any disruption. Increased attendances at the ED (Emergency Department) and an increase in outpatient referrals remained a possibility.

The Academy was advised of low national blood stocks for O –ve/+ve (amber alert). Trusts were asked to deprioritise procedures which may further deplete stocks. A small number of elective procedures were cancelled; however stocks are recovering, and it is unlikely that many/any further cancellations will be needed.

Assure:

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

The HLRR report was received. One new risk 2605 (as alert above) was added, no risks have been closed or reduced in score since the last meeting. One risk has increased in score (2542). The Haemonetics blood track kiosks are now end of life and need replacing. Mitigations are in place with an expectation that the system will be replaced in the next few months. The score was increased from 16 to 20 due to a failure with the main fridge door. This has now been repaired and the score will reduce accordingly.

Risk 2509 (score 16) was followed up from the June meeting (average waiting time for Autism and ADHD (Attention Deficit Hyperactivity Disorder) assessment of 42 weeks with the longest wait 110 weeks). The increasing demand for this service is recognised

nationally and discussions about the need for changes to current pathways are ongoing The Academy asked the Chief Nurse for a summary paper by the Children's CSU (Clinical Service Unit) to be presented to Academy to enable better oversight and assurance of this risk.

Five risks were beyond the review date. 2605 the new risk with a short review date - the situation has improved, 87 impact of Covid – agreement this needs to be revised, 2509 is discussed above. Two others (257& 512) relate to staffing (Children and Young People & Maternity CSUs) and are also within the remit of People Academy,

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

Patient Safety Incident Investigation (PSII) and Maternity & Neonatal Safety Investigations (MNSI) and briefing on Never Event

The report provided oversight of PSII and MNSIs declared, ongoing and concluded between 1st June and 31st July 2024. One ongoing PSII and one new MNSI were reported. One new declaration on PSIRF has been made in relation to an index case of a patient with learning disability (LD). This was identified as a 'theme' because it is recognised there is a need in training related to LD and addressing inequitable care for adult patients with LD. Two MNSIs were concluded (see Maternity section)

The Academy was briefed on the outcomes of PSII 2024/2217 Never Event (biopsy of wrong kidney). All actions assigned have been successfully completed 'with confidence' (Range of structures and processes in place supporting compliance/evidence supporting compliance available and used by the organisation) as of 5/8/24. It was noted that the speed of the investigation and the higher quality assurance via the reporting of levels of confidence in actions taken demonstrates the benefits of the PSIRF (Patient Safety Incident Response Framework) approach.

The Academy was updated on the Trusts transition to the PSIRF and approval for future reporting to for assurance purposes was given. Academy will continue to receive monthly updates on the management of incidents, a quarterly PSIRF update, and an annual report to align with the review and reissue of the Trust Patient Safety Incident Response Plan. Wider assurance around patient safety learning will be provided via the quarterly Insight report (replacing CLIP (Collaborative Learning in Practice)).
The Academy noted the current position, emerging themes, risks, work to mitigate and noted the next steps in relation to maturing the implementation of PSIRF. It confirmed it has sufficient assurance that BTHFT has processes in place to identify, investigate, and learn from patient safety investigations.

Clinical Audit Annual Report

The Academy received a summary report from the Clinical Outcomes Group of the Trust's performance and progress against the High Priority Clinical Audit Plan for 2023/24. Between 1/4/23 and 31/3/24, BTHFT were eligible to participate in 59/74 audits within the National Clinical Audit and Patient Outcomes Programme. The Trust received three outlier alerts (1) Intensive Care National Audit & Research Centre audit relating to the number of out-of-hours discharges to ward - responded to quickly and learning shared. (2) Dementia audit based on patient feedback – actions implemented, and (3)

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Bradford was a positive outlier for the National Clinical Audit for Seizures and Epilepsies in Children and Young People (CYP) in relation to % of CYP with Epilepsy receiving input by an ESN within the first year of care.

The Academy noted the strong performance against the CQUIN (Commissioning for Quality and Innovation) five core indicators, which were agreed by the Trust with NHSE and ICB.

Update on progress re: IA report BH382024 13 April 2024 (EPR record deletion)
An internal audit in April 2024 gave an assurance rating of low against Trust plans and progress re the deletion and destruction of electronic records. This impacts on our ability to meet NHSE's Record Management Code of Practice. It was identified there was a general lack of governance oversight of medical records, including unclear reporting lines and policy documentation. This will be added to the Risk Register.

Audit Yorkshire have agreed a deadline for 31/12/24 for a Task and Finish group to be set up. The T&F group will report directly to Board and their first meeting will be 20 August 2024. The Academy was assured by the progress and plans reported.

Infection Prevention and Control (IPC) Quarterly Report
This report summarised progress against the IPC work plan for 2024/25 and set out the Trust's infection control activities and performance between April and June 2024.

Levels of infection rates for MRSA, MSSA, CDiff, Klebsiella, Pseudomonas and E.coli benchmarked against national and regional data were presented. Except for MSSA, BTHFT is performing well above average. Infection reduction measures were set out. The success of an intervention to reduce UTIs by increasing patient hydration has helped reduced Trust attributable E.coli cases. The Trust is fully compliant with 53 of the 54 IPC BAF standards. It will be fully compliant once the Water Safety plan in in place and risk assessments associated with ventilation are complete.

The Academy noted the high level of assurance given by the Internal Audit of Hand Hygiene (17/07/24). The report noted the effective systems and processes in place for staff, patients, and visitors to enable practice of hand hygiene to a high standard.

Academy was assured that the Trust is compliant against national frameworks and codes of practice. It noted good progress against the annual IPC work programme.

Maternity and neonatal services
The Academy noted the position for June 2024

- 4 stillbirths (1 Butterfly baby): 15 stillbirths in total in six-month period
- 0 cases of Hypoxic-ischemic Encephalopathy
- 7 ongoing maternity SIs/Level 1 investigations: 2 MNSI and 4 Trust level, plus an MNSI referred by Leeds (initially under care in Bradford).
- 2 maternal deaths (one post-natal suicide, one during antenatal period (no cause of death found) resulting in 1 new MNSI referral and 1 internal PSII report.
- 3 occasions where the unit was assessed as needing to divert women to other trusts

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- 2 neonatal deaths, both anticipated due to extreme prematurity (11 this year of which 10 expected)
- 0 new or ongoing neonatal PSIIs (Patient Safety Incident Investigation)

There were 3 completed investigations this month (with learning and actions reported.

Two MNSIs were completed:

- SI (serious incident) 2023/20335 neonatal death. Four safety recommendations from the report were shared, three related to risk assessment for women whose care plan deviates from staff guidance, and one related to MDT (Multi-Disciplinary Team) training.
- SI 2023/22608 baby readmitted with hypoglycaemia. One safety recommendation was made re telephone triaging of unwell babies.

The Academy was alerted to an escalation of concern letter from MNSI on 14/06/24 relating to use of Maternity Early Warning Score (MEWS) following death of a woman in Leeds who had received antenatal care at BTHFT. They asked if *"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 were not satisfied with the written response and the Director of Midwifery and Clinical Director of Women's CSU met with them on 30/7/64. This enabled colleagues to share the electronic process, improvements already made to implementation of MEWS at Bradford including training and internal audits and clarify the queries they had and respond directly. The Trust are now waiting for MNSI to reconvene a panel to look at the information provided and get back to us to tell us whether they are assured or not, or whether they want anything further.

Assurance against midwifery staffing levels has been a focus within the Academy for some time. 38 newly qualified midwives have been offered posts to start in the autumn, returning staffing levels close to full establishment. The importance of training and support to develop and retain these midwives was recognised.

The Academy was 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

19th August 2024

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Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Academy

Date of meeting: 14th September 2024

Key escalation and discussion points from the meeting
Alert:
Academy was appraised of the ongoing challenge of addressing our high Summary Hospital-level Mortality Indicator (SHMI), which does not reflect our actual mortality rates (best in region). The expected deaths data are related to multi-morbidity and incorrectly suggest Bradford has an extremely healthy population. This means we are not able to access multi-morbidity funding as well as this being a reputational risk. Coding concerns and associated issues with SHMI will be added to the High-Level Risk Register. It was noted that Trust work on Learning from Deaths has been highly commended. Academy agreed that addressing the underlying cause of our SHMI was high priority and a resourced programme of focussed work is now warranted. Academy was advised of a moderate risk to achieving compliance with safety action 8 of the Maternity Incentive Scheme (90% of all relevant staff groups attending multi-disciplinary emergency skills training). Non-compliance of 1 action results in overall failure of the scheme and financial implications for the Trust. Plans to address were shared and training attendance will be closely monitored until deadline (30 November). Academy was advised of an increase in cases of MSRA colonisation in babies as part of routine swabbing within Women and Newborn services (19 since June). There have been no associated cases of bacteraemia and no instances of harm to babies. Ongoing plans were shared re identifying the possible source(s) of infection (community, equipment, staff) and intensified infection control measures, including staff decolonisation therapy and increased swabbing. Academy were assured by the timely identification of the outbreak and robust plans to address.
Advise:
Risk 2605 (lack of chairs and skilled nursing capacity to meet demand for daily haematology/chemotherapy) scoring 25 was added to the High-Risk Register in June, this risk has now been reduced to 20. Academy was advised of the high rate of ad hoc queries being passed on to the Trust by CQC (17 since June) which increases workload for staff due to the short turnaround deadlines. It is hoped that this will improve once monthly meetings with the CQC resume and queries can be dealt with in a more effective and efficient manner.

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Assure:

Academy Dashboard

The case for including Medicine Incidents in the Dashboard was accepted as one of the priority areas in the Patient Safety Improvement Plan. Monthly oversight at Academy will increase assurance.

High level risks relating to the Academy

The HLRR report was received. Four new risks were added in August and September, with review dates.

- 2604 (score 20) high number of patients attending ED outstripping capacity.
- 2618 (score 20) recruitment of substantive consultants and Stroke Services adding further risks to Stoke Services as identified in Risk 396 (now merged).
- 2630 (score 20) Contract with Dedalus system used by HIV services ending
- 2601 (score 20) Cath lab equipment failure leading to longer waits for some elective procedures and pressure on beds

Risk 2509 (score 16) was followed up from the August 2024 meeting (average waiting time for Autism and ADHD assessment of 42 weeks with the longest wait 110 weeks). A summary paper was presented by the Children's CSU to enable better oversight and assurance of this risk. The significance of the risk, which is at local, place and national levels, was clearly explained. Ongoing system-based options to address the risk were shared along with potential cost implication for BTHFT. Academy was assured that this risk is being addressed and will continue to provide oversight

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

Patient Safety Incident Investigation Report (PSIIR) and Quality Oversight and Assurance Exception Profile (June/July 20240

The PSIIR provided oversight of PSII and MNSIs declared, ongoing and concluded. One new PSII (potential jump risk within BRI estate) and one new MNSI (see Maternity section) were reported in August. There are two ongoing investigations (care of adults with a learning disability and the newly identified 'jump' risk). Two local formal investigations had been completed and learning shared (review of gentamicin prescribing as outcome, and development of non-occlusive aortic clot in a newborn, for which no modifiable factors were identified). The majority of PSIIs are now taking less than 30 days to complete, enabling early learning and improvement. No Duty of Candour breaches were reported. No Never Events were reported.

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

Health Inequalities

Academy received an update on the Trust's Tackling Health Inequalities Programme. Plans were shared including training (including Board Development) and closer working with the Reducing Inequalities Alliance. Discussions around impact of this work were

discussed including how the Trust assess meaningful progress. The Academy will provide continued oversight of progress against the plans.

Maternity and neonatal services

The following position for the 2-month period was shared with Academy

- 4 stillbirths (19 in total in 2024)
- 3 cases of Hypoxic-ischemic Encephalopathy (HEI), 1 meets MNSI criteria (term baby referred to NNU due to oxygen requirement and therapeutic cooling
- 4 neonatal deaths, one anticipated (15 this year of which 11 expected)
- 0 maternal deaths
- 5 occasions where the unit was assessed as needing to divert women to other trusts (7 women diverted). Diversions needed were needed due to increased acuity versus staffing and available beds.
- 7 ongoing maternity SIs/Level 1 investigations: 3 MNSI and 4 Trust level. There are 2 After Action Reviews (one relating to HEI)
- Sustained improvement in delivering 1:1 care in labour over 90%
- 0 new or ongoing neonatal PSIIs

There were two completed investigations in August, with learning and actions reported:

- SI 2023/140163 Term baby with trisomy 21 admitted to the NNU–seizures noted at 12hrs of age. Learnings in terms of communications and processes were identified but did not affect outcome of baby (HEI).
- MI-036808 Neonatal death of baby with genetic condition who needed cooling. Learning in terms of identifying polyhydramnios earlier and responding to mother's perceptions of baby movements being different to previous baby. These were not considered to affect outcome for baby.

The two escalations of concern from MNSI relating to use of Maternity Early Warning Score (MEWS) and obstetrician attendance following death of a woman who had received antenatal care at BTHFT have now been closed by the MNSI following the Trust's response. Learning has been identified and shared.

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

Internal Audits

Of the three audits relevant to the Academy, two received significant assurance (BH/04/2025: Freedom to Speak Up and BH/05/2025: Discharge Management). The third (BH/43/2024: Nursing Assessment and Care Plans) received limited assurance, due to some nursing assessments and care plans not being fully completed. There is no indication that patients had been harmed as a result. Academy were appraised of plans to further understand the extent of the findings (audit was very small number), reasons for non-completion and approaches to support and improvement where required.

Academy was assured that plans were in place to address the audit findings and was asked to keep Academy appraised of progress,

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Report completed by:

Louise Bryant

Academy Chair and Non-Executive Director

20th September 2024

BO.9.24.7- MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

Only PDFs are attached

- Bo.9.24.7 - Maternity and Neonatal (PERINATAL) Board Assurance June & July 2024 (cover).pdf
- Bo.9.24.7 - MatandNeoServicesUpdate.App3.Improvement plan MNSI.(002)Final.pdf
- Bo.9.24.7 - MatandNeoServicesUpdate.App4a.BRI Practice Concern 20240702 FINAL.pdf
- Bo.9.24.7 - MatandNeoServicesUpdate.App4b.MNSIResponse 2 for BRI 20240722 FINAL.pdf

Meeting Title	Board of Directors		
Date	25.09.24	Agenda item	Bo.9.24.7

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – JUNE AND JULY 2024

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide Trust Board with the bi-monthly assurance that Quality and Patient Safety Academy/Quality Academy, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For 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/Quality Academy	July and August 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 Academy (QA), ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QA, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Serious Incident (SI) reports.

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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 QA, 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, 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 QA, 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 QA provide Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to June and July 2024 activity, was presented and key elements discussed including:

- The number of harms occurring in June and July, 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.

This paper also includes:

- Information regarding the outcome of a formal ‘Escalations of Concern’ letter from MNSI regarding Maternal Early Warning Score (MEWS) and the associated improvement plan.
- Information regarding a 2nd formal ‘Escalations of Concern’ letter from MNSI regarding Consultant attendance and the Trust response.
- Action plan required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Moderate risk associated with achieving overall compliance with year 6 of the Maternity Incentive Scheme.
- Information regarding an increase in babies with MRSA positive results in July and of the ongoing monitoring and actions in progress.

Meeting Title	Board of Directors		
Date	25.09.24	Agenda item	Bo.9.24.7

Recommendation

- Trust Board to confirm that they are assured that QA have reviewed and discussed the contents of the June and July 2024 Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in June and July 2024 and both newly reported and ongoing investigations.
- Trust Board is asked to note that the contents of the June update paper have been discussed at the July Perinatal Oversight Group, attended by representatives from the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board. The August Perinatal Oversight Group meeting was postponed, and the July update paper will be presented and discussed in September.
- Trust Board is informed that the Perinatal Leadership Quad joined the July bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- Trust Board is informed of the outcome of an 'escalation of concerns' letter from MNSI regarding MEWS and the associated action plan.
- Trust Board is informed of a further 'escalation of concerns' letter from MNSI, received in July, and of the Trust response (appendices 4a and 4b)
- Trust Board is asked to approve and 'sign off' appendix 3, the MNSI escalation of concerns improvement plan, specifically the actions relating to consultant attendance at clinical scenarios. This is a compliance requirement of Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board is informed of the moderate risk to achieving full compliance with Year 6 of the Maternity Incentive Scheme, based on the current trajectory of PROMPT training compliance required for safety action 8.
- Trust Board is informed of the increase in babies with MRSA positive results in July and of the ongoing monitoring and actions in progress.

Meeting Title	Board of Directors		
Date	25.09.24	Agenda item	Bo.9.24.7

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):

Meeting Title	Board of Directors		
Date	25.09.24	**Agenda item**	**Bo.9.24.7**

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	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 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 Academy (QA), ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QA, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed MNSI and internal Serious Incident (SI) reports.

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

Meeting Title	Board of Directors		
Date	25.09.24	Agenda item	Bo.9.24.7

The monthly paper also serves as the main mechanism for QA, 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, 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 QA, including the approval of any reports required to demonstrate compliance with the annual MIS.

Maternity and Neonatal Updates June and July 2024:

The June and July updates and associated appendices were respectively discussed at the July and August QA. To note: July QA was held on 14 August and August QA held on 17 September.

The key elements of the papers discussed included:

- The number of harms occurring in June and July, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and SI cases were discussed.
- There were 0 completed Internal/MNSI reports to share for June and July.
- August QA was asked to note that the Perinatal Leadership Quad joined the July bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- July and August (held August and September) QA 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 QA, the service would like to update Trust Board on several other items:

- In July, Trust Board was informed of the receipt of a formal escalation of concerns letter 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 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 were not fully assured by the information and evidence provided and a face-to-face meeting took place on 30 July. This was a positive meeting and provided an opportunity for open dialogue and explanations of systems

and processes. An immediate action following the meeting, was to ensure that the electronic system for calculating MEWS, matches our written guidance. This has been confirmed. The remaining action was to share an improvement plan with MNSI. An improvement plan (appendix 3), relating to MEWS, SBAR handover and Consultant Attendance as per RCOG guidance, was shared with MNSI on 9 August and following panel review they have formally written to the service closing the escalation, assured by the actions and responses taken. Progress on the improvement plan will be shared with MNSI at planned quarterly review meetings (QRM).

- A second MNSI escalation of concerns letter, regarding the same investigation into the maternal death of a Bradford woman who died in Leeds, was received in July (appendix 4a). A response was provided within the stipulated timeframe (appendix 4b) providing explanation and assurances of our processes regarding consultant obstetrician attendance at specific clinical situations, as per Royal College of Obstetricians and Gynaecologists (RCOG) recommendations. MNSI were assured by the response provided and closed the escalation of concern with no further action.
- Safety Action 4 of the Maternity Incentive Scheme (MIS), Year 6, requires Trust Board sign off of agreed strategies and action plans implemented to prevent subsequent Consultant non-attendances at mandated clinical scenarios/situations. The second safety escalation from MNSI was in relation to non-attendance of a consultant obstetrician in the clinical scenario of a pregnant woman with a deteriorating condition in the emergency department. The on-call consultant was providing remote support and guidance, and their lack of physical attendance did not affect the care or clinical decisions required. However, this did not meet national or local guidance. Audit of this standard strongly suggests that this is an isolated incident. The improvement plan shared with MNSI (appendix 3) contains a number of actions specific to consultant attendance and the CSU seeks Trust Board sign off in order to meet safety action 4 and enable self-certification of compliance with this standard.
- August QA was informed that there is moderate risk to achieving compliance with Safety Action 8 of the Maternity Incentive Scheme, based on the current trajectory of obstetric and anaesthetic compliance. There is a high level of confidence that the obstetric position will be recovered before the 30 November deadline. However, there is less confidence that the anaesthetic position will be recoverable within the remaining training days available. Failure to achieve safety action 8, jeopardises achievement of the entire scheme and carries a significant financial penalty for the Trust. Obstetric and Anaesthetic leads have been asked to provide a recovery plan demonstrating how they plan to achieve the required compliance by the end of November. This will be closely monitored and both QA and Trust Board will be updated on the position.
- August QA was informed of an increased number of babies testing positive for MRSA across the Women's and Newborn unit during July. Colleagues from maternity and neonatal have worked closely with members of the infection prevention team, clinical science and external colleagues to manage and monitor the situation. No babies have

developed bacteraemia or harm as a result of the infection. There have been no new cases in August.

3 RECOMMENDATIONS

- Trust Board to confirm that they are assured that QA have reviewed and discussed the contents of the June and July 2024 Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in June and July 2024 and both newly reported and ongoing investigations.
- Trust Board is asked to note that the contents of the June update paper have been discussed at the July Perinatal Oversight Group, attended by representatives from the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board. The August Perinatal Oversight Group meeting was postponed, and the July update paper will be presented and discussed in September.
- Trust Board is informed that the Perinatal Leadership Quad joined the July bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- Trust Board is informed of the outcome of an 'escalation of concerns' letter from MNSI regarding MEWS and the associated action plan.
- Trust Board is informed of a further 'escalation of concerns' letter from MNSI, received in July, and of the Trust response (appendices 4a and 4b)
- Trust Board is asked to approve and 'sign off' appendix 3, the MNSI escalation of concerns improvement plan, specifically the actions relating to consultant attendance at clinical scenarios. This is a compliance requirement of Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board is informed of the moderate risk to achieving full compliance with Year 6 of the Maternity Incentive Scheme, based on the current trajectory of PROMPT training compliance required for safety action 8.
- Trust Board is informed of the increase in babies with MRSA positive results in July and of the ongoing monitoring and actions in progress.

4 Appendices

- Appendix 1 - Closed Board Harms June 2024.
- Appendix 2 - Closed Board Harms July 2024.
- Appendix 3 - Escalation of Concerns Improvement Plan (including Consultant non-attendance).
- Appendix 4 a and b - Escalation of Concerns Letter and Service Response.

Area for improvement: The tools and technology in place to support recording of clinical observations and the identification of deterioration in a mother's clinical condition							
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***
1.	Review of the MEWS parameters in the electronic patient record and update the local pathway to ensure alignment	Donna Patchett Maternity Workstream Lead | Informatics Carly Stott Head of Midwifery	18 September 2024	02.09.24	Complete. No discrepancies in current EPR and pathway. On investigation the tool used as the example was from an earlier developmental version.	Nil Required	Women's Quality & safety Group
2.	Agree a roll out date for National Maternity MEWS and update the pathway to reflect this	Nada Sabir Clinical Director for Women's services John Anderson Consultant Obstetrician	1 December 2024 (subject to Airedale EPR roll out)		EPR Guideline	Audit of compliance	Women's Quality & safety Group

3.	Explore the barriers to staff, of all levels, completing a full MEWS in the system using a QI approach ensuring changes take place to improve compliance	Jo Stubbs Specialist Midwife Megan Hargreaves Deputy ward manager	In progress – monthly progress reports to be reviewed. Note this workstream commenced in July 2024 and is being supported by the OMS Matron		Audit QI data	Monthly	Women's Quality & safety Group
4.	Provide additional education and on the job training to staff in the clinical areas, in relation to completion and accessing MEOWs charts.	Monica Parmar – Digital Midwife Ilham Al-Bayati – Data Quality Midwife Amy Taylor - Data Quality Midwife	30 December 2024		Newsletters Education documents Training records	At induction and part of the ongoing MEOWs audit	Women's Quality & safety Group

Area for Improvement: The processes that support early escalation to the multidisciplinary team **The skills and knowledge of all staff undertaking clinical observations to recognise abnormal readings and where to seek advice and support**							
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***
1.	Ensure staff are aware of the escalation guidance and the alerts within the EPR system which support early escalation and management of a deteriorating patient	Monica Parmar – Digital Midwife Ilham Al-Bayati – Data Quality Midwife Amy Taylor - Data Quality Midwife	30 December 2024		Newsletters/ Education documents Training records	At induction and part of the ongoing MEOWs audit	Women's Quality & safety Group
2.	Explore the barriers faced by staff when escalating concerns using a QI	Jo Beer – Maternity Matron	01 September 2024 Progress will be monitored		QI data	Monthly	Women's Quality & safety Group

	approach to ensure women receive care in the right place by the right people	Ismail Elkashif – obstetric lead Labour ward coordinator TBC	monthly via the progress reports				
3.	Reinforce the use of SBAR for handovers of care and at shift change	Department Managers & Q&S team	30/08/2024		Newsletter, yearly audit of handovers		Women's Quality & safety Group
4.	Implement the RCOG escalation toolkit using a QI approach • To reduce delays in escalation by improving the response escalation and action taken • To standardise the use of safety critical language • To reduce feelings of hierarchy, creating a	Jo Beer – Maternity Matron Ismail Elkashif – obstetric lead Labour ward coordinator TBC	01/09/2024 It is necessary to understand the barriers and complete action 2 before this project can commence. Progress will be monitored monthly via the progress reports		QI data		Women's Quality & safety Group

	supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake						

Area for Improvement: Handover: within and between teams and hospital departments							
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***
1.	Review verbal handovers in all maternity clinical areas and AED to ensure information is being communicated by the relevant people directly involved in	Monica Parmar – Digital Midwife John Anderson – consultant obstetrician	01 September 2024 Progress will be monitored monthly via the progress reports		QI data	Monthly	Women's Quality & safety Group

	care and that the information communicated is structured and includes key information.	Ward Managers S Khan – AED lead E Clinton – ED Matron					
2.	Review written handovers to ensure to ensure MEWS is captured, that the information is complete and accurate	Ward managers Monica Parmar – Digital Midwife	01 September 2024 Progress will be monitored monthly via the progress reports		QI data	Monthly	Women's Quality & safety Group
3.	Ambulance assessment records to be readily available for staff, ensuring relevant staff know how to access these. Review existing processes and provide education to relevant practitioners	Quality and safety facilitators for Maternity & ED	30 December 2024		Audit	Annually	Women's Quality & safety Group

Area for Improvement: Attendance of a Consultant Obstetrician in line with local and RCOG recommendations						
Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***
Re-audit the consultant attendance at emergencies as a priority, to provide both ourselves and external parties with the assurance that this is not a regular occurrence at Bradford.	Nada Sabir – Clinical Director K Adeniji – first on call doctor	30 September 2024		Audit	Biannual	Women's Quality & safety Group
Revisit the existing guideline Duties and Responsibilities of the Labour ward Consultant on call,	V Brown – Consultant Obstetrician	30 September 2024		Guideline review	Consultant attendance audit	Women's Quality & safety Group

which is in date until June 2025 and in line with the RCOG standards and strengthen any areas in response to the learning from this case.						
We will reinforce to the consultant body, the labour ward coordinators and the second on call doctors, the importance of consultant attendance according to the guideline together with the reason for doing so.	Nada Sabir - Clinical Director Mary Naylor – Maternity Matron Helen Sharp – Q&S Specialist midwife	30 September 2024		Newsletters Meeting minutes	Consultant attendance audit	Women's Quality & safety Group
The learning from this case will be shared with clinical team, our existing doctors as well as new first on calls and middle grade doctors at their inductions in August	Amy Hufton – Consultant Obstetrician	30 September 2024		Confirmation of completion from college tutors	Consultant attendance audit	Women's Quality & safety Group

and September respectively as part of the learning from local events session.						
Planned creation of the two-tier middle grade rota will reduce the likelihood of no middle grade presence on the labour ward.	Nada Sabir – Clinical Director	30 September 2024		Rota		Women's Quality & safety Group

Maternity & Newborn Safety Investigation Programme
Care Quality Commission
2 Redman Place
Stratford
London
E20 1JQ

Bradford Teaching Hospitals NHS Foundation Trust
Bradford Royal Infirmary
Smith Lane
Bradford
BD9 6DA

2 July 2024
MNSI case reference number: MI-036777 / Concern CA-037598

Dear Amal and Nada,

Escalation of concern Investigation case number MI-036777 (Maternal Death, Leeds)

The Maternity and Newborn Safety Investigations (MNSI) programme began in October 2023 after formerly being known as the Healthcare Safety Investigation Branch (HSIB). Our role is to undertake independent investigations into cases which meet our eligibility criteria.

This case was reviewed by the MNSI concern's panel on 28 June 2024. As part of the review the medical records and all documentation relating to this investigation obtained to date have been considered.

A concern has been raised in relation to the attendance of the on call obstetric consultant working on the night of 28-29 January 2024.

Background

- A pre-alert was shared with the ED advising of the imminent arrival to ED of a mother with a Glasgow coma score of 9 and new onset of confusion.
- After admission, blood gases showed a pH 7.18 and lactate of 14.9mmol/L and an obstetric doctor was asked to attend at 01:56 hours. The ST6 was able to be present by 02:20 hours.
- At approximately 03:00 hours, the obstetric consultant on call was telephoned; they were informed of the mother's history and that the current working diagnosis was acute

fatty liver of pregnancy with encephalopathy, disseminated intravascular coagulation and possible HELLP syndrome.

- The obstetric consultant attended the ED at approximately 05:00 hours, having previously provided telephone advice from home. Obstetric consultant presence was requested as the ED staff anticipated further deterioration of the mother requiring a possible perimortem caesarean birth.

The concerns identified are

- The obstetric consultant did not attend the ED when first contacted in line with national guidance (Barber et al, 2021). This requires the attendance of the consultant obstetrician in clinical scenarios including eclampsia, maternal collapse or when critical care or HDU care is likely to be needed. Attendance supports leadership, clinical expertise, maintaining safe care of mothers and babies within the maternity unit while managing an obstetric emergency within the ED, and an ability to support the team present.
- For a period of time the labour ward obstetric team had no immediate senior oversight as the ST6 was required to be in the ED.
- When the ST6 returned to the maternity unit, there was a period of time with no obstetric support or oversight in the ED to assist the mother's ongoing care.

We want to make you aware of these concerns to enable learning and safety improvements to begin before completion of the final investigation report. We may also include in our report any relevant changes or improvements you put in place in response to these concerns.

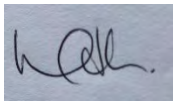
We request the following actions

1. Please confirm receipt of this letter within 24 hours to MNSI concerns MNSIConcerns@mnsi.org.uk: copying in Helen Smith and Eamonn Breslin.
2. Please confirm your plan for how you will review these concerns within 5 working days.
3. Please confirm you have shared our concerns externally with the maternity lead at the ICB.
4. In line with NHS 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.

You may wish to contact the Practitioner Performance Advice service which provides impartial advice to healthcare organisations about effectively managing and resolving concerns raised about the practice of individual practitioners.

If you would like to discuss this further, please contact MNSIConcerns@mnsi.org.uk

Yours sincerely,



pp

Helen Smith
Head of Region (North)

Eamonn Breslin
North Regional Clinical Advisor (Obstetrics)

cc.
Director of Midwifery: Sara Hollins sarah.hollins@bthft.nhs.uk
Head of Midwifery: Carly Stott Carly.Stott@bthft.nhs.uk
MNSI Team Leader: Cara Taylor cara.taylor@mnsi.org.uk
MNSI concerns: MNSIConcerns@mnsi.org.uk
Regional Chief Obstetrician: r.gosakan@nhs.net
CQC

Ref:
Barber, J., Cunningham, S., Mountfield, J., Yoong, W., Morris, E. on behalf of Royal College of Obstetricians and Gynaecologists. (2021) Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology. Updated May 2022. Available at https://www.rcog.org.uk/media/1e0jwloo/roles-and-responsibilities-of-the-consultant-workforce-report-may-2022-update.pdf

Maternity & Newborn Safety Investigation Programme
Care Quality Commission
2 Redman Place
Stratford
London
E20 1JQ

Bradford Teaching Hospitals NHS Foundation Trust
Bradford Royal Infirmary
Smith Lane
Bradford
BD9 6DA

22 July 2024

Dear Nada

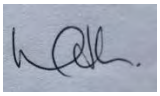
Escalation of concern investigation, case number MI-036777/CA-037598 (Maternal Death, Leeds)

Thank you for responding to our letter of concern, dated 2 July 2024. We have received your response, dated 8 July 2024, along with the evidence you have shared. Your response and the evidence you shared with us have been reviewed by the MNSI concerns panel on 17 July 2024.

MNSI had asked for assurance in relation a concern raised in relation to the attendance of the on call obstetric consultant working on the night of 28 to 29 January 2024.

The concerns panel agreed the information provided gave assurance that the issues raised have been acknowledged by the Trust and that work is underway to address these.

Yours sincerely,



Helen Smith | Head of Region | MNSI

cc.

Director of Midwifery: Sara Hollins sara.hollins@bthft.nhs.uk

Head of Midwifery: Carly Stott Carly.Stott@bthft.nhs.uk
MNSI Team Leader: Cara Taylor cara.taylor@mnsi.org.uk
MNSI concerns: MNSIConcerns@mnsi.org.uk
Regional Chief Obstetrician: r.gosakan@nhs.net
CQC: Enquiries@cqc.org.uk

BO.9.24.8 - RESEARCH ACTIVITY IN THE TRUST

REFERENCES

Only PDFs are attached

Bo.9.24.8 - Research Activity in the Trust - Update (cover).pdf

Bo.9.24.8 - Research Activity in the Trust.pdf

Meeting Title	Board of Directors		
Date	25th September 2024	Agenda item	Bo.9.24.8

RESEARCH ACTIVITY IN THE TRUST - UPDATE

Presented by	Dr Ray Smith, Chief Medical Officer	
Author	Professor John Wright (Director of Research) & Dr Tracy Watson (Director of Research Operations) & Research Department Heads	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	To provide information on some of the key research activities in the Trust	
Key control	N/A	
Action required	For assurance	
Previously discussed at/ informed by	N/A	
Previously approved at:		**Date**

Key Options, Issues and Risks

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

- Applied Health Research Activity
- Clinical Research Activity

Analysis

As above.

Recommendation

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

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

Meeting Title	Board of Directors		
Date	25th September 2024	Agenda item	Bo.9.24.8

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

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

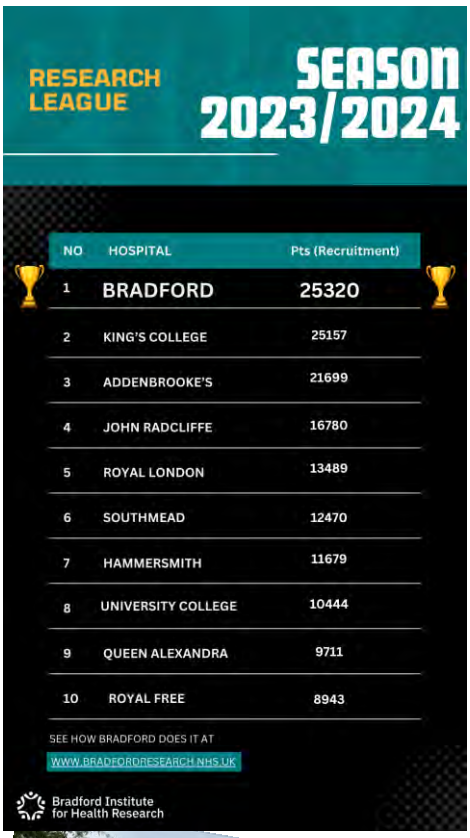
Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose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

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

Research in the Trust

Report for Quality Academy

July 2024



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

RESEARCH ACTIVITY AND PERFORMANCE

At the end of 2023/24 the Trust's recruitment into research studies was 26,325 (highest in Yorkshire and Humber region) with the Bradford Royal Infirmary site being the highest recruiting site in the country with 25,320 recruits.

RESEARCH INFRASTRUCTURE

Work continues to progress on the entrance extension for the Bradford Institute for Health Research. The project has incurred some delays (approx. 2 Months) and completion is now anticipated in August. The new extension will enable improved way finding for our research participants with a dedicated reception area as well as providing additional informal and formal meeting spaces, a new waiting area and an additional research clinic room.

INTERNAL AUDIT

In May/ June an internal audit was undertaken in research by the Trust Internal Auditors. The objective of this was to provide assurance that there is an effective research and development culture in place within the Foundation Trust.

The outcome of this was that Internal Audit provided 'High assurance' that there is an effective research and development operation in place within the Foundation Trust, and this is supported by comprehensive policies, procedures, processes and reporting mechanisms, overseen by the Trust Research Committee; the Quality Academy and the Trust Board. A minor recommendation was advised that a list of reports that research teams/ Trust provide to funding bodies, regulatory organisations etc. demonstrating adherence to Good Clinical Practice and/or research activity should be listed as part of this Quality Academy report going forward; this list is attached in Appendix A for this reporting period.

APPLIED HEALTH RESEARCH

Born in Bradford

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

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

Funded by the Wellcome Trust, Age of Wonder (AoW) is a seven-year project capturing the journeys of up to 30,000 Bradford teenagers during adolescence, using quantitative and qualitative methods. This academic year, over 7000 teenagers have taken part in questionnaires, physical health measures, and motor/cognitive tests. An additional 15 schools have consented to take part in the data collection, bringing the number of schools up to 30. We recently published the protocol for this first wave of data collection in Wellcome Open Research. Young people have also worked with the team on a number of opportunities, including data science and careers workshops, and creating and filming a live broadcast with students from Leeds Trinity University.

Since September 2022, we have been capturing the stories of Bradford's teenagers through qualitative longitudinal research in the Age of Wonder programme. We recruit young people aged 12-13 and follow their growing up experiences over the next seven years. Currently we are in year 2 of the research and have 80 participants. Using traditional and creative qualitative research methods, we are collecting rich, in-depth data on their growing up experiences. We hold annual portrait sessions with our artist-in-residence to document participants' journeys through adolescence. 41 portrait sessions have taken place so far. We have conducted 29 in-depth interviews, involved 43 young people in group discussions, and collected 54 creative expressions of participants' hopes, dreams, and fears for the future. Participants have used video, poetry, photography, drawing, painting, voice notes, written expressions, memes, screen recordings of video games, and music to share their creative expressions, which give describe different aspects of their health and wellbeing.

Lewis, 13

Lewis, 14

"I don't know what I want to do when I grow up. But hopefully something to do with what I'm doing at the minute, which is guitar, or I guess since I'm doing computer science, coding. Ambitions…to be successful? Have just a nice life, I guess, not to fall behind and be financially stable." – Lewis, 14

Physical activity Research: Spotlight on academic dissemination of research.

The physical activity research team are currently focussing on analysing, interpreting, and disseminating research findings from two of our flagship research projects, Join Us Move Play (JUMP) and Play in Urban Spaces for Health (PUSH).

The team have had the following scientific abstracts accepted for the **International Society for Physical Activity and Health** (ISPAH) which will be held in Paris in October 2024, this is a fantastic opportunity for our work from Bradford to influence both nationally and internationally.

- The bigger picture: developing and describing a place-based whole system approach for children's physical activity (Dr Sally Barber)
- Embedding physical activity in local policy: a Bradford District (UK) case study (Dr Jamie Crowther)
- Children's and Family's Experiences of the JU:MP Whole Systems Intervention to Enhance Physical Activity: Findings from the Process Evaluation (Rados Keravica)
- JU:MP Leads: Developing Young Physical Activity Leaders in Bradford, UK (Dr Jamie Crowther)
- What works to support Islamic Religious Settings to facilitate children's physical activity (Dr Sally Barber)
- Gender-sensitive greenspace development: evaluation of a co-designed approach with adolescent girls in Bradford, UK (Dr Amanda Seims)

Senior Research Fellow Dr Amanda Seims also presented findings from two projects at the Conference: **Health in the City. Exploring Urban Health from a Social Sciences Perspective.** This took place on 25th and 26th June.

- Designing play into urban environments: challenges and good practice within the city of Bradford, UK
- Gender-sensitive greenspace development: evaluation of a co-designed approach with adolescent girls in Bradford, UK

The team represented JUMP, Born in Bradford and the Bradford Institute for Health Research at the inaugural **International Whole School Physical Activity Conference** 17-19th June, which was hosted at Bradford University. Dr Sally Barber gave a keynote: 'Using mixed methods to evaluate a whole system approach to increasing children's physical activity' and the JUMP team delivered a workshop: 'Changing the whole picture of children's physical activity: development and description of a place-based whole system approach.'

We also have a new article accepted for publication in the **International Journal of Behaviour Nutrition and Physical Activity**: Hall et al., Reflections on co-producing an obesity-prevention toolkit for Islamic Religious Settings: a qualitative process evaluation".

Health Promotion through Faith Settings in Bradford

BiB's health promotion programmes through faith settings harness the potential of place-based community groups affiliated with faith settings to implement hyper-local childhood obesity prevention plans. 30 Islamic faith settings in Bradford have implemented healthy behaviours such as physical activities and healthy diet. Some faith settings are at advanced stage of implementing healthy behaviours while others are on the learning trajectory. Active Faith Settings workstream within JU:MP programme will involve faith settings in the embed and sustain phase to plan how sports and physical activities can be delivered across Bradford District with children and young people living in deprived neighbourhoods. Some Islamic faith settings have organised stalls in collaboration with BiB Genes and Health research programme team to increase the participation of South Asian and other ethnic minority groups in research on how genetic make of participants determines health outcomes in ethnic minorities.

Youth Resilience Programme

BiB research facilitated coproduction of a neighbourhood plan in Barkerend, Bradford that builds capacity of grassroots local organisations to prevent young people from the harms of violence, drugs, and anti-social behaviour. Youth Resilience Programme completed its year 1 by facilitating BiB researchers to directly learn from young people on what can be useful in preventing youth from the harms of drugs, violence, and anti-social behaviour. BiB researchers are planning the organisation of a second annual neighbourhood youth forum. 27 community organisations from Barkerend neighbourhood pledged continuing their active participation in research and learning directly from young people and parents on how young people can grow up happy and healthy and with positive experiences.

Centre for Applied Education Research

Born in Bradford's Centre for Applied Education Research (CAER) remains committed to improving outcomes for children and young people (CYP) through the power of science. CAER collaborates with schools, public service leaders, and decision-makers across Bradford and beyond to conduct research, implement evidence-based educational strategies, eliminate learning barriers, and improve life outcomes.

CAER researchers primarily focus on 8 research and development themes, relevant to children and young people. These have been recently updated and going forward will include: Special Educational Needs & Disabilities (SEND); social, emotional and mental health; digital makers; vulnerabilities & future policing; cognition, motor skills, physical activity & nutrition; birth to 5 years, and Child Health in Schools.

CAER continues to strengthen its linkages with its sister organisation in Leeds - Child Health Outcomes Research at Leeds (CHORAL), and through increased collaboration with universities, such as the University of Bradford. Going forward, there are plans for both University of Leeds and University of Bradford to have designated theme leads, for each of the 8 R&D themes. There will also be practitioners leading on each theme.

These themes also correspond to series of reports that CAER has played a key role in coordinating, in collaboration with the Centre for Young Lives and the N8 Research Partnership (research intensive universities across the North of England). The reports focus on key challenges facing the UK's children and young people and how they can best be addressed by policy makers, through education settings. The reports include evidence, policy recommendations, and examples of real world innovations, relevant to each topic. There will be 12 reports published over the course of 2024, and 5 have been released to date, including on: physical activity and healthy nutrition, building a new 'Sure Start' for coordinated service support, improving mental health and wellbeing, addressing poverty, and tackling the autism assessment and support crisis.

CAER emphasizes a place-based approach in its work and carries out place-based work in Bradford through Act Locally, an initiative of the Bradford-based multi-service partnership called Education Alliance for Life Chances (EALC). CAER serves as the R&D partner on this work and continues to be involved in 3 localities, focused on 3 main priorities – Holme Wood (crime & anti-social behaviour), Manningham & Girlington (mental health), and Keighley (food insecurity, poor diet & nutrition). The aim of Act Locally is work with practitioners on the ground to join up services and

support offers, to make sure children and families get the right support at the right time. Act Locally has had significant impact in the localities being worked with, having grown local cross-sector community partnerships to improve outcomes for children and young people. Currently a range of funding opportunities are being explored to provide further resources and support for this partnership work, with the idea that this way of place-based working could also be replicated across the UK, to improve children's life chances and outcomes.

CAER is continuing to develop partnerships with Integrated Care Boards (ICBs), with the West Yorkshire Futures Institute (WYFI) and the Yorkshire Futures Institute (YFI), to connect data and coordinate research efforts and insights across the region. Moving forward, CAER and CHORAL are set to lead and coordinate child health and education research in Leeds, Bradford, and West Yorkshire, working closely with various universities and public service partnerships to challenge policies and inform collaborative efforts. This strategic expansion and formalization of their position within the research ecosystem underscore CAER's commitment to improving outcomes for children and young people through evidence-based, community-driven approaches.

Healthy families' theme of the Yorkshire and Humber ARC

The healthy families theme continues to support nearly 60 active research projects across the Yorkshire and Humber region. The theme has recently worked with communities in Hull to establish and facilitate the Shaping Family Wellbeing Group, to support research based on community priorities in the area. Lunch and learn sessions on a range of topics continue to be well received and a new website for the ARC has recently been launched.

Healthy Urban Places

A new £8 million, four-year research programme, Healthy Urban Places, led by Born in Bradford began on 1st April 2024. The programme is looking at how and why population health is affected by local environments such as clean air, quality housing, parks, public transport, access to schools and health services etc, and aims to directly influence decisions that improve local places for health. The study will be based in Bradford District and Liverpool City Region, working with 10 national and

international collaborators. It is one of four new awards from UK Research and Innovation (UKRI) and is part of a new Population Health Improvement UK initiative.

Connected Bradford

Connected Bradford is a nationally trailblazing population digital repository that unites the whole of the Bradford and Airedale health, education, social care, environmental data for over 600,000 people within a secure and expansive research database. At the heart of our database is a strong ethos of community collaboration uniting our valued partners from the NHS, local authority, Department for Education, Yorkshire Ambulance Service, various other dedicated organisations and the public. They are all united within Connected Bradford as part of their commitment to unlock the potential of a data driven revolution and leverage the power of linked anonymised data to improve the health and wellbeing across the region. Created through extensive engagement with patients and the public and building upon the foundation established by Born in Bradford, Connected Bradford holds significant promise to unlock the power of a data driven revolution. By maintaining strong ties with our partners and the public, we are able to understand their needs and leverage the power of linked anonymised data..

Bradford Genes & Health

The Bradford Genes&Health study aims to learn how genes vary in adult Bangladeshi & Pakistani communities. The study is also recruiting in East London and Manchester with the view to including 100,000 people from these communities in the research study. In order to better understand why heart disease, diabetes and stroke occur in higher levels in these groups, it is important to know what is normal when searching for genes that may cause inherited diseases.

Participants are asked to complete a short questionnaire, consent form and provide a saliva sample. One in four participants will be asked to attend stage two clinic visits where further consent is obtained, blood samples and a second short questionnaire is completed. We have extended our recruitment activities to Kirklees and Calderdale and Leeds and some parts of South Yorkshire, working closely with research partners across the West Yorkshire region, engaging with GP practices and community settings including Mosques. To date we have recruited over 5893 participants to the study.

The BaBi Network

In June, the BaBi Network recruited its 40,000th participant and BiB4All (Born in Bradford 4 All) recruited its 10,000th mother into the study. Running in 12 sites

across the country (Bradford, Leeds, Doncaster, Wakefield, East London, Tameside, Warwick, York, Scarborough, Harrogate, Hull and Nottingham). The BaBi Network continues to grow, with Sheffield, Calderdale, North Lincs and Goole, East Lancashire and Medway in set up and hoping to open this year, as well as many other Trusts expressing an interest and working on feasibility.

The BaBi study aims to invite all pregnant women at a participating Trust to join. The study, supported by the NIHR Applied Research Collaboration Yorkshire & Humber aims to make use of routinely collected data from health, education, social care and other sources to build up a rich picture of families lives over time. This data can then be used to help us understand what helps to keep families happy and healthy.

The BaBi coordinating team based in Bradford is currently working on producing a common data model for the BaBi Network that will assist with creating a shared dataset to answer research questions using data from across the BaBi Network. There has also been significant interest from clinicians wishing to apply for a PhD across the BaBi sites using BaBi data, and a PhD peer support group has been created to share knowledge and opportunities to build capacity in this area. This group adds to our already established communities of practice that cover data/IT, research delivery, and communications/impact.

Each BaBi site is its own data controller and is supported by the central BaBi team at Bradford to work with local partners and stakeholders such as service users, community groups, clinicians, local authorities and policy advisors to explore local priorities to use their data locally. For example, in Doncaster BaBi has been used to inform the Doncaster Local Authorities Women's Health Strategy, and in Bradford, BiB4All was used to research the impact of Covid during pregnancy.

We have produced a new infographic, explaining the BaBi Network, and it can be viewed here.

The Bradford Centre for Qualitative Research

Advanced NVivo training has been delivered to 14 qualitative researchers who volunteered to become NVivo 'champions'. Over the next 12 months these champions will deliver some introductory NVivo training sessions to wider staff. We have established a Qualitative Advisory Group, comprising 12 external experts, to advise on the direction of qualitative research within BiB.

The group have met three times since inception in October 2023. Partnering with a University of Leeds QUAG member we secured a White Rose Doctoral Training

Partnership PhD student who will commence in October 2024 and work closely with the BiB qualitative team. We are continuing to deliver a number of qualitative research projects:

ALPACA

25 interviews have been conducted with community members to inform the development of an inclusive intervention to improve shared decision making during surgery. Data is currently being analysed and written up for publication.

Leaders Like Us

We have secured funding from the Medical Research Council (MRC) Public Health Intervention Development (PHIND) scheme to develop a framework to support young females from underserved groups to become physical activity leaders. We are currently preparing our ethical submissions and convening a young leader's advisory group in advance of the official project start in October.

Create and Dance

We have been funded by the Royal Opera House to evaluate their Create and Dance programme in Bradford primary schools. Over the next 12 months we will be conducting in-depth participatory research within 10 primary schools to understand whether and how the programme is implemented and influences children's wellbeing.

Bradford Mental Health Collaboratory

Funded by a recent NIHR Programme Grant for Applied Research, the new Bradford Mental Health Collaboratory aims to establish a programme of interventional research to address the gap that currently exists in finding good quality evidence on the effectiveness of preventative interventions which tackle adolescent mental health. The programme will build on the substantial research infrastructure in Bradford, allowing for efficient evaluations. This infrastructure includes the 'Born In Bradford' birth cohort study; the new 'Age of Wonder' study collecting longitudinal measures of mental health for all 30,000 secondary school pupils in Bradford; and Connected Bradford, a research database of administrative records from the NHS, education, and social care.

The programme will run seven work packages including coproduction and adaptation of interventions, a feasibility trial, natural experiments, and qualitative research. Collaboration agreements are in place with partners, an executive group has been formed and the programme is ready to start on 1st July 2024.

The Centre for Co-production and Peer Research

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

Peer Researchers have recently attended training sessions on Safeguarding adults and a basic introduction to research. The next stage is to develop research questions and for us to then upload them onto electronic devices so Peer Researchers can conduct walk-along interviews and start data collection.

Findings will be shared with decision-makers to advocate for changes that can reduce inequalities and improve wellbeing. The CoPPeR model also intends to build capacity amongst communities and partner organisations to continue conducting research beyond this initial project.

Supporting Young Bradford

Funded by the Health Foundation, Supporting Young Bradford has explored the impact of families' working lives on the quantity and quality of emotional support young people aged 12 -15 experience. In February and March we completed the final four community workshops, using appreciative inquiry to consider interventions which would enable better emotional support, both at a family level and a wider, system level. In May we delivered a webinar to practitioners, researchers, third sector workers and Local Authority representatives and have produced an evidence briefing for employers.

Improvement Academy

Based within Bradford Institute for Health Research, the Improvement Academy undertakes implementation and improvement projects nationally, provides training across many areas, including Quality Improvement, Thematic Analysis, and Behaviour Change, and hosts one of NHS England's Patient Safety Collaboratives. The Improvement Academy is also the implementation arm of the Yorkshire and Humber Applied Research Collaborative.

Artificial Intelligence in the Real-World

Funding from The MPS Foundation was awarded in 2022 to support a new collaboration between the Improvement Academy and the Assuring Autonomy International Programme (AAIP) at the University of York. The funding is being used to understand how Artificial Intelligence might be used in the real world with clinicians and patients. Different human-machine interaction models for shared decision-making in healthcare were tested and their ethical and legal implications considered. Data collection has almost completed, and we have started analysing the data.

The project team recently presented at the Designing Interactive Systems Conference in Copenhagen, where we received an honourable mention; the conference paper can be accessed here. The study was also presented at the Second Workshop on Multimodal AI (The Alan Turing Institute and University of Sheffield), where our Clinical Leadership Fellow, Nee Ling Wong, won the award for Best Student Talk.

HSJ Awards Community Health Checks

We have been shortlisted for an HSJ award, for our Community Health Checks Project, in the category: Improving Health Outcomes for Minority Ethnic Communities.

Bradford has some of the highest levels of deprivation and ethnic diversity in England, as well as high levels of morbidity and mortality across the lifespan compared to England averages. Anecdotal and clinical data indicated that a high proportion of socio-economically deprived and ethnic minority population were experiencing negative health outcomes related to cardiovascular disease.

The project is a community-led initiative to support the health and well-being of our population by conducting health checks in local community settings and providing information and resources to support individuals in making healthier lifestyle choices.

Secure Data Environment

The Yorkshire and Humber Secure Data Environment is an NHSE-led national programme to develop secure data environments to provide approved researchers with approved projects secure access to NHS data. Bradford Teaching Hospitals

NHS Foundation Trust is one of 11 selected sites to host a regional secure data environment, and we are working with colleagues across Yorkshire and Humber to develop the SDE and make data available for research and to improve population health. As part of this, we have started to make datasets available on the HDR UK Gateway, with plans to add further datasets over the next few months.

We would also like to welcome our new team members (L to R: Jabu Phiri, Nicola Drake, Dasha Zakharets, Chole Parekh, and Grace Mullins,). They are leading on the PPIE and Comms for the SDE, ensuring the voice of the people is being captured to shape the SDE and communicating to the public, data providers, and data users about the SDE and the benefits it brings. We will soon be launching the SDE website to support the dissemination of information and sharing of case studies about how data saves lives.

Yorkshire & Humber SECURE DATA ENVIRONMENT | Part of the NHS Research Secure Data Environment Network

Academic Unit of Ageing and Stroke Research

ASR Academic Unit for Ageing and Stroke Research

Amazing survey response rate

The INCLUDE Study team within the Academic Unit for Ageing and Stroke Research have been amazed and overwhelmed (in a good way!) by the response to their survey exploring older people's digital engagement. Surveys were sent in Spring to people aged 65+ registered at two regional GP practices. Over 3000 responses have been received. These data will support development of a replicable identification system for digitally excluded older adults - the first part of the INCLUDE study. For more information please visit https://ageingstrokeresearch.org/research-projects/include/ or contact Liz Graham (liz.graham@bthft.nhs.uk) or Caroline Brundle (caroline.brundle@bthft.nhs.uk).

New research grant award to explore and improve osteoporosis care for older women

We have officially started our new research grant to undertake qualitative exploration of older women and healthcare professional experiences to guide improvements in osteoporosis care.

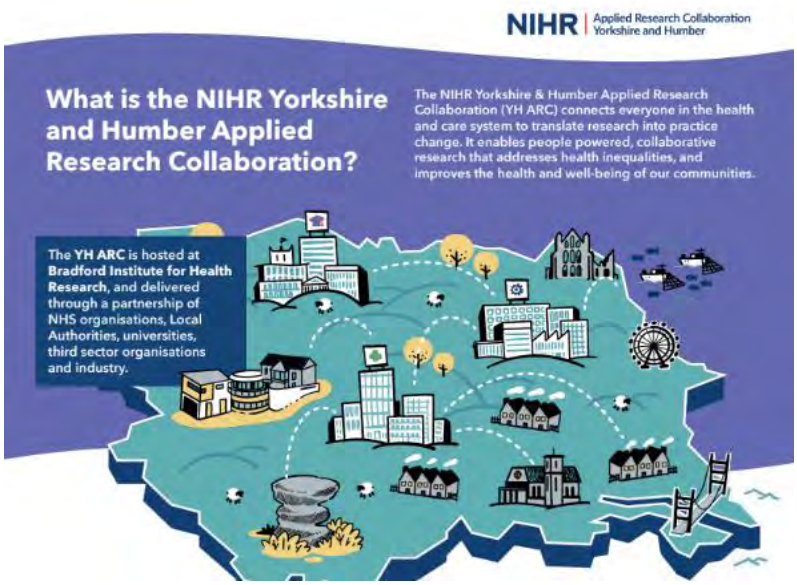
The Women's Health Strategy for England highlights the lack of focus on older women's needs and experiences. Older women told us they felt unseen, unimportant, unheard and uninformed. They also felt bone/joint health and osteoporosis were important issues for women like them (aged 70+). Osteoporosis leads to around 180,000 fractures per year causing significant pain, disability and death. The related cost is estimated at £4.4 billion a year. Women are four times more likely to suffer with osteoporosis than men and tend to suffer fractures earlier. Despite comprehensive guidelines being available, evidence suggests that

osteoporosis care is lacking in primary care. Our aim is to develop strategies to improve osteoporosis care using insights from the experience of primary healthcare professionals and older women.

This 18-month qualitative study is led by Anne Heaven as the Chief Investigator. This project is funded by the National Institute for Health and Care Research (NIHR) under its Research for Patient Benefit (RfPB) Programme.

NIHR | Applied Research Collaboration Yorkshire and Humber

In May, the ARC Yorkshire and Humber (YH ARC) submitted the annual report for 2023/2024, celebrating the successes from the year, including influencing policy through our externally validated novel falls prediction model, eFalls. Using routinely collected primary care electronic health records (EHR), it predicts risk of emergency department attendance or hospitalisation with fall or fracture within 1 year. This predictive clinical tool received considerable media interest and support from the Health Minister and has been submitted to NICE for the forthcoming falls prevention guidelines.



Our work in the priority area of identifying solutions for Avoidable Hospital Admissions continued with a policy briefing and recommendations to the DHSC explaining the characteristics of winter admission demand. These findings identified variation in key management strategies such as utilisation of Same Day Emergency Care (SDEC), a key intervention highlighted in the NHSE Urgent and Emergency Care (UEC) Recovery Plan 23-24. As a result, national work is now underway to examine best SDEC practices in England, in collaboration with the Royal College of Emergency Medicine.

We also produced an evidence summary for the Urgent and Emergency Care (UEC) Policy Lead at No.10, in response to the NHSE UEC Recovery Plan. This evidence

drew on ARC work around identifying avoidable attendance and admission, understanding the impact of digital technology in care homes and the evaluation of unscheduled care coordination hubs.

We successfully influenced policy on children's oral health (including an election pledge in the Labour Party manifesto) through the BRUSH project, a national study focused on evaluation and implementation of supervised toothbrushing in early years settings.

We have continued to work closely with our three ICS partners in Yorkshire and Humber, both at a project level (e.g. evaluating green social prescribing 'test and learn sites', spread and adoption of the Born and Bred In electronic birth cohort study, tackling childhood obesity through co-productive approaches with Islamic religious settings, delivery of NHSE Research Engagement Network (REN) projects) and at a strategic level (e.g. leadership of the Research Strategy for West Yorkshire, senior representation on research and innovation structures in South Yorkshire and Humber and North Yorkshire).

We also provided a summary of all our current projects. These summaries will be added to a searchable, public facing NIHR database. YH ARC currently has over 160 live projects as we move towards the 18-month extension, which begins in September.

We continue to work collaboratively across the region and beyond to secure significant research investment. In the reporting period we have leveraged £9.6m in new grant funding. A particular highlight which builds on last year's contribution to the Chief Medical Officer annual report, is our £8 million, four year "Healthy Urban Places" grant from UKRI. The project is interdisciplinary, multisite (Bradford and Liverpool, including respective Health Determinants Research Collaborations), multi-ARC (Yorkshire and Humber and North West Coast) and multi-stakeholder including community collaboratives which will co-produce and drive the research agenda.

Our new website has been launched and now includes searchable summaries of all projects and publications, refreshed descriptions of our themes, and a comprehensive resources section. The website also includes a new video about YH ARC; what it is and what we do, and an interactive infographic that goes into more detail.

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

The past Lunch & Learn webinars on our You Tube channel have been incredibly popular, with more than 8500 views so far.

Our next quarterly newsletter will be sent out in July, rounding up all the latest YH ARC news, publications, blogs and events, you can view past editions here. We also plan to have special editions throughout the year, and you can sign up to receive the newsletter here.

Our 18-month contract extension begins in September 2024. During the extension period we will focus on knowledge mobilisation, implementation and building regional links and partnerships to increase the dissemination and impact of our work to decision makers. To do this, we are hosting an event with each Yorkshire & Humber ICS. The events will bring together NIHR and other local research infrastructure in the Yorkshire & Humber region and the ICS, to understand the ICS priorities and how the research infrastructure can provide the high quality evidence that can be implemented to drive change.

Yorkshire Quality and Safety Research Group

On 11th June the Quality and Safety Research group hosted a two hour seminar with BTHFT senior executive team including Ray Smith, John Bolton, Judith Connor, Liz Tomlin and Deborah Horner. We shared our vision for patient safety research, presented and discussed five of our current research projects that address key priorities for the Trust and identified ways of ensuring our research was visible and useful within the Trust. This was a fantastic opportunity for shared learning and we plan to continue to do this on an annual basis.

ACTEARLY

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

We held our ActEarly 'Tackling the Wider Determinants of Health' event on 18th April 2024 at Bradford City Football Club. It was a fantastic day and we have had overwhelmingly positive feedback about the event. Highlights included:

- Keynote presentation by Brian Ferguson, Director of Prevention Research Programme NIHR
- Panel sessions including interactive audience participation via Slido
- Our Healthy Places Panel presented videos of their work which can be viewed here: https://www.youtube.com/watch?v=n6hM5ruCFk8 and https://youtu.be/XJX632POAUg

Our ActEarly website https://actearly.org.uk/ has more details and other information about what we've been doing in ActEarly.

ActEarly has secured a no-cost extension from September to the end of March 2025 but is nearing the end of its funding period. Any further outputs and updates will be included in the BiB Programme update.

Clinical Research

Clinical Research Delivery Workforce

Training -Training has been highlighted as an area of priority due to the inconsistencies evident when the clinical workforce was centralised. A new, standardised, mandatory training matrix has been developed and implemented. This was created with input from the Trust Mandatory and Statutory Training Lead and Director of Nursing Operations.

Trust Research Unit Council -The Unit council continues to operate and is currently arranging workforce connection events, supporting the newly formed research support staff network, and working on a project regarding the archiving of research records.

Staff News

Welcome to new staff - Waheeda Ahmed and Sangavy Loganathan have joined the respiratory research team as Clinical Trials Assistants**.** We have also appointed and are waiting for the start dates for 3 further clinical trials assistants to help with the administration and delivery of clinical research across the Trust.

Clinical Research Specialty News

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

Maternity

The Maternity Research Team have successfully completed a large national study GBS3, attempting to ascertain the best way to screen pregnant women for Group B Streptococcus. This study involved offering screening at the bedside to eligible woman in labour in Bradford and the team were successful in surpassing their target, screening 2793 women over the year. The team have also just become the second highest recruiter nationally for the Stoppit3 study (beaten only by the study site themselves). This study is offering pregnant women with twin pregnancies the chance to participate in a trial to see if antenatal corticosteroids are effective in reducing neonatal morbidity for twins.

A collaboration between **Renal** and **Rheumatology** teams recently saw over 300 patient recruited to the RESOLVE study, which is still recruiting with a target of just x10 ! This study with its high recruitment over a short period of time has been supported by staff from all the research teams based at St Luke's. RESOLVE is a

large NIHR study which is looking at the amount of sodium in dialysate fluid for dialysed patients.

St Lukes:
The Friends of St Luke's have kindly donated two blood pressure monitors and an incubator for the use of research teams at St Lukes.

Appendix A: Submission of research reports to external monitors/ sponsors/ funders

Research Team	Report Name	Project	Purpose	Submitted to	Date
Born in Bradford	PUSH NIHR Interim progress report	PUSH	Finance and Governance Monitoring	NIHR (Funder)	30/01/2024
Born in Bradford	Quarterly Data Submission	BSB Innovation Hub	Monitoring	National Lottery Community Fund	01/02/2024
Born in Bradford	Annual Update Report	BSB Innovation Hub	Monitoring	Better Start Bradford (Funder)	15/04/2024
Born in Bradford	Active Bradford Board meeting	JU:MP	Finance and Monitoring	Active Bradford Board	22/04/2024
Born in Bradford	Sport England bi-annual progress report	JU:MP	Monitoring	Sport England (Funder)	30/04/2024
Born in Bradford	Annual Data Submission	BSB Innovation Hub	Monitoring	National Lottery Community Fund	01/05/2024
Born in Bradford	JU:MP Executive Board	JU:MP	Finance and Governance Monitoring	JU:MP Exec Board	02/05/2024
Born in Bradford	NIHR Annual Progress Report	BiB Breathes	Finance, Governance and Project Progress	NIHR (Funder)	10/05/2024
Born in Bradford	Annual report for the Applied Research Collaboration	ARC	Finance, Governance and Project Progress	NIHR (Funder)	14/05/2024
Born in Bradford	Financial Claims	Age of Wonder	Finance	Wellcome (Funder)	21/05/2024
Born in Bradford	Bristol BRC Progress Report	Bristol BRC	Finance, Governance and Project Progress	NIHR (Funder)	01/06/2024

Research Team	Report Name	Project	Purpose	Submitted to	Date
Born in Bradford	Independent Steering Advisory Group	BiB Breathes	Finance, Governance and Project Progress	NIHR (Funder)	07/06/2024
Born in Bradford Born in Bradford	Annual Contract review	BSB Innovation Hub	Monitoring	Better Start Bradford (Funder)	15/06/2024
Born in Bradford	SYB End of Project Report	Supporting Young Bradford	Finance, Governance and Project Progress	Health Foundation (Funder)	18/06/2024
Born in Bradford	Active Bradford Board meeting	JU:MP	Finance and Monitoring	Active Bradford Board	24/06/2024
Academic Unit of Ageing and Stroke Research	HSDR Progress report	Optimising Structured Medication Reviews for Older People with Severe Frailty and Care Home Residents to Reduce Overprescribing and Associated Inequalities	Project Progress	NIHR	June 2024
ARC	Annual report FY 2023/24	NIHR Applied Research Collaborations (ARCs)	Annual report	NIHR	13/5/24

BO.9.24.9 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY

REFERENCES

Only PDFs are attached

Bo.9.24.9 - Report from the Chair of People Academy - August 2024.pdf

Bo.9.24.9 - Report from the Chair of the People Academy- 19 September 2024.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.9

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 09 August 2024

Key escalation and discussion points from the meeting
Alert:
Freedom to speak up (FTSU) – the FTSU Guardian shared the Q1 report and progress on the recruitment of more ambassadors across the Trust. She has been out to areas with ongoing investigations and the Networks and has had 20 expressions of interest across many bands and areas. The recent internal audit identified the need for follow up training albeit this is not mandatory. There is a low completion rate of the Speak Up, Listen Up and Follow Up training, with only 3 Board Members completing the Follow Up training. A plea to my fellow Board Members to please complete the training and ensure their teams do the same, The Academy spoke about the importance of 'the why' in ensuring people understand the need and benefits of the training rather than mandating this (wanting to because it's the right thing rather than having to). October is Speak Up month and there will be a focus on the power of listening. Of the 22 concerns raised in Q1, the majority of these relate to inappropriate attitudes and behaviours and Nursing and Midwifery roles, which is reflective of the national profile. The FTSU Ambassador was challenged to think about how the Trust captures the listen up and follow up data to draw out examples and themes that will then lead to wider improvements. **Closing The Gap** – the impact of the programme on Trust staff was raised, particularly relating to recruitment freezes, overtime reductions and health and safety concerns. The Academy was assured that more requests for recruitment have been approved than not, the risks of any decisions are assessed and that there is a robust process for assessing ideas and initiatives. The Chief Nurse asked that people who have safety concerns raise them with their line manager or escalate to her or the Chief Medical Officer.
Advise:
National Education & Training Survey (NETs) – the Head of Education shared the 2023 NETs results in April and was asked to return to the Academy with more data on how we compare to other Trusts. The quality of the Trust's education was highlighted as the top performer in WYATT and among the top performing teaching hospitals overall. Only 9% of learners would not recommend the Trust for training. Despite this, only 49% of nursing students indicate they would apply to BTHFT on qualifying, with 28% indicating they would not apply. 100% of midwifery students are undecided about applying for a role at the Trust. This is a huge opportunity, and a plan is in place to ensure the Trust attracts recruitment from its learners, including an understanding of the barriers to staying at BTHFT, better collaboration with the university, greater engagement with learners and showcasing BTHFT's career development opportunities. **Dashboard** – core mandatory training continues to perform above target at 90%. Non-medical appraisal rate continues to rise albeit still under target and medical appraisals

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.9

are at 97% outcome measure 1 (appraised) and 3% outcome 2 (approved missed appraisal). June saw a slight increase in absence at 5.63% and turnover grew to 9.95% from 8.99% in May. There is a focus on absence management across the Trust. The turnover dip in August is seasonal with the roll off of FTC (fixed term contracts) and rotations.

Assure:

Positive progression - staff story. We heard from Rashmi, who dialled into the meeting from India, to share her story. A physio in India previously, who joined BTHFT's PPE Hub as a Therapy Assistant as she did not have her Health & Care Professions Council (HCPC) registration, Rashmi was encouraged by the Chief Executive (CEO) and Chief Nurse (CN) to apply for her registration. Rashmi was successful and explained how she could not have got through the process with the significant support she received. The learning for the Academy was the unconscious bias in the process that made it difficult for Rashmi to apply despite her transferable skills. There were accessibility issues and had the CEO and CN (through an incidental contact) not identified and supported Rashmi, it would have been very difficult for her to progress. Such as the essential and desirable criteria in the job description requiring a driving licence, and a difficult recruitment process that was not understood by the Therapies team created barriers. The Chief People and Purpose Officer (CPPO), Head of Organisational Development and Head of Equality, Diversity and Inclusion agreed to review the end-to-end process and improve it to create an equal platform for BTHFT's people to progress. A great story of support and resilience and the Academy celebrated Rashmi's success. We are looking forward to hearing about how the improvements to the process progress.

Extraordinary Pause For Peace – the Pause for Peace, initiated by the SPaRC (Spiritual, Pastoral and Religious Care) team, has taken place across the Trust each Tuesday since last December and is a safe space for people affected by global events to process how they're feeling, share, connect and reflect with their BTHFT family. Following the recent riots in the UK, the Trust held an extraordinary Pause for Peace to show a unified and diverse BTHFT team to its patients and the public. Everyone was (and are) encouraged to check in on their colleagues as some Trusts have experienced significant events in the wake of the riots. The event was well attended and appreciated by the BTHFT team.

Karen Walker
People Academy Chair and Non-Executive Director

09 August 24

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.9

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 19 September 2024

Key escalation and discussion points from the meeting

Alert:

Dashboard – YTD (year to date) absence at 5.73% is down from 6.09% in July 23 but is a key focus area. Actions to mitigate include manager briefings and training, proactive analysis and challenge of managers in areas with high absence, a sickness policy review, increased data sharing and bespoke training, where appropriate. 25% of all absence relates to stress, depression and anxiety and OH (Occupational Health) can provide data on whether these occurrences are work related. One barrier for managing absence is the volume of paperwork and admin and the Academy discussed how the process could be simplified to make it less admin heavy and burdensome. A deep dive on absence management and sickness is on October's People Academy agenda.

Staff survey engagement – the 2024 Staff Survey launches on 30 September and 7,850 survey invitations will be issued across the Trust, some for on-line completion and some paper based. There will be a robust campaign to boost the response rate from the 43% achievement in 2023. The Chief People and Purpose Officer would like to see a 92% response rate which requires a huge focus on psychological safety and the reiteration that it's safe to speak up and use your voice to better the Trust. There are no financial incentives for increased completion rates because of the Closing the Gap challenge and anonymity is always an area of cynicism when people who have not completed the survey are reminded to do so. The Trust will consider sharing transparently how survey anonymity can be assured and whether or not offering a paper-based option to those completing on-line may increase response rates.

Advise:

Dashboard – the dashboard shows progress on recruitment with staff in post growing to 7,408 from 6,801 a year ago. 90 newly qualified nurses have been appointed in month with slower progress on HCA (Health Care Assistant) enrolment. Turnover is reducing, at 8.97% for July, down from 10.5% a year ago.

Flu vaccine plan – The Trust is required to vaccinate all patient-facing people against flu to protect them, their families and their patients, and has a desire to vaccinate people against Covid. The Trust is using Rimmington's Pharmacy to vaccinate all those who qualify against flu and Covid by the end of December. They can provide a flexible proposition covering weekends, out of hours, drop-in clinics and can accommodate both flu and Covid vaccines in one appointment. There is no cost to the Trust as Rimmington's will use the Trust's supply already procured for staff. The campaign starts on 7 October and will be publicised on screensavers, bulletins and other comms channels, with

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Rimmington's also catching people on the concourse. Uptake data will be presented to the People Academy to share progress.

NHSE Training and Education Annual Self-Assessment – the Academy reviewed and **approved** the self-assessment in which the Trust evaluates the quality of education and training against six quality framework domains. The top three successes in relation to education provision are the collaboration and partnerships that support enriched, credible, high-quality education, innovative approaches to learning that meet the changing needs of learners and the workforce, and proactive quality improvement initiatives in response to learner feedback. The top three challenges highlighted are the lack of space for training due to the growth of the education department and the ageing and declining nature of the estate, the service pressure of BTHFT's workload impacting training and the lack of belonging and support learners feel when on placement. The Academy is assured that the Training and Education team are aware of and mitigating each of the challenges.

Assure:

Medical Appraisal and Revalidation Annual Statement – the Academy took assurance from the regular updates and the fact that the annual statement summarised great progress – 96.89% of doctors connected to the Trust received an outcome measure 1 (fully compliant) with 3.11% allocated outcome measure 2 (includes doctors with extended leave and those recently connected to the Trust but not in post long enough). There were no outcome measure 3 allocations (non-compliant).

Staff appraisal – the Trust has been focused on ensuring all its people are engaged in the appraisal process and has created an action plan based on regular dynamic conversations. These will cover health and wellbeing, development, performance and prioritisation and are supported by a resourceful toolkit. There has been great progress made on personal development with the introduction of progression mapping which maps all roles into job families at service and band level; this helps people to understand career pathways and shows opportunities to move sideways, upwards, out of area, etc. This sits well with the proposed staff appraisal changes. At the end of April, the appraisal rate for the Trust sat at 77.62% and the Academy is looking forward to tracking the progress of the new approach.

Karen Walker
People Academy Chair and Non-Executive Director

19 September 24

WORKFORCE REPORT

REFERENCES

Only PDFs are attached

Bo.9.24.9 - Workforce Report - September 2024.pdf

Introduction

The last Workforce report was presented to the People Academy in August 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 July 2024

	DIVISION						
	Unplanned Services	**Planned Services**	**Diagnostic & Corporate Operational Services**	**Corporate Services**	**Estates & Facilities**	**Research**	**Whole Trust**
Staff in Post (Headcount)	2,139	2,166	1,424	785	630	262	7,408
Staff in Post (FTE)	1,874.14	1,937.57	1,257.10	711.50	506.71	227.41	6,516.43
Establishment	2159.83	2164.87	1414.10	790.12	642.59	209.49	7381.00
Agency Usage (FTE)	3.36	22.18	22.26	0	10.61	0	58.41
Bank Usage (FTE)	273.13	182.48	100.95	28.21	118.65	2.79	706.21
Turnover	10.24%	9.99%	9.76%	10.39%	9.25%	4.21%	8.97%
Leavers within 12 months/Joiners	42/313	45/293	29/225	11/73	7/131	0/0	134/1035
Monthly Sickness %**	5.96%	5.53%	5.75%	4.22%	7.14%	2.68%	5.69%
YTD Sickness %**	6.15%	5.67%	5.94%	4.32%	7.23%	2.83%	5.73%
Jnr Dr Sickness (Monthly) %	4.44%	2.61%	2.80%	3.60%	0.00%	0.00%	3.56%
Jnr Dr Sickness (YTD) %	3.86%	2.59%	1.90%	2.98%	0.00%	0.00%	3.12%

	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)	168	1,270	1,678	511	605	120	979	2,065	7,408
Staff in Post (FTE)	142.10	1,100.51	1,488.95	448.15	472.15	110.11	910.30	1,832.95	6,516.43
Establishment	150.87	1335.58	1639.39	512.11	624.60	102.65	983.75	2032.05	7381.00
Agency Usage (FTE)	22.45	0	2.60	15.22	8.01	0	8.31	1.82	58.41
Bank Usage (FTE)	9.02	316.47	44.97	27.53	120.45	0	45.29	142.48	706.21
Turnover	10.10%	11.90%	10.37%	10.04%	9.46%	6.45%	4.09%	9.83%	8.97%
Leavers within 12 months/Joiners	0/14	54/373	31/203	5/61	7/123	0/12	2/17	35/231	134/1035
Monthly Sickness %**	4.23%	8.20%	5.58%	4.21%	8.07%	4.24%	2.27%	5.54%	5.69%
YTD Sickness %**	4.34%	8.40%	5.72%	4.35%	8.15%	4.40%	2.31%	5.77%	5.73%

*** 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 July 24**
***** Includes usage for centralised budget code for COVID-19**

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**	**1/4/24**	**30/4/24**	**1/5/24**	**31/5/24**
Headcount	7,148	7,152	7,148	7,236	7,240	7,298	7,292	7,306	7,283	7,328	7,326	**7,331**
Month	**1/06/24**	**30/06/24**	**1/7/24**	**31/7/24**								
Headcount	7,332	7,356	7,349	7,408								

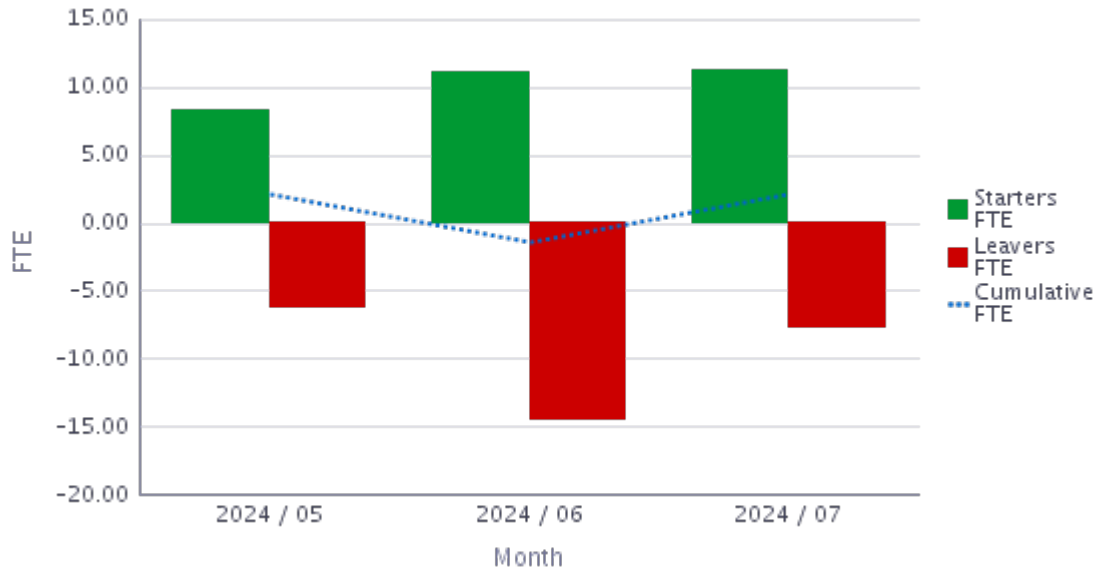
Staff in Post

Since the last report staff in post FTE has increased from 6,463.71 in May 2024 to 6,516.43 in July 2024 representing an overall increase across all staff groups of 52.72 FTE.

The largest increase in FTE over the period was in the Estates & Ancillary Staff Group (18.05 FTE) followed by the Nursing & midwifery Registered Staff Group (11.77 FTE). The increase in Estates & Ancillary staff group can be attributed to Agency staff who have gone through the recruitment process to be recruited substatnively rather than working via an Agency.

The staff group that has shown the largest reduction is Add Prof Scientific & Technic which has reduced by 12.58 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 2.17 FTE with 30.70 FTE registered nurses / midwives joining the Trust and 28.53 FTE leaving.



e-Job Planning and e-Rostering

In August the total number of requests sent to bank was 9282 compared with July's requests 9189 an increase of 93 requests. The split for August is 3860 requests for registered staff and 5422 requests for unregistered staff. Of those 9282 requests a total of 7226 were filled by bank staff. 2740 are filled by registered and 4486 filled by unregistered staff. Out of the 2740 filled registered shifts, 627 were filled by registered Theatre staff.

Agency staff filled 284 shifts in the month of August. This is split 284 registered and 0 unregistered staff. Out of the 284 filled registered shifts, 249 were filled with registered theatre staff.

There are currently 957 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 416 Medics, 345 AHPs and 196 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. Currently there are 172 Job plans signed off for Medics with 11 awaiting 1st Sign off, 31 awaiting the 2nd sign off and 143 in review.

Turnover

Turnover has shown a slight reduction to 8.97% in July 2024 from 8.99% in May 2024. Turnover has increased slightly across all staff groups apart from Admin & Clerical, Healthcare Scientists and Medical & Dental where it has reduced 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 7.2% (July 2024) compared to a median of 10% with peers. We have moved from the 4th quartile into the 2nd quartile over the last 6 months

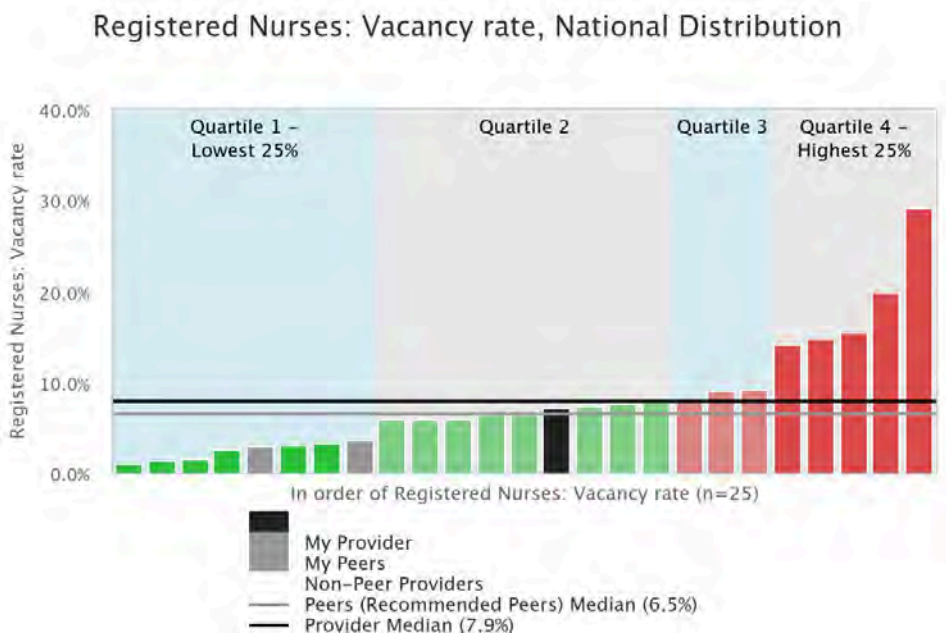


Figure 1 (July 2024)

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 and we are in the lowest Quartile (Figure 3).

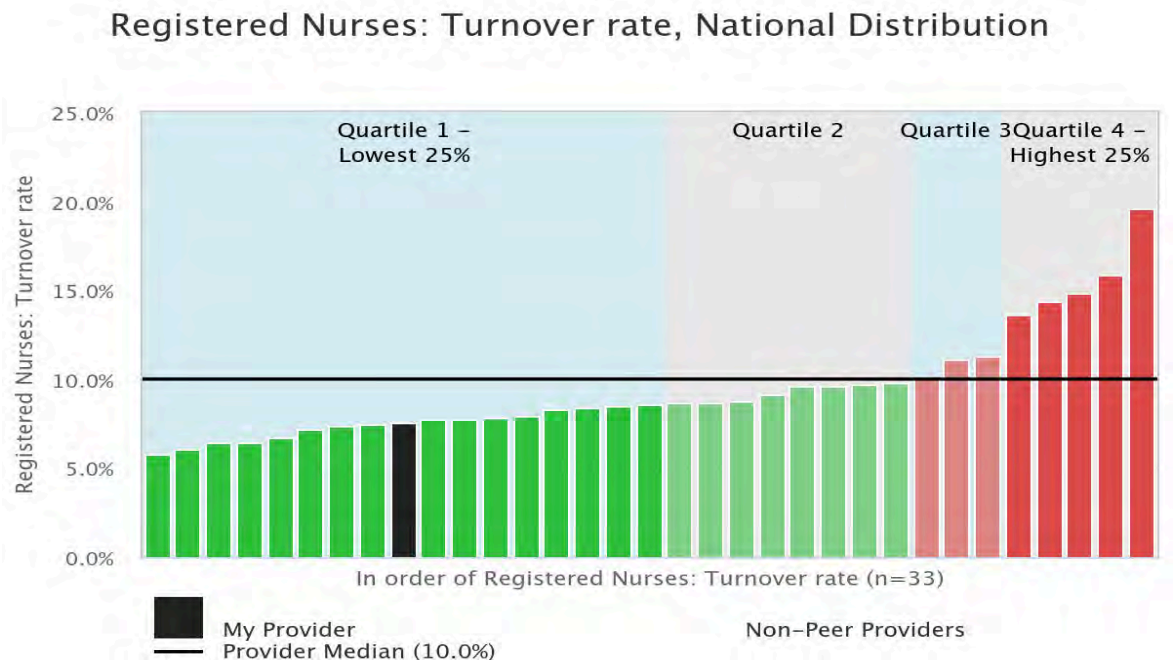


Figure 3

We have also the see Nursing Turnover rate reduce to 7.6% over the last 12 months (Figure 4)

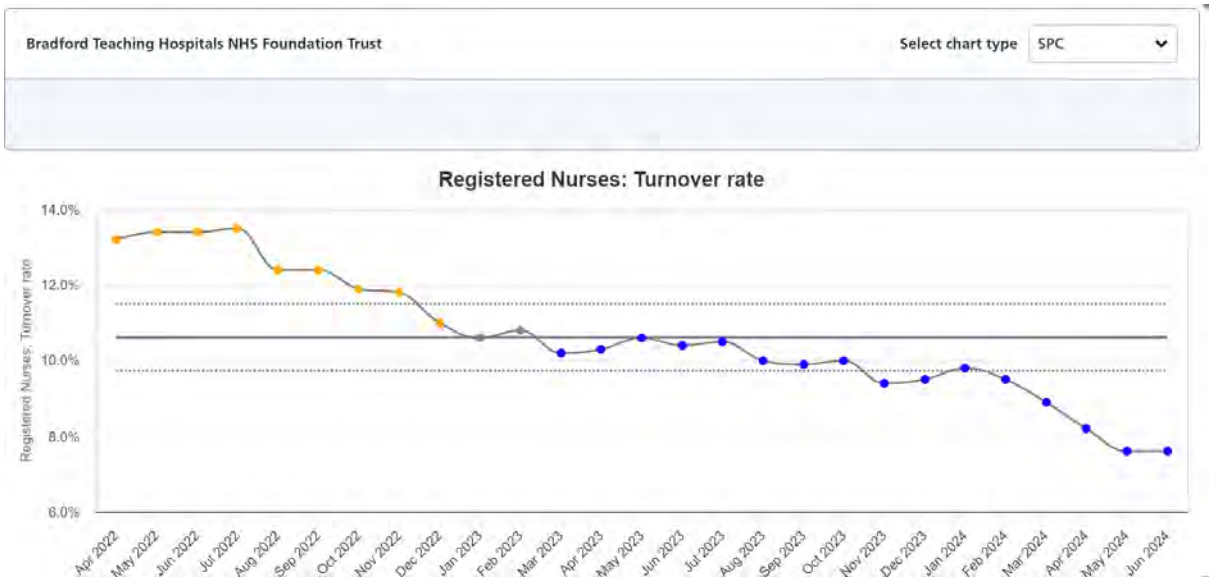


Figure 4

Risks and Recruitment

In view of the vacancy position Nursing and Midwifery staffing was on the Chief Nurse Risk Register (Risk ID 3732) as 4x4 (April 2024) however this has been reduced to 3x4 (July 2024) in view of the improved position. Staffing Fill Rates at a ward level continue to improve and are consistently above 85% for Registrants and 95% for Healthcare Support workers.

From our monthly finance data, we are reporting 70 vacant Band 5 nursing posts and 140 Band 2 Healthcare Assistant posts. Our aim is to maintain our registrant vacancy position to less 10%. Work is ongoing to reduce out Healthcare assistant vacancy to 5% with ongoing monthly recruitment by March 2025.

Band 5 Recruitment Events

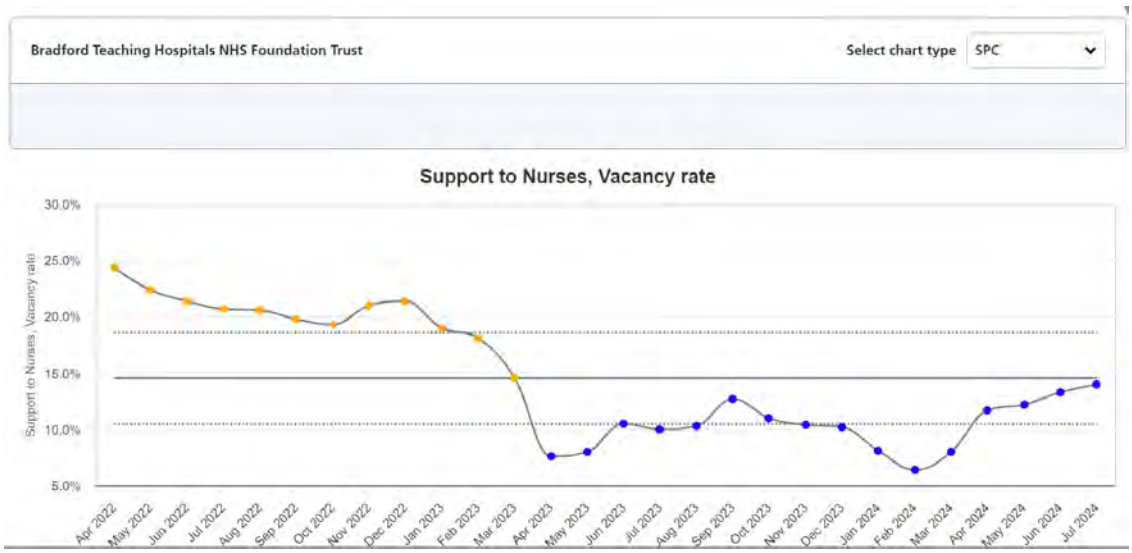
We appointed approximately 90 newly qualified nurses (NQN) into the organisation from an event held in March 2024. We will plan a further recruitment event in January 2025. We will continue to work with Human Resources to support the onboarding process to maximise retention of those waiting to start 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. We are also undertaking a Career Progression mapping exercise to support our International Colleagues to access the opportunities at BHFT and track their career progression within the organisation.

Band 2 Recruitment

Work is ongoing to recruit Healthcare Assistants and enrol them on the monthly bootcamp, we have an average of 20 new starters each month and will be working with our recruitment team and education to see if we can increase this to achieve our aim of a 5% vacancy rate by March 2025. We have seen an increase in our vacancy rate (figure 5) which is part explained by progression to other roles (Student Nursing Associate). We will continue to monitor progress against the 5% target.



Support to Nursing Turnover Rate (Figure 5).

In addition to the work outlined above, several other initiatives are ongoing to improve our vacancy position and reduce our reliance upon bank and agency. These include;

- **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 25 Trainee Nursing Associates to start in October 2024.

- **Engagement events Universities:** We will be holding listening events with 3rd year students to discuss their career options at BTHFT. These will be hosted by the Deputy Chief Nurse.

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, from the open day 31.45 WTE graduates were appointed and expected to start in October 2024. There is also a plan for a rolling midwifery advert to attract experienced midwives to join or return to BTHFT. 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.

The has been a slight increase in the reported Midwifery turnover rate to 10% (June 2024) (Figure 6) and we will continue to monitor this trend.

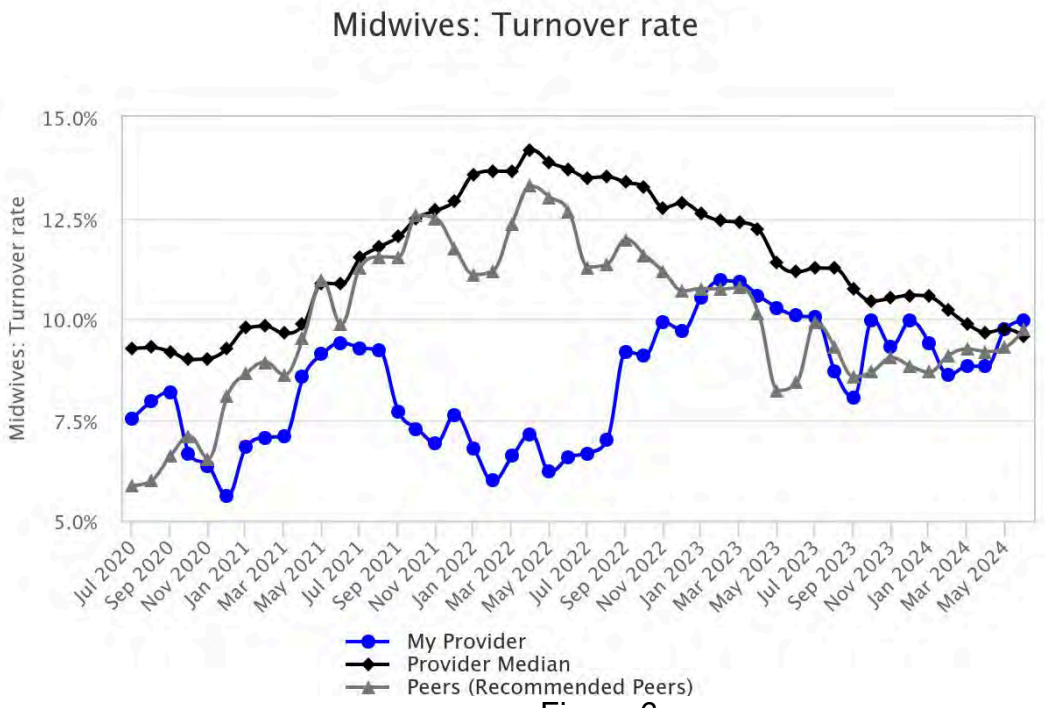


Figure 6

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;

- Learning career conversations and mapping career opportunities.
- Recognition of staff via Daisy and NHS England's Chief Nurse Awards.
- Support to move staff from Bank to substantive contracts.
- Benchmarking our position with NHS Employers and NHS England's retention toolkits.

Allied Health Professionals

Physiotherapy vacancies have increased to 11.9% with most vacancies at B6. However, all B6 posts have been recruited to with several internal applicants being successfully promoted. B5 posts are currently being recruited to following the promotions and agreement to over-recruit to the B5 line. Currently using 1 agency member of staff to support the additional demand from the HFAST pilot. Two new apprentices have started this month.

Occupational Therapy vacancies are 0.14% - there are not currently any significant issues with OT recruitment at any band.

Speech & Language Therapy vacancies (within Therapies) are currently 14%, a reduction from 25% as a result of over-recruiting to B5 posts to mitigate gaps on B6 line. A B7 post in stroke has not been filled despite advertising it several times.

Dietetics vacancies remain relatively low. Newly qualified staff offered posts earlier in the year are starting to enter the workforce. Despite this there is number of B5 gaps as no over-recruitment was undertaken this year, and this position is expected to worsen through the year. A newly funded service is unable to start as the specialist posts have not been recruited to, work is underway with the funder to agree a way forward. B5-B6 development posts have been established and a B6-B7 upgrade has recently been enabled. Retention is high priority due to regional recruitment challenges

Orthoptics have no current vacancies.

ODPs currently have 13 apprentice ODP's on the programme. 3 ODPs will qualify in Sept 2025, 6 in April 2026 and 4 in September 2026. By 2026 the vacancies will have been filled via the apprentice programme. 14 newly qualified ODPs have been appointed which will qualify in September 2024 across theatres and the SLH DCU. The CSU worked alongside JUST R to recruit ODPS and qualified nursing staff. There are still concerns regarding the out of hours roster due to working agreements however once the new starters are trained and competent this will address these concerns.

Orthotics have no vacancies at present, but currently renegotiating contracted services.

Radiographers
Primary imaging department has recently had 2 x B5 starters with 4 more due to start imminently. There has been successful recruitment for MR/CT vacancies and the Community Diagnostic Centre is almost fully recruited (8.6 wte in post with 9.0 wte funded). In ultrasound, 3 Sheffield Hallam students started at the beginning of September.
Plans to move from the existing overtime model to bank contracts for Radiographers have been difficult. Workforce plans are being developed to support the process of moving to a bank arrangement within a few months.

Healthcare Scientists

Audiology
Several staff on are maternity leave but fixed term posts have been recruited into to cover these. One specialist Audiologist retired at the end of August and at present there has been no success in appointing to the post - there was very limited interest. Another Band 7 specialist Audiologist is due to retire next year and there is concern about filling this post given lack of experienced Band 6/7 staff nationally.

Success in gaining 2 Scientist Training Posts (STP) - started last week, fixed term for 3 years.

A Level 4 apprentice has completed their training and will now take up a vacant Band 4 post, but a Band 2 apprentice has recently left.

The delivery of quality training to both degree (PTP) students, apprenticeship and STP students has a significant drain on clinician time which needs supporting through funding.

Neurophysiology currently advertising for replacement Band 8A for a second time. Band 7 staff fully staffed at present. Clinical Neurophysiology is nationally difficult to recruit to.

Medical Illustration
Trainee Clinical Photographer position, Band 5, Annex 21 is newly in post and will train towards Post Grad Certificate in Clinical Photography through Staffordshire University for 1 year, starting in January 2025.

Clinical Engineering
1x HC Scientist Assistant 'CTG Post freeze'.
1x HC Scientist Specialist – Maternity leave anticipated March 2025.
1x HCS Scientist Trainee (Band 5 Annex 21) enrolled onto 2nd year BSc Medical Engineering Apprenticeship PTP programme (University West of England).

No NHSE 24/25 funding to support paid Clinical Engineering student placement opportunities, however; Clinical Engineering is supporting 2x voluntary (unpaid) UoB student placements in post.

Unable to utilise additional Apprenticeship levy as no supporting salary to implement substantive trainee posts.

No NHSE funding model to support CPD & manufacturer technical training to existing HC Scientists/ Specialists (Circa 50k internal cost pressure to develop and upskill Clinical Engineering Team last year).

Cardiac and respiratory scientists
Difficult to recruit to 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.

Continue to make use of HEE funding support for trainees at Level 2, Level 4 and Level 7.
In the absence of dedicated CPD funding or additional support from HEE, funding from income streams is being utilised to support the development of staff in an effort to 'grow our own' and increase retention.

Other Clinical Professions

Clinical Health Psychology department remains committed to diversifying the workforce and although there has been success in recruiting to some substantive posts an application for further NHSE money to support up to 4 Assistant Psychology posts for people from minoritised backgrounds has been made – this was not successful in the Spring round of applications. Retention rates are good, currently there are 2 vacancies out of 31 posts but these were anticipated due to staff moving into training positions. A relatively large number of training positions continue to be offered within the service including psychiatry STs, counsellors, clinical psychologists and specialist CBT placements.

Optometry team of 10 x B7 plus a Head Optometrist and Deputy Head optometrist are fully recruited. Deputy Head currently on maternity leave – unable to provide cover for this role due to the specialist nature of the clinics. Recruitment is OK at B7 but very few applicants

have previous hospital experience, which means recruiting and training relatively junior applicants for what is a senior clinical role. Majority of applicants are not wanting more than 2-day per week roles due to better pay in the private sector. Retention is not currently a concern.

Pharmacy

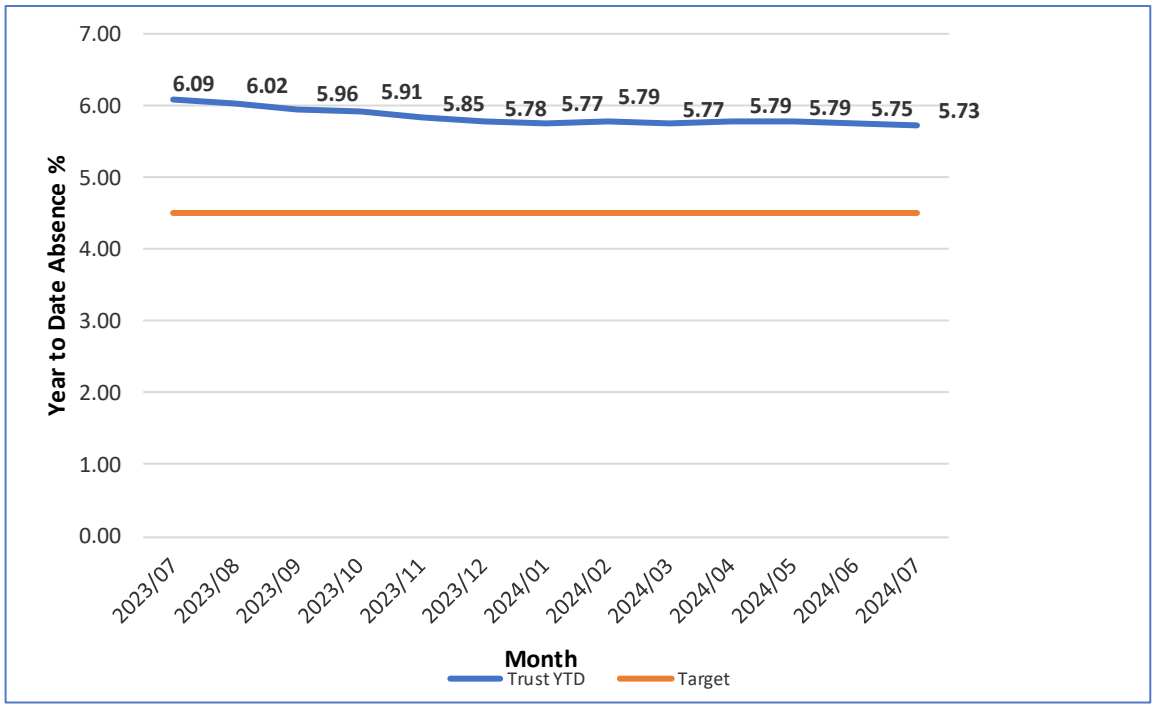
The Outstanding Pharmacy Services (OPS) Programme continues to make an impact, in particular, the workstreams have developed a wide range of projects including:

- All-staff communication meetings taking place regularly
- Line manager network monthly meetings to share ideas, get support, and update about relevant training
- Service Improvement Training available for all – new cohort starting September 2024
- Workplace civility – bespoke session with OD support piloting with Dispensary team, first week in October

The following initiatives are underway or in planning stages:

- Patients voice and feedback – forming part of Medicines Management workstream for Closing in the Gap
- Mental Health First Aid training
- Annual leave working groups – ensuring that policies and procedures are implemented fairly across the department with feedback and suggestions from staff
- Clinical Pharmacy Congress – Wellbeing workstream presenting about the work they have done, “Outstanding Pharmacy Services: driving service improvement through staff wellbeing.”
- Staff survey 2024 planning is underway to follow the incredible success of last year.

Absence Timeline – Year to Date Absence % Rate – Table 1



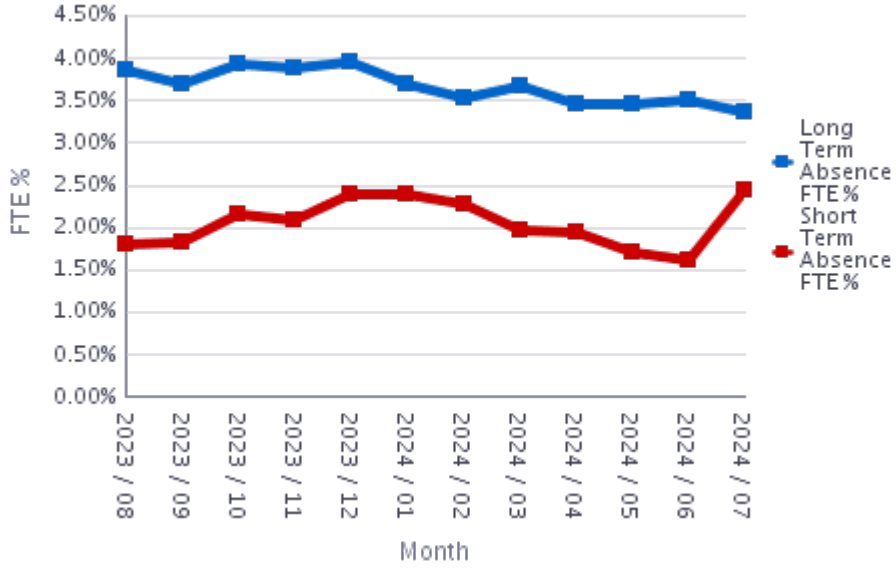
The year to date absence percentage rate in July 2024 is 5.73%. The absence rate has remained stable since December 23. At this time last year the year to date absence rate was 6.09%. The graph above also shows Year to Date sickness absence (%) up to July 2024.

Top 5 Absence Reasons by FTE Lost – Table 2

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	24.1
S98 Other known causes – not elsewhere classified	15.1
S13 Cold, Cough, Flu - influenza	8.5
S12 Other musculoskeletal problems	8.1
S25 Gastrointestinal Problems	7.6

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 March. Short-term sickness has shown a slight reduction since January however has risen significantly in July.

Organisational Development (OD) Update

Brilliant Bradford Awards 2024

Over 250 nominations were received for the 7 categories for this years' Awards. This year, the awards are fully sponsored by Sovereign Health Care, and around 250 colleagues will be attending the evening on 26 September 2024 to celebrate and recognise our achievements.

Thrive Live

Thrive Live was relaunched in July with some new additions following feedback from colleagues. The new format includes subject matter experts who will be present at the session to answer relevant questions.

Two events have taken place this quarter, the first one in Education and the second event in Research. In total across both sessions, 89 participants attended, which is a large improvement compared to previous numbers. Some themes have been specific to both sessions and others to the individual session.

Thrive Hive

Thrive Hive has now launched and received positive feedback. The Thrive Hive is an exciting, new, interactive digital space where colleagues can access a wide range of activities, clubs, and events via an engagement calendar. This has been designed to actively encourage communication and collaboration of colleagues with similar interests; to celebrate the vast diversity of skills and interests of everyone at BTHFT and help to embed a culture of belonging in the Trust. We have currently got around 25 activities / events which colleagues have offered to lead on and we are actively looking for more.

Equality, Diversity and Inclusion

Planning for Black History month (Oct 2024) & Disability History Month (Dec 2024)

The RESIN network Core Group have started to develop plans for activities for this years' Black History Month celebrations. Activity will include a feature for Mel's Weekly Round-Up video in October.

Progression

A number of progression maps have been created which showcase the range of roles available at the Trust, organised by area and band. This will support colleagues looking for different/new opportunities to understand and see at a glance what is available to them. A 'personal development plan' template has also been created, as well as a manager conversation tool, to support conversations around development and progression. This will be aligned to our Trust appraisal and 1-1 paperwork. Next steps include sense checking the maps with subject matter experts and creating a bank of development opportunities aligned to each map so that colleagues can clearly see the opportunities available to them should they be considering a change in role.

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 STATEMENT OF COMPLIANCE

REFERENCES

Only PDFs are attached

Bo.9.24.9 - Medical Appraisal and Revalidation Annual Report Statement of Compliance (cover).pdf

Bo.9.24.9 - Annex A - Professional Standards Framework for Quality Assurance and Improvement.pdf

Meeting Title	Board of Directors		
Date	25th September 2024	Agenda item	Bo.9.24.9

Medical Appraisal and Revalidation Annual Statement of Compliance

Presented by	Ray Smith, Chief Medical Officer	
Author	Remi Akerele, Associate Medical Director for Professional Medical Standards	
Lead Director	Ray Smith, Chief Medical Officer	
Purpose of the paper	Compliance statement supporting the Medical Appraisal & Revalidation Designated Body Annual Board Report	
Key control		
Action required	For assurance	
Previously discussed at/ informed by	The Medical Appraisal & Revalidation Designated Body Annual Board Report was discussed at the People Academy and Trust Board in July 2024.	
Previously approved at:	People Academy	19th September 2024

Key Options, Issues and Risks

The paper sets out the information and metrics that a designated body is expected to report upwards, to assure compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

It describes the general progress of the Trust in this regard, outlining the high level of compliance with the appraisal and revalidation requirements of the medical staff. References are made to recent changes in appraisal software, the mechanisms in place to provide quality assurance, any areas of concern, and actions outstanding and / or planned.

Analysis

In keeping with many Acute Trusts, BTHFT continued to face a number of multifactorial challenges in 2023-2024 which included the impact of medical and non-medical Industrial Action thus impacting to some degree on the ability of doctors to deliver non-clinical activity. Despite this we have managed to achieve an overall appraisal rate of 96.89% - this exceeds our pre-pandemic rates of appraisal. This is testament to the engagement of both our appraisers and appraisees. No doctors received an Outcome Measure 3 for this period; one doctor was subject to a REV6 referral but subsequently completed his appraisal successfully.

The Medical Appraisal 2022 format is now embedded within the Trust and, in keeping with guidance, our software has been updated to reflect Good Medical Practice guidelines (2024).

Local Network Meetings, Appraisal and Revalidation Committee Meetings and Quality Assurance Audits based on NHSE's ASPAT form have now all been resumed on a regular basis. Regional Network meetings are attended by the Responsible Officer, Associate Medical Director for Professional Medical Standards and the Appraisal and Revalidation Officer and relevant information from these is disseminated within the Local Network Meetings.

Despite training and recruiting 12 additional appraisers in the preceding year (2022-2023), a continual cycle of retirements and changes in job plan mean that our appraiser numbers have fallen from 91 appraisers to 84 trained appraisers increasing our appraiser:appraisee ratio slightly to 1:6.1. Further recruitment will need to be undertaken over the next 6 -12 months in order to maintain/improve this ratio as per NHSE guidance.

All appraisers are aware of the recent changes in GMP guidelines and a bespoke session on how these impact on the duties of appraisers is due to be delivered by our Regional GMC Liaison Advisor in the next 4 – 6 weeks.

Meeting Title	Board of Directors		
Date	25th September 2024	Agenda item	Bo.9.24.9

As per 2022-2023, the process of Peer Review has not as yet resumed within our region. However, BTHFT underwent an Internal Audit (Final Report August 2022, undertaken by Audit Yorkshire) which has rated the assurance of our appraisal processes as being 'significant'. There were 4 recommendations (one moderate/three minor) arising from the audit, all of which have been actioned.

Recommendation

We recommend the Academy consider this return, in conjunction with the main report previously discussed, as part of the assurance around this process.

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	☐	☐

Meeting Title	Board of Directors		
Date	25th September 2024	Agenda item	Bo.9.24.9

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)
☐	☐	☐	☐

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No change from 2022-2023
Comments:	Dr Raymond Smith remains in post as Chief Medical Officer and Responsible Officer – appointed January 2021
Action for next year:	No change anticipated

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Continued resources in place to support continued Supporting Professional Activity of established Medical Appraisers and to ensure on-going recruitment of new appraisers in support of the Responsible Officer. This includes successful delivery of Case Investigator training in 2023 and the planned delivery of Case Manager training in 2024/2025 – also in support of Responsible Officer duties
Comments:	
Action for next year:	Anticipated training and further recruitment of new appraisers in 2024-2025 in order to maintain/enhance current medical appraiser:appraisee ratios. Planned delivery of Case Manager training in 2024/2025 – dates to be confirmed.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Appraisal and Revalidation Officer maintains a record of all doctors connected to BTHFT as a Designated Body.
Comments:	Appraisal and Revalidation Officer ensures that the BTHFT database of Designated Body connections is continually reviewed and cross-referenced against the Trust Electronic Staff Database (ESR) to ensure up to date and accurate information.
Action for next year:	No anticipated change in practice

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	The BTHFT Medical Appraisal and Revalidation Policy can be found within the Trust Intranet. This was reviewed and updated in April 2023. The Associate Medical Director for Professional Medical Standards and the Appraisal and Revalidation Officer monitor participation in annual medical appraisal by all appraisees as well as participation in 360 feedback within each revalidation cycle as per guidance. Support, advice and guidance are offered to both appraisees and appraisers as/when required. Individual portfolios are regularly reviewed with agreed terms of reference by the Responsible Officer, Associate Medical Director for Professional Medical Standards and the Appraisal and Revalidation Officer to ensure that standards are met/maintained. Escalation occurs where necessary with urgent concerns being escalated directly to the Responsible Officer as required.
Comments:	As above, the BTHFT Medical Appraisal and Revalidation Policy was updated in 2023. In addition, the BTHFT Remediation Document has been updated in 2024 to reflect changes in governance nomenclature within the Trust, changes at NHS Resolution level and to reflect the recent change in GMC domains
Action for next year:	No anticipated change in practice

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	BTHFT have previously been part of a 3 way peer review group however this has not taken place since the onset of the COVID-19 pandemic, and it is unclear when this will be re-instated. BTHFT undertook an internal independent review of our processes (completed in August 2022 - Audit Yorkshire) with all recommendations from the audit having been completed/actioned. The audit rated the Trust compliance with the Appraisal and Revalidation process as offering 'Significant Assurance'
Comments:	
Action for next year:	Responsible Officer will await information with regards to the resumption of the peer review process at regional level.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Support is offered to all doctors on short term placements including doctors in locum posts in the form of an offer of an appraisal/abridged appraisal if BTHFT is their primary place of work. All doctors, including those with a prescribed connection to another Trust, undergo mandatory induction at the start of the employment and are supported by BTHFT with regards to their Continuing Personal Development, governance and support with regards to the appraisal and revalidation process.
Comments:	There will always be recognised challenges due to the occasional unpredictability of individual doctors' length of employment at BTHFT in the context of locum and /or short term placement work, however systems are in place to try and mitigate for this.
Action for next year	There is continual work to try and improve systems to identify doctors on short term placements or locum positions in a timely fashion and to ensure they receive the appropriate support as above.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	MAG 2022 is now embedded in our medical appraisal process. The format facilitates review of each doctors' whole scope of practice including information about complaints, significant events and outlying clinical outcomes both within the Trust and for work carried out in any other organisation. Our experience has been that the MAG 2022 format (and previously MAG 2020) has enabled better support of appraisees by our appraisers. This includes escalation of concerns (wellbeing and otherwise) as required. In keeping with guidance, our appraisal forms have now been updated by our platform provider (Premier IT) to reflect the recent 2024 update to Good Medical Practice.
Comments:	96.89% of doctors connected to BTHFT received an Outcome Measure 1 for the appraisal period 2023 to 2024. 3.11% were allocated an Outcome Measure 2. This includes doctors with extended leave such as sick leave/maternity, and doctors who had recently connected to us but who had not been in post long enough to have undergone an appraisal. No doctors received an Outcome Measure 3 for the period 2023-2024. One doctor was subject to a REV6 referral during 2023-2024 but subsequent to this successfully completed the appraisal process for the year. BTHFT transitioned to a new incident reporting system (InPhase IRIS Incident Reporting) at the beginning of 2024. In keeping with embedding new systems, we experienced challenges with regards to retrieval of information on incident reports for appraisees by our Appraisal and Revalidation Officer. The issues were recognised and placed on the Trust Risk Register and all appraisers/appraisees were made aware of the issue which has now been resolved. All appraisees continued to declare and demonstrate reflective practice where they were aware that they had been involved in any incidents and these continued to be discussed with them by appraisers within the context of the appraisal meeting. Trust governance processes mean that individual doctors continued to be aware when they were involved in either the complaints process or serious incidents throughout this period.
Action for next year:	Support appraisers with regards to the new 2024 GMP domains now reflected in MAG 2022. Session discussing updates due to be held by GMC Regional Liaison Adviser with appraisers in October 2024. Support Appraisal and Revalidation Officer with regards to the changes relating to IRIS Incident Reporting and retrieval of information thus supporting appraisees/the appraisal process.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	As per Q1B(i) All doctors connected to BTHFT undergo medical appraisal covering the whole scope of their practice.
Comments:	As above, 96.89% of doctors connected to BTHFT received an Outcome Measure 1 for the appraisal period 2023 to 2024. 3.11% were allocated an Outcome Measure 2 – this included doctors with extended leave such as sick leave/maternity, and doctors who had recently connected to us but who had not been in post long enough to have undergone an appraisal. No doctors received an Outcome Measure 3 for the period 2023-2024.
Action for next year:	No anticipated change in practice

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	The Appraisal and Revalidation Policy for Consultants and Doctors in Non-Training Posts was reviewed and updated in April 2023. This is accessible to all staff via our Trust-wide Intranet.
Comments:	Compliant with national policy Approved by the Education and Workforce Sub-Committee/Trust Operational Group
Action for next year:	No anticipated change – next policy review date expected in 2028.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	There is a continual process of recruitment of appraisers and retirements/changes in job plan necessitating continual review. At 31/03/2024, the Trust had 84 trained appraisers bringing our Appraiser:Appraisee ratio to 1:6.1. An increase in the number of GMC connections combined with on-going retirements means that recruitment is a continual process with the aim to achieve the optimal 1:4 ratio as per NHSE guidance.
Comments:	
Action for next year:	Continued review of appraiser numbers with anticipation of impending retirements spanning 2024/2025 to allow timely recruitment of new appraisers in order to maintain/enhance appraiser:appraisee ratios (anticipated optimal ratio of 1:4 as per NHSE guidance). It is anticipated that further new appraiser training will be required in 2024-25 despite having recruited 12 new appraisers in 2022 - 2023.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	All appraisers receive aggregated feedback from their appraisees on an annual basis including numerical and non-numerical data. This feedback is auto-populated within appraisers' portfolios at the point of download, and appraisers are asked to reflect on their personal feedback. All feedback for individual appraisers is reviewed by the Associate Medical Director for Professional Medical Standards with support/guidance offered to appraisers where required. Appraisers also attend regular local Appraiser Network meetings with dissemination of information from Regional Network Meetings. In addition, local Network Meetings provide an opportunity for discussion of any issues arising. A local Quality Assurance audit based on the NHSE ASPAT form is held annually with learning points from the audit being disseminated to all appraisers. Where required, specific feedback is shared on an individual appraiser basis.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	All established appraisers underwent a Continuing Professional Development update in appraisal (Supporting Experienced Appraisers) as per guidance in 2022/23. As per Q1B(i), Appraisers have been invited to attend an update with respect to the 2024 GMP domains to be hosted by our Regional GMC Liaison Advisor in October 2024.
Comments:	As above, local Network Meetings provide an opportunity for appraisers to network, but are also a forum to raise queries and discuss issues that have arisen.
Action for next year:	Continue processes as above.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	The Appraisal and Revalidation Committee meets biannually to review medical appraisal processes within the Trust and to ensure that Terms of Reference for the process remain fit for purpose. Information from supporting processes feed into the committee meeting such as outcomes from Quality Assurance Audits and Minutes from Local Network Meetings. Findings are reported to the Trust People Academy which is a Committee of the Board of Directors.
Comments:	Whilst peer review has yet to be re-established within the region, BTHFT underwent an Internal Audit (completed by Audit Yorkshire – August 2022) with assurance of our medical appraisal processes being rated as ‘significant’.
Action for next year:	Continue processes as above. Participate in peer review once this is re-established within the region.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	BTHFT continues to make fitness to practice recommendations for all doctors with a prescribed connection and in accordance with GMC requirements and Responsible Officer protocol. A total of 83 revalidation submissions were made for the period 2023 - 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. There were no deferrals based on a doctor being subject to on-going processes. There were no late recommendations for the period 2023-2024.
Comments:	
Action for next year:	No anticipated change in practice.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	All doctors are contacted by the Appraisal and Revalidation Officer, supported by the Associate Medical Director for Professional Medical Standards prior to their revalidation due dates. Where the recommendation is one of deferral, a clear explanation and set of objectives are communicated to the individual doctor. Where concerns are raised with regards to non-engagement, in addition to the measures above, this is escalated to the Responsible Officer for further management.
Comments:	
Action for next year:	No change anticipated to current practice

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	The current Clinical Governance Framework was implemented in 2015 allowing doctors to access relevant information in relation to their specialty and individual practice. The Quality Academy was launched in 2021 with monthly meetings and a focus on safety and quality. This promotes a culture of learning and improvement with the resultant enhanced assurance. The Quality Governance Framework for the Trust was amended in 2023 to support the new Clinical Service Unit structure which was implemented in September 2022.
Comments:	
Action for next year:	No change anticipated to current practice

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	The Trust migrated to a new incident reporting system (InPhase IRIS Incident Reporting) in 2024. Prior to this, our Incident Reporting System (Datix) provided all doctors with supporting information required for inclusion in appraisal portfolios. This information was provided to individual doctors by the Appraisal and Revalidation Officer in advance of their projected appraisal due dates. Following the introduction of IRIS Incident Reporting, we faced challenges with regards to the timely retrieval of incident reports for individual doctors due to software issues beyond our control resulting in partial reports for the year. This was added to the Trust Risk Register and appraisees/appraisers were made aware of the issues which have now been resolved. As per Q1B(i), appraisees continued to declare and reflect on incidents where they were aware of them and these were discussed as per our normal practice within appraisal meetings. Additional corporate processes continued to provide information to doctors about compliments, complaints and claims for inclusion and reflection within portfolios and discussion within the appraisal meeting. Where doctors provide medical care/services outside BTHFT, the same information is sought by the individual doctor for inclusion and discussion within the appraisal process.
Comments:	

Action for next year:	Issues with IRIS Incident Reporting have now been resolved. Ensure support for Appraisal and Revalidation Manager as new IRIS system continues to be embedded

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	All doctors are made aware of the required information to complete the appraisal process at the point where they are given access to our appraisal software. Appraisers are also able to provide guidance with respect to relevant information. Where relevant, information is provided by the Appraisal and Revalidation Officer to the individual doctor for inclusion within their portfolios. This includes a summary of involvement in Clinical Incidents/complaints and/or Serious Incidents provided to individual doctors by our Appraisal and Revalidation Officer within 4-6 weeks of an appraisal due date. This also includes a pdf copy of 360 feedback which is returned to individual doctors via their appraisers. At BTHFT, a local requirement is inclusion of a mandatory training matrix which is easily obtainable by individual doctors via the Trust Electronic Staff Record. Appraisers receive individual appraiser feedback on an annual basis which is automatically embedded within their portfolios by the appraisal software for reflection.
Comments:	
Action for next year:	No anticipated change to current practice

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Concerns about an individual doctor's practice may be raised through the Trust's Raising Concerns at Work Policy or via the Trust's Disciplinary, Capability, Ill Health and Appeals Policy and Procedures. Concerns are escalated to the Responsible Officer as appropriate with ensuing investigation and/or intervention as appropriate
Comments:	
Action for next year:	No change to current practice anticipated

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	A quality assurance process is in place reporting to a closed board on a bimonthly basis. Analysis is inclusive of aspects such as staff group, protected characteristics and country of primary medical qualification.
Comments:	
Action for next year:	No change to current practice anticipated

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	The Appraisal Office both requests information from and gives information to other designated bodies with regards to the movement of a connected doctor to or from our Trust. In addition, there is a process for dialogue between Responsible Officers and/or transfer of information between Responsible Officers should any particular areas of concern with regards to connected doctors be highlighted.
Comments:	
Action for next year:	No anticipated change in practice

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	BTHFT ensures consistent standards for clinical governance are in place and maintained. This includes ensuring safe and effective care by contributing to professional development and by reviewing complaints and incident reports. Appropriate learning from incidents is identified and shared with staff where relevant/required. The appraisal process is subject to continual review and, where concerns are escalated, the Trust ensures that these are managed fairly, without bias and/or discrimination. The principle of fairness and being free from bias and discrimination is applied to all Trust policies and processes, and these are accessible via the Trust Intranet.
Comments:	
Action for next year:	No anticipated change in practice.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Where there is learning from events outside the Trust e.g. following national reviews/enquiries, this is identified by the Trust Quality and Safety Academy and/or the Trust People Academy. Action plans are generated and disseminated accordingly either Trust-wide, or via individual Clinical Service Units. Examples of this include identifying learning/action plans from the National GMC Survey and/or National Education and Training Survey; and/or the introduction/implementation of a Freedom To Speak Up Guardian in light of the national Francis Report.
Comments:	
Action for next year:	No anticipated change in practice

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Recent national investigations have highlighted the importance of culture and behaviour on the delivery of a high standard of care. This is particularly important in the context of our highly diverse workforce at BTHFT with expectations with respect to culture and behaviour now being better understood Trust-wide. The principles of Equality, Diversity and Inclusion are continually being embedded within all facets of the workforce thus promoting an inclusive and fair culture. Professional standards across all healthcare groups including medical and non-medical staff are reviewed on a regular basis and aligned wherever possible to ensure our standards of care are maintained/enhanced.
Comments:	
Action for next year:	No anticipated change in practice

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	All pre- and post-employment checks comply with NHS Employment Check Standards. As part of the checks, registration and qualifications of individual doctors are checked in addition to their professional registration being monitored. All checks are managed through the Human Resources Department and policies/procedures are disseminated to and understood by all managers involved in the recruitment process. This applies to all doctors employed at BTFHT including doctors with short term contracts and those undertaking locum / bank work.
Comments:	
Action for next year:	No anticipated change in practice

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	As above, the importance of maintaining professional standards across the workforce is understood and systems are in place to support this both across healthcare groups. This includes activities to enhance professional development as well as systems to review incidents/complaints and identify where support and/or escalation is required. Where learning is identified (either from incidents, changes in guidelines or otherwise), this is disseminated to relevant staff groups in order to continually improve/enhance patient care.
Comments:	
Action for next year:	No anticipated change to current practice

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	BTHFT is committed to promoting an environment which is fair and inclusive at all times. As a Trust with a highly diverse workforce, compassion, fairness, respect, diversity and inclusivity are inherent within our objectives and much is done in support of this to promote a healthy work environment. Support from the Equality, Diversity and Inclusion (EDI) team is readily available as required and the EDI and related policies are available for all staff to access via the Trust Intranet
Comments:	
Action for next year:	No anticipated change to current practice

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	The importance of openness and transparency is understood and encouraged within BTHFT. There is clear guidance with respect to the freedom to speak up, and a Freedom To Speak Up (FTSU) Guardian is appointed within the Trust. All staff in leadership positions are aware of the policy and will disseminate information to staff on FTSU as required. The FTSU policy is accessible to all members of staff via the Trust Intranet.

Comments:	
Action for next year:	No anticipated change in practice.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Feedback is welcomed from connected doctors about the Trust's professional standards processes and Line Managers have the appropriate training to deal with feedback as required– this includes feedback in the form of formal complaints. The process is also supported by the Trust Human Resources Department. The Trust's Grievance Policy is accessible within the Trust Intranet. Feedback is escalated to executive level where required/appropriate.
Comments:	
Action for next year:	No anticipated change in practice

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	The importance of assessing the parity between doctors involved in incidents is understood well, in particular given the diverse workforce at BTHFT. This information is noted with every new concern raised and is subject to continual review. NHS Resolution/Practitioner Performance Advice have recently completed a parity analysis of doctors connected to BTHFT and involved in concerns in January 2024.
Comments:	
Action for next year:	No change in practice anticipated

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Professional standards processes are continually reviewed and calibrated against other Trusts within the region. The Responsible Officer, the Associate Medical Director for Professional Medical Standards and the Appraisal and Revalidation Officer attend Regional Network meetings to inform practice and as an opportunity to network. The peer review programme has been paused within the region since the outset of the pandemic however the expectation is that the Trust would engage in peer review as/when this is re-introduced. The Trust undertook an Internal Audit of processes in 2022 rating our appraisal and revalidation processes as 'significant'.
Comments:	
Action for next year:	Await information with regards to regional peer review

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	514

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	498
Total number of appraisals approved missed	16
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	83
Total number of late recommendations	0
Total number of positive recommendations	78
Total number of deferrals made	5
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	21
Total number of trained case managers	1
Total number of new concerns registered	4
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March	16 months
Median duration of concerns processes closed	6 months
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	278
Number of new employment checks completed before commencement of employment	278

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
General Progress: The number of doctors connected to BTHFT as a Designated Body continues to grow such that at 31st March 2024, 514 doctors had a prescribed GMC connection with Bradford Teaching Hospitals NHS Foundation Trust. Of these, 349 were Consultant staff, 39 were Specialty Doctor grades and 126 were Doctors with temporary or short-term contracts. Despite multifactorial challenges within the Trust including repeated periods of Industrial action for the period 2023-2024, on 31st March 2024, 498 doctors (96.89%) had received an Outcome Measure 1 (Completed appraisal), and 16 doctors (3.11%) 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. As highlighted before, 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. No doctors were allocated an Outcome Measure 3 (Unapproved Missed Appraisal) for this period. During the period 2023-2024, BTHFT made one REV6 referral for one doctor based on their previous appraisal engagement history resulting in effective engagement in the process thereafter. 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 largely on the basis of insufficient evidence to support a positive recommendation. There were no deferrals based on a doctor being subject to an on-going process for the period 2023-2024. At 31st March 2024, we had a total of 84 trained appraisers representing a slight fall from the preceding year (91 appraisers in 2022-2023) as a result of a combination of retirements and changes in job plans. This is despite recruiting 12 new appraisers in the period 2022-2023. Our overall appraiser: appraisee ratio now stands at 1:6.1. Whilst this is not a significant change in the distribution of the appraisal workload, we will need to recruit more appraisers over the next 12 month period to maintain our ratio and/or to try and achieve the NHSE recommended Appraiser:Appraisee ratio of 1:4 in the future. Regular Local Appraiser Network Meetings were resumed in 2021 following the Covid pandemic. Appraisers attend these as an opportunity for information relating to changes in process/NHSE guidance to be disseminated, but also as an opportunity for discussion and feedback of the appraisal process at BTHFT by our appraisers. Learning from the Regional Network Meetings is shared with appraisers at the local meetings. Meeting summaries are circulated to all appraisers following the meetings.

Quality Assurance Audits attended by the Responsible Officer, Associate Medical Director and 3-4 experienced appraisers have also resumed annually based on NHSE's ASPAT form. The results of the audit are used to disseminate learning for appraisers. The results of the Quality Assurance Audit are also shared with the Appraisal and Revalidation Committee as a means of providing assurance that our processes are fit for purpose. Where individual appraiser learning is identified, this is with support from the Associate Medical Director for Professional Medical Standards.

As per our Statement of Compliance for 2022-2023, peer review has yet to be restarted in the region however BTHFT underwent an Internal Audit of our Appraisal and Revalidation processes in 2022. This was undertaken by Audit Yorkshire. The results of the audit were finalised in August 2022 and the assurance in the Appraisal and Revalidation process was rated as 'Significant'. There were 4 recommendations from the audit (one rated as moderate, three rated as minor). All recommendations have been actioned/completed.

Appraisal Software:

The software used for medical appraisal was updated in 2021 to PReP hosted by Premier IT. As expected, the process for introducing the software was extended but this is now embedded within the Trust. When PReP was initially adopted, this was expected to be in combination with an application (Centric) to facilitate it's use on a handheld device thus facilitating contemporaneous entry into each individual doctor's portfolio. Due to software issues beyond our control, Centric has only been introduced to the Trust in 2023-2024 and is now available for doctors to use alongside PReP. Centric pulls information into each doctor's main PReP account and is designed to complement rather than to replace PReP.

The introduction of Centric has also meant that we are now in a position to update our 360 feedback software from our existing msf360 platform which is now comparably outdated. Negotiations have begun to move to Edgecumbe Doctor 360 feedback with support from our current appraisal software providers (Premier IT).

Maintaining High Professional Standards:

With regards to raising concerns, as above we have had concerns raised with respect to 4 individual doctors, however none of the concerns raised have progressed to formal MHPS investigation. Whilst we have made no direct GMC referrals as a Trust for the period 2023-2024, we currently have 4 doctors connected to us as a Designated Body who have been referred via other routes. At 31st March 2024, one doctor had made a self-referral to the GMC, one was referred to the GMC by the Police and 2 doctors were subject to referral to the GMC by members of the public.

We now have a total of 21 trained Case Investigators within the Trust having had training delivered by NHS Resolution in October 2023. Case Manager training is in the process of being confirmed with training expected to be delivered within the next 3 – 6 months.

Actions still outstanding

As per 2022-2023, peer review has yet to be restarted within the region following the pandemic. We would expect BTHFT to participate in this at the point where it is restarted. As above, BTHFT have undergone an Internal Audit and assurances of our processes have been rated as 'Significant'.

A trust-wide medical appraisee satisfaction survey of the processes in place is to be undertaken before completion of the appraisal year 2024-25**.**

Update to 360 feedback platform expected in 2024-2025.

Current issues

As per section 1D(ii), the Trust moved Datix incident reporting to InPhase IRIS Incident Reporting in January this year. Prior to this, our Appraisal and Revalidation Officer provided individual doctors with a summary of their incidents for inclusion in their portfolios to facilitate reflection and discussion. Following the introduction of IRIS Incident Reporting, we faced challenges with regards to the timely retrieval of incident reports for individual doctors due to software issues beyond our control. This impacted on appraisals in the final quarter of 2023-2024 and was added to the Trust Risk Register at the time. Appraisers and appraisees were made aware of the issue which has now been resolved. As such, reports are once again being generated by the Appraisal and Revalidation Officer for individual doctors in advance of their appraisals as per our previous practice.

As per Q1B(i), for this period, appraisees continued to declare and reflect on incidents where they were aware of them and these were discussed as per our normal practice within appraisal meetings. Additional corporate processes continued to provide information to doctors about compliments, complaints and claims for inclusion and reflection within portfolios.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Continue on-going programme of appraiser recruitment and CPD for established appraisers.
- Facilitate delivery of 'Implementing Good Medical Practice 2024 as Appraisers' by GMC Regional Liaison Advisor (scheduled for 18/10/2024)
- Continue to embed the use of Centric App for handheld devices as a means of facilitating contemporaneous appraisal portfolio entry (to be used alongside PReP).
- Continue discussions with regards to updating 360 feedback platform and plan to migrate to Edgecumbe Doctor 360 feedback (or similar) in 2024 – 2025 thus updating our current 360 feedback process.
- Complete a Trust-wide user satisfaction survey of medical appraisees during appraisal year 2024-2025.
- Participate in Peer Review once this process is resumed within the region.
- Ensure Case Manager Training delivered as planned within appraisal year 2024-2025

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

In keeping with many Acute Trusts, BTHFT continued to face a number of multifactorial challenges in 2023-2024 which included the impact of medical and non-medical Industrial Action thus impacting to some degree on the ability of doctors to deliver non-clinical activity. Despite this we have managed to achieve an overall appraisal rate of 96.89% - this exceeds our pre-pandemic rates of appraisal. This is testament to the engagement of both our appraisers and appraisees. No doctors received an Outcome Measure 3 for this period; one doctor was subject to a REV6 referral but subsequently completed his appraisal successfully.

The Medical Appraisal 2022 format is now embedded within the Trust and, in keeping with guidance, our software has been updated to reflect Good Medical Practice guidelines (2024).

Local Network Meetings, Appraisal and Revalidation Committee Meetings and Quality Assurance Audits based on NHSE's ASPAT form have now all been resumed on a regular basis. Regional Network meetings are attended by the Responsible Officer, Associate Medical Director for Professional Medical Standards and the Appraisal and Revalidation Officer and relevant information from these is disseminated within the Local Network Meetings.

Despite training and recruiting 12 additional appraisers in the preceding year (2022-2023), a continual cycle of retirements and changes in job plan mean that our appraiser numbers have fallen from 91 appraisers to 84 trained appraisers increasing our appraiser:appraisee ratio slightly to 1:6.1. Further recruitment will need to be undertaken over the next 6 -12 months in order to maintain/improve this ratio as per NHSE guidance. All appraisers are aware of the recent changes in GMP guidelines and a bespoke session on how these impact on the duties of appraisers is due to be delivered by our Regional GMC Liaison Advisor in the next 4 – 6 weeks. As per 2022-2023, the process of Peer Review has not as yet resumed within our region. However, BTHFT underwent an Internal Audit (Final Report August 2022, undertaken by Audit Yorkshire) which has rated the assurance of our appraisal processes as being 'significant'. There were 4 recommendations (one moderate/three minor) arising from the audit, all of which have been actioned.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

REFERENCES

Only PDFs are attached

Bo.9.24.9 - 2024 Training and Education self-assessment report (cover).pdf

Bo.9.24.9 - 2024 Training and Education self-assessment report - Appendix 1 Self Assessment Report.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.9

2024 TRAINING AND EDUCATION SELF- ASSESSMENT REPORT

Presented by	Dr Ray Smith, Chief Medical Officer	
Author	Laura Gornall - Education Manager: Professional Education	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	To provide an update on the outcome of the 2024 Self-Assessment Report (SAR) as part of the quality assurance process for NHSE WTE (Workforce Training and Education)	
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:	People Academy	19.9.24

Key Options, Issues and Risks

NHS England have adopted the control mechanism set out in the HEE Education Quality Strategy 2021, which includes an annual self- assessment process, by which organisations carry out their own quality evaluation against a set of standards. The Trust is required to submit a self-assessment report (SAR) for all of the education provision for health care professions.
Training and Education (T&E) have completed the SAR in conjunction with key internal stakeholders and have provided a multi professional response (Appendix 1).

Analysis

The SAR covers reporting on six quality framework domains against the HEE Education Quality Standards 2021. Information has also been provided relating to; finance from NHS England tariff, supervision and assessment for students and trainees, and any issues relating to risk.

The Education Manager for Professional Education led the self-assessment, involving team leaders and representatives from professional groups to assess if standards were being met. During the process areas of good practice or concern were also highlighted.

From a strategic perspective our top three successes in relation to education provision are:

Collaboration/Partnerships: The Education and Training department has a diverse and multi-professional workforce which enables the provision of enriched, credible and high quality education provision. New roles, such as the Associate Educator, have been piloted this year and these roles are having positive effects on the workforce and the Education and Training provision. Collaboration with departments around students has enabled Education to be facilitated in clinical areas, by the Education Department, which eases workload pressure for clinical areas.

Innovative Training/Course Development: BTHFT has responded over the last year to meet the changing needs of learners and the workforce through stakeholder engagement. Innovative examples of responding to workforce needs include the introduction of a regional simulation course on organ donation and introduction of a teaching package for the Medical Licensing Exam for medical students. Education has engaged with internal and external stakeholders to support the development of the next BTHFT Education Strategy for 2025-2030. Innovation in course development and responding to the needs of the developing workforce are key components of the next Education Strategy.

Quality – Improvement initiatives, response to data, positive feedback: BTHFT has worked to ensure that feedback received from learners is shared widely across the organisation. The increased awareness of the different feedback streams received from learners has increased understanding and

desire to improve/develop across the Trust. Quarterly learner feedback is reviewed by the Workplace Civility Programme Board providing oversight of the learner's voice (medical and non-medical) within the Trust Civility agenda. BTHFT has been awarded the interim Quality Mark for the multi-professional Preceptorship Programme in 2024. The Quality Mark robustly demonstrates BTHFT's commitment to supporting newly registered practitioners and the support offered to them and their preceptors.

The top three challenges reported were:

Training Space/Facilities: A challenge for Education and Training remains the ageing and declining estate and facilities at BTHFT. The Education and Training department have expanded without capital investment, causing increased pressure and strain on training facilities. The Education and Training department have outgrown its current footprint and space is at a premium with regular struggles around room availability to host teaching. Due to the building age, accessibility is a challenge and can limit the teaching BTHFT is able to offer to staff and students.

Training affected by service pressures (cannot release staff): A challenge for BTHFT is the priority afforded to Education and Training across the Trust. This is in part due to the significant workload challenges faced, BTHFT ranked 216/230 in the UK for workload in the GMC survey 2024. Safe patient care is understandably prioritised over the delivery of Education and Training. However, this can cause issues where courses are cancelled on the day due to clinical need/ lack of skill mix for effective course delivery, lack of faculty. Active monitoring of exception reports for missed training opportunities and close working with Deputy Directors of Nursing to ensure training is prioritised are some of the mechanisms in place to highlight the importance of Education and Training opportunities.

Culture: BTHFT is aware that the culture of learning environments impacts the learner experience. In instances learners have provided feedback around a lack of belonging and feeling unsupported to achieve when on placement. When feedback such as this is identified, targeted support is provided to learners and those supervising/assessing learners within the learning environment. Many of our departments now have 'Learner Boards' and dedicated learner resources alongside a designated person to support students/learners. Furthermore, the Education and Training department have developed an initial three-year plan to implement outcomes from the Safe Learning Environment Charter (SLEC). The SLEC provides a framework to develop learning environments in line with key domains. Key initial areas of focus at BTHFT include Flexibility, Supervision, Positive Identity and Respect and Value.

NHSE will review the completed SAR within their education quality team and will provide feedback once this is completed. Ongoing monitoring and review of our progress against our plan to address the challenges highlighted within the SAR will be undertaken by NHSE via the Senior Leaders Engagement meeting, scheduled for July 2025.

Recommendation

- To note at Trust Board prior to the SAR submission deadline of 2nd October 2024.
- Note the positive findings of the education service.
- Note the challenges and be assured that the Training and Education team are aware of the concerns and have a delivery plan to mitigate the risks.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients						

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.9

To deliver our financial plan and key performance targets						
To be in the top 20% of NHS employers						
To be a continually learning organisation						
To collaborate effectively with local and regional partners						
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

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

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

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

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

NHS England Self-Assessment for Placement Providers 2024

1.

Introduction

The NHS England Self-Assessment (SA) for Placement Providers is a process by which providers carry out their own quality evaluation against a set of standards. Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most questions to provide comments to support your answer.

Completing the Self-Assessment

- **Your region and trust name has been pre-populated - do not amend this**.
- The SA saves your progress at the end of each page - **click save** and next page button.
- **You can amend/change your responses any time prior to completing the final submission** box in section 12 (click save after any changes).
- Anyone completing any part of the SA can do so using the same link supplied by your regional NHS England WT&E quality team. **Only one person should use the link at any one time**. You must close the weblink for someone else to access the survey to avoid overwriting previous entries.
- **To print the SA**, prior to/after submission, skip through to the last page and use the print button. Only questions with responses will print.
- You can move around the SA without being forced to complete questions/sections before moving to another section. **Save each update even if only partially completed**.
- **All sections are mandatory**, please undertake a final check that every question has been completed prior to submission. If a question/section has not been answered after submission, the SA will be returned to you for completion.
- Where free text comments are available the word or character limits are shown within each question.

- The SA does not support the upload of attachments. If we require any evidence as part of your submission, we will contact you separately after submission.

****This submission should be completed for the whole organisation. It's important that those responsible for each section feed into and contribute to the response.****

Sections of the Self-Assessment

Section 1: Provide details of (up to) 3 challenges within education and training that you would like to share with us.

Section 2: Provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3: Confirm your compliance with the obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation.

Section 4: Confirm your compliance with the Quality, Library, Reporting Concerns, and Patient Safety training obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas feed into this section.

Section 5: Confirm your policies and processes in relation to Equality, Diversity and Inclusion. Should normally be completed by your placement provider EDI Lead.

Section 6 - 11: Self-assess your compliance against the Education Quality Framework and Standards. Each section must be completed once on behalf of the whole organisation. There are opportunities to share good practice examples. You are asked to confirm whether you meet the standard for all professions / learner groups or provide further details where you do not meet or partially meet the standard(s). Where you are reporting exceptions, you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard.

Section 12: Final sign-off.

Further Questions

If you have any queries regarding the completion of the SA, please review the FAQ document. If you still require further information, you can contact your regional NHS England WT&E quality team.

2 – 9 Region and Provider Selection – Do Not Amend

Please do not amend the region you have been allocated to. If you feel this is incorrect please continue to complete the SA and email your regional NHS England WT&E quality team.

- [ ] East of England
- [ ] London
- [ ] Midlands
- [x] North East and Yorkshire
- [ ] North West
- [ ] South East
- [ ] South West

10. Training profession selection

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

2. Please select from the list below those professional groups your organisation currently train, please select all those which apply. Please select only one option for each row.

	Yes we train in this professional group	N/A we do NOT train in this professional group
Advanced Practice	x	
Allied Health Professionals	x	
Dental	x	
Dental Undergraduate		x

	Yes we train in this professional group	N/A we do NOT train in this professional group
Healthcare Science	x	
Medical Associate Professions	x	
Medicine Postgraduate	x	
Medicine Undergraduate	x	
Midwifery	x	
Nursing	x	
Paramedicine	x	
Pharmacy	x	
Psychological Professions	x	
Social Workers		x

11. Section 1 - Provider challenges

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us. Please consider whether there are any challenges which impact your ability to meet the education quality framework standards. Please select the category which best describes the challenge you are facing, along with a brief description/narrative of the challenge (*the character limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

3. Example 1: Please choose the most appropriate category for your challenge.

- [ ] Apprenticeships
- [ ] Burnout / Wellbeing
- [ ] COVID / Post COVID return to norms

- [ ] Culture
- [ ] Curricula / Training Standards
- [ ] Educational Governance & Strategy
- [ ] Funding - Requirements / Unpredictability / Timeliness
- [ ] HEI Issues/ Processes
- [ ] Increase in LTFT / Reasonable Adjustment Requests
- [ ] IT Systems
- [ ] NHS England Issues/ Processes
- [ ] Other
- [ ] Placement Management / Capacity
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (recruitment / retention)
- [ ] Supervisors / Educators (training)
- [ ] Training affected by service pressures (cannot release staff)
- [ ] Training Equipment / Systems
- [x] Training Space / Facilities
- [ ] Trust Merger or Reconfiguration
- [ ] Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

A significant challenge for Education and Training remains the ageing and declining estate and facilities at BTHFT. The Education and Training department have expanded without capital investment, causing increased pressure and strain on training facilities. The Education and Training department have outgrown its current footprint and space is at a premium with regular struggles around room availability to host teaching. Due to the age of the estate, in parts, the physical environment is not conducive to professional and quality training delivery. When considering implications of the NHS Long-term Workforce plan, which outline the requirement for expansion of student/trainee numbers across all Professional Education cohorts, capacity will become an extreme challenge. Due to the building age, accessibility is a challenge and can limit the teaching BTHFT is able to offer to staff and students.

4. Example 2: Please choose the most appropriate category for your challenge.

- [ ] Apprenticeships
- [ ] Burnout / Wellbeing
- [ ] COVID / Post COVID return to norms
- [ ] Culture
- [ ] Curricula / Training Standards
- [ ] Educational Governance & Strategy
- [ ] Funding - Requirements / Unpredictability / Timeliness
- [ ] HEI Issues/ Processes
- [ ] Increase in LTFT / Reasonable Adjustment Requests
- [ ] IT Systems
- [ ] NHS England Issues/ Processes
- [ ] Other
- [ ] Placement Management / Capacity
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (recruitment / retention)
- [ ] Supervisors / Educators (training)
- [x] Training affected by service pressures (cannot release staff)
- [ ] Training Equipment / Systems
- [ ] Training Space / Facilities
- [ ] Trust Merger or Reconfiguration
- [ ] Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

Another challenge for BTHFT is the priority afforded to Training and Education (T&E) across the Trust. This is in part due to the workload challenges faced, BTHFT ranked 216/230 in the UK for workload in the GMC survey 2024. Safe patient care is understandably prioritised over the delivery of T&E. However, this can cause issues where courses are cancelled on the day as delegates are required to work clinically, or multi-professional training cannot proceed as there is an incorrect delegate mix. This issue also effects faculty for courses, faculty are unwilling to put themselves forward to support course delivery due to clinical pressure or are unable to due to workload. We are actively monitoring exception reports for lack of training opportunities and working with Deputy Directors of Nursing to ensure preceptorship and other training is prioritised. We continually highlight the importance of T&E to executives and line managers, so they can support colleagues and learners to access.

5. Example 3: Please choose the most appropriate category for your challenge.

- [ ] Apprenticeships
- [ ] Burnout / Wellbeing
- [ ] COVID / Post COVID return to norms
- [x] Culture
- [ ] Curricula / Training Standards
- [ ] Educational Governance & Strategy
- [ ] Funding - Requirements / Unpredictability / Timeliness
- [ ] HEI Issues/ Processes
- [ ] Increase in LTFT / Reasonable Adjustment Requests
- [ ] IT Systems
- [ ] NHS England Issues/ Processes
- [ ] Other
- [ ] Placement Management / Capacity
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (recruitment / retention)
- [ ] Supervisors / Educators (training)
- [ ] Training affected by service pressures (cannot release staff)
- [ ] Training Equipment / Systems
- [ ] Training Space / Facilities
- [ ] Trust Merger or Reconfiguration
- [ ] Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

There are a multitude of factors that influence a learner's experience when on placement, a key factor is the culture within the learning environment. Feedback from learners is received through many channels and is rigorously reviewed. In instances learners have fed back a lack of belonging and feeling unsupported to achieve when on placement. When feedback such as this is identified, targeted support is provided to learners and those supervising/assessing learners within the learning environment. Many of our departments now have 'Learner Boards/Resources' developed and a designated person to support students/learners. A pilot is ongoing providing learners with 'This is Me' cards to display on the wards when they are on placement to increase feelings of belonging. Furthermore, the Education and Training department have developed an initial three-year plan to implement outcomes from the Safe Learning Environment Charter (SLEC). The SLEC provides a framework to develop learning environments in line with key domains. Key initial areas of focus at BTHFT include Flexibility, Supervision, Positive Identity and Respect and Value.

12. Section 2 - Provider achievements and good practice

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 achievements within education and training that you would like to share with us. Please select the category which best describes the achievement you wish to share, along with a brief description/narrative (*the word limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

6. Example 1: Please choose the most appropriate category for your achievement.

- [x] Collaboration / Partnerships
- [ ] Covid - Response / Catch up
- [ ] CPD
- [ ] Culture
- [ ] Development of TEL Provision
- [ ] Improved Facilities
- [ ] Increased SIM for Training
- [ ] Innovative Training / Course Development
- [ ] Learner / Trainee Support or Wellbeing
- [ ] Multi-professional Initiatives

- [ ] New/Improved Strategy or Governance
- [ ] Other
- [ ] Placement Capacity / Expansion
- [ ] Quality - Improvement Initiatives, response to data, positive feedback
- [ ] Recruitment / Retention Initiatives
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (training)

Please provide your narrative in the comments box

BTHFT is extremely proud to have a diverse and multi-professional education and training department. In the last year this has expanded and staff from differing professional groups have enriched the education provision, relevance and quality of education BTHFT provides. New roles have been piloted and these are having positive effects on the workforce and the education and training provision. It is hoped that new roles, such as a Band 4 Associate Educator embed into the department as they provide an excellent additional educational offer to our Healthcare Support worker workforce and help to drive forward the quality of care provided to patients.
Increased investment has enabled Education to be facilitated in clinical areas or additional teaching provision for students and this has eased workload pressure that student groups have within clinical settings, whilst also providing an enriching and valuable learning experience.

7. Example 2: Please choose the most appropriate category for your achievement.

- [ ] Collaboration / Partnerships
- [ ] Covid - Response / Catch up
- [ ] CPD
- [ ] Culture
- [ ] Development of TEL Provision
- [ ] Improved Facilities
- [ ] Increased SIM for Training
- [x] Innovative Training / Course Development
- [ ] Learner / Trainee Support or Wellbeing
- [ ] Multi-professional Initiatives
- [ ] New/Improved Strategy or Governance

- [ ] Other
- [ ] Placement Capacity / Expansion
- [ ] Quality - Improvement Initiatives, response to data, positive feedback
- [ ] Recruitment / Retention Initiatives
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (training)

Please provide your narrative in the comments box

BTHFT has responded over the last year to meet the changing needs of learners and the workforce. BTHFT regularly liaise with a wide range of stakeholders to ensure that developments in Education respond to new and emerging learning needs. Innovative examples of responding to workforce needs include the introduction of a regional simulation course on organ donation to provide specialist simulation across the region. Development, review and introduction of a teaching package for the Medical Licensing Exam for medical students, to support learners through this newly introduced process.
Education has engaged widely with internal and external stakeholders to support the development of the next BTHFT Education Strategy for 2025-2030. Innovation in course development, responding to the needs of the developing workforce and active identification of learning needs are key components of the soon to be launched strategy.

8. Example 3: Please choose the most appropriate category for your achievement.

- [ ] Collaboration / Partnerships
- [ ] Covid - Response / Catch up
- [ ] CPD
- [ ] Culture
- [ ] Development of TEL Provision
- [ ] Improved Facilities
- [ ] Increased SIM for Training
- [ ] Innovative Training / Course Development
- [ ] Learner / Trainee Support or Wellbeing
- [ ] Multi-professional Initiatives

- [ ] New/Improved Strategy or Governance
- [ ] Other
- [ ] Placement Capacity / Expansion
- [x] Quality - Improvement Initiatives, response to data, positive feedback
- [ ] Recruitment / Retention Initiatives
- [ ] Supervisors / Educators (investment)
- [ ] Supervisors / Educators (training)

Please provide your narrative in the comments box

BTHFT has worked to ensure that feedback received from learners is shared widely across the organisation. The increased awareness of the different feedback streams received from learners has increased understanding and desire to improve/develop across the Trust. Quarterly learner feedback is reviewed by the Workplace Civility Programme Board providing oversight of the learner's voice (medical and non-medical) within the Trust Civility agenda.

Furthermore, in the last year BTHFT has been pleased to be awarded the interim Quality Mark for the multi-professional Preceptorship Programme. The Quality Mark robustly demonstrates BTHFT's commitment to supporting newly registered practitioners and the support offered to them and their preceptors.

The quality of Undergraduate Medical Education provided by BTHFT is high with feedback exceeding the Trust average in many domains. The team utilises feedback to develop and enhance the offer to improve the learner experience throughout the year.

13. Section 3 - Contracting and the NHS Education Funding Agreement

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the **NHS Education Funding Agreement (2024-27)**. This should be completed once on behalf of the whole organisation. Please select only one option for each row. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters.

9. Please confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the NHS Education Funding Agreement (EFA).

This should be completed once on behalf of the whole organisation. Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	x	
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.	x	
We undertake activity in the NHS Education Funding Agreement which is being delivered through a third party provider.		x
The Provider or its sub-contractor did not have any breaches to report in relation to the requirement of the NHS Education Finding Agreement (EFA)	x	
We are compliant with	x	

	Yes	No
all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHE Education Funding Agreement.		
The Provider did not have any health and safety breaches that involve a learner to report in the last 12 months.	x	
The organisation facilitates a cross-system and collaborative approach, engaging the ICS for system learning.	x	
We have collaborative relationships with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.	x	

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

BTHFT regularly collaborate with our Higher Education Institutions (including curriculum development and engagement meetings). BTHFT actively attend ICS and regional education meetings to discuss and share opportunities and challenges.

Funding received via the education contract is utilised for the provision of education and support of learners both locally within the Education department and across the wider Trust.

10. Please provide the name and email address of the board named individual responsible for education and training.

Name	Dr Ray Smith
Email Address	Ray.smith@bthft.nhs.uk

11. Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall, Education Manager, laura.gornall@bthft.nhs.uk

14. Section 4 - Education Quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the **NHS Education Funding Agreement (EFA)**. This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

12. Can you confirm as a provider that you...
Please select only one option for each row.

	Yes	No	N/A
We are aware of the requirements and process for an education quality intervention, including who is required to attend.	x		
We are reporting and engaging with the requirements and process to escalate issues, in line with NHS England's education concerns process.	x		
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	x		
Has the provider been actively promoting, to all learners, use of	x		

	Yes	No	N/A
the national clinical decision support tool funded by NHS England?			
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners.	x		
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners.	x		
Are aware of the Safe Learning Environment Charter (SLEC)	x		
Are actively implementing and embedding the SLEC multi-professionally.	x		

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

BTHFT are working across postgraduate and undergraduate education to embed outcomes in the Safe Learning Environment Charter.

The trust provides all staff and learners with access to library and knowledge management services staffed by qualified professional staff. The library includes learning, study and IT space that is conducive to learning and accessible to all staff 24/7. The library and knowledge service has a quality and improvement plan which is regularly reviewed, and we are currently awaiting our Outcome Frameworks assessment which will highlight priority areas for future development. The library and knowledge service actively promotes and supports the use of BMJ Best Practice and UptoDate clinical decision support tools.

Freedom to Speak Up is promoted consistently across all inductions and for all learner groups.

13. As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc)
Note: we are not seeking information about the referral of an individual learner.

- [x] **We have not** been referred to a regulator
- [ ] **We have** been referred to a regulator and the details are shared below.

If you have received conditions from a regulator please provide more details including the regulator, the profession involved and a brief description

NMC Exception reports have been completed by Higher Education Institutions due to high profile media coverage for Bradford Teaching Hospitals related to Leadership and Neonatal Unit. BTHFT are not aware of any learners or students who have been adversely affected by these concerns.

14. Did you actively promote the National Education and Training Survey (NETS) to all healthcare learners?

- [x] Yes
- [ ] No

Please briefly describe your process for encouraging responses including your organisations response rate for the 2023 NETS.

We encouraged all learners to complete the NETS by emailing all learners, engaging with our HEI partners to promote completion. BTHFT also utilised an I-pad to take the survey to the departments and wards and encourage completion by learners.

We were pleased with the uptake in NETS which increased by 40% from 2022. (2022 n=173, 2023 n= 308)

15. Have you reviewed, at Board Level, and where appropriate, taken action on the outcome of the results of the National Education and Training Survey (NETS).

- [x] Yes
- [ ] No

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

The NETS results were presented at People Academy on 24/04/2024 which reports to the Board.

Initial actions:

1. Detailed Analysis: Further examination of Surgery Foundation feedback and updates on workload and workforce issues in O&G are warranted to devise targeted interventions.
2. Investigation: Delve into reasons behind low scores in midwifery supervision and explore strategies for improvement.
3. Capacity Building: Enhance opportunities for QI and leadership development, particularly among AHPs, midwives, and nurses, to foster a culture of continuous improvement and professional growth.
4. Continuous Monitoring: Regularly monitor indicators and domains to track progress and ensure ongoing enhancement of the educational environment at BTHFT.

16. 2024's NETS will be open from 1 October 2024 until 26 November 2024. How will your organisation increase their NETS response rate for 2024?

BTHFT will continue to encourage NETS completion using methods outlined in question 14.

BTHFT will specifically target undergraduate medical students as the response rate in 2023 was particularly low.

The use of pocket sized survey QR codes will be trialled for 2024, to provide to learners when visited by an educator in the clinical areas.

17. Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Dr Ray Smith ray.smith@bthft.nhs.uk Professor Karen Dawber karen.dawber@bthft.nhs.uk
Name and email address of your non executive director representative for Patient Safety	Professor Louise Bryant louise.bryant@bthft.nhs.uk
Name and email address of your Patient Safety Specialist/s	Leah Richardson Leah.Richardson@BTHFT.nhs.uk Judith Connor Judith.Connor@bthft.nhs.uk
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%)	92%

18. Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall, Education Manager, laura.gornall@bthft.nhs.uk

15. Section 5 - Equality, Diversity and Inclusion

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks about your policies and processes in relation to equality, diversity and inclusion and should normally be completed by your nominated EDI lead. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

19. Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

- [x] Yes
- [ ] No

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alonside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

We have a dedicated Equality, Diversity and Inclusion unit this consists of the Assistant Director of Equality, Diversity and Inclusion (Kez Hayat) and two part time Equality, Diversity and Inclusion managers.

20. Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...
Please select only one option for each row.

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	X	
Implement reasonable adjustments for learners with a disability?	X	
Ensure policies and procedures do not negatively impact learners who may have a	X	

	Yes	No
protected characteristic(s)?		
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	X	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	X	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	X	
Do you have initiatives to support reporting of sexual harassment?	X	
Has your organisation signed up to the NHS England Sexual Safety in Healthcare - Organisational Charter?	X	
Does your organisation have a designated sexual safety lead, such as a	X	

	Yes	No
Domestic Abuse and Sexual Violence (DASV) lead?		

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Equality Impact Assessment methodology is used for all policy reviews and for new polices including criteria and any other required assessments.

International Medical Graduates (IMG) and internationally recruited staff have a bespoke welcome and onboarding package at BTHFT. BTHFT have a named IMG Lead in Trust – Dr Shafi Khan, who works closely with our LED tutor to provide bespoke induction to IMG.

Work is currently taking place to overhaul the existing Bullying and Harassment Policy (which includes harassment and discrimination). This policy will be replaced by the Civility, Respect and Resolution Policy. This will include management of sexual harassment and provide accompanying guidance and signposting support for staff and managers.

There are many avenues available for staff to raise concerns regarding ED&I and these are promoted throughout the Trust. These include Freedom to Speak Up, HR policies, incident reporting, Staff Advocacy Service, Staff Equality Networks, and the Equality and Diversity Unit.

Recent listening events have been completed with internationally educated staff to identify areas to develop and improve this included feedback on career development/progression and onboarding of internationally recruited staff.

Policies are in place to manage discriminatory behaviour from patients include ‘Managing physical violence and aggression at work policy’ and ‘Bullying and Harassment Policy.’

21. How does your organisation manage sexual harassment reports?

BTHFT has a designated sexual safety lead. Work is ongoing to raise awareness of sexual safety as an organisation and developing materials to support potential victims.

Where reported, the disciplinary and grievance policies are utilised.

Staff have a variety of avenues to report or seek advice regarding sexual safety including from line managers, Human Resources, Freedom to Speak Up, Staff Advocacy Service, Staff Equality Networks, or the Equality, Diversity and Inclusion Unit.

22. Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

BTHFT is committed to ensure our workforce is representative of the community we serve. At 40% representation, our target of 35% of staff being in ethnic minority groups has been achieved. BTHFT recognise the positive impacts that a representative workforce brings to our patients, including improved patient care and experience.

Recent analysis on the Medical Workforce has shown that at Bradford c.45% of the medical and dental workforce is from an ethnic minority group.

To discuss this data further contact: Kez Hayat (kez.hayat@bthhft.nhs.uk)

23. For education and training, what are the main successes for EDI in your organisation?

There continues to be considerable focus within the Trust in advancing Equality, Diversity and Inclusion. The Equality, Diversity and Inclusion Strategy is in its second year of implementation, which is helping to raise awareness of EDI across the Trust including within Education and Training.

In November 2023 BTHFT was awarded the Nursing Times Award for 'Best Employer for Equality Diversity and Inclusion'. This award recognises BTHFT nationally for the work the Trust has done to embed Equality, Diversity and Inclusion processes across the organisation.

We have active staff networks including Race Equality, LGBT Equality, and Disability Equality. These networks are open to staff, learners, allies and provide a voice to influence practice. BTHFT has a Disability Equality Policy and a focus on enabling reasonable adjustments in work and education.

Within Education and Training a large-scale review has been launched to review accessibility in relation to Equality, Diversity and Inclusion. Training on mental health and inclusivity was provided for education staff in January 2024. Education and training continue to have an active role in widening participation initiatives for our local community to join careers in the NHS.

Learners are encouraged to share their Personal Learning Support Plan with their educator to enable adjustments to be made to maximise their learning experience. Early identification of

trainees that require support has helped ensure appropriate adjustments are in place. BTHFT has been working with HEI's to enable these to be provided in advance of placements.

24. For education and training, what are the main challenges for EDI in your organisation?

The EDI challenges remain consistent to the previous year including the challenge to managing disability needs effectively. Hidden needs (eg.ADHD/neurodiversity) are often undisclosed causing delays to support and reasonable adjustments to be implemented. A SOP related to supporting learners with neurodiversity is in place and a wider focus in place to encourage disclosure of hidden needs.

The ageing estate at BTHFT causes issues with those who have mobility difficulties or accessibility requirements.

Students often do not want to share learner plans, for fear of being treated differently. This stigma impacts the student experience and reduces the support we can offer and provide. Breaking down stigma is discussed at all inductions and learners are informed of the importance to share their learner support plans. Delay in the provision of information from the HEI can cause challenges to put timely support in place for students.

Understanding the inequalities across our workforce in relation to career/personal development opportunities is vital to encourage the uptake and ensuring equity of access across the workforce.

25. Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall, Education Manager, laura.gornall@bthft.nhs.uk

16. Section 6 - Assurance Reporting: learning environment and culture

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

26. Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

BTHFT have a strong commitment to supporting staff and have a dedicated Organisational Development team who provide training around Our People Charter, Civility and Respect alongside leadership and management development training. BTHFT have developed an online platform 'THRIVE' which contains resources and support for all staff including learners. BTHFT are progressing actions in the Safe learning Environment Charter which is a longitudinal piece of work embraced by the Education Department.

Within our Undergraduate Medical Education team there has been renewed focus on visibility of student support in clinical areas through use of clinical in-reach. This has relieved pressure on clinical areas by providing a dedicated education staff member to support learners in the clinical area. This has fostered positive relationships between clinical areas and improved the learner's experience.

Within our Practice Education team feedback about students struggling to gain feedback from staff has been acknowledged and trial completed of students using a QR code for feedback gathering. This has been effective and relieved the burden on both staff and learners fostering a positive environment for learning and constructive, timely feedback. Furthermore feedback highlighted that certain student groups were struggling with skills/role understanding and therefore bespoke teaching sessions have been implemented to support learners.

Our proactive Postgraduate Medical Education team provide positive, supportive and helpful guidance to trainees. They have explored opportunities to improve and streamline the training and onboarding experience through integration of the HealthToolbox App.

BTHFT continue appreciation cards, these are available for staff and students to nominate staff/students that they are appreciative of. The appreciation cards are hand delivered to the nominee to recognise their commitment to promoting a positive learning environment.

27. Quality Framework Domain 1 - Learning environment and culture
Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
The learning environment is one in which education and training is valued and championed.	x	
The learning environment is inclusive and	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
supportive for learners of all backgrounds and from all professional groups.		
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	x	
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	x	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	x	
The environment is one that ensures the safety of all staff, including	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
learners on placement.		
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	x	
The environment is sensitive to both the diversity of learners and the population the organisation serves.	x	
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	x	
There are opportunities to learn constructively from the experience and outcomes of patients and service users,	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
whether positive or negative.		
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to knowledge and library specialists.	x	
The learning environment promotes multi-professional learning opportunities.	x	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	x	

28. Areas of exception

<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
- [ ] Dental Postgraduate
- [ ] Dental Undergraduate
- [ ] Medicine Postgraduate
- [ ] Nursing
- [ ] Midwifery
- [ ] Allied Health Professionals
- [ ] Pharmacy
- [ ] Paramedicine
- [ ] Medical Associate Professions
- [ ] Advanced Practice
- [ ] Psychological Professions
- [ ] Healthcare Science
- [ ] Medicine Undergraduate
- [ ] Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

29. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

30. Signature

- [ ] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall, Education Manager, laura.gornall@bthft.nhs.uk

17. Section 7 - Assurance Reporting: educational governance and commitment to quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to

submission.

For each standard, please confirm whether the you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

31. Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

BTHFT are committed to robust educational governance. The Education department hold quarterly Professional Education Quality Meetings which bring together undergraduate medical and non-medical education alongside postgraduate medical education. This meeting review's themes, patterns and risks across learning environments and provides a forum to discuss quality issues affecting all learners.

Across education a peer review process is in place for all staff who deliver education. Educators are expected to complete three peer reviews per year, which is monitored via yearly appraisals.

Within the Practice Education team processes have been developed to share feedback with the learning environment focusing on quality, recent successes, challenges and support available to overcome these. These have been well received and enable departments to have oversight of the quality of the learning environment they are providing.

Within Education a journal club is promoted to inform education practice across the department. Teaching material produced by BTHFT is utilises national guidance, subject matter experts to ensure accuracy. All designed teaching material is peer reviewed to ensure quality.

BTHFT have well-established Steering Groups for Foundation and Postgraduate Medical Education meeting quarterly and chaired by the Director of Education, with College Tutor representatives from various specialities, including GP Training Programme Directors and LED Tutor. This is alongside a well-established Junior Doctor Forum meeting quarterly, chaired by the Guardian of Safe Working, with representation by Associate College Tutors from various specialities, Medical HR, Director of Education, LNC Chair and BMA.

32. Quality Framework Domain 2 - Educational governance and commitment to quality
Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
professional and, where appropriate, inter-professional approach to education and training.		
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	x	
The governance arrangements promote fairness in education and training and challenge discrimination.	x	
Education and training issues are fed into, considered and represented at the most senior level of decision making.	x	
The provider can demonstrate how educational resources (including financial) are allocated and used.	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.	x	
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	x	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
views of learners, supervisors and key stakeholders (including WT&E and Education Providers).		

33. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Dental Postgraduate
- ☐ Dental Undergraduate
- ☐ Medicine Postgraduate
- ☐ Nursing
- ☐ Midwifery
- ☐ Allied Health Professionals
- ☐ Pharmacy
- ☐ Paramedicine
- ☐ Medical Associate Professions
- ☐ Advanced Practice
- ☐ Psychological Professions
- ☐ Healthcare Science
- ☐ Medicine Undergraduate
- ☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

34. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are

impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

35. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall, Education Manager, laura.gornall@bthft.nhs.uk

18. Section 8 - Assurance Reporting: developing and supporting learners

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

36. Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

BTHFT have a monthly Multi Professional Learners Forum, which is open to all undergraduate students and staff. It has a varied programme of speakers from across the hospital to provide detailed insight into roles, responsibilities or subjects.

BTHFT encourage learners to engage in a shared governance approach and are welcome to join any of the Trust or Unit councils. Within the next year an undergraduate specific student council is being created.

Reflective Practice Forums are held for undergraduate non-medical learners to attend to reflect on clinical placement experiences. Student drop-in sessions are held for a variety of professional groups to help embed knowledge and make solid links between theory and practice.

The Education department is dynamic and innovative in their teachings to meet needs of the learners. Within Undergraduate medical education new simulation programmes have been developed to meet the needs of learners including an Integrated Clerking Experience and a Simulated On-Call experience. Feedback from these have been excellent and increase student confidence for final year medical students.

There are robust processes in place to monitor and support Doctors in Difficulty (DiD) with a dedicated TPD to support each DiD and regular contact from Education and Training.

A range of leadership opportunities are available to doctors in training, e.g. Associate College Tutors, Junior Doctor Mess Committee roles, Education Champions, Chief Registrar, lunchtime teaching opportunities, Post Foundation Fellowships, Health Toolbox champions.

The Library and Knowledge Service provide bulletins about new research or evidence related to specific areas of interest.

37. Quality Framework Domain 3 - Developing and supporting learners

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	x	
The potential for differences in	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.		
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	x	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	x	
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
outcomes required.		
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	x	
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	x	
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	x	
Learners understand their role and the context of their placement in relation to care	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
pathways, journeys and expected outcomes of patients and service users.		
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	x	
Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.	x	

38. Areas of exception

<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Dental Undergraduate
- ☐ Dental Postgraduate
- ☐ Medicine Postgraduate
- ☐ Nursing
- ☐ Midwifery
- ☐ Allied Health Professionals
- ☐ Pharmacy

- [ ] Paramedicine
- [ ] Medical Associate Professions
- [ ] Advanced Practice
- [ ] Psychological Professions
- [ ] Healthcare Science
- [ ] Medicine Undergraduate
- [ ] Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

39. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

40. Signature

- [ ] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall, Education Manager, laura.gornall@bthft.nhs.uk

19. Section 9 - Assurance reporting: developing and supporting supervisors

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to

submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

41. Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

BTHFT actively promote teaching and learning opportunities within education. Doctors in training are encouraged to become an Education Champion and take an active role in supporting the development/facilitation of teaching/simulation for undergraduate medical students. Education Champions receive a monthly newsletter highlighting opportunities for their development.

In 2024 the remuneration for Undergraduate supervisors has been reviewed and refined in line with the Education Funding Agreement to appropriately compensate staff for undertaking a lead supervisor role.

The Standards for Supervision and Assessment continue to be actively discussed at Supervisor Updates and a condensed teaching session prepared for a ‘bedside teaching’ update where required. Within Physiotherapy and Occupational Therapy work has been completed to develop supervisors, listen to their challenges when supporting students and partnership with the Higher Education Institutes to develop robust support processes.

Educational supervisor catch-ups have been held to enable supervisors to network, gain peer support and share learning. Educational Supervisor face to face training is delivered by the Director and Deputy Director of Education 3 times per year. Regular monitoring of supervision capacity vs number of doctors in training with new consultants encouraged to consider a supervisor role as part of the Consultant Development Programme.

In-reach activities have been a particular focus this year enabling staff to support with educational activities out in practice, relieving supervisory requirements in clinical areas.

Support and guidance is provided to supervisors of IMG doctors, including a webinar by the Trust IMG Lead and support information and materials for IMG doctors.

42. Quality Framework Domain 4 - Developing and supporting supervisors

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.		x
Those undertaking	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, WT&E).		
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	x	
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
ability to support learners' progression.		
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	x	
Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.	x	
Supervisors can easily access resources to support their physical and mental health and wellbeing.	x	

43. Areas of exception
From the professional groups you train, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
- [ ] Dental Undergraduate
- [ ] Dental Postgraduate
- [ ] Medicine Postgraduate
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- [ ] Allied Health Professionals
- [ ] Pharmacy
- [ ] Paramedicine
- [ ] Medical Associate Professions
- [ ] Advanced Practice
- [ ] Psychological Professions
- [ ] Healthcare Science
- [x] Medicine Undergraduate
- [ ] Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

44. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Historical payment structures of remunerating undergraduate medical education supervisors have been reviewed. These have been adapted to bring them in line with principles set out in the Education Funding Agreement.

Under these changes 'Lead Placement Supervisors' will be identified and an appropriate renumeration provided equal to 0.25PA as an additional payment.

45. Thinking about the Educator Workforce Strategy, please confirm that your organisation

	Yes	No
Is aware of the Educator Workforce Strategy.	x	
Ensures educators/supervisors undertake a skills gap / learning development needs analysis for this role.	x	
Ensures educators/supervisors have formal development to undertake this role.	x	

	Yes	No
Considers the educator workforce in wider clinical workforce planning.	x	

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

A yearly Learning Needs Analysis is conducted and completed within Education.

Educators are encouraged to gain formal recognition of their knowledge through a Post Graduate Certificate in Health Professional Education or other formal teaching/facilitation qualification appropriate to their role.

BTHFT are developing a new Education Plan 2025-2030, educators and the strategic priorities in the Educator Workforce Strategy will be encompassed as a key component of the BTHFT Education Plan.

46. Implementation of the Educator Workforce Strategy

- [ ] We have **fully implemented** the recommendations of the Educator Workforce Strategy.
- [x] We have **partially implemented** the recommendations of the Educator Workforce Strategy.
- [ ] We have **not yet started** implementation of the recommendations of the Educator Workforce Strategy.

47. Signature

- [x] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Laura Gornall laura.gornall@bthft.nhs.uk Education Manager

20. Section 10 - Assurance reporting: delivering programmes and curricula

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

48. Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

The introduction of simulation in year two in the undergraduate medical education curriculum has been beneficial. Further simulation has been developed including a simulated experience of clerking patients for fifth year learners. This has provided opportunities for development of skills and knowledge and an innovative way to embed theoretical knowledge to practical application. The undergraduate teaching scaffolds learning through a progressively developing curriculum over the year to build on students increasing knowledge.

The Practice Education Team have been involved in supporting the re-design of the curriculum for Nursing at the University of Bradford. This has been valuable to shape the curriculum to the changing requirements needed in clinical practice.

A blended approach to the delivery of programmes being offered to cater for all preferences.

BTHFT have ASPiH accredited Simulation Centre and Technical Skills Laboratory facilities which is regularly utilised for Doctors in Training and provides high quality simulation and training across the region.

The quality of training delivery is monitored and discussed and fed back to facilitators and Training Programme Directors to facilitate improvements.

BTHFT regularly review FY1 lunchtime teaching content to ensure it remains relevant to curriculum requirements.

49. Quality Framework Domain 5 - Delivering programmes and curricula

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	x	
Placement providers work	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
in partnership with programme leads in planning and delivery of curricula and assessments.		
Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	x	
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	x	☐
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.	x	☐

50. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
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- ☐ Paramedicine
- ☐ Medical Associate Professions
- ☐ Advanced Practice
- ☐ Psychological Professions
- ☐ Healthcare Science
- ☐ Medicine Undergraduate
- ☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

51. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

52. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

21. Section 11 - Assurance reporting: developing a sustainable workforce

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

53. Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like yo share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

BTHFT are committed to training, recruiting and retaining staff. A pilot project has been granted funding for 'Medical Student Assistants' where undergraduate medical students can join the staff bank and work alongside a foundation doctor to complete clinical tasks to support management of workload. This role has been discussed with our partner Medical School and is available only when students are not in placement – eg weekends and bank holidays. It is hoped that this provides two-way benefits, specifically for the learner it provides opportunities to refine clinical skills and receive a salary, for the Trust it supports the relief of workload pressures for clinicians.

'Skills Boost' sessions have been held for Undergraduate Nursing and Midwifery students in their 3rd year to help refine skills prior to qualifying. These sessions were well received by students and increased their confidence.

BTHFT have been awarded the interim Quality Mark for Preceptorship in 2024. This supports attracting new talent to BTHFT and the retention of staff.

Within Undergraduate Medical Education detailed planning was undertaken to support the 'Post-Finals Assistantship' by matching students with the speciality allocated for their first Foundation Post. This was extremely beneficial for students and will support their transition once qualified.

BTHFT are looking at developing a proficiency passport for Undergraduate Students to enable transferability of clinical skills/competencies completed as an undergraduate learner to translate into competencies/proficiencies as a registrant.

BTHFT take an active role in supporting widening participation activities to support the understanding and accessibility of careers in the NHS.

54. Quality Framework Domain 6 - Developing a sustainable workforce
Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	x	
Does the provider provide opportunities for learners to	x	

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
receive appropriate careers advice from colleagues		
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	x	
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	x	

55. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
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- [ ] Medical Associate Professions
- [ ] Advanced Practice
- [ ] Psychological Professions
- [ ] Healthcare Science
- [ ] Medicine Undergraduate
- [ ] Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

56. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

57. Signature

- [ ] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

22. Section 12 - Final Submission

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Before completing your final submission please ensure you have:
1. Completed all questions within the Self-Assessment (including the free text sections)
2. Received Board level sign off for your submission

58. Board level sign-off (Premises, Learning Environment, Facilities, and Equipment)

☐ I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.

59. Board level sign-off

☐ I confirm that the responses in this SA have been signed off at board level

Name, email address and role of Board representative for education and training

60. Please confirm the date that board level sign off was received:

*

61. Final Submission (please only tick this box when you ready to submit your self-assessment)

☐ I confirm that all sections of this self-assessment have been completed and that this is the final version for submission

23. Thank you for your time

Thank you for your time on the NHS England Self-Assessment for Placement Providers

You can continue to update this self-assessment using the link supplied to your by your regional NHS England WT&E education quality team.

If you would like to print a version of your draft submission at any time, please use the print button on the next page (note that you will only print those sections currently completed)

Once you have completed all sections in full of this self-assessment please ensure that you complete section 12 final submission and tick the box Complete Submission. At which point your final response will be sent to your regional NHS England WT&E education quality team.

BO.9.24.10 - EQUALITY & DIVERSITY COUNTIL UPDATE

REFERENCES

Only PDFs are attached

Bo.9.24.10 - Equality Diversity Council Update (1).pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.10

Strategic Equality and Diversity Council September 2024 Update

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

Key Options, Issues and Risks

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

This report provides an update on the key highlights from the last EDC meeting which was held on 17th July 2024.

Analysis

The following key items were discussed at July EDC meeting:

- Staff Equality Network Updates on progress and future plans
- Reducing Inequalities Alliance
- Project Search
- Chief People & Purpose Officer: First 90 days plan
- WRES and WDES update

Recommendation

It is recommended that the Trust Board:

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

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.10

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

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

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

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

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

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.10

1 PURPOSE/ AIM

The purpose of this report is to:

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

2 BACKGROUND/CONTEXT

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

2.4 EDC Membership

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

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

3 Highlights of the EDC Meeting – Wednesday 17th July 2024

3.1 EDC continues to be well attended and generates lots of useful discussion, with 18 people attending the July meeting. This section provides a summary of agenda items and actions arising from EDC since the last Trust Board update provided in May 2024.

The table below captures some of the key discussions from the meeting which took place on 17th July 2024.

Staff Network Updates
General Update (from all Networks) Development of Inclusive Recreational Areas: Sonia Sarah (EDI Manager) is working with the networks and Estates to ensure the development of the new Field House Recreational area is an inclusive space for staff. They are also exploring possibilities for incorporating an inclusive information hub either into this design or to be situated somewhere on the main concourse at BRI. However, current financial pressures may mean this has to be put on hold for now. Skills House: Georgi Dyson provided an update on how the Trust has been working with ANHST, BDCT and Skills House (the employment and skills service strand for Bradford Council) upskilling and training local residents to achieve sustainable job outcomes.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.10

Equality & Human Rights Week: Network members worked with the EDI team to celebrate Equality & Human Rights Week with a face-to-face event in the Sovereign Lecture Theatre. Karen Walker hosted the event which featured guest Speaker Fatima Khan Shah, West Yorkshire Inclusion Champion who shared her vision around Inclusion and how we achieve this across West Yorkshire. Saj Azeb also shared his personal journey and reflections on his career. The EDI team gave an overview of EDI at BTHFT (where we are now, current activity and where we are headed). The session, which was really well received, was rounded off with a Q&A session.

In the afternoon, to celebrate 'International Day for Staff Networks' network members joined forces on the main concourse showcasing the important role that networks play in the progress of EDI at BTHFT.

Enable Staff Network Update

Sonia Sarah provided an update as convenor for Enable. The network are currently experiencing some challenges with core group involvement and Sonia is actively seeking a new co-chair to lead the group.

RESIN Staff Network Update

Raquel provided EDC with an update on a series of listening events for international staff. The sessions were led by Renee, with support from the RESIN network and the OD team. The feedback from the sessions (both positive and negative) have helped to inform Renee's 3 stage plan and will also feed into the ongoing work that Sean Willis and Jo Hilton are doing to provide comprehensive induction and onboarding for international staff, (aligned to the NHS EDI Improvement plan).

The network are making plans for upcoming Diwali and Filipino day celebrations.

LGBT Staff Network Update:

Karla provided an update for the LGBT+ network. In terms of activity they have successfully celebrated PRIDE on the main concourse and collaborated with OD/ Comms/ Medical Illustration/ EDI to develop a screensaver to raise the profile of the network and LGBT+ equality.

Unfortunately, with dwindling involvement in recent months from network members project work continues to be on hold until this can be resolved. They are working with network members and Exec Lead Karen Dawber to understand why there may be a reluctance to get involved in activity and how they may be able to resolve some of these challenges for colleagues and are working to try and re-build their core membership. EDC members were able to provide some useful connections for navigating some of these challenges and also for restarting the Rainbow Badge training.

Reducing Inequalities Alliance

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.10

Polly Masson from the Reducing Inequalities Alliance attended to provide a presentation outlining the outcomes and determinants of health inequalities and the role the RIA are taking to address health inequalities, supporting local activity and seeking out opportunities to apply 'best practice' at scale across place. She shared some of the current workstreams they are involved in and the outputs that are being achieved in terms of access, experience and outcomes and then went on to lead a discussion about how we can work more closely with the RIA and how we as an anchor organisation can 'make every contact count' in terms of sharing some of this work/ information (e.g. around Living Well) with patients, communities and colleagues across the Trust. There was a lot of interesting discussion and ideas generated on how we can achieve this.

Polly requested that all EDC members review the RIA website and their 'call to action' including a number of resources and examples of best practice that colleagues may find useful in their approaches to tackling health inequalities, including some focus on 'closing the gap'.

Naveed confirmed that they would be working with RIA to provide a Trust Board development session around this topic.

Project Search

Kez Hayat invited along Amanda Clayman (Project Search Co-ordinator) to present an overview of Project Search, our award winning 1-year internship programme for young people with learning disabilities or autism, which was launched in the Trust in 2013.

The presentation included why it is needed, our partnership approach, some of our success and some of the challenges we have faced in recent years. With 20 graduates employed by the Trust over the last 9 years, EDC members discussed how we can expand and improve on the offer. Some suggestions included, offering shadowing and mentorship opportunities, easing the requirement for applicants to have a formal diagnosis of autism/ learning disability or a EHCP and also potential for widening and increasing the annual number of internships available.

Chief People & Purpose Officer – First 90 days plan

Renee Bullock, Chief People & Purpose Officer, talked to EDC colleagues about the observations she has made during her first 90 days in post, and shared some of her vision for EDI in the Trust. She asked colleagues to help her shape some of this work.

Renee complimented the EDI team on their "exemplar" EDI strategy and with good foundations and lots of initiatives in place we are heading in the right direction. Renee then shared with EDC her 3-stage plan and some of the activity she is leading on for ensuring we are achieving our ambitions:

1. A review of people policies and practices (with an EDI and OD improvement lens), including a review of our recruitment & selection policy and practice

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.10

2. Further building on the success of our refreshed staff equality networks, setting up a chair of chairs meeting for the existing networks (to encourage collaboration and shared vision "Inclusion as a collective") and considering:
   - What other networks do our people need?
   - What support are we giving the chairs of those networks?
   - Do they need protected time?
   - Do they need administrative support to do their job well?
   - What development do network chairs need?
3. Management Development: Working to re-align our leadership approaches and culture. With support from Cat Shutt, Renee commenced this work by leading a 2-day workshop for some of our organisations most senior leaders.

EDC welcomed Renee's proposals, which are centred not just around 'our people' but also around 'our purpose' ensuring the best access, outcome and experience for our diverse patients and communities. Some useful discussions and resources were shared.

WRES & WDES update

Ruth Haigh and Kez Hayat provided a presentation slide and a very brief update on progress with this years WRES and WDES data submission and the development of action plans, which will be more focussed this year, with just one or two key actions included.

3.2 Next EDC is due to take place on Wednesday 16th October 2024.

4 RECOMMENDATIONS

It is recommended that the Trust Board:

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

5 Appendices

N/A

BO.9.24.11 - REPORT FROM THE CHAIR OF THE FINANCE AND PERFORMANCE ACADEMY

JULY AND SEPTEMBER 2024

REFERENCES

Only PDFs are attached

Bo.9.24.11 - Report from the Chair of the Finance and Performance Academy - July 2024.pdf

Bo.9.24.11 - Report from the Chair of the F&P Academy - September 2024.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Committee

Date of meeting: 24 July 2024

Key escalation and discussion points from the meeting

Alert:

Monthly Finance Report – The month 3 financial report shows an improvement in run rate from that reported at month 2. This extrapolates to a forecast position broadly in line with our £14m deficit plan. The risk of not delivering our financial plan remains high and work continues to mitigate this risk.

Treasury Management Report - The Academy also noted the associated risk to the Trusts liquidity and cash position should the financial plan not be delivered. Based on current forecasts it looks likely that we will need cash support from NHSE from Quarter 3 and this will need requesting in September 2024.

Advise:

.

Closing the Gap Update – 273 schemes have now been identified - an increase of 67 schemes from last month. These have the potential to deliver £25.6m of savings against the £38.9m required. The risk to delivering the full plan remains high.

Operational Highlight Report – Performance across the Trust remains strong. Emergency Care Standard performance for Type 1, 2 and 3 attendances was 83.13% for June 2024 and at the time of the meeting was at 83.78% for July, this position remains in the upper decile of Acute Trusts in England. Attendance remained high in June with increases in acuity of patients seen and numbers passing through the department. Referral to Treatment performance remained stable in June at 64.31%. 52-week performance remains in the upper quartile but has dropped below plan.

Assure:

Revised Academy Terms of Reference (ToR) and Workplan – the Academy approved the latest changes to our TOR and associated work plan.

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.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

Operational Improvement Plan Cancer and Diagnostics – A presentation was shared with the Academy highlighting the work underway on our Cancer and Diagnostics Improvement Plan. A Time Out session was held by the Cancer Board to develop a shared clinical vision for the Trust's Cancer Strategy. Improvement work continues across the three areas, Transformation, Proactive Improvement and Business as usual. A new one stop Neck lump clinic opened in July 24 aimed at improving the clinical pathway to enable earlier diagnosis and treatment. . The new Community Diagnostic Centre at Eccleshill Hospital is now, up and running and next steps are to move to a 7-day working model. The presentation also included an update on the Histopathology programme which aims to improve turn around times for samples and improve overall cancer performance.

Health Inequalities and Waiting List Analysis –The Academy was assured about the ongoing work being undertaken to reduce health inequalities. The presentation included an action plan covering four areas, Data and Insight, DNA (did not attend) reductions, Referral Analysis and Post Referral Prioritisation.

Estates Procurement Internal Audit Report – The Academy received a report explaining the reasoning behind the conclusion of the audit report (Limited Assurance Audit Report) and a summary of the work that is being undertaken to mitigate the risks highlighted in the report. All the recommendations included in the report have been agreed by management.

Report completed by:

Julie Lawreniuk
Academy Chair and Non-Executive Director

20th August 2024

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

Committee Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 19th September 2024

Key escalation and discussion points from the meeting

Alert:

Monthly Finance Report – There is a significant risk that the Trust will not deliver its financial plan. As at month 5 the Trust is reporting a forecast deficit of £11.2m, an adverse variance of £0.4m against the planned forecast of £10.8m. The variance is due to industrial action costs which are expected to be reimbursed by NHS England.
The plan becomes more challenging in the latter months of the financial year and discussions are planned with the Board in October and November to understand the implications should the financial plan not be delivered.

Closing the Gap – There is a significant risk that the Trust will not deliver the £38.9m of schemes required to deliver the financial plan. As at month 5 £28.6m of schemes are forecast to be delivered against the financial plan requirement of £38.9m. The Committee discussed the recurrent nature of schemes within the programme and the need to understand the 2025/26 Closing the Gap position.
Work continues within the programme to improve this position, and monthly meetings are in place between the CSUs (Clinical Service Units) and Executives. These meetings aim to challenge, scrutinise and support delivery of the Closing the Gap plan,
A "Closing the Gap "week is being held week commencing 16th September which aims to give CSUs time to update their plans and to ensure that the right people are available to support them in this work.

Treasury Management Update (cash position) – there is a significant risk that the Trust will require cash support from NHS England in the latter months of the financial year.

Advise:

Core Standards and EPRR Update – The Academy approved three documents to satisfy core standards 2, 5 and 8 of the core standards submission. These were the EPRR policy, the EPRR resource and relevant risk assessments.

Lockdown Policy – The Academy approved the Trusts new Lockdown Plan.

Generic Internal Mass Vaccination Plan – The Academy approved the Trust Mass Vaccination plan.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

Operational Improvement Plan Urgent and Emergency Care – The department has now been designated as an UTC (Urgent Treatment Centre) which is positive news. Works continues to improve flow, performance and patient experience. Real transformation work has taken place on the Stroke pathway which is delivering an improved SSNAP (Sentinel Stroke National Audit Programme) score. A consultant business case has been approved by the Executives to expand cover overnight in the department which will improve performance.

Procurement Update – The government has overhauled the EU (European Union) procurement rules and there are a number of new principles that the Trust must regard when undertaking procurement. Further updates will be provided to the Committee as the Trust works through and understands these principles.

Assure:

Capital – The Trust is forecasting to deliver its capital plan.

Performance Highlight Report – The Academy received and reviewed the monthly comprehensive report.

Summary of PWC Review of the Trust's Governance Structure – Given the financial challenge West Yorkshire is facing, PWC have conducted a rapid review of the 6 West Yorkshire Trusts. The report from PWC highlights areas our Trust can consider to improve its financial governance and position. An action plan has been completed with timescales by the Trust to capture the opportunities.

High Level Risks Relevant to the Academy -. A new risk re the Emergency Department has been included on the risk register and the existing risk re chemotherapy has now been aligned to the Academy. A discussion took place on the financial and cash risks about ensuring they were adequately captured on the risk register and BAF.

Report completed by:

Julie Lawreniuk
Committee Chair and Non-Executive Director

20th September 2024

CLOSING THE GAP

REFERENCES

Only PDFs are attached

Bo.9.24.11 - Closing the Gap Update - 25 Sept 2024.pdf

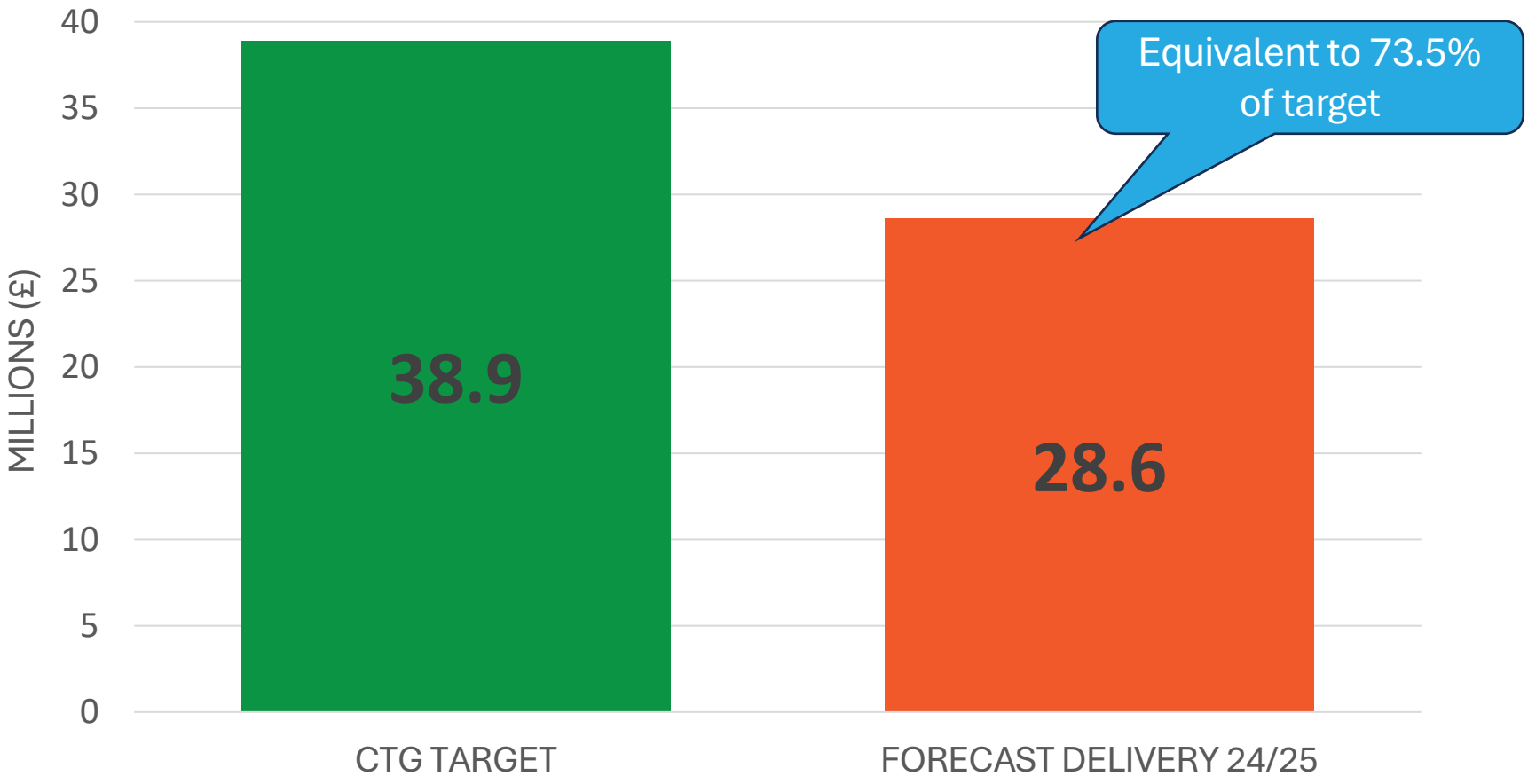
CLOSING THE GAP UPDATE

BOARD OF DIRECTORS

SEPTEMBER 2024

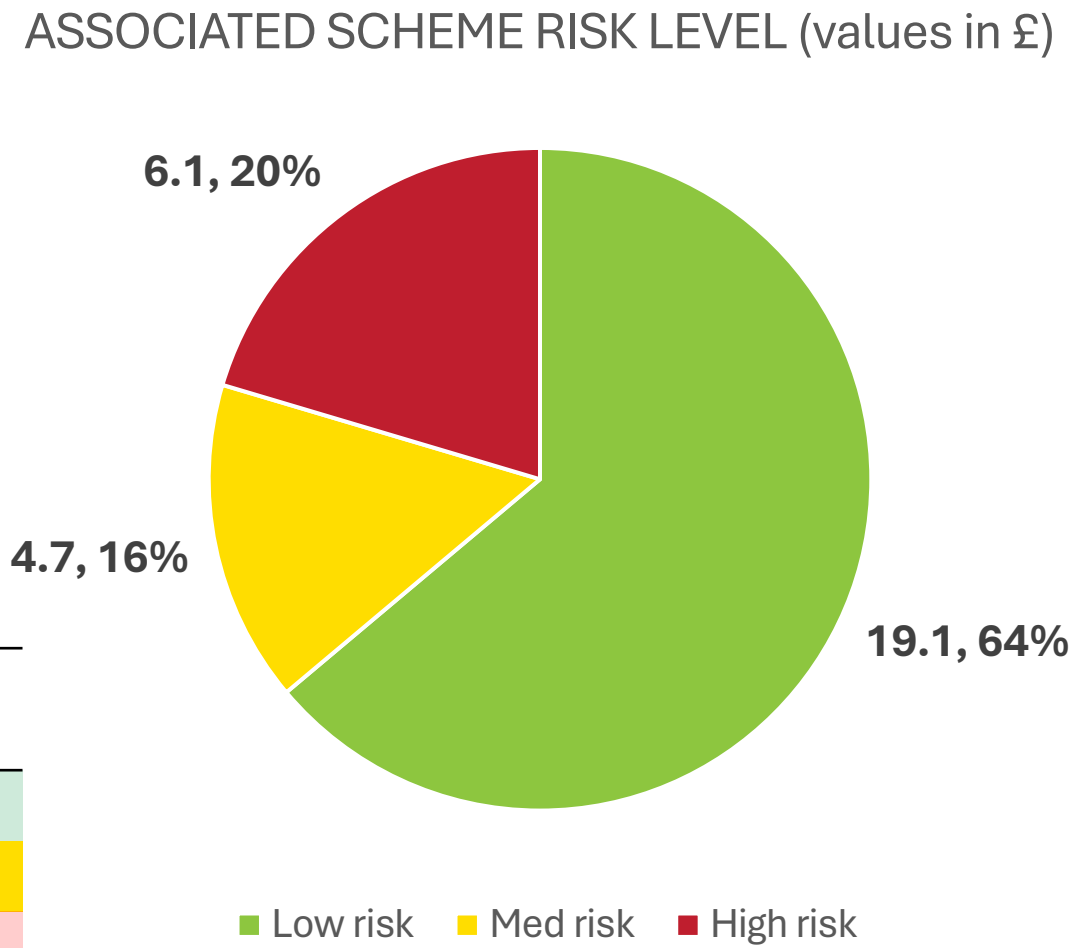
CONTENTS

POSITION Vs TARGET



Data correct as of 9th Sept 2024

SCHEMES



July update

Low	53%
Medium	26%
High	20%

Data correct as of 9th Sept 2024

GOVERNANCE

Board of Directors	Next update 25th September
Finance & Performance Academy	Update 19th September
Executive Team Meeting	Weekly updates taking place, inc. decisions on exceptions to non-clinical vacancy freeze
Closing the Gap Board	Took place 11th September

Workstreams

Elective productivity | Workforce | Medicines Mgt | Financial controls

Workstream charters approved at CTG Board, have started formal meetings

Variable Pay Panel

Clinical Oversight Group

Meeting weekly to review variable pay requests, and review scheme impact assessments

GOVERNANCE

Executive to CSU – Closing the Gap Focus

1

Executive oversight of CTG plans for each of the CSUs

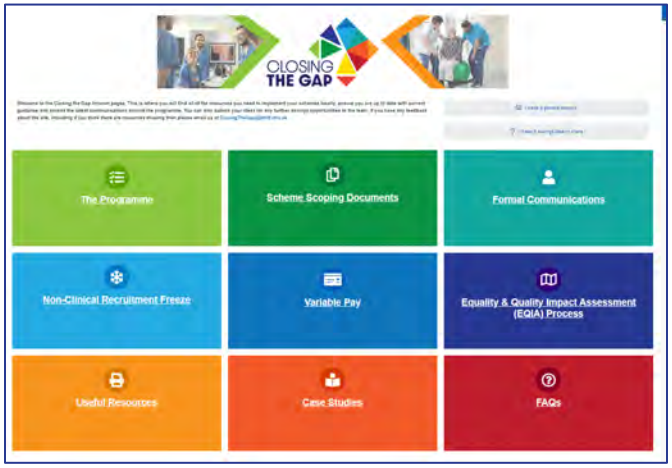
2

Meetings are bi-monthly and alternate every other month with “Full Exec to CSU” meetings that cover the comprehensive agenda

3

Agenda covers CTG and budget position, ensures accountability and provides CSUs opportunity to escalate issues that require executive support

ENGAGEMENT



Since it's launch in June, the Intranet page has had over 3,000 unique views

The first CTG bulletin was published in August

"Closing the Gap Week" is being planned for the week of the 23rd September. Aim to give CSUs time back to update this years plans and forecasts and ensure key people to be available to support them.

Will also launch a series of webinars, to support the development of further plans for this and next year

EXTERNAL PWC WYAAT REVIEW

16 Recommendations in all.

Split across three themes:

- Leadership and culture
- Financial accountability
- Turnaround opportunities

Each action has an executive owner, and progress against the plan will be monitored through ETM monthly.

NEXT STEPS

1. • Focus on delivery of identified schemes
2. • Progress plans around CTG week
3. • Implement PWC recommendations
4. • Strengthen connections with BD&C place and partners equivalent work

INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.9.24.11 - Integrated Dashboard August 2024 (cover).pdf

Bo.9.24.11 - Integrated Dashboard August 2024.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

Integrated Dashboard

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 assurance	
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 will be recovered (deteriorating) 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	25 September 2024	Agenda item	Bo.9.24.11

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

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

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

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

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

Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard

Board of Directors

August 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

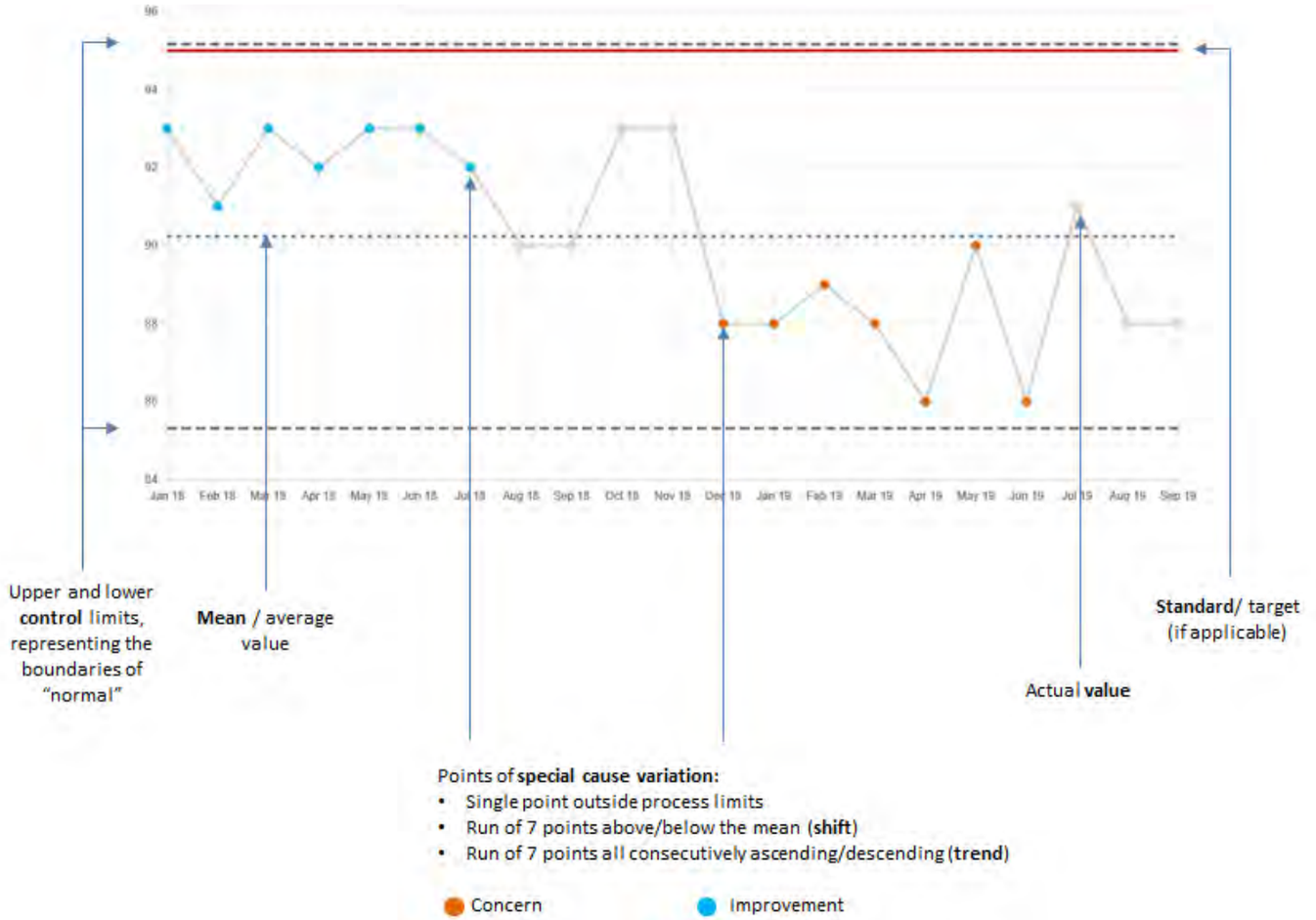
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

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.

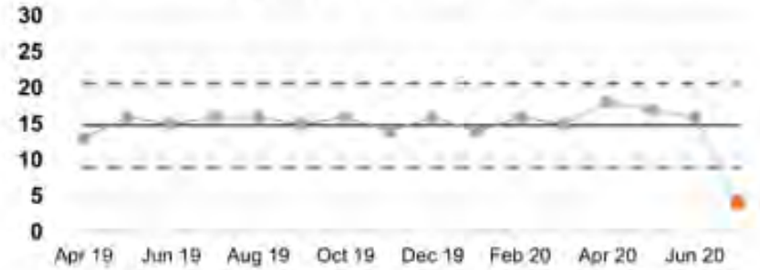
SPC charts



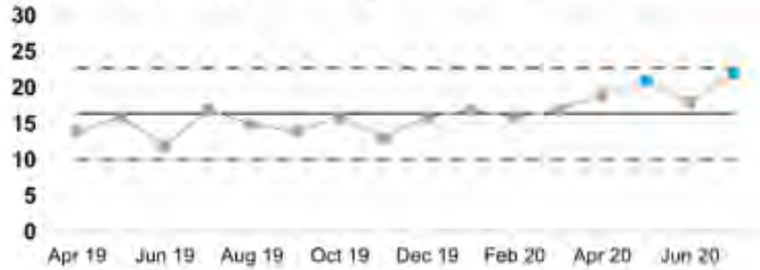
Interpreting Statistical Process Control Charts

SPC rules : special cause variation

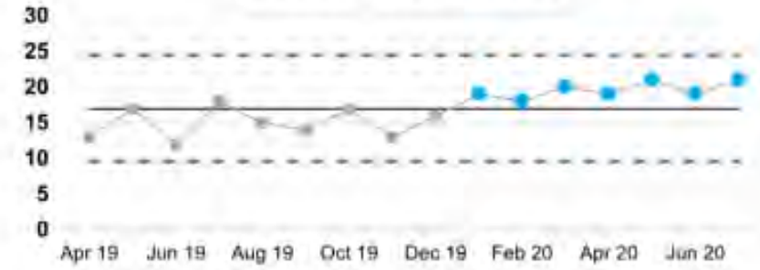
A single point outside the process limits



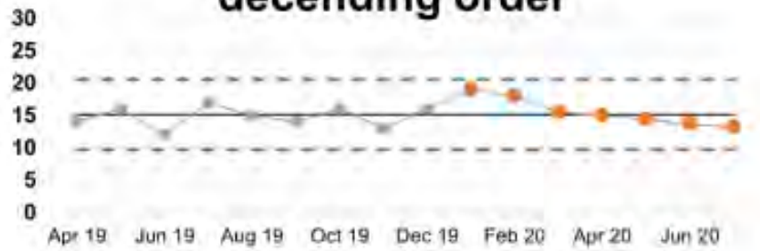
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or decending order



Operational Performance – Executive Director: Sajid Azeb

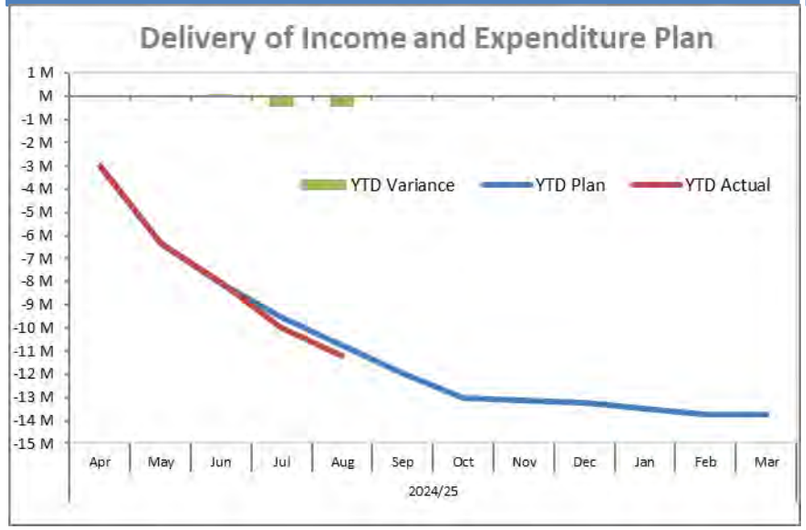
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	Aug-24	45.9%				56.40%
% Ambulance Handover <30 Mins - * All	Aug-24	79.3%				85.80%
% Ambulance Handover <60 Mins - * All	Aug-24	95.3%				96.50%
Ambulance Arrivals - * All	Aug-24	3,212				3,200
Bed Occupancy - * All	Aug-24	88.70%	93%			90.70%
Cancer 2 Week Wait - * All	Jun-24	94.40%				93.80%
Cancer 28 Day Faster Diagnosis	Jun-24	75.20%				81.6%
Cancer 31 Day 1st Treatment	Jun-24	91.50%				92.6%
Cancer 62 Day Wait - * All	Jun-24	72.20%	75%			74%
Day Case Rate - * All	Jul-24	88.50%				88.90%
Diagnostic Waiting List - * All	Jul-24	8,080				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	Jul-24	79.60%	95%			72.50%
DTA to Admission > 12 Hours	Aug-24	2.6%				2.01%
DNA Rate - All	Jul-24	7.50%				8.85%
ED - Time to Initial Assessment - * All	Aug-24	21.20				24.4
ED Attendances (% < 4hr) - * All	Aug-24	81.70%	77.30%			75.60%
Elective Ordinary and Daycase Admissions	Jul-24	4,614				4,190
Elective Theatre Sessions Volume Completed	Jul-24	593				520
Length of Stay 21+ Days - * All	Aug-24	104				103.5
Not Meeting Criteria to Reside - * All	Aug-24	11.70%	14.79%			13.06%
Outpatient Attendances	Jul-24	46,178				41,567
Outpatient Attendances % New or with Procedure	Jul-24	54.40%				56%
Outpatients Discharged to PIFU	Aug-24	3.12%				2.14%
Patients Discharged on/before DRD	Aug-24	81.4%				81.90%
Pts in ED >12 Hrs - * All	Aug-24	633				680.1
RTT 18 Weeks (%) - * All	Jul-24	63.30%				68.90%
RTT 18 Weeks (Total Pathways) - * All	Jul-24	35,398	30571			35,619
RTT 52 Week Breaches - * All	Jul-24	499				613.3
RTT 65 Week Breaches - * All	Jul-24	65				81.6
Theatre Capped Utilisation	Jul-24	83.20%				82%

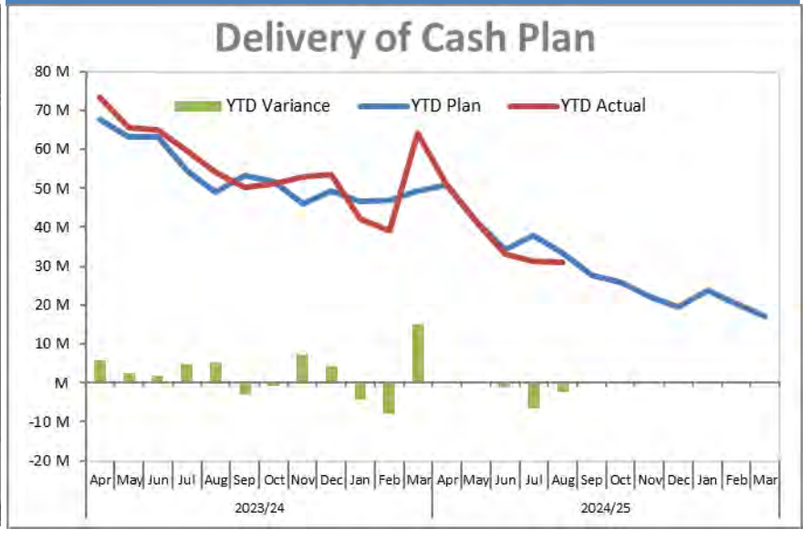
Finance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

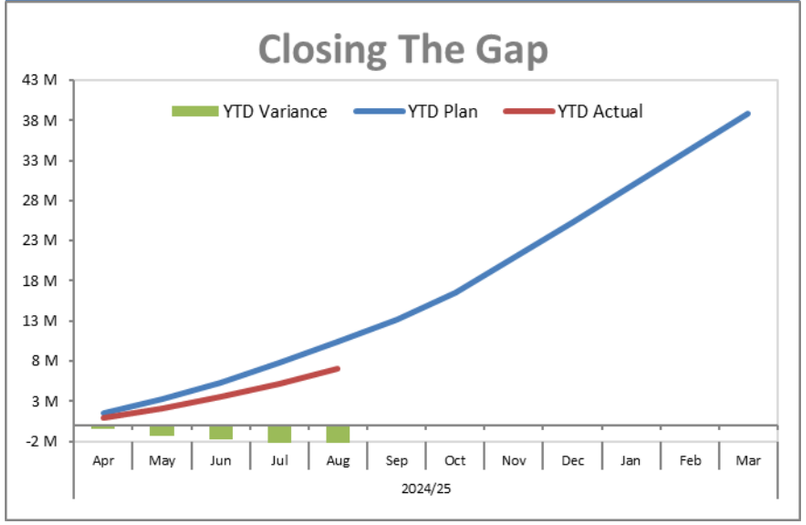
August 2024 – -£11.2m



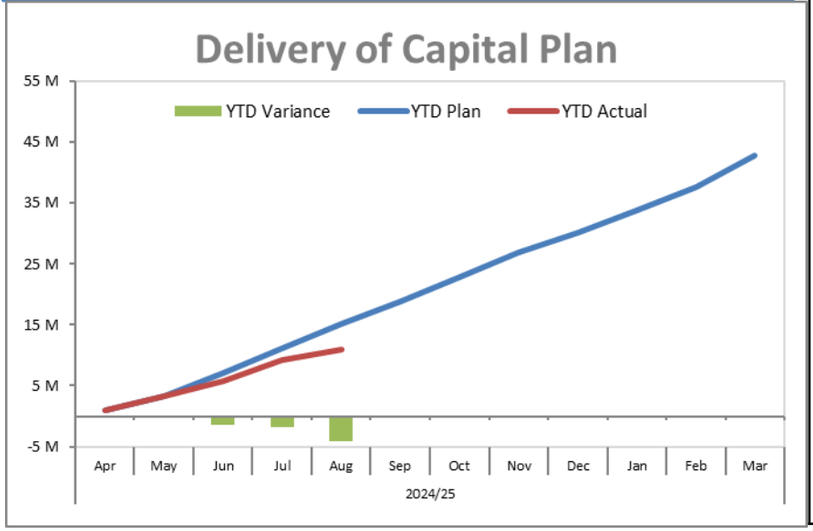
August 2024 – £31.0m



August 2024 - £7.1m



August 2024 – £10.9m



Analysis

Income & Expenditure

The Trust has reported a deficit of £11.2m at Month 5, which is £0.45m adverse to the planned £10.8m deficit. This adverse variance is due to the direct costs of industrial action, which NHSE has confirmed will be funded in Quarter 3. The reported in-month position for August is a deficit of £1.5m, although this is supported by the deployment of £1.5m of non-recurrent flexibilities, meaning the underlying in month position is a deficit of £2.7m. Minimal flexibilities remain for future months. The scale of the underlying run rate deficit suggests that the Trust will be unable to deliver its I&E plan for Quarters 3 and 4 without a material increase in delivery from the Closing the Gap programme in excess of the currently forecast level of efficiencies.

Cash

Year to date cash has reduced by £32.8m from the opening balance of £64.2m to £31.0m. This is primarily due to a net cash spend of £12.6m on the I&E and £20.6m capital.

Closing cash for 2024/25 is forecast at £11.5m assuming full delivery of the savings programme. Cash support could be required from February onwards if the saving programme isn't achieved as planned.

Capital

Year to date capital spend is £10.9m which is £4.2m lower than planned. The full year capital forecast is £43.3m which is £0.5m higher than planned due to an unplanned charitable donation. This includes £17.2m of PDC and TIF schemes and £0.5m unplanned expenditure related to donated funds.

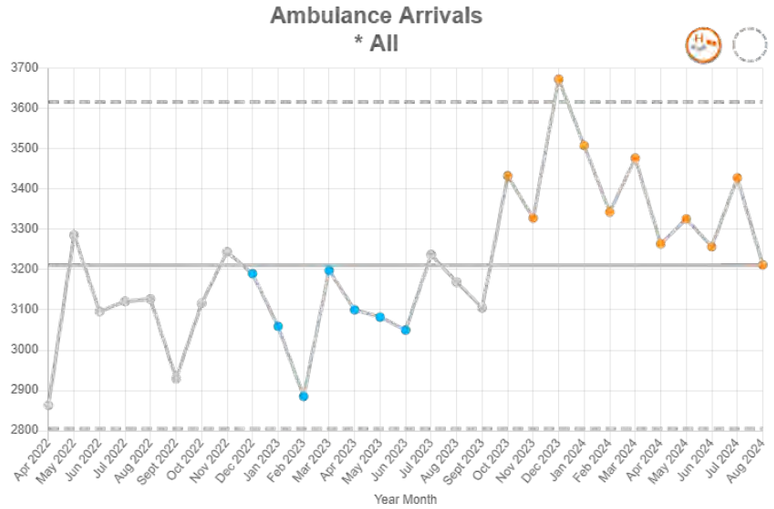
Closing the Gap

The Closing the Gap programme has delivered £7.0m of cost reductions against a target of £10.4m, resulting in a £3.4m shortfall. The risk adjusted year end forecast is delivery of £26.7m of savings against the £38.9m target leaving a shortfall of £12.2m. Focused work is ongoing to improve this forecast by converting the significant opportunities identified within each department into concrete plans for delivery.

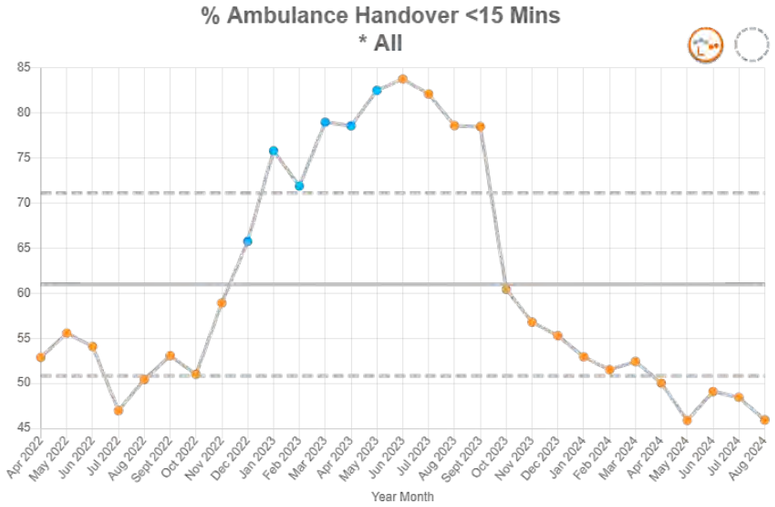
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

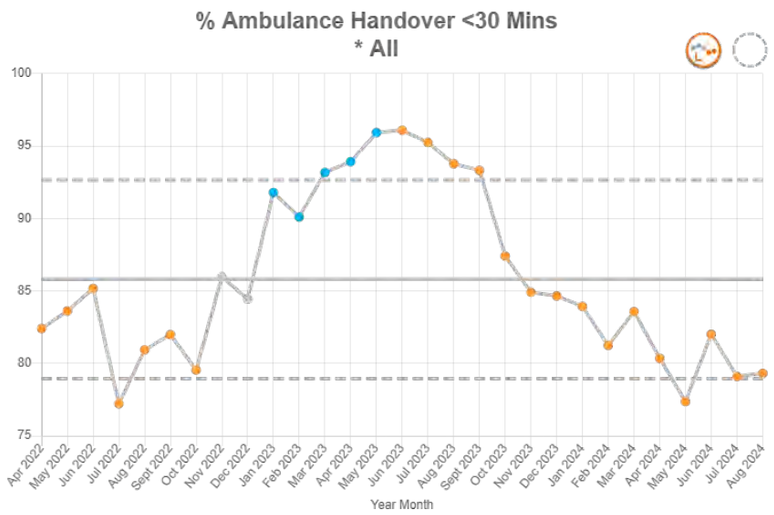
August 2024 – 3,212 ambulance arrivals
Special cause variation of a **concerning** nature



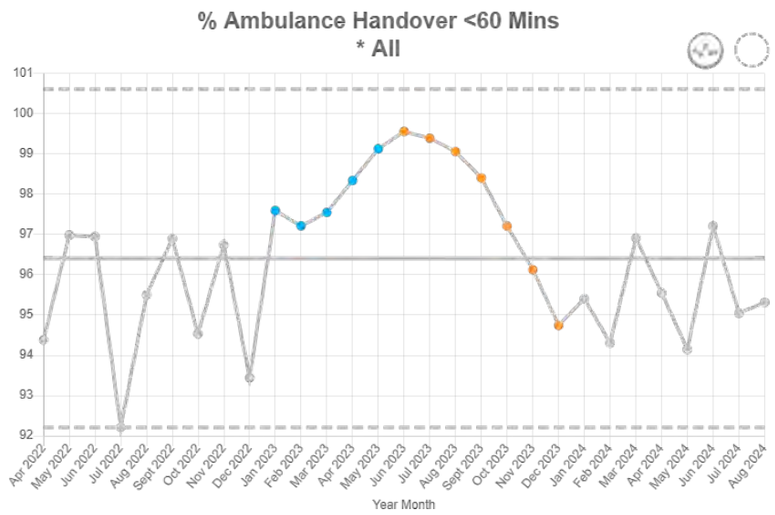
August 2024 – 45.9% ambulance arrivals
Special cause variation of a **concerning** nature



August 2024 –79.3% ambulance arrivals
Special cause variation of a **concerning** nature



August 2024 – 95.3 % ambulance arrivals
Common cause variation



Analysis

Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 45.94% in August compared to 48.44% in July. The average number of ambulances arriving daily has seen a slight reduction compared to recent months although the acuity of patients arriving by ambulance remains high.
Patient flow challenges remain due to high adult G&A bed occupancy and Amber Zone capacity which continue to impact ambulance handover times (22 minutes 18 seconds in August compared to 22 minutes 4 seconds in July).

Risks, Mitigations and Assurance

While using YAS AMDT for ambulance handovers streamlined data entry for paramedics, accuracy discrepancies persist. Validation has now been reinstated focussing on handover delays > 30 mins.
Collaborative work with YAS is ongoing. The ambulance handover process has been mapped with YAS, which identified issues, and assigned ownership for improvement. The new handover process (YAS & BTHFT approved) is now operational in ED.
A review is also underway to streamline ambulance self-handover processes at the front door/ reception to ease AAA congestion.
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.

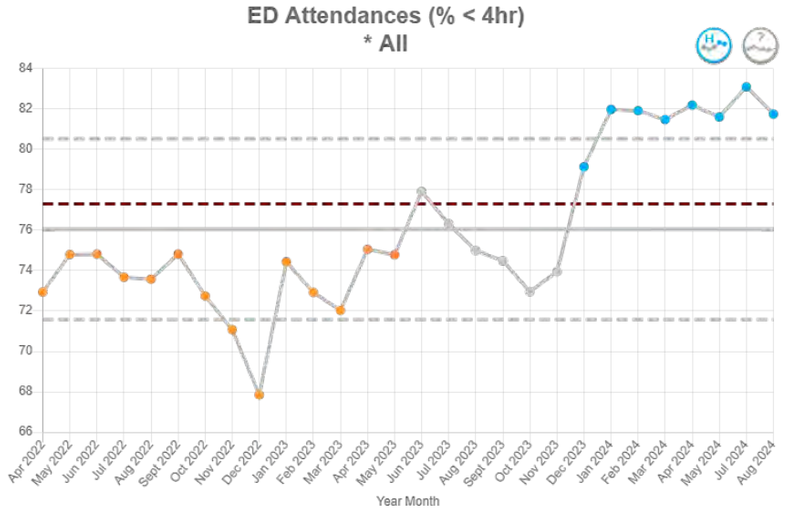
Benchmarking

Nationally mandated changes in clock reporting commenced in October 2023. This added 8-10 minutes to handover times and performance dropped accordingly but compared to peer we have sustained a better than average position.

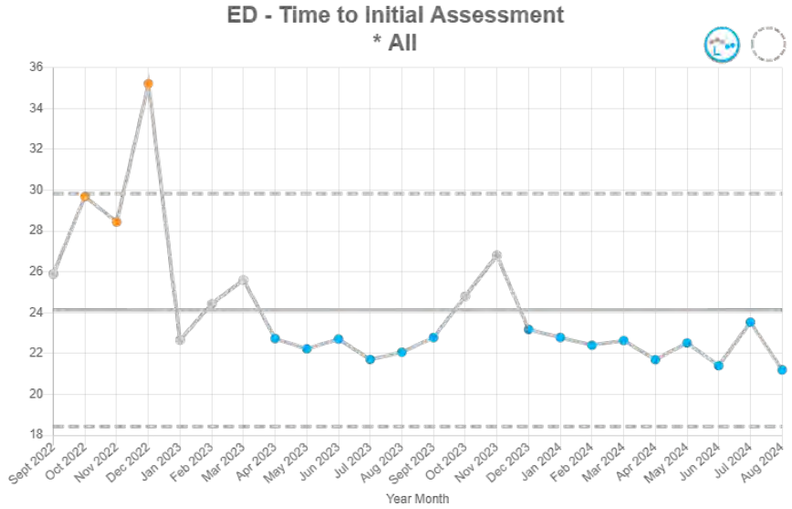
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

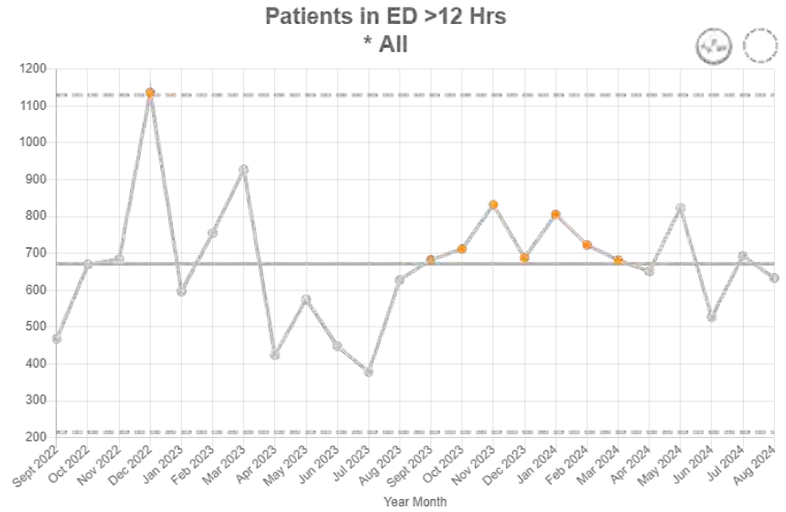
August 2024 – 81.7% - Year end target 77.3%
Special cause variation of an **improving** nature



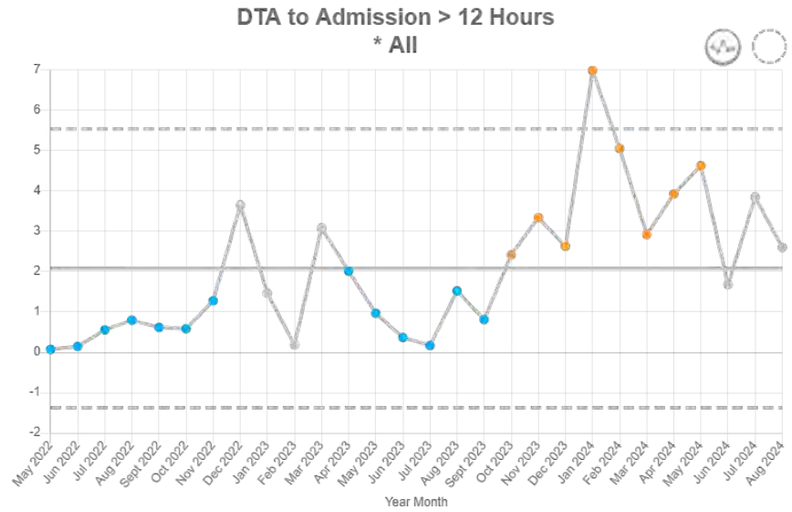
August 2024 – 21.2 minutes
Special cause variation of an **improving** nature



August 2024 –633 patients
Common cause variation



August 2024 – 2.6%
Common cause variation



Analysis

ECS performance for Type 1, 2 & 3 attendances was 84.34% for August 2024 and is currently forecast at 81.66% for September 2024. The position remains in the upper decile of Acute Trusts in England. Daily attendance has reduced in August with an average of 373 ED arrivals per day compared to 411 in July. Attendances are now comparable with August 2023 however high acuity attendances are up ~23% compared to the same period last year.

Risks, Mitigations and Assurance

Streaming to the AECU service continues to remain effective, positively impacting a range of UEC metrics. Length of stay metrics for both admitted and non-admitted patients remained broadly in line with July performance.
G&A adult bed occupancy reduced slightly to 88.72% in August compared to 89.28% in July although adult bed occupancy remained higher at 90.64% with high acuity patients and issues within the social care sector continuing to impact the timely discharge of patients.
The UTC 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 UTC.

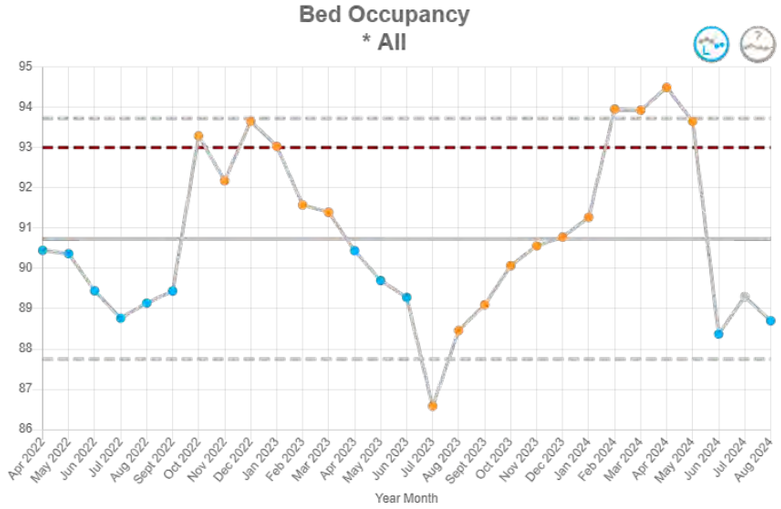
Benchmarking

Performance is above national, peer and WY averages. For ECS the Trust performs in the upper decile of Acute Trusts in England.

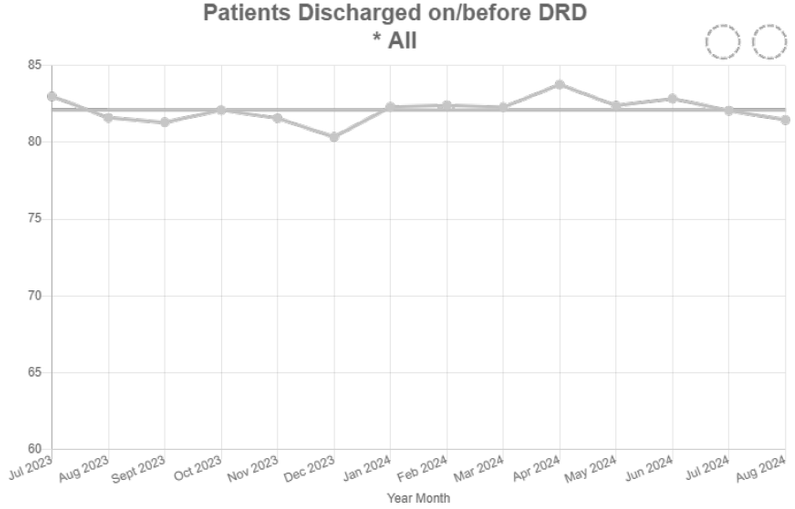
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

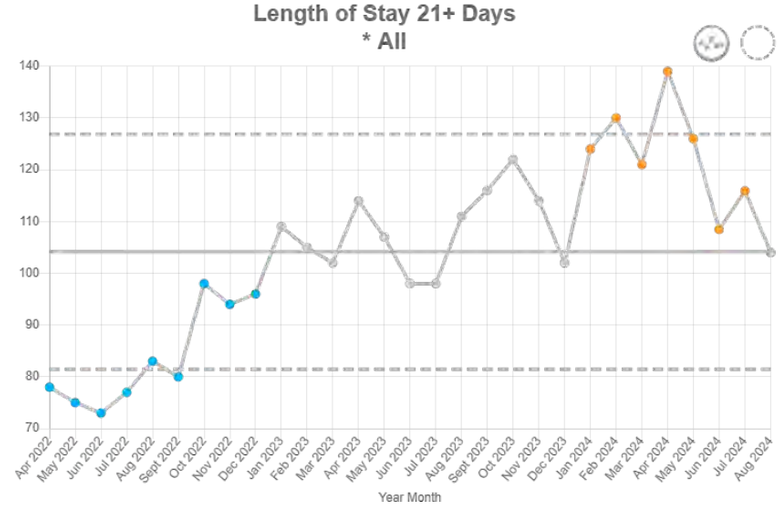
August 2024 –88.7% occupancy – Year end target 93%
Special cause variation of an **improving** nature



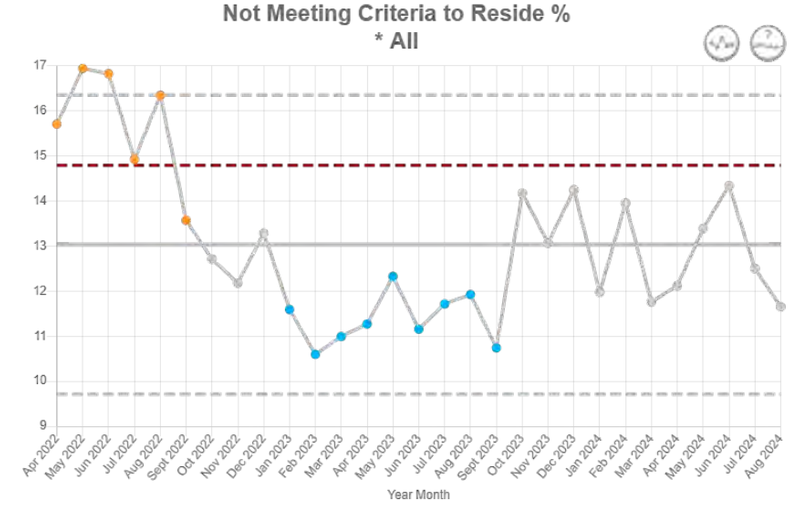
August 2024 – 81.4%
Common cause variation



August 2024 – 104 patients
Common cause variation



August 2024 –11.7 patients – Year end target 14.79%
Common cause variation



Analysis

The daily average number of patients with a length of stay (LOS) > 21 days reduced to 104 in August 2024 and is forecast to remain stable in September at 103. Since launching H-Fast in July the number of P1 discharges has increased from one to two patients per day. The program has now expanded to cover the entire Bradford Council district and is expected to increase incrementally over the next 5 weeks up to 6 discharges per day (30 per week) - to date 47 patients have been discharged via H-FAST.

Risks, Mitigations and Assurance

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.

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 pilot of a discharge coordinator position was introduced on Wards 28 and 29 in July to accelerate patient discharges. The presence of these coordinators has been well-received by ward staff and a review of the model will be completed in October to determine scalability across the trust.

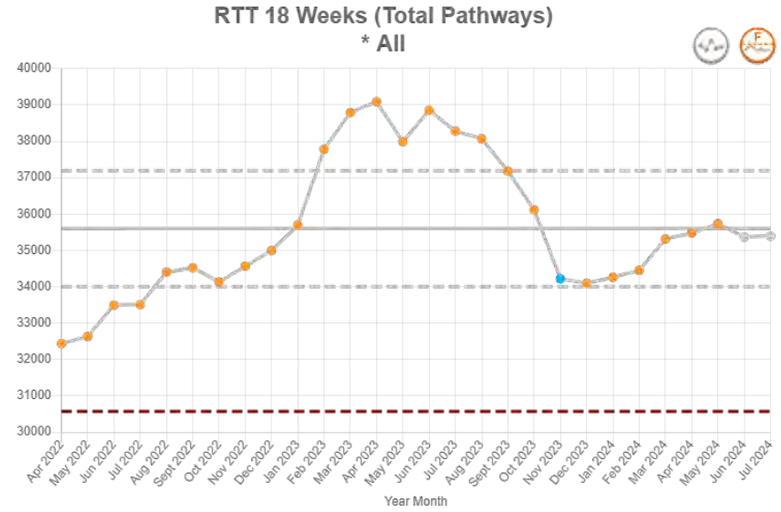
Benchmarking

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.

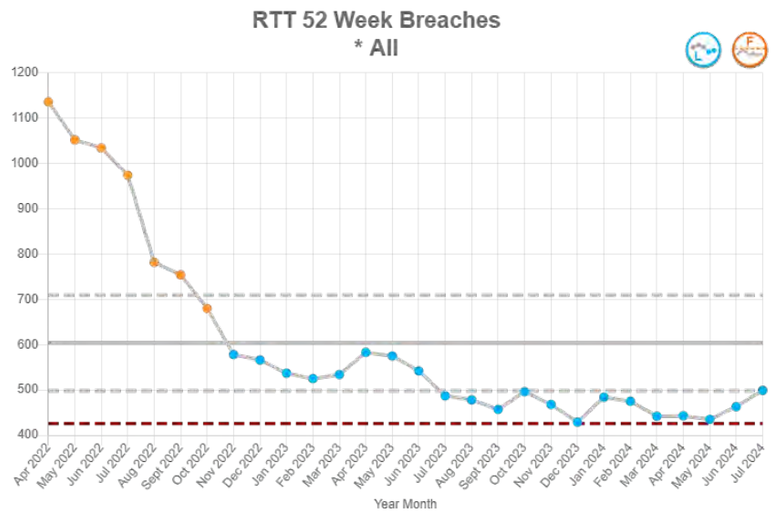
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

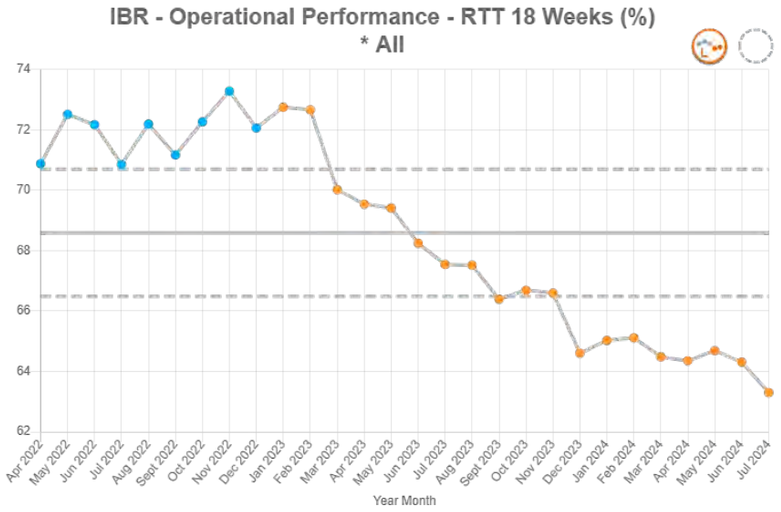
July 2024 – 35,398 pathways – Year end target 30,571
Common cause variation



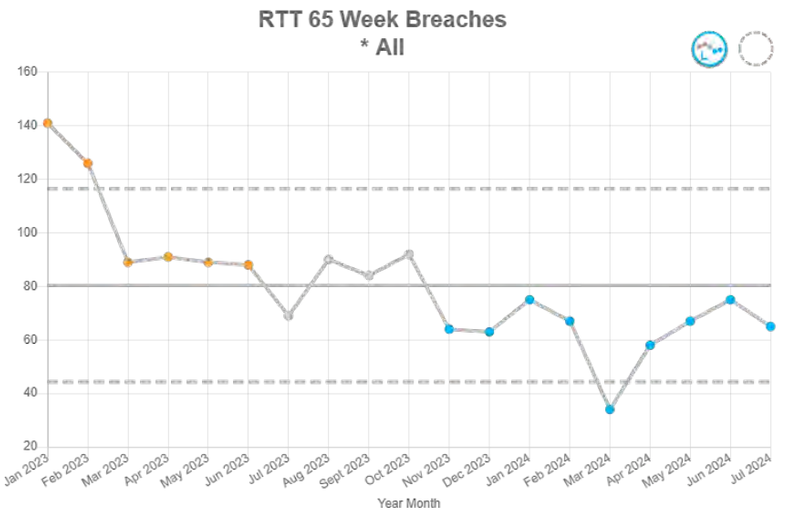
July 2024 – 499 pathways – Year end target 426
Special cause variation of an **improving** nature



July 2024 –63.3%
Special cause variation of a **concerning** nature



July 2024 –65 patients
Special cause variation of an **improving** nature



Analysis

Referral to Treatment (RTT) performance is projected to remain stable in August 2024 at 63.16%. 52-week performance has dropped behind plan. Whilst activity, particularly for admitted pathways remains below plan this trend will likely continue.
There was 1 patient reported over 78 weeks at the end of August 2024 with 4 patients projected to breach 78 weeks at the end of September 2024. 55 patients breached 65 weeks at the end of August 2024, predominantly in Trauma & Orthopaedics (T&O) who continue to review theatre capacity and allocations to support a reduction in long-waiters over the coming months as part of their recovery plan.

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 being targeted 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.

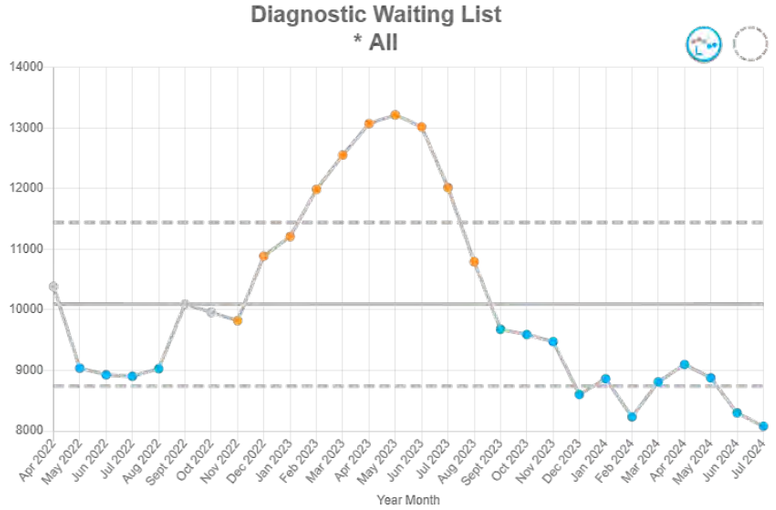
Benchmarking

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.

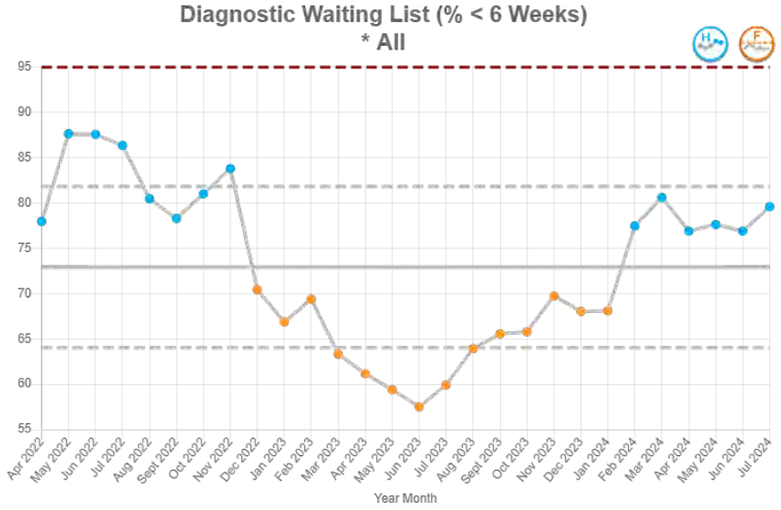
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

July 2024 – 8,080 pathways
Special cause variation of an **improving** nature



July 2024 – 79.6% <6 Wks – Year end target 95%
Common cause variation



Analysis

DM01 performance for July 2024 was 79.63% remaining behind target the expected improvement trajectory. The forecast performance for August is a further improvement led by recovery in Cardiology and NOUS.

Risks, Mitigations and Assurance

CDC capacity is now available for all modalities we had planned to include. Process and efficiency improvements are being explored to further capitalise on this resource.
MRI capacity has been challenged July due to equipment issues and staff sickness. Equipment failures at the CDC have also contribute to the impact on performance. There is a shortfall in staffing to support the ideal capacity model and further work is needed to maximise potential and realise improvements.
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.
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.

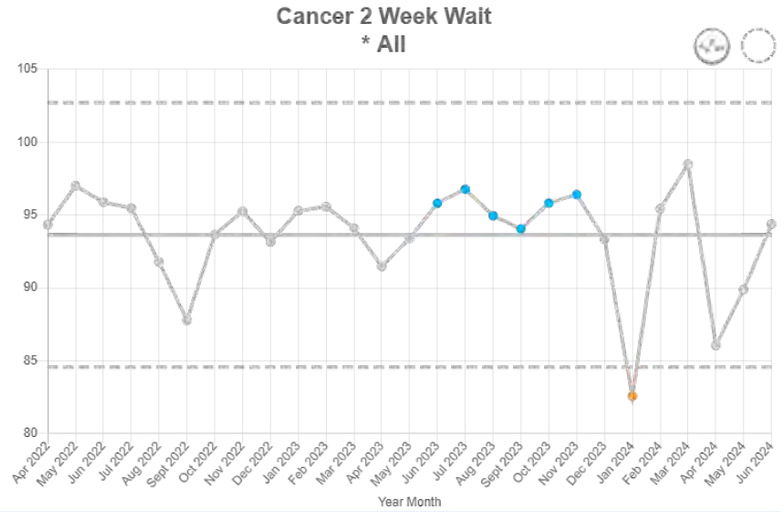
Benchmarking

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.

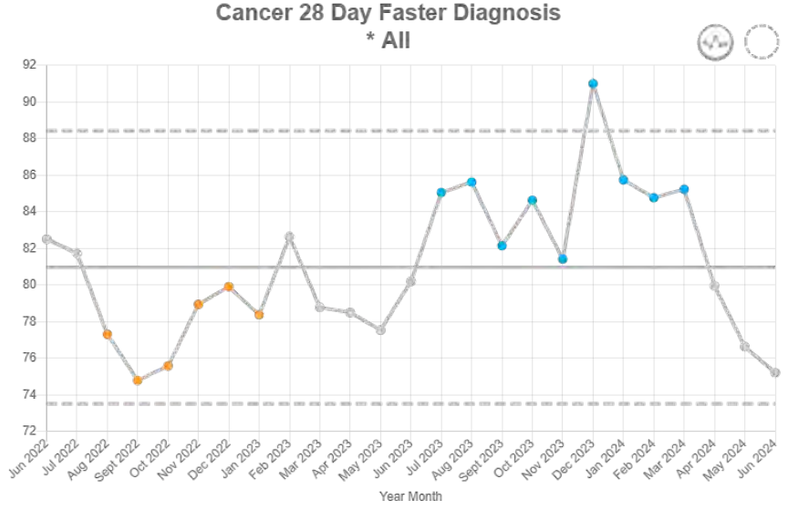
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

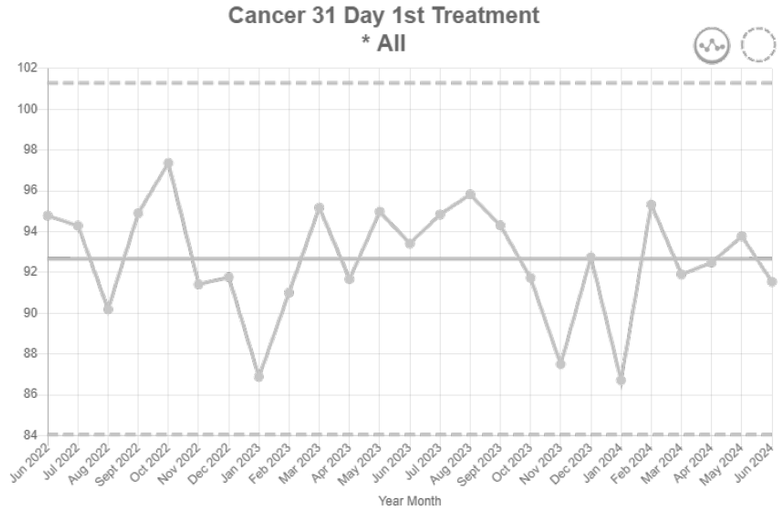
June 2024 – 94.4
Common cause variation



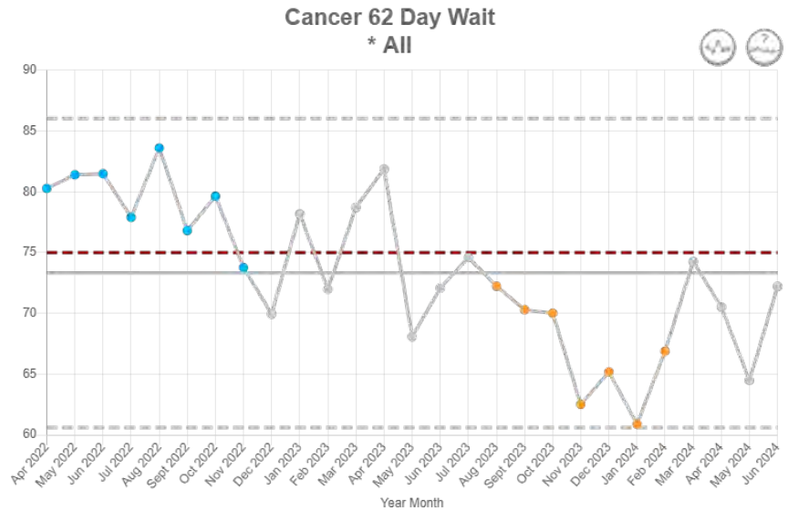
June 2024 – 75.2%
Common cause variation



June 2024 – 91.5%
Common cause variation



June 2024 – 72.2%
Common cause variation



Analysis

The 28-day faster diagnosis standard (FDS) performance improved to 79.45%. There has been significant focus on fast-track diagnostic turnaround times as part of the diagnostic improvement described in that section of this report.
Performance is forecast to dip and remain below the 70% target for the 62-day general treatment standard for July and August. Treatments remain low but there is no single cause for this with tumour groups experiencing increased complexity, reduced treatment capacity, diagnostic delays, and patient-initiated delays.

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 Skin Lesion Investigation Clinic (SLIC) pilot has successfully reduced Fast Track referrals for suspected Skin cancer into Dermatology during summer, this model is now being embedded in the referral pathway. Weekly One Stop Clinics for palpable neck lumps commenced 31st July 2024, which provide access to ENT, Consultant Radiologist & Ultrasound at the initial appointment. Referral forms have been revised to ensure correct patients are referred to this weekly clinic. 31-day general treatment is forecast to remain below target for July and August over the holiday period. Cancer treatment within theatre remains a priority and early identification of capacity issues is in place. Head & 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.

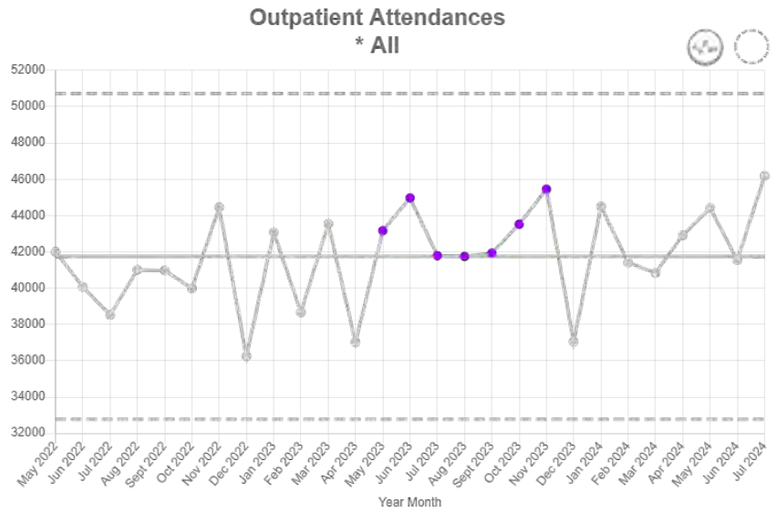
Benchmarking

The Trust has returned to the upper decile for 28-day FDS and is in line with national and peer average for 62-day general treatment.

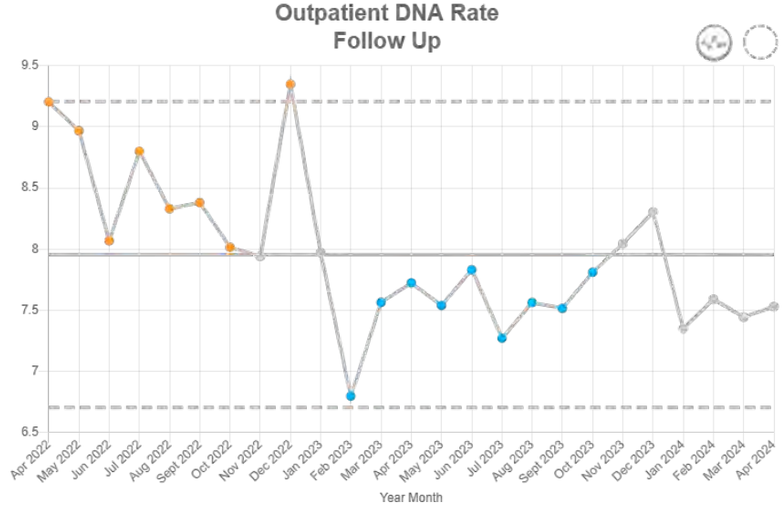
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

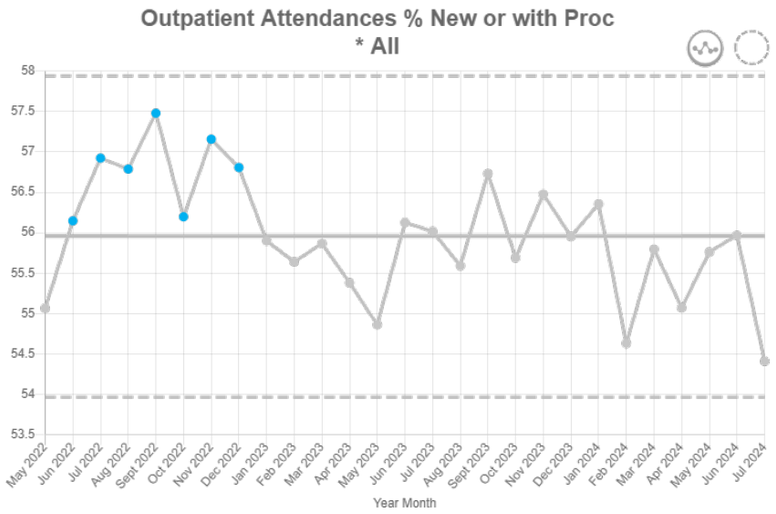
July 2024 – 46,178
Common cause variation



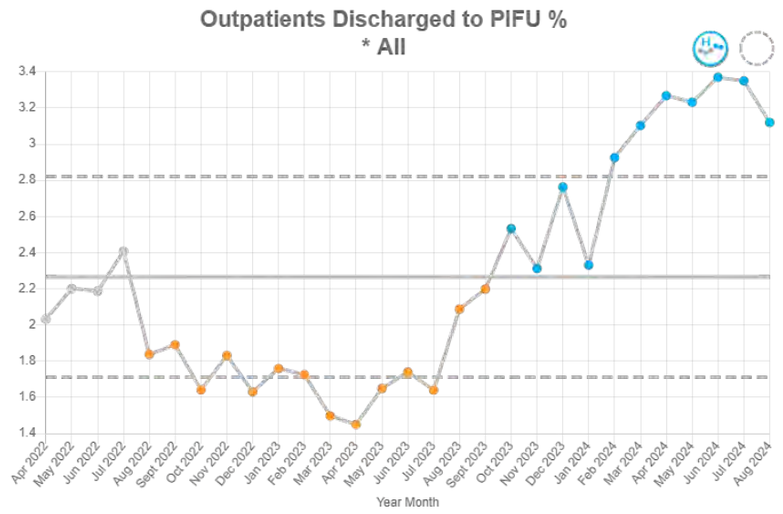
July 2024 – 7.5%
Common cause variation



July 2024 – 54.4%
Common cause variation



Augst 2024 – 3.12%
Special cause variation of an **improving** nature



Analysis

Outpatient activity delivered again slightly above plan in August 2024. Follow ups are not yet reducing but PIFU use remains at the improved levels. 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 this has been combined with existing improvement plans. One focus is optimising outpatient pathways to improve earlier interventions and decision making to reduce follow up appointments. Several examples of good practice have been identified and a place based workstream established.
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.
DNA prevention is also being revisited with a combination of telephone and automated telephone options tested.

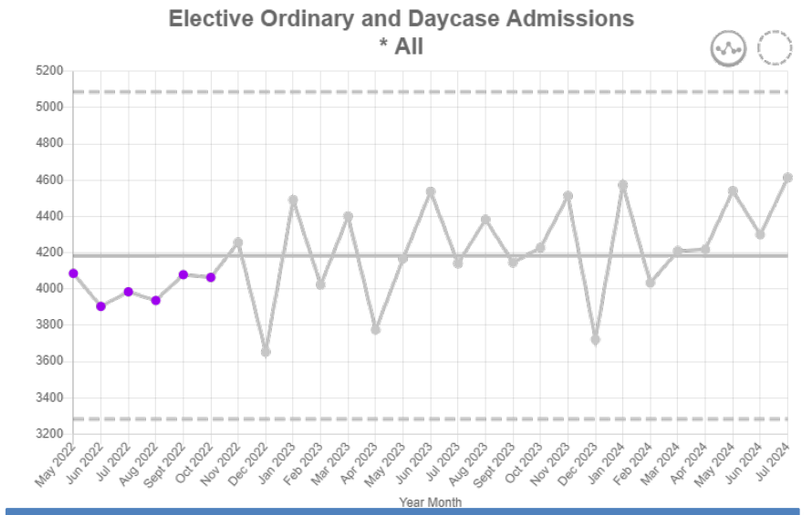
Benchmarking

Outpatient recovery and plans compared favourably to neighbouring Trusts.

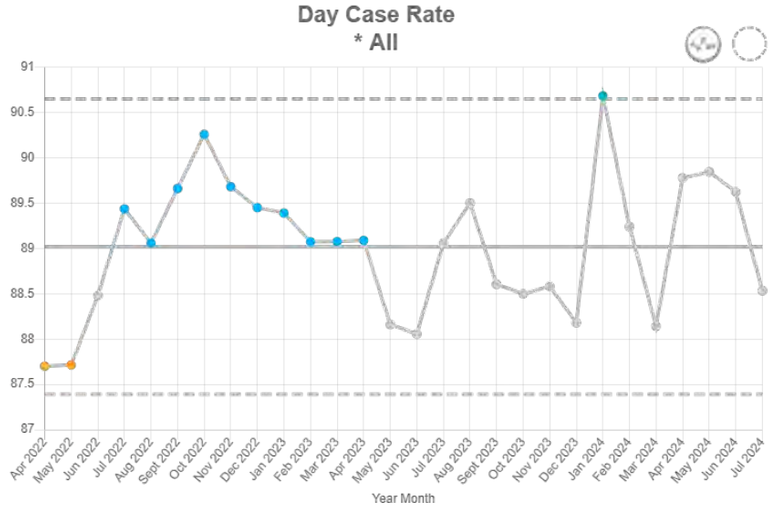
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

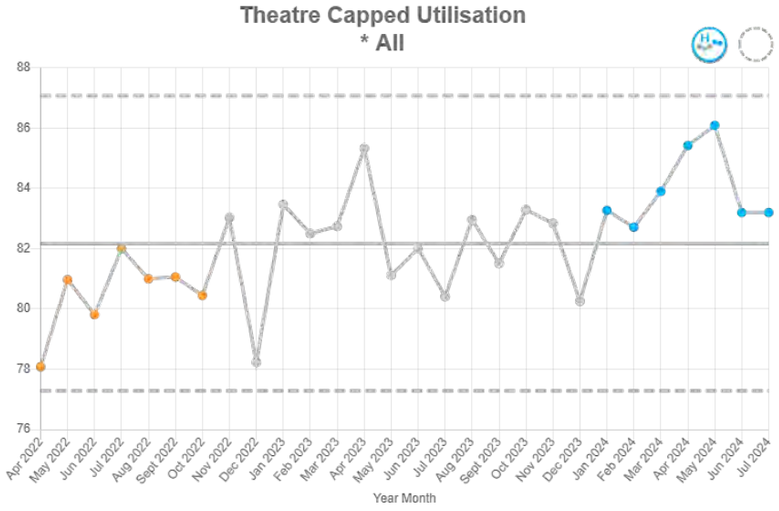
July 2024 – 4,614
Common cause variation



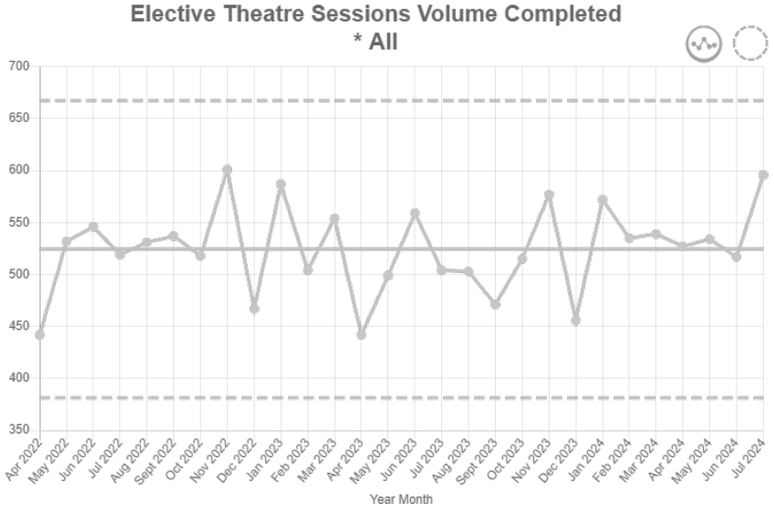
July 2024 –88.5%
Common cause variation



July 2024 – 83.2%
Special cause variation of an **improving** nature



July 2024 – 596
Common cause variation



Analysis

Inpatient activity delivered below plan in August 2024 and is projected to remain in line with plan in September 2024. Lists are running at expected levels whilst patients per list and capped utilisation remain relatively stable, although improvement in both is needed to support ERF targets.

Risks, Mitigations and Assurance

Theatre efficiencies aiming to increase the number of lists run and the number of patients per list are being explored as part of the Closing the Gap project. This includes an analysis of job plans to identify discrepancies with the current theatre session plan.
A demand & capacity exercise for Anaesthetics will also identify if anaesthetist gaps are a limiting factor in the number of theatre list delivered and any opportunity for improvement.
Observations in theatre, ward and admission areas have been undertaken and CSU teams are now being supported to implement changes to reduce time lost. As the programme progresses it is hoped services will have the confidence to increase patients booked per theatre session.
Day cases will also increase when the SLH unit opens and through targeted efficiency work within Endoscopy and the Cath-Lab.

Benchmarking

The Trust is above the national average for day case rates, and capped utilisation. Elective activity compares below other Trusts in our region as a percentage of 2019/20 baselines.

People – Renee Bullock

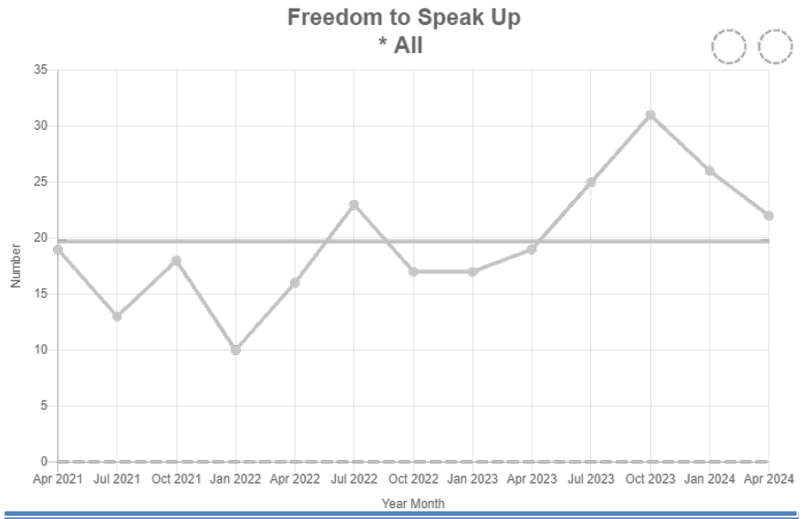
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	Jul-24	0.89%				2.33%
Appraisal Rate - Non-Medical	Jul-24	75.33				75.30%
BAME Split - Band 8+	Oct 23 - Mar 24	18.7%				17.45
BAME Split - Bands 1-5	Oct 23 - Mar 24	48.2%				43.91
BAME Split - Bands 6-7	Oct 23 - Mar 24	27.6%				25.57
BME - * All	Oct 23 - Mar 24	41%				38.47
BME - Senior Leader	Oct 23 - Mar 24	19%				17.45
Core Manadatory Training - * All	Aug-24	93.8%				90.20%
Disability Declaration - * All	Oct 23 - Mar 24	4.9%				3.9%
Freedom to Speak Up - * All	Jan 24 - Mar 24	26.00				13.81%
Harrassment and Bullying - Disciplinary Action	Oct 23 - Mar 24	3				0.67
Harrassment and Bullying - Informal Action	Oct 23 - Mar 24	1				3.00
Harrassment and Bullying - In-progress	Oct 23 - Mar 24	3				7.00
Harrassment and Bullying - No Case To Answer	Oct 23 - Mar 24	3				3.00
Harrassment and Bullying - Resigned	Oct 23 - Mar 24	1				0.67
Harrassment and Bullying - Total Investigations	Oct 23 - Mar 24	11				14.33
Job Planning - Allied Health Professionals	Jul-24	4%				49%
Job Planning - Medics	Jul-24	34%				25%
Job Planning - Nurses	Jul-24	0%				60%
Nursing Agency Fill Rate - %	Aug-24	7.4%				12.9%
Nursing Bank Fill Rate - %	Aug-24	71.0%				46.3%
Staff Advocacy - Contacts	Oct 23 - Mar 24	10				14.00
Staff Advocacy - Contacts Not Resolved	Oct 23 - Mar 24	1				0.00
Staff Advocacy - Formal Complaints/Investigations	Oct 23 - Mar 24	0				0.67
Staff Advocacy - In-progress	Oct 23 - Mar 24	3				0.67
Staff Advocacy - Outcome Unknown	Oct 23 - Mar 24	3				0.33
Staff Advocacy - Resolved Informally	Oct 23 - Mar 24	3				9.00
Staff Sickness - * All	Jul-24	5.73%				6.5%
Staff Stability - * All	Jul-24	99.2%				98.8%
Staff Turnover - * All	Jul-24	8.97%				11.4%

People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

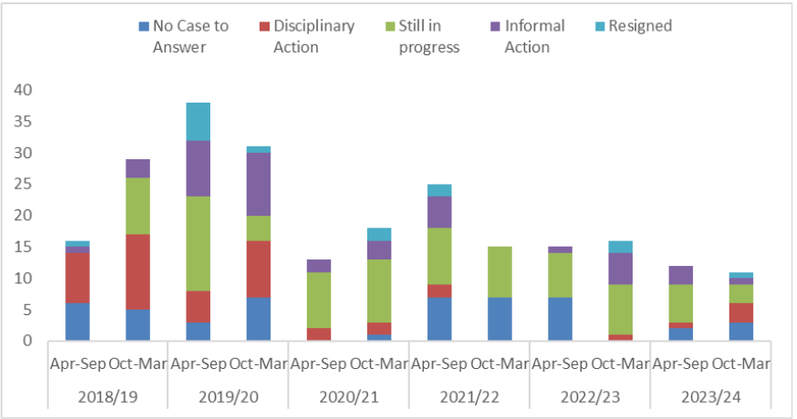
2023/24 Quarter 4 – 26



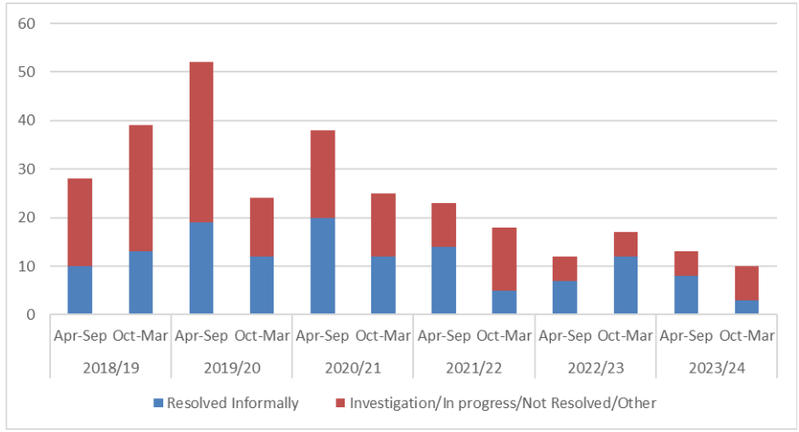
2023/24 October to March– Staff Advocacy

Month	Contacts	Formal complaint/ investigation	Resolved Informally	In Progress	Contacts not resolved	Outcome unknown
Apr 18 - Sep 18	28	5	10	6	3	4
Oct 18 - Mar 19	39	18	13	5	3	6
Apr 19 - Sep 19	52	11	19	6	4	12
Oct 19 - Mar 20	24	3	12	2	1	8
Apr 20 - Sep 20	38	4	20	5	1	8
Oct 20 - Mar 21	25	1	12	2	1	9
Apr 21 - Sep 21	23		14			
Oct 21 - Mar 22	18	5	5	4	0	4
Apr 22 - Sep 22	12		7			
Oct 22 - Mar 23	17		12			
Apr 23 - Sep 23	13	2	8	2		1
Oct 23 - Mar 24	10	0	3	3	1	3

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 22 concerns raised to the FTSU team in Q1. The highest number of concerns (7) had an element of inappropriate attitudes and behaviours and the highest groups of staff raising concerns were nurses and midwives and Administration and clerical staff. 6 concerns were reported anonymously via the App.

Risks, Mitigations and Assurance

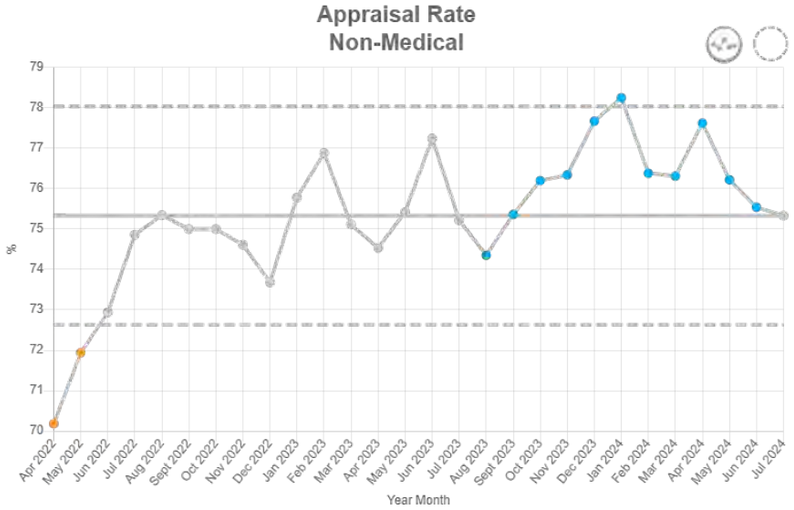
Harassment & Bullying Outcomes: Our Trust wide civility in the workplace campaign is making excellent progress. The Introduction of a new people charter, workplace mediation service, refresh of the staff advocacy service, EDI training for line managers, poster campaign, refresh of the harassment & bullying 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.

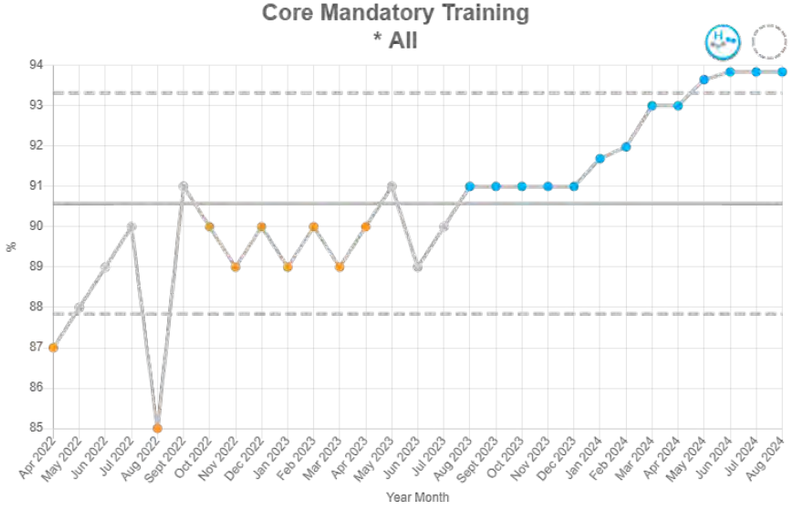
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

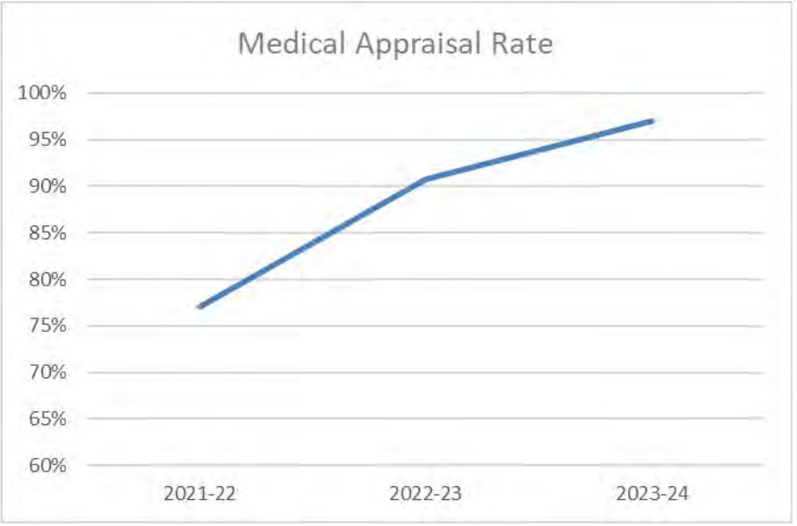
July 2024 -75.3%
Common cause variation



August 2024 -93.8%
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, but compliance continues to improve month on month.
- 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 83%, a 1% increase from last month. The education team are actively targeting staff to complete to improve compliance.
- Safeguarding Adults compliance is 77%, 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**

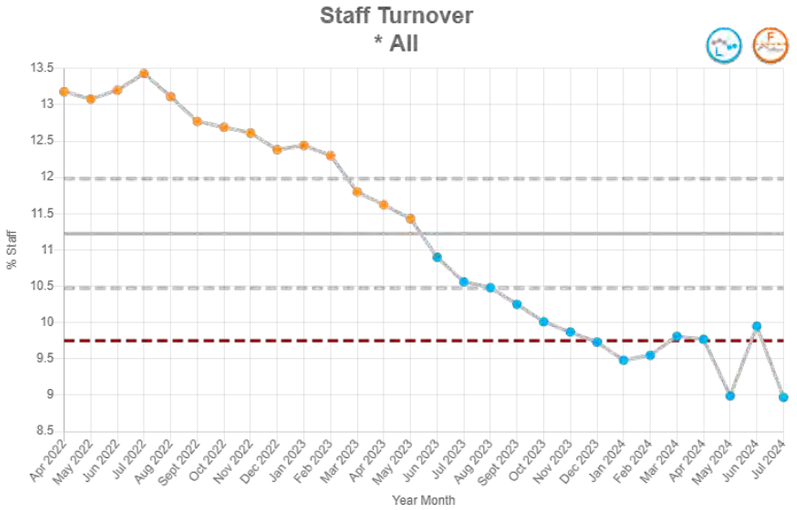
Appraisal

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.

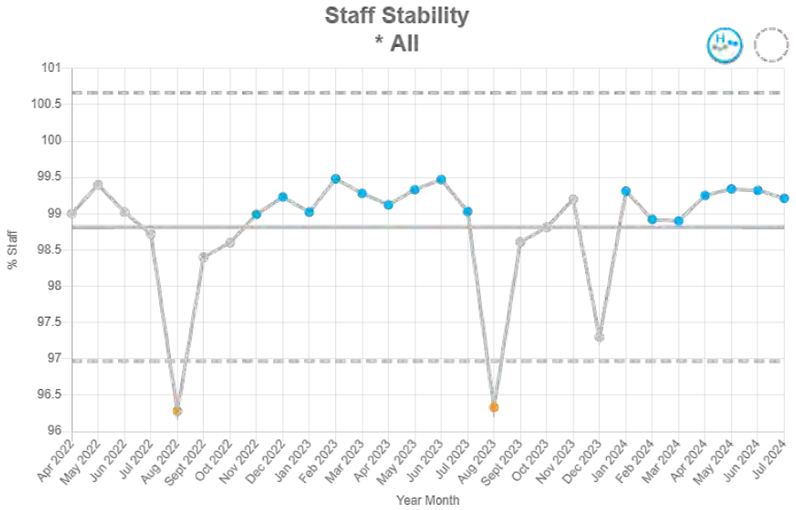
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

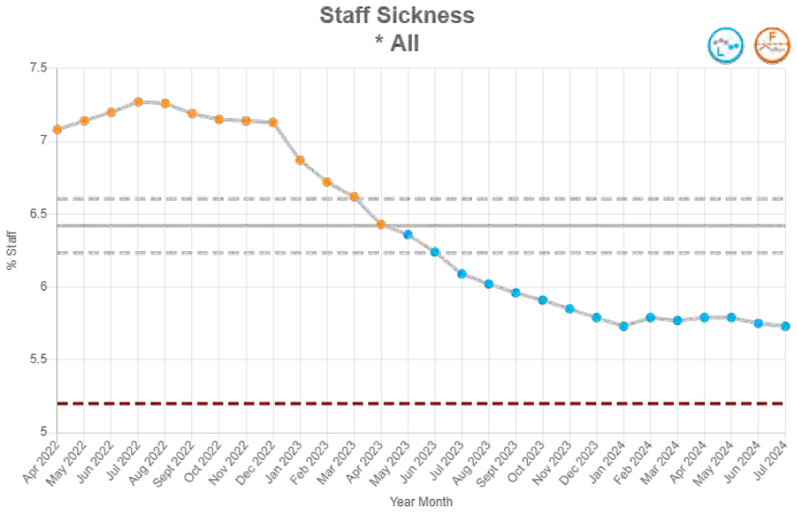
July 2024 - 8.97%
Special cause variation of an **improving** nature



July 2024 – 99.2%
Special cause variation of an **improving** nature



July 2024 (rolling 12 months) -5.73%
Special cause variation of an **improving** nature



Analysis

Sickness for the month of July is 5.69% and the YTD is 5.73%, in comparison with June where the monthly sickness rate was 5.26% and YTD 5.75%.
The staff groups with the highest sickness rates are Additional Clinical Services at 8.20%, Estates and Ancillary staff at 8.07%, Admin & Clerical at 5.58% and nursing & midwifery at 5.54%. The remaining staff groups remain under 5.5%.
The overall sickness % has been under 6.5% for the past 12 months. From October 2023 sickness has remained steady above 5.5% but below 6%.
The monthly **turnover** rate in June is 9.95%, an increase on the May rate of 8.99%. This is the first increase in the rate since March 2024.
The **stability** 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 stability rate in July 2024 remains unchanged for the last 3 months at 99%. The rate over the last 12 months has been consistently around 98% to 99% . We anticipate a dip in August 2024 due to the rotations for junior doctors. There was a slight increase in leavers in June to 10% but this has fallen again to 9%. Our target is 9.75% .

Risks, Mitigations and Assurance

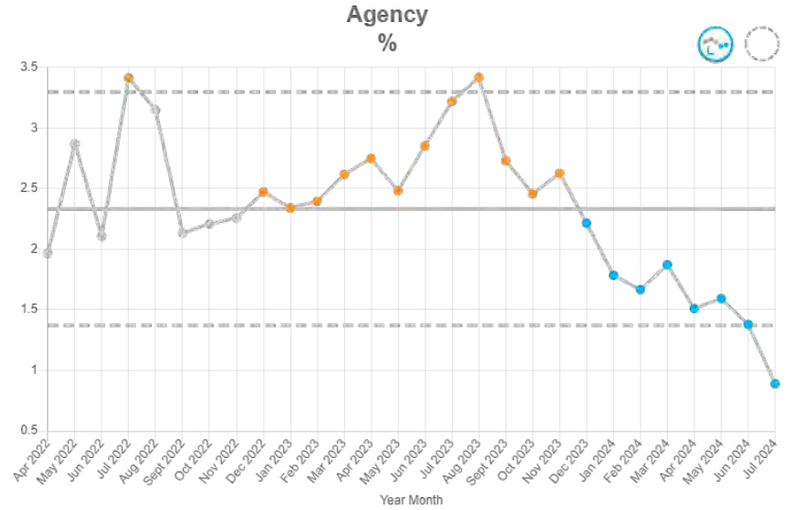
Since July 2022 sickness rates have been on a downward trajectory towards the Trust target of 5.5%. Although, over the last 6 months rates have levelled off remaining between 5.5% and 6% each month.
The following supportive measures have been put in place to improve rates;

- Briefing sessions have been undertaken to ensure managers are aware of their roles and responsibilities in relation to the Health, Wellbeing and Management of Attendance Policy.
- Bi-monthly training is offered over the year for training on the Health, Wellbeing and Attendance Policy and also bespoke training is undertaken, if required, for all departments within the Trust.
- Regular monthly meetings established between management and members of the HRBP team to go through sickness cases and obtain assurance that policy is being followed and cases progressed in a timely manner.
- Further work being undertaken to try and ensure a more focussed approach to sickness management across nursing and midwifery areas.
- The HRBPs continue to attend monthly CSU Triumvirate and Performance meetings where sickness rates are discussed alongside ward/department turnover rates .
- Continued work to improve the people experience at the recruitment and onboarding stages.
- The team is also 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.

Turnover has been on a downward trajectory over the last 2 years, reducing month on month and is currently below the target of 9.75%. Often, the turnover rate may reduce due to an increase number of colleagues in post rather than staff leaving. As we progress with growth and CtG we anticipate the turnover rate to begin to plateau.

People – Engagement – To be in the top 20% Employers

July 2023 – 0.89%
Special cause variation of an **improving** nature



Bradford Teaching Hospitals
NHS Foundation Trust

Analysis

There has been an overall decrease in agency use in July, this has been in the following staff groups AHP's, Medical and Dental, Nursing and Midwifery & Estates and Facilities.

Admin and Clerical remain the same for July.

There has been a further increase in agency use during July for the following staff group Professional Scientific & Technical.

Healthcare scientists and Additional clinical services have used no agency.

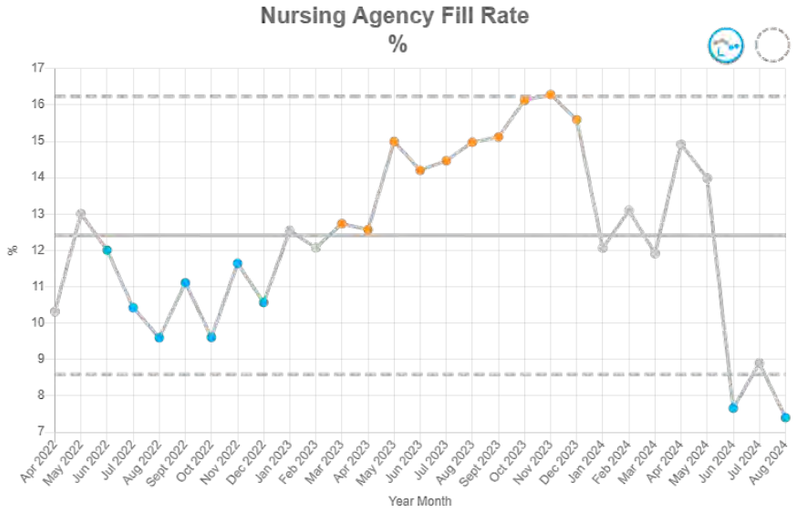
Risks, Mitigations and Assurance

The Trustwide bank is working across the Trust to reduce the reliance on agency. CSU's are working to remove agency where it is safe to do so. No risks have been identified by the removal of agency.

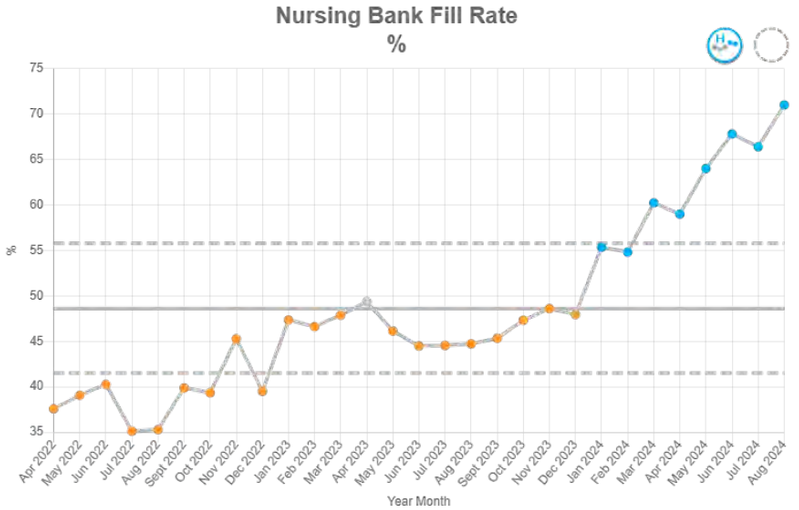
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

August 2024 -7.4%
Special cause variation of an **improving** nature



August 2024 – 71.0%
Special cause variation of an **improving** nature



Analysis

Nursing Agency use
Agency staff filled 284 shifts in the month of August. This is split 284 registered and 0 unregistered staff. Out of the 284 filled registered shifts, 249 were filled with registered theatre staff.

Nursing Bank use
In August the total number of requests sent to bank was 9282 compared with July's requests 9189 an increase of 93 requests. The split for August is 3860 requests for registered staff and 5422 requests for unregistered staff. Of those 9282 requests a total of 7226 were filled by bank staff. 2740 are filled by registered and 4486 filled by unregistered staff. Out of the 2740 filled registered shifts, 627 were filled by registered Theatre staff.

Risks, Mitigations and Assurance

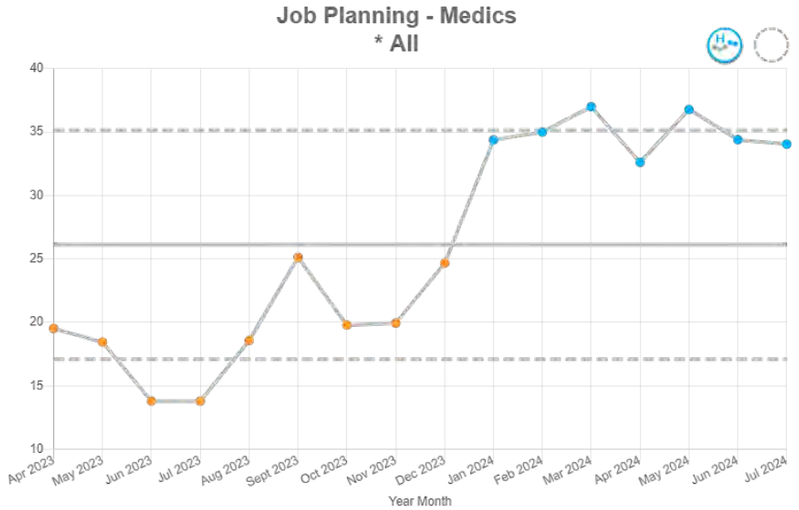
From the 20th November 2023 a new nursing agency approval process was put in place to give assurance around agency use for nursing. Confirm and challenge meeting were added from January 2024 for all areas with an overspend. Reports are being shared on a monthly basis with Nursing workforce lead.

People – Engagement – To be in the top 20% Employers

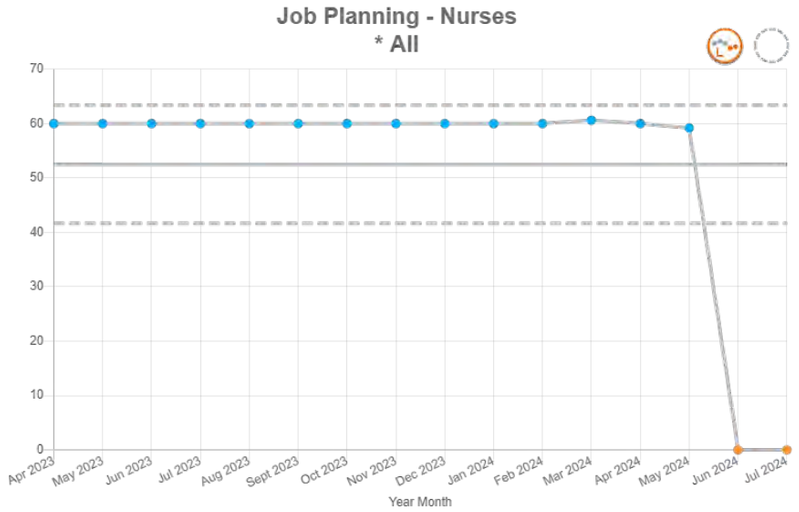
Bradford Teaching Hospitals NHS Foundation Trust

July 2024 – 4.0%
Special cause variation of a **deteriorating** nature

July 2024 – 34.1%
Special cause variation of an **improving** nature



July 2024 – 0.0%
Special cause variation of a **deteriorating** nature



Analysis

There are currently 957 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 416 Medics, 345 AHPs and 196 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. Currently there are 172 Job plans signed off for Medics with 11 awaiting 1st Sign off, 31 awaiting the 2nd sign off and 143 in review.

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.

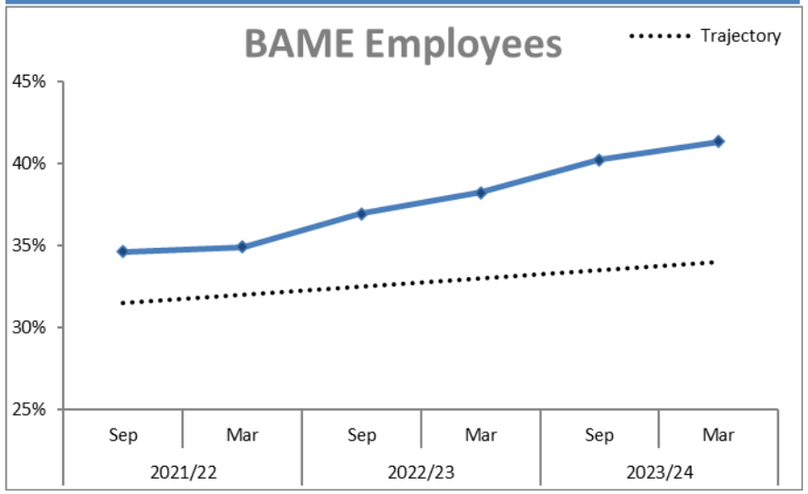
The Trust recently had an audit on job planning. All the recommendation from this audit have either been completed or are in the process of being completed.

The Trust is moving to a new software system for job planning which is a better experience for end users and will provide the Trust with better data to understand capacity.

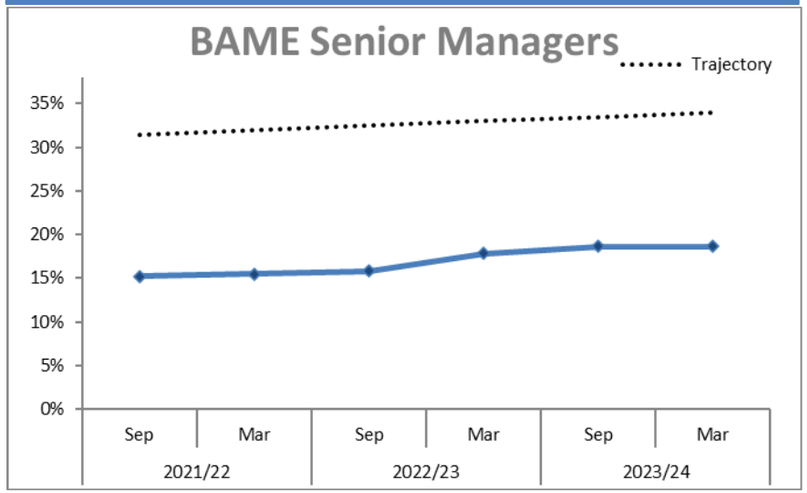
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

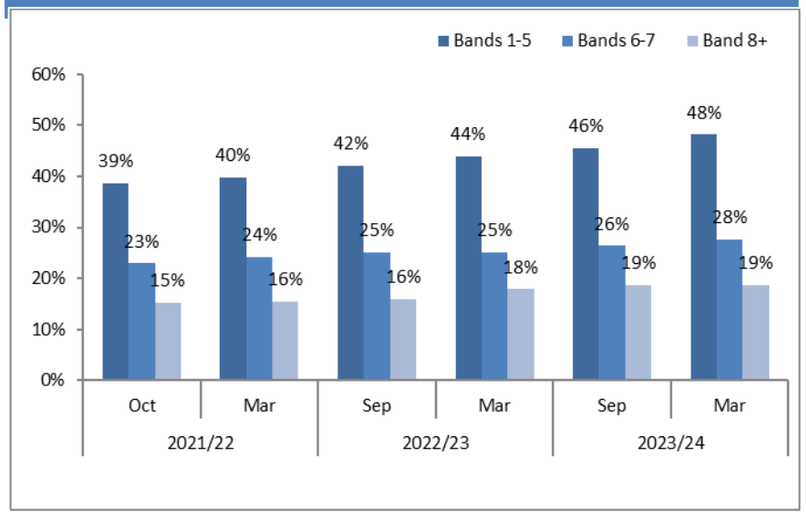
2023/24 Quarter 4 - 41.34%



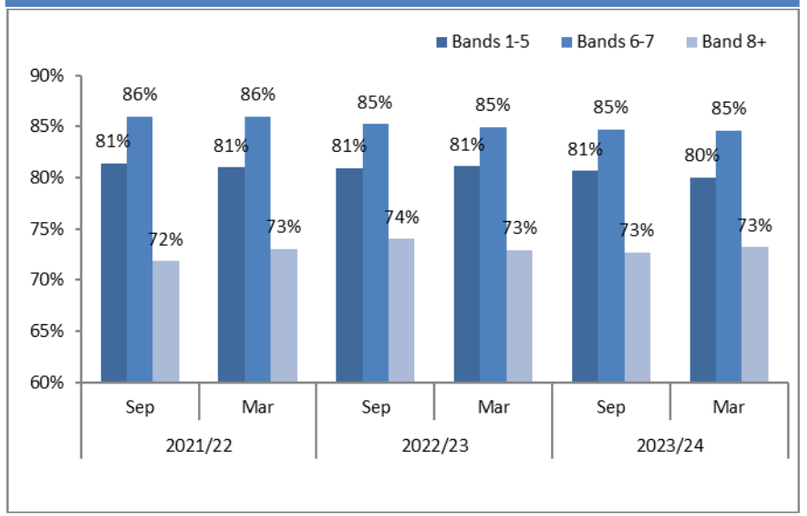
2023/24 Quarter 4 – 18.65%



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.

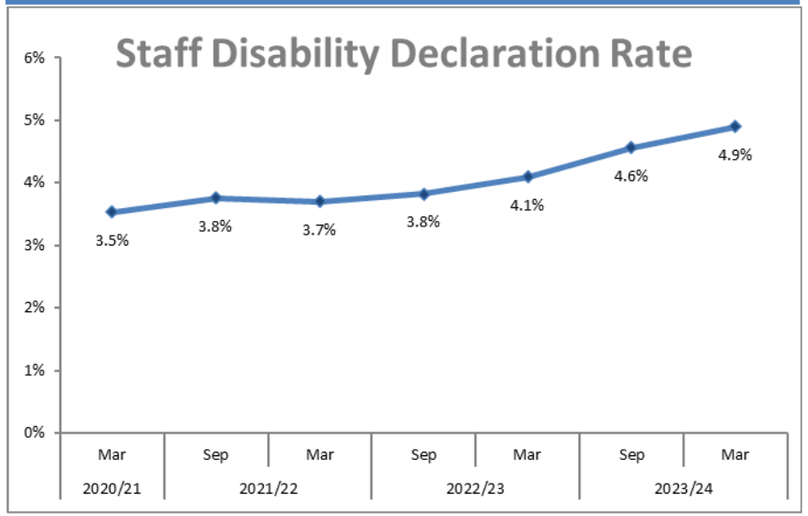
Our gender pay gap and next steps for gender equality were taken to People Academy in March. We will be working collaboratively with our gender equality reference group and the wider ICS over the next few months to address gender inequalities in the workplace, with focus on women in leadership and addressing 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.

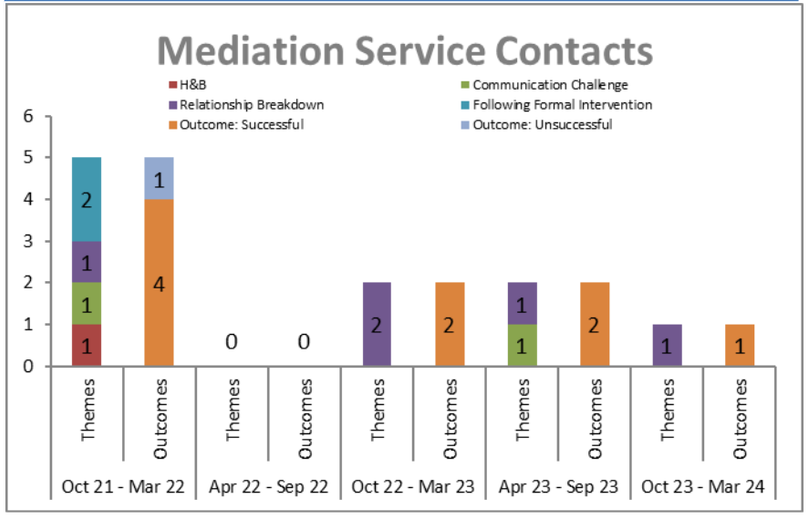
People – Engagement – To be in the top 20% Employers

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.

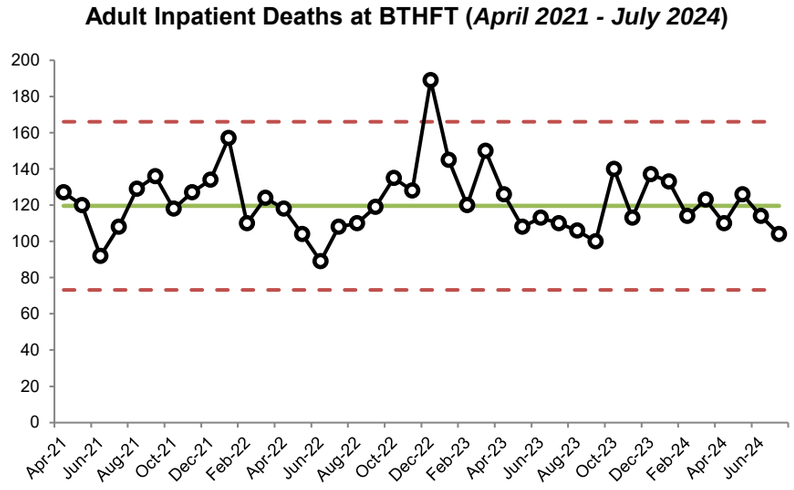
Mediation provides a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud'. The mediation service will become a key component of the newly developed Respect, Civility and Resolution policy and process when it is finalised 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.

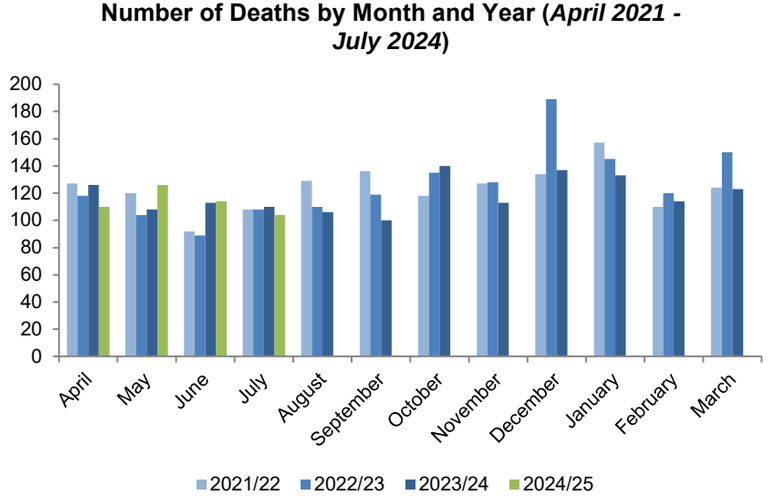
Quality – Executive Director: Dr Ray Smith and Karen Dawber

Clinical Effectiveness - To provide outstanding care for patients

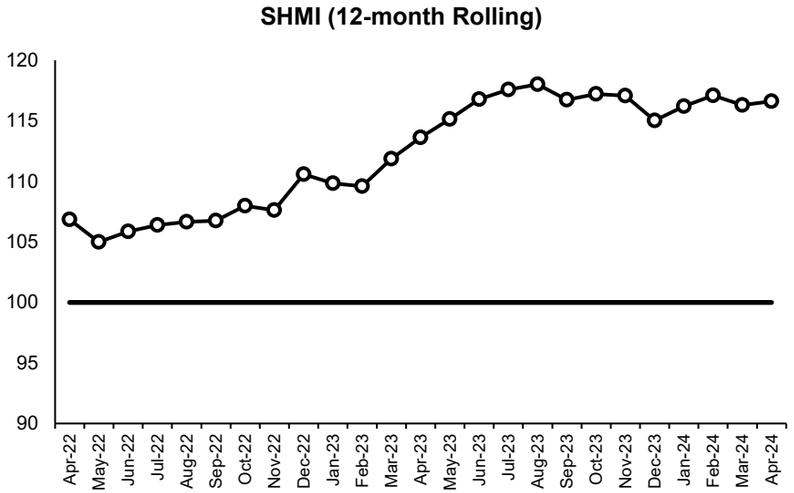
Bradford Teaching Hospitals NHS Foundation Trust

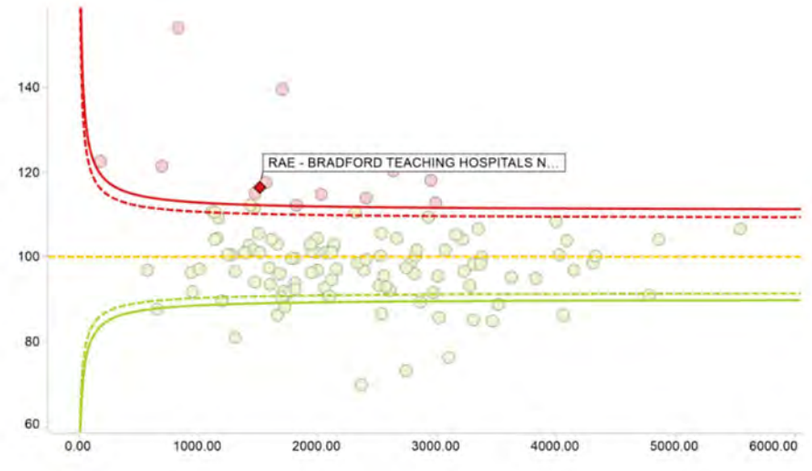
July 2024 – 114 Adult Inpatient Deaths





SHMI 12-month Rolling – 116.61 (*figure covering May 2023 – Apr 2024: Reported July 2024*)





Analysis

In July 2024 the Trust saw 114 adult inpatient deaths which is lower than figures seen in the past three July months. The Learning from Deaths Team will continue to monitor monthly mortality numbers and act if significant increases are observed.

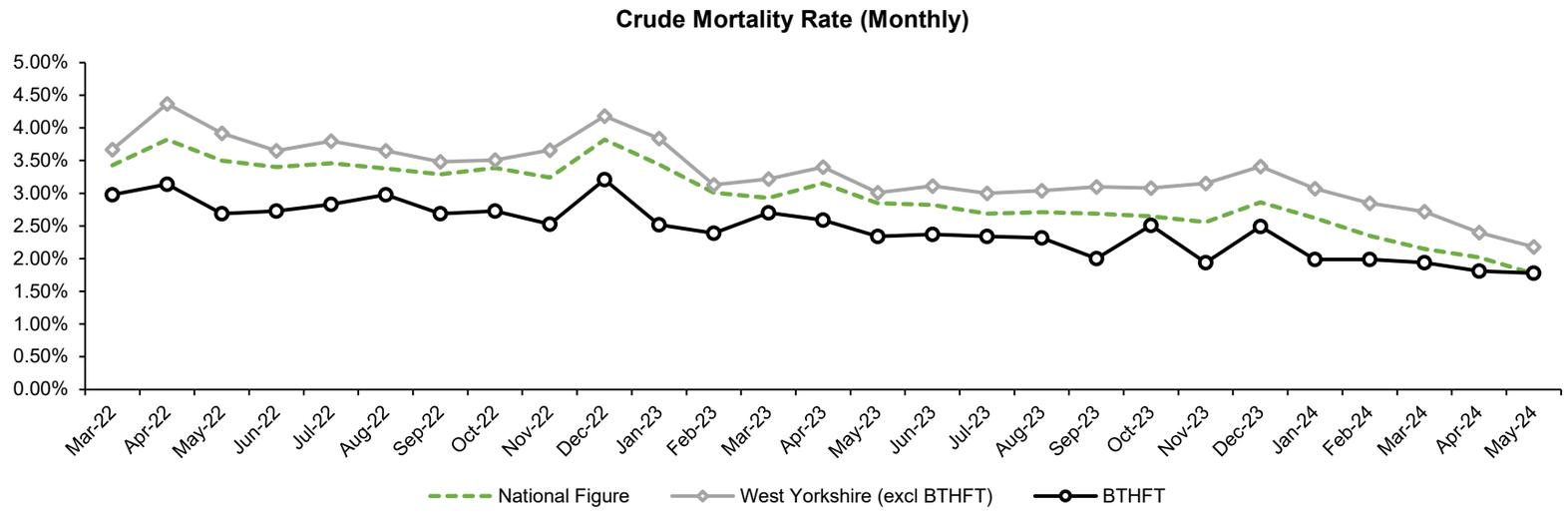
Whilst SHMI is still high at 116.61, the collaborative work between the Learning from Deaths Team and Business Intelligence on coding issues continues, which will help to reduce our SHMI moving forward.

Learning, Improvement, Assurance

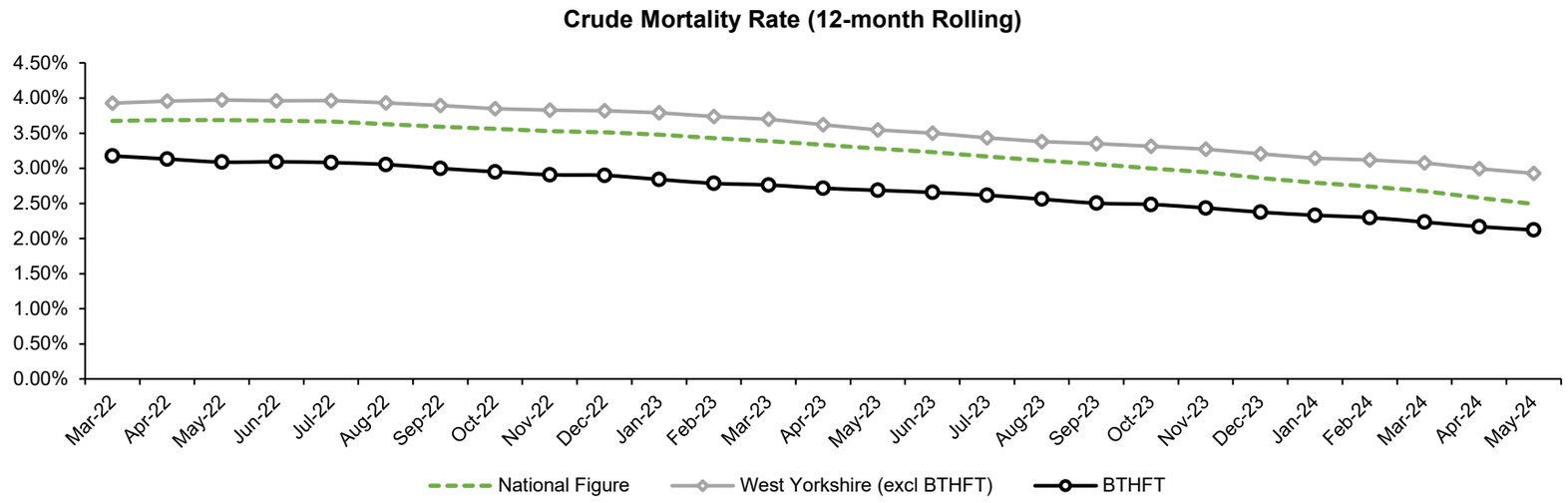
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

Crude Mortality Rate (monthly) – 1.78% (*figure for May 2024: Reported July 2024*)



Crude Mortality Rate (12-month Rolling) – 2.12% (*figure covering Jun 2023 - May 2024: Reported July 2024*)



Analysis

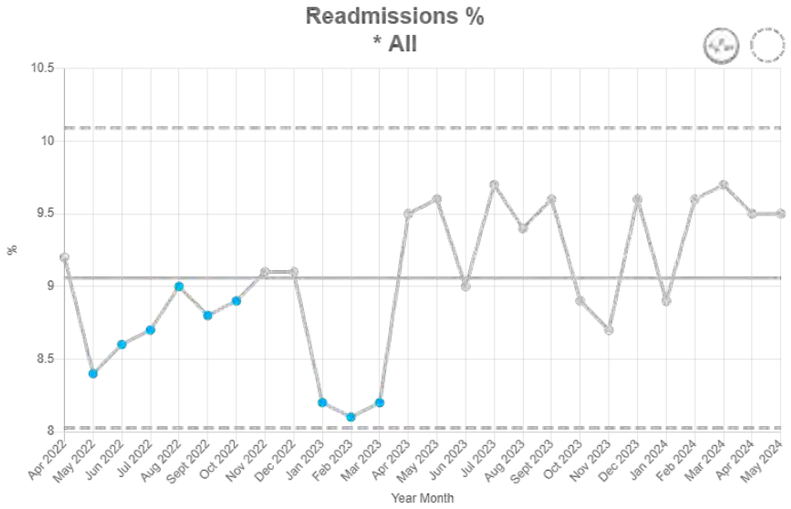
Our crude mortality rate continues an overall pattern of reduction at 1.78% for the month of May, the latest reported figure *(reported in July 2024*). We continue to have the lowest crude mortality rate in West Yorkshire for the month and are in line with the national average.
As a 12-month rolling average, BTHFT currently has a mortality rate of 2.12%, lower the national average of 2.49% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.93%.

Learning, Improvement, Assurance

Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

May 2024– 9.5%
Common cause variation



Analysis

Overall re-admissions within 28 days in 2024 have increased slightly compared to 2023.
Data analysis indicates that this increase, and one of the reasons why our re-admission rates appear higher than regional average, is down to the coding of patients who are brought back for a planned follow-up after an initial Non-Elective spell (e.g. GATU/EPAU, paediatrics and general surgery)

Learning, Improvement, Assurance

There is on-going work with BI, performance and CSUs to understand if there needs to be a different approach to the coding of a planned returners.
This work may take most of 2024 to complete.

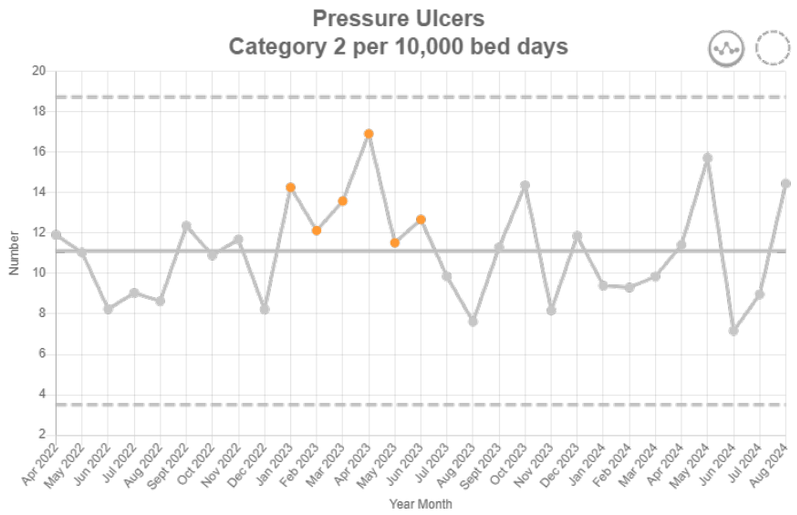
Generally higher re-admission rates are a marker of a poor or failed discharge from hospital and can indicate avoidable unplanned emergency admissions. However, what appears to be driving some our higher figures is actually a safety netting process to keep patients safe post-discharge.

The balancing metrics relating to in-patient care (LoS, crude mortality, long LoS in AED) are all in the upper quartile when comparing our peer group.

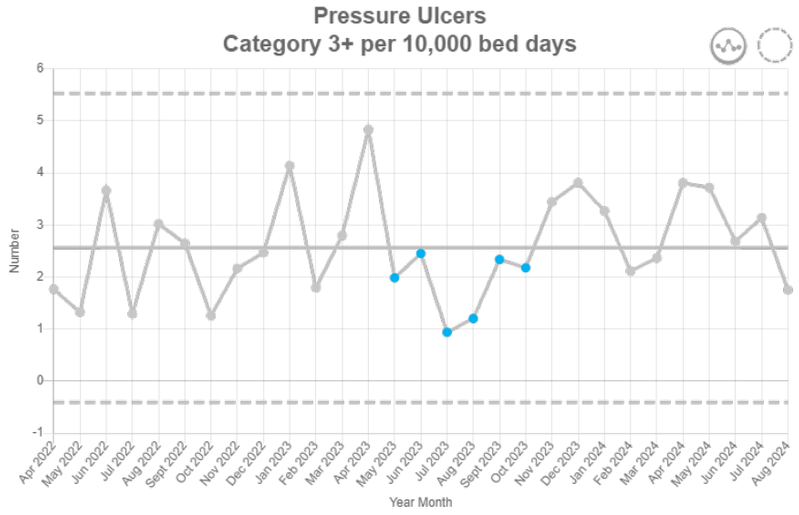
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

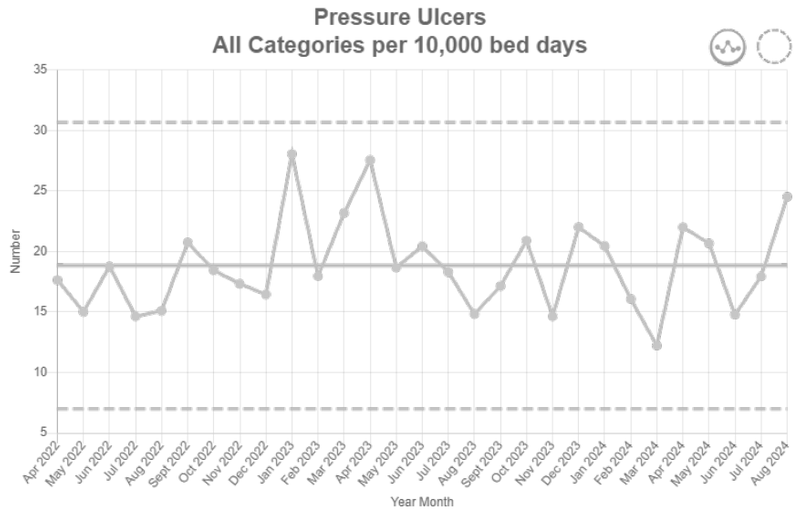
August 2024 – 14.5
Common cause variation



August 2024 – 1.8
Common cause variation



August 2024 – 24.5
Common cause variation



Analysis

In June & July the number of pressure ulcers per 10,000 bed days dropped below the control limit however, incidents rose above this limit for August. This pattern is also noted for category 2 incidents whereas category 3 and above incidents fell below the control limit for August.
During August there were 8 wards that 4 or more pressure ulcer incidents. Data over time is being reviewed to help us to understand whether this is a developing trend for 5 of the wards. The remaining 3 wards (17, 23 & 26) are currently working on quality improvement using the Model for Improvement although progress is at different stages.
It should be noted that Westwood Park have achieved 12 months without a hospital acquired pressure ulcer and wards 5 & 30/32 have achieved 6 months.

Learning, Improvement, Assurance

Risks:
1. Upward trend of pressure ulcer incidents on ward 23, 26 & 17.
2. Increased incidents for August – this will be monitored.

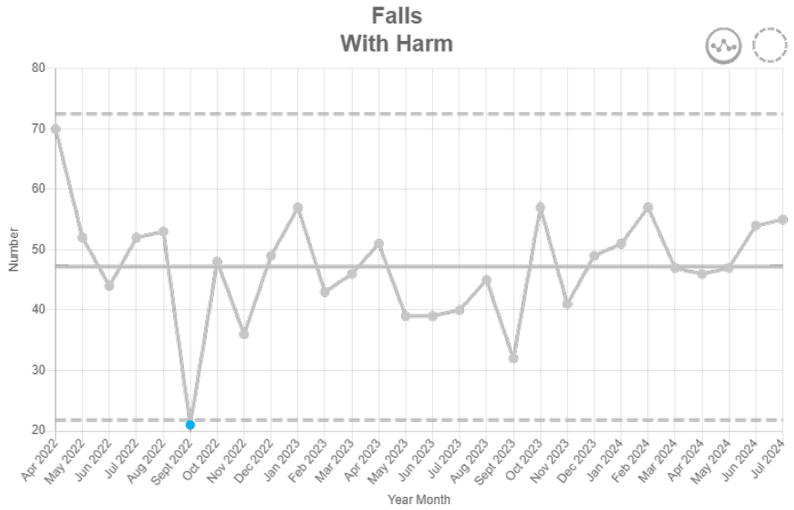
Mitigations:
1. Update to pressure ulcer SSKIN bundle on EPR has been completed. Some of the changes are a result from learning as well as staff feedback. Date of release to the live domain to be confirmed.
2. Quality improvement support has been provided to wards 23, 26 & 17.
3. Consider collaborative approach to improvement based on data analysis as described above.
4. Review performance on WWP to understand what they do well and how.

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.

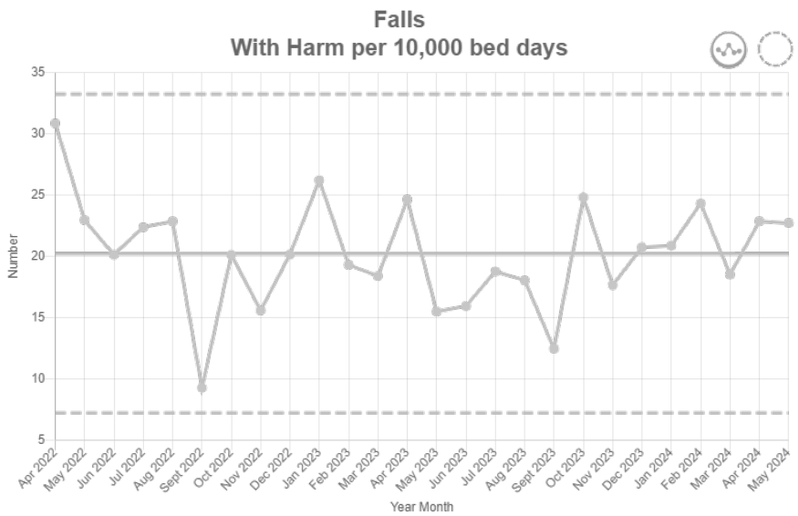
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

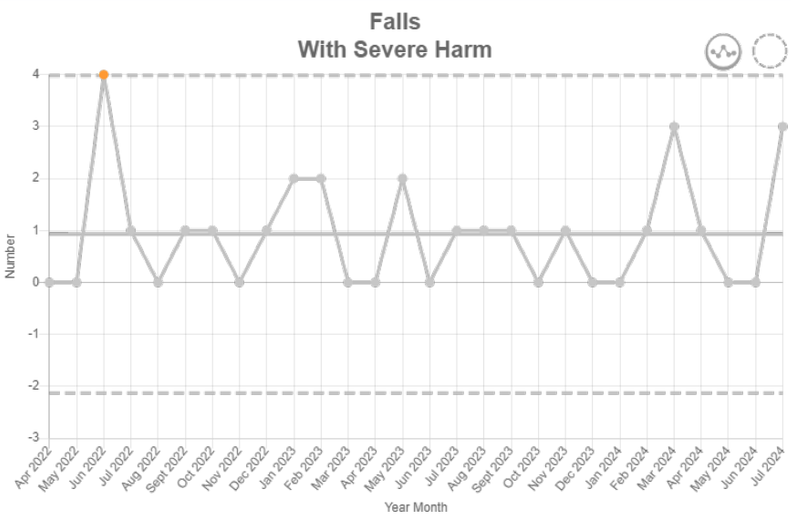
July 2024 - 55
Common cause variation



May 2024 –22.7
Common cause variation



July 2024 - 3
Common cause variation



Analysis

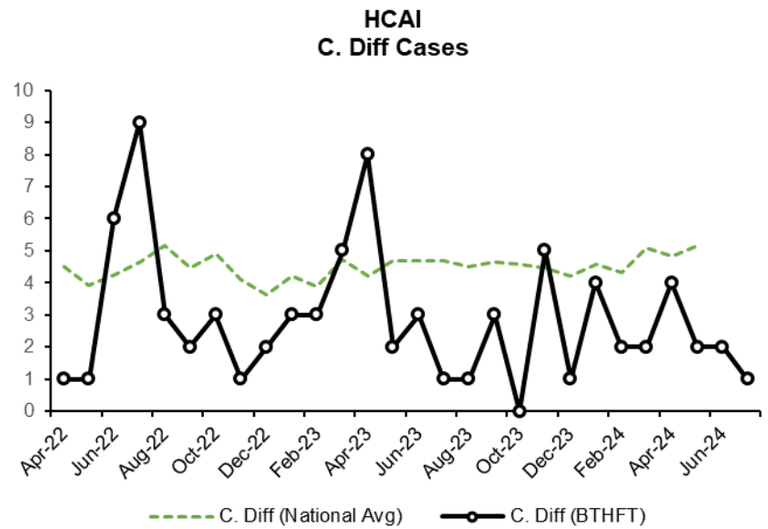
Learning, Improvement, Assurance

- 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.
- We have launched our 'mission statement, and 'Get the 6 pack' for ward areas.

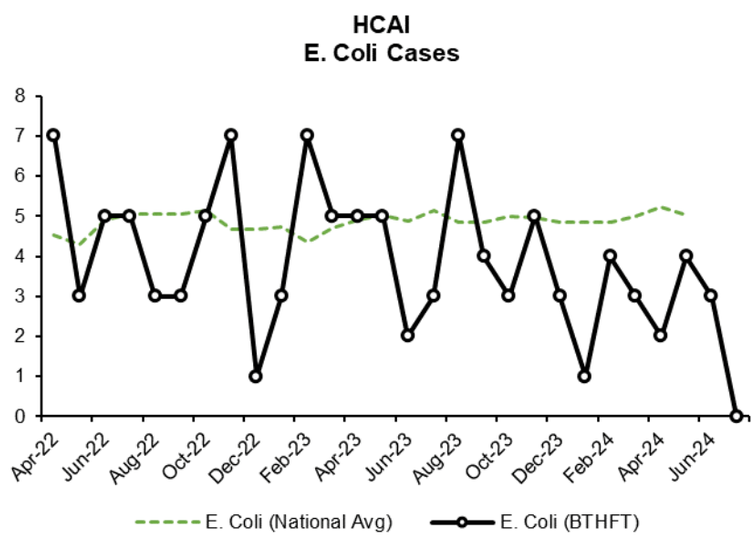
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

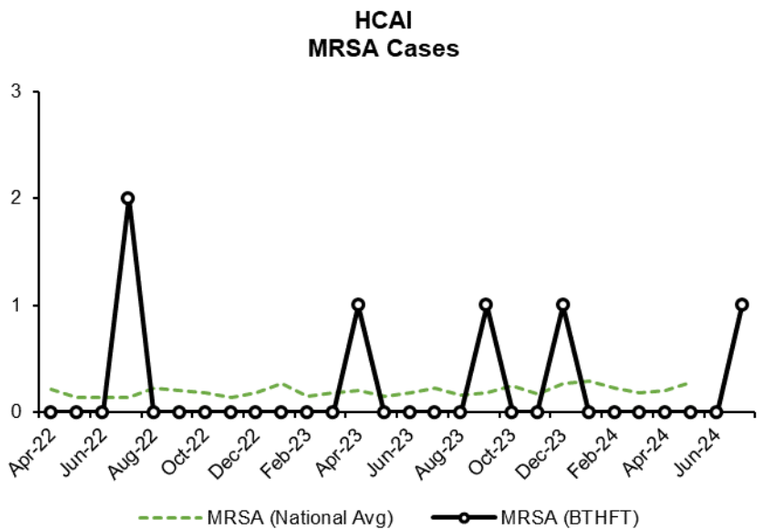
July 2024 – C. Diff Cases - 1



July 2024 – E. Coli Cases - 0



July 2024 – MRSA Cases - 1



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. There were no healthcare onset E. coli bacteraemia in July 2024.

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
One MRSA bacteraemia has been observed in July 2024. No cases were observed in the last six months before that.

Learning, Improvement, 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

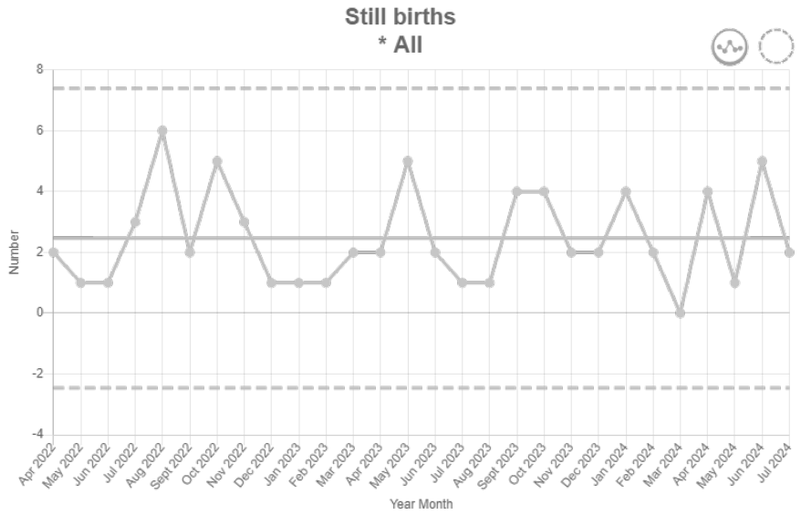
Bactearaemia Reduction plan

- 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

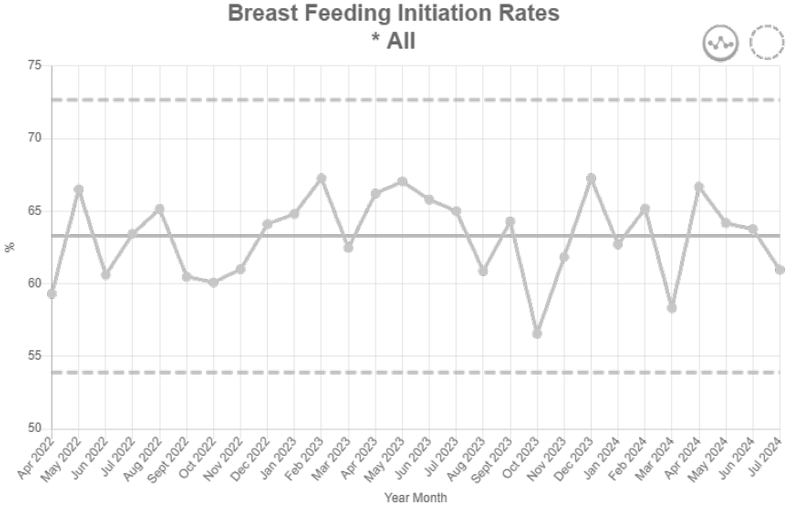
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

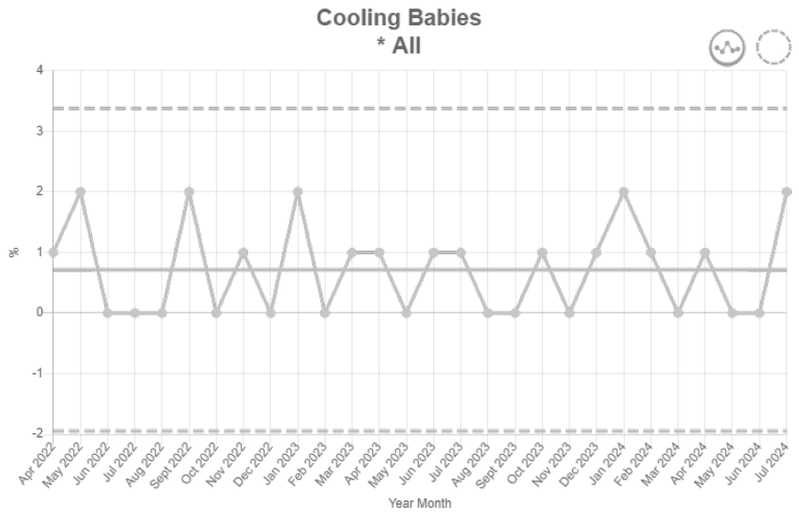
July 2024 - 2
Common cause variation

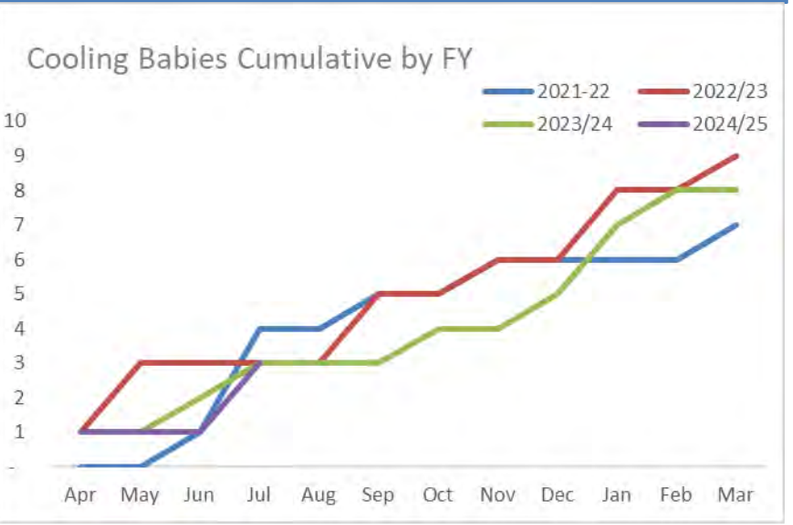


July 2024 – 66.7%
Common cause variation



July *2024* - 2
Common cause variation





Analysis

Stillbirths are monitored and reported on a monthly basis, with a thematic approach if more than 4 are reported in any month. Each baby is subject to a Perinatal Mortality Review Tool (PMRT) and any intrapartum stillbirth of a term baby is referred to MNSI for independent investigation.

All cooled babies meeting MNSI criteria are referred for independent investigation.

Cooled babies not meeting MNSI criteria are reviewed as an MDT case review and after action review/PSSI as required.

Learning, Improvement, Assurance

FINANCE REPORT

REFERENCES

Only PDFs are attached

Bo.9.24.11 - Finance Report - Month 5.pdf

FINANCIAL PERFORMANCE REPORT | MONTH 5

Meeting:	**Board of Directors (Open Meeting)**
Meeting Date:	**25 September 2024**
Agenda Item:	**Bo.9.24.11**

KEY HEADLINES

1. The year to date I&E position (£11.2m deficit) is £0.45m adverse to the planned £10.8m deficit.
2. The £0.5m adverse variance is due to £0.5m of direct Industrial Action costs which NHSE will provide funding for in Quarter 3.
3. The in-month position (£1.2m deficit, in line with plan) is supported by a number of one off benefits which will not be repeated in future months.
4. The Trust is formally reporting delivery of the planned £14m deficit by year end.
5. Delivering this plan remains feasible, although significant risks exist to this forecast in the context of the extremely challenging financial plan.
6. The Closing the Gap (CTG) efficiency programme has delivered £6.8m of savings to date - £3.6m behind the required £10.4m at Month 5.
7. Forecast CTG delivery of £28.3m is £10.6m below the £38.9m planned efficiencies.
8. Opportunities exist to bridge the savings shortfall to improve the run rate and forecast and are being pursued via Closing the Gap programme.
9. CTG schemes of up to £52m have been identified for delivery in 2024/25 - the Trust is active in developing and implementing these opportunities to bridge the £10.6m forecast gap in efficiency delivery.
10. Significant progress has been made in engagement in the Closing the Gap programme across the organisation but this has not yet translated into run rate improvements on the scale needed.
11. Major unresolved risks remain to delivering the financial plan in full with a risk of a significantly greater deficit than planned.
12. There is a risk that if the run rate does not improve and the Income & Expenditure plan is not delivered that the Trust may require external revenue cash support from NHSE in Quarter 4.

SECTION A - INCOME & EXPENDITURE

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	**577.7**	**49.0**	**50.1**	**1.1**	**240.7**	**247.7**	**7.0**
Expenditure	**(591.7)**	**(50.2)**	**(51.3)**	**(1.1)**	**(251.5)**	**(258.9)**	**(7.5)**
Pay	(389.5)	(31.8)	(32.4)	(0.5)	(161.2)	(163.5)	(2.3)
Non-Pay	(202.2)	(18.4)	(18.9)	(0.6)	(90.3)	(95.5)	(5.2)
Grand Total	**(14.0)**	**(1.2)**	**(1.2)**	**(0.0)**	**(10.8)**	**(11.2)**	**(0.5)**

Commentary

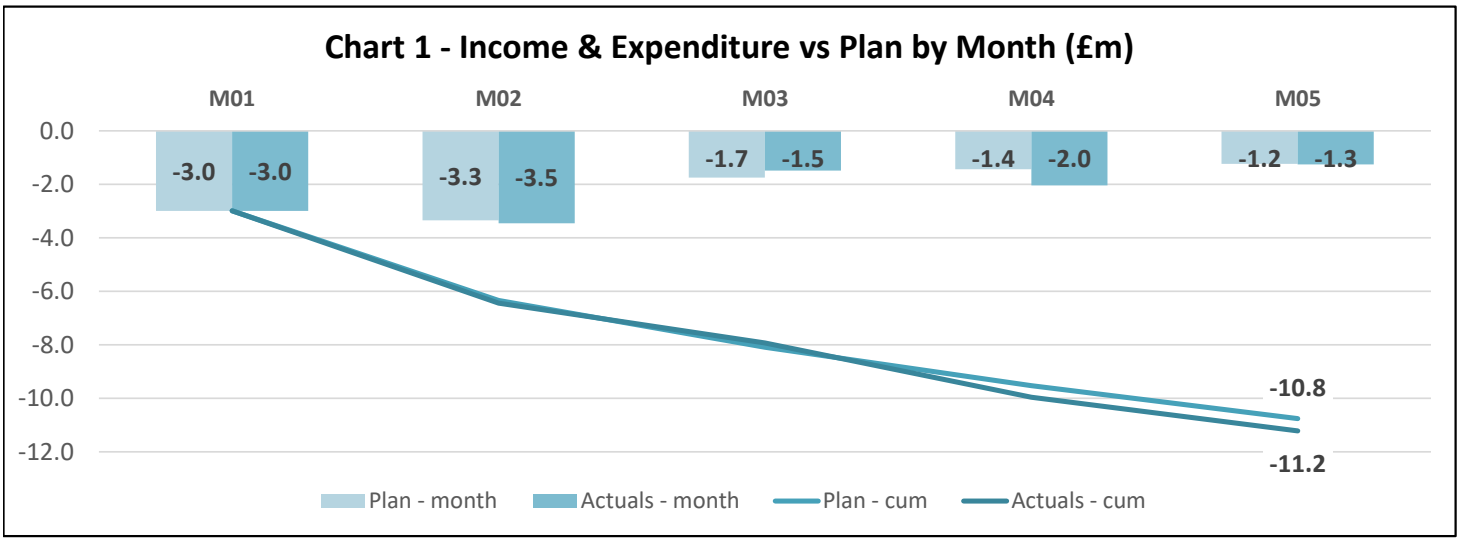
The Trust has reported a deficit of £11.2m at Month 5, which is £0.45m adverse to the planned £10.8m deficit. This adverse variance is due to the direct costs of industrial action, which NHSE has confirmed will be funded in Quarter 3. The reported in-month position for August is a deficit of £1.5m in line with plan.

The Trust formally continues to forecast delivery of the £14m deficit plan by year end. The scale of the required run rate improvements as the plan becomes more challenging from Quarter 3 onwards means there is a risk that the Trust may be unable to deliver its I&E plan for Quarters 3 and 4 without a material increase in delivery from the Closing the Gap programme in excess of current monthly levels of cost improvements. The plan for Months 8 - 12 is broadly breakeven in each month.

Work on the Closing the Gap (CTG) programme is intensifying to increase efficiency delivery to achieve this forecast. A significant number of efficiency schemes and opportunities remain available to the organisation to make the required run rate improvements, although there remain significant risks inherent in converting these plans into tangible cash-releasing delivery. This process is being facilitated and supported by the Closing the Gap governance structure, maturing CTG workstreams and engagement of the Executive Team with the Trust's Clinical Support Units (CSUs).

If the CTG programme were not to not deliver as required and the Trust were to fall behing its I&E plan, then it is projected that the Trust would require external revenue cash support from NHSE in Quarter 4. NHSE's cash support processes have been amended, with organisations now required to request cash support one month in advance rather than in the preceding quarter as was previously the case. This change in process allows providers more flexibility in the timing of submissions of requests for cash support.

The reported Month 5 I&E 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. The latest internal analysis suggests the Trust is slightly behind its ERF target at Month 5, which presents a risk to the reported position that will be validated in Month 6 reporting.



Commentary

A number of non-recurrent benefits arose in the August position which supported the on-plan delivery in month. These items will not be available in future months and the outlook for the underlying run rate remains extremely challenging.

Updates to income assumptions relating to the Community Diagnostic Centre and the Lung Health Check resulted in an adverse swing of £0.8m in month. Both services are now funded on a PbR basis and are delivering signficantly less activity than planned. Recovery plans are being developed with both services to increase activity and income in Quarters 3 & 4.

Expenditure on clinical supplies increased by £0.7m in August, particularly in Theatres. It is to be expected that the clinical supplies cost growth relates to increased Elective activity which will be reflected in an improved ERF position once the activity is coded.

Variable pay expenditure reduced by £0.25m compared to Month 4. This is a positive trend, although the cost reductions targeted by the CTG programme are far more substantial and progress with pay cost reductions remains slower than required. The CTG Workforce workstream is implementing a number of initiatives to accelerate these reductions in bank and agency expenditure.

2. EFFICIENCY PROGRAMME (CLOSING THE GAP)

2a. 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	10,441	5,922	(4,519)	38,868	19,842	(19,026)
Medium risk	0	626	626	0	5,444	5,444
High Risk	0	299	299	0	3,031	3,031
Grand Total	**10,441**	**6,848**	**(3,593)**	**38,868**	**28,316**	**(10,552)**

Commentary

The annual plan requires £10.4m of efficiencies to be delivered to Month 5. A total of £6.8m of savings have been recorded, which leaves the Closing the Gap programme £3.6m behind plan at Month 5. The shortfall has been offset by increased income, expenditure controls not recorded as efficiencies under the Closing the Gap (CTG) programme and non-recurrent one off financial benefits.

The CSUs' combined forecast at Month 5 is delivery of £28.3m of effiencies in 2024/25, which would result in a £10.6m shortfall against the required £38.9m of financial improvements. This forecast must improve to enable the Trust is to deliver its financial plan and the organisation is focused on achieving this via the Closing the Gap programme.

This forecast does not yet include a number of initiatives led by the CTG workstreams and equally excludes a significant number of opportunities being developed by the CSUs, which if implemented will materially improve the projected level of efficiencies delivered in 2024/25. Table 2b summarises the scale of opportunities identified by the Trust's budget holders which the organisation must take advantage of in the coming months.

2b. Efficiency Programme Summary - Risk Adjusted Plan Status

Scheme Risk Rating (deliverability)	Full Year Opportunity £000s	Risk Adjusted Full Year Opportunity £000s	Part Year Opportunity 24/25 £000s	Risk Adjusted Part Year Opportunity 24/25 £000s	CSU Forecast 24/25 at Month 5 £000s
Low Risk	(25,084)	(25,084)	(22,667)	(22,667)	(19,842)
Medium risk	(11,236)	(6,742)	(8,823)	(5,294)	(5,444)
High Risk	(27,753)	(8,326)	(20,776)	(6,233)	(3,031)
Grand Total	**(64,073)**	**(40,152)**	**(52,266)**	**(34,193)**	**(28,316)**

Commentary

Value of Efficiency Opportunities Identified

The totality of schemes under development and identified efficiency opportunities is estimated to be up to £64m on a full year basis. This is an ambitious figure and reflects the maximum possible opportunity and it is therefore unrealistic that this will be achieved in full, even in the medium term. The unadjusted part year opportunity in 2024/25 of these schemes is up to £52m - this represents up to £24m of additional in-year savings over and above the CSUs' latest £28.3m forecast for the year.

This indicates that the Trust's budget holders and the Closing the Gap workstreams have the opportunity to bridge the forecast £10.6m savings gap in the remainder of the financial year but urgent action is required. 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

To avoid over-stating the forecast delivery from schemes that are not fully mature and implemented, the Trust applies a basic risk stratification to schemes to adjust down the value of schemes in the tracker which require further development.

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 £50.2m of unadjusted opportunities have been recorded as deliverable within 2024/25. The Trust's risk adjustment methodology reduces this down to a £34.2m opportunity based on the assessed maturity 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 £28.3m. As and when schemes mature into the delivery phase, they will translate into an improved forecast for delivery - the challenge facing the Trust is the conversion of these schemes at pace into concrete delivery in Quarters 3 & 4.

CTG Programme Focus

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. In September, a dedicated Closing the Gap week will run with non-essential meetings stood down to enable all CSU and coporate departments to focus on improving their CTG forecasts and implementing the plans identified.

There remains significant risk to delivery of the full efficiency programme, however every option is being pursued to recover the forecast and to deliver the financial plan in 2024/25.

3. INCOME & EXPENDITURE - FORECAST OUTTURN SCENARIOS

Commentary

The Trust continues to formally report a forecast delivery of the financial plan in full with the planned £14m deficit not exceeded, although this forecast is reliant on a material improvement in monthly run rates from Quarter 3 onwards. Three scenarios for the I&E forecast for the remainder of the financial year have been modelled:

Do Nothing Forecast, £26.5m deficit, £12.5m adverse variance to plan

In a scenario in which there are no improvements to the underlying run rate, winter cost increases and known cost pressures arise as planned, Elective activity does not increase and in which no additional CTG efficiency opportunities are converted into delivery, it is estimated that the Trust would post a year end deficit of £26m - £27m. The Trust is actively taking measures to improve on this forecast.

Best Case, in which the financial plan is delivered in full - £14m deficit

This remains the formal forecast for the Trust - full delivery of the financial plan. The measures being implemented to bridge from the do-nothing forecast to achieve delivery of the financial plan include:

- Closing the Gap development of schemes to deliver the £38.9m efficiency plan in full
- Elective activity growth to increase ERF income (including capacity from St Lukes Hospital Daycase Theatres)
- Increasing other variable income streams
- Further financial controls
- Balance sheet review

Worst Case - £34.3m deficit, £20m adverse variance to plan

An extreme worst case has been modelled for reference, which results in a £34m deficit. This scenario factors in unplanned cost pressures arising, reductions in Elective activity vs run rate and unexpected shortfalls against existing CTG forecasts. This is not considered to be a realistic scenario but is presented for completeness.

Cash Impact of I&E Forecasts

In the "Do Nothing" and Worst Case scenarios, revenue cash support would be required from NHSE in Quarter 3 or more likely Quarter 4. The cash forecast is discussed in Section 4.

Table 3a - Year End Forecast I&E Scenarios

Scenario	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Best Case	-14.0	-14.0	0.0
Do Nothing	-14.0	-26.5	-12.5
Worst Case	-14.0	-34.3	-20.3

4. CASH POSITION AND FORECAST

Table 4a - Year End Forecast Cash Scenarios

Statement of Cashflows	Year to Date			EOY	Forecast Outturn		
	Plan £000	Actual £000	Variance £000	Plan £000	Best £000	Do Nothing £000	Worst £000
Opening Cash	**64,154**	**64,154**	**0**	**64,154**	**64,154**	**64,154**	**64,154**
Net Movement in Cash	(30,766)	(33,199)	(2,433)	(47,193)	(53,448)	(65,903)	(73,708)
Closing Cash	**33,388**	**30,955**	**(2,433)**	**16,961**	**10,706**	**(1,749)**	**(9,554)**

Commentary

Year to Date Cash Position

As a the end of month 05 the Trust held £31.0m in the bank which is £2.4m less than planned (£33.4m). Income and Expenditure cash is £6.1m less than plan mainly during to movements in working capital (payables £5.7m). Capital cash is £3.4m more than plan as the programme is currently behind plan at month 5 (£4.1m). The Capital programme is forecast to deliver in full by year end.

Best Case Forecast

In the best case I&E forecast scenario (delivering the £14m deficit plan), the Trust is projected to have £10.7m cash in the bank at 31 March 2025. The organisation would not require any external revenue cash support in 2024/25 in this scenario.

Do Nothing Forecast

In the "do nothing" scenario, the Trust is projected to end the financial year with a negative £1.7m cash balance. In this scenario, the Trust would require external revenue cash support from NHSE in Quarter 4.

The cash forecast scenarios highlight the importance of the ongoing work to increase delivery from the Closing the Gap efficiency programme and to maximise ERF income to deliver the I&E plan in full.

4. APPENDIX - AGENCY EXPENDITURE

Appendix 1 - Agency Expenditure by Staff Group

Staff Group	Q1 Ave £000s	M04 £000s	M05 £000s	YTD £000s	Annual Plan £000s	Straight Line Forecast £000s	Forecast Variance £000s
Consultants	268	197	269	1,269	1,752	3,046	1,294
Other Medical Staff	26	19	6	102	312	245	(67)
Nurses, ODPs & Midwives	222	124	211	1,001	2,664	2,402	(262)
HCAs	(0)	1	0	(0)	360	(1)	(361)
Physiotherapists	11	12	5	49		118	118
Pharmacist	24	13	16	102	101	245	144
Radiographers	40	56	19	196	307	470	163
Other Clinical Roles	13	15	25	79		190	190
Estates & Facilities	72	54	31	301	1,488	722	(766)
A&C	44	33	13	177	500	426	(74)
Total Agency Spend	**719**	**524**	**594**	**3,276**	**7,484**	**7,862**	**378**
Annual Plan	**807**	**728**	**622**	**3,770**			
Variance to Annual Plan	**(87)**	**(204)**	**(28)**	**(494)**			

Commentary

The annual plan includes maximum agency expenditure of £7.5m (a £2.5m reduction from 2023/24). At Month 5, agency expenditure was £3.3m against planned spend of £3.8m, meaning agency expenditure is £0.5m below plan at Month 5.

The plan phased greater reductions in agency spend from Quarter 2 onwards. A straight line extrapolation of Month 5's agency spend results in £7.9m of agency costs which would be £0.4m above the annual plan. However, monthly agency spend has reduced since Quarter 1 and if this run rate reduction can be increased and maintained over winter delivery of the planned maximum agency spend may be achieved.

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.

PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

Bo.9.24.11 - Performance Report- Aug 2024 (cover).pdf

Bo.9.24.11 - Operational Performance Report - Aug 2024.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

PERFORMANCE REPORT – FOR THE PERIOD AUGUST 2024

Presented by	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Author	Carl Stephenson, Associate Director of Performance	
Lead Director	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Purpose of the paper	To update on the current levels of performance and associated plans for improvement.	
Key control	This paper is a key control for the strategic objective to deliver our financial plan and key performance targets.	
Action required	For assurance	
Previously discussed at/ informed by		
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 August 2024.

Analysis

Ambulance Handovers:

- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 45.94% in August compared to 48.44% in July. The average number of ambulances arriving daily has seen a slight reduction compared to recent months although the acuity of patients arriving by ambulance remains high.
- Patient flow challenges remain due to high adult G&A bed occupancy and Amber Zone capacity which continue to impact ambulance handover times (22 minutes 18 seconds in August compared to 22 minutes 4 seconds in July).
- While using YAS AMDT for ambulance handovers streamlined data entry for paramedics, accuracy discrepancies persist. Validation has now been reinstated focussing on handover delays > 30 mins.
- Collaborative work with YAS is ongoing. The ambulance handover process has been mapped with YAS, which identified issues, and assigned ownership for improvement. The new handover process (YAS & BTHFT approved) is now operational in ED.
- A review is also underway to streamline ambulance self-handover processes at the front door/ reception to ease AAA congestion.
- 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 84.34% for August 2024 and is currently forecast at 81.66% for September 2024. The position remains in the upper decile of Acute Trusts in England.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

- Daily attendance has reduced in August with an average of 373 ED arrivals per day compared to 411 in July. Attendances are now comparable with August 2023 however high acuity attendances are up ~23% compared to the same period last year.
- Streaming to the AECU service continues to remain effective, positively impacting a range of UEC metrics. LoS metrics for both admitted and non-admitted patients remained broadly in line with July performance.
- G&A adult bed occupancy reduced slightly to 88.72% in August compared to 89.28% in July although adult bed occupancy remained higher at 90.64% with high acuity patients and issues within the social care sector continuing to impact the timely discharge of patients.
- The UTC 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 UTC.

Long Length of Stay and Discharge Pathways:

- The daily average number of patients with a length of stay (LOS) > 21 days reduced to 104 in August 2024 and is forecast to remain stable in September at 103.
- 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.
- Since launching H-Fast in July the number of P1 discharges has increased from one to two patients per day. The program has now expanded to cover the entire Bradford Council district and is expected to increase incrementally over the next 5 weeks up to 6 discharges per day (30 per week) - to date 47 patients have been discharged via H-FAST.
- 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 pilot of a discharge coordinator position was introduced on Wards 28 and 29 in July to accelerate patient discharges. The presence of these coordinators has been well-received by ward staff and a review of the model will be completed in October to determine scalability across the trust.
- 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 below plan in August 2024 in line with increased annual leave due to the summer holidays and is projected to remain stable in September 2024. Outpatient activity delivered above plan in August 2024 and is projected to deliver in line with plan in September 2024.
- Elective productivity improvement workstreams have been reviewed with the lens of "do once, do well". There is now a parallel structure between clinically led GIRFT further faster deliverables, existing operational improvement, and some specific enhancements to be picked up by senior operational leads to extend activity beyond planned levels in support of Closing the Gap targets.
- Outpatient procedure work is progressing at pace with improvements in delivery and recording.
- 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.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

Referral to Treatment:

- Referral to Treatment (RTT) performance is projected to remain stable in August 2024 at 63.16%. 52-week performance has dropped behind plan.
- Access meetings continue weekly to review the entire RTT agenda, new dashboards are making DNA rates, discharge rates, and activity against plan more visible and accurate. These will highlight areas of efficiency opportunity for services, and allow them to connect over achievement with potential financial savings against CTG.
- There was 1 patient reported over 78 weeks at the end of August 2024 with 3 patients projected to breach 78 weeks at the end of September 2024.
- 55 patients breached 65 weeks at the end of August 2024, predominantly in Trauma & Orthopaedics (T&O) who continue to review theatre capacity and allocations to support a reduction in long-waiters over the coming months as part of their recovery plan. The number of patients waiting over 65 weeks is expected to increase in September 2024 up to 68. An arthroplasty consultant position is currently out to advert and will support longer term improvement for T&O.
- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.32% in August 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.

Diagnostic waiting times:

- DM01 performance for July 2024 was 79.63% remaining behind target the expected improvement trajectory. The forecast performance for August is a further improvement led by recovery in Cardiology and NOUS.
- CDC capacity is now available for all modalities we had planned to include. Process and efficiency improvements are being explored to further capitalise on this resource.
- MRI capacity has been challenged July due to equipment issues and staff sickness. Equipment failures at the CDC have also contribute to the impact on performance. There is a shortfall in staffing to support the ideal capacity model and further work is needed to maximise potential and realise improvements.
- Echocardiography recovery has continued with the backlog of breaches being addressed into August. Plans are being explored to ensure sustained service resilience. Long term sickness is expected to impact capacity through summer leading to alternative venues being explored.
- 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:

- 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.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.11

- The new cancer IT system (Civica) is in project scoping phase with a planned go live of October 2024. This will bring many benefits, including supporting Personalised Stratified Follow Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups.
- 2WW performance position was below target in July and is expected to remain below target in August. Demand remains high and each tumour group is reviewing their long-term capacity plans to reduce reliance on weekly escalations.
- The Skin Lesion Investigation Clinic (SLIC) pilot has successfully reduced Fast Track referrals for suspected Skin cancer into Dermatology during summer, this model is now being embedded in the referral pathway.
- The 28-day faster diagnosis standard (FDS) performance improved to 79.45%. There has been significant focus on fast-track diagnostic turnaround times as part of the diagnostic improvement described in that section of this report.
- Weekly One Stop Clinics for palpable neck lumps commenced 31st July 2024, which provide access to ENT, Consultant Radiologist & Ultrasound at the initial appointment. Referral forms have been revised to ensure correct patients are referred to this weekly clinic
- 31-day general treatment is forecast to remain below target for July and August over the holiday period. Cancer treatment within theatre remains a priority and early identification of capacity issues is in place. Head & 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 and remain below the 70% target for the 62-day general treatment standard for July and August. Treatments remain low but there is no single cause for this with tumour groups experiencing increased complexity, reduced treatment capacity, diagnostic delays, and patient-initiated delays.

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	25 September 2024	Agenda item	Bo.9.24.11

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 (*)** Performance for elective KPI remains a challenge and improvement plans are taking time to deliver on expected benefits.					

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 Meeting - 25/9/24

August 2024

Headline KPI Summary

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Section	Headline KPI	Latest Month	Target / Plan	Perf.	3 M'th Trend
1	Avg. Ambulance Handover	Aug-24	19:00	22:18	↑
2	Emergency Care Standard	Aug-24	78.82%	83.34%	→
4	Length of Stay ≥21days	Aug-24	135	104	↓
8	18 Week RTT Incomplete	Aug-24	66.01%	63.16%	↓
8	52 Week RTT Incomplete	Aug-24	1.23%	1.35%	→
11	6 Week Diagnostic Standard	Aug-24	88.60%	81.07%	↑
12	Cancer 28 Day FDS	Jul-24	77.50%	79.44%	↑
13	31 Day General Treatment	Jul-24	96.00%	92.34%	→
13	Cancer 62 Day General Treatment	Jul-24	72.14%	66.13%	→

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement

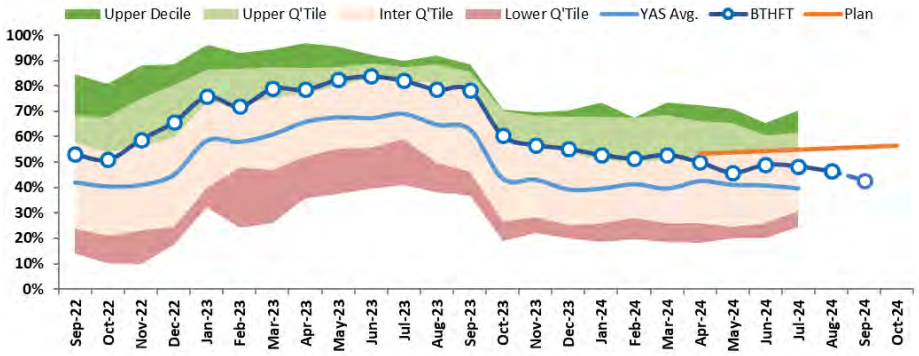
Urgent and Emergency Care (UEC)

1. Ambulance Handover Performance

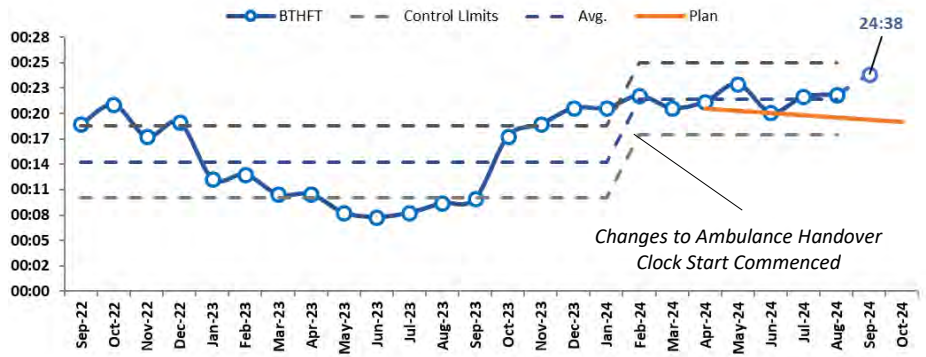
Bradford Teaching Hospitals NHS Foundation Trust

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Avg. Daily Arrivals -	104	111	111	118	113	115	113	109	107	109	111	108	102
Total Turnaroud Time (MM:SS)	46:32	46:00	44:02	47:50	46:59	49:00	46:13	47:53	50:27	47:24	49:15	50:29	51:55
Avg. Handover Time (MM:SS)	10:30	17:35	18:57	20:48	20:48	22:10	20:48	21:30	23:32	20:16	22:04	22:18	24:38
% Handovers <30 mins -	93.3%	87.4%	84.9%	84.7%	83.9%	81.2%	83.6%	80.3%	77.4%	82.0%	79.1%	79.6%	78.4%
% >60 mins -	1.6%	2.8%	3.9%	5.3%	4.6%	5.7%	3.1%	4.5%	5.9%	2.8%	5.0%	4.6%	6.2%

Latest position

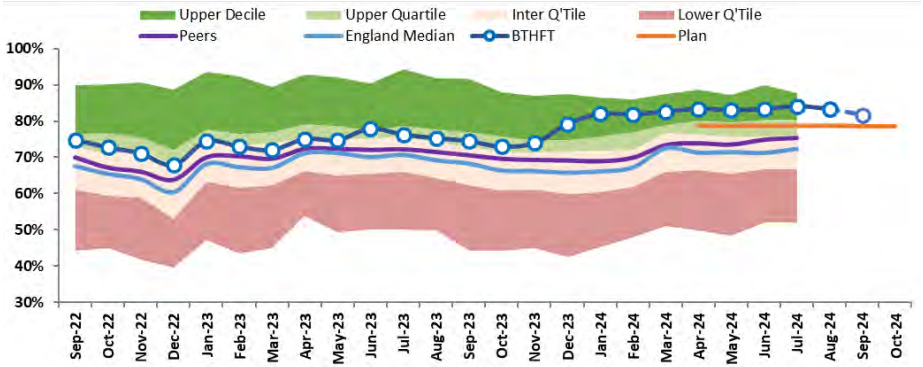
- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 45.94% in August compared to 48.44% in July. The average number of ambulances arriving daily in August has reduced, but patient acuity continues to remain high.
- High acuity coupled with pressures in the Amber zone and high adult bed occupancy continue to impact downstream flow resulting in delayed Ambulance handovers. Despite this BTHFT handover performance continues to track above the regional average.
- The new handover process, approved by both YAS and BTHFT that ensures handover times are recorded correctly is now fully operational in the ED from mid-August.
- 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. Internal validation has now been reinstated during September following changes to YAS reporting and focusses on the review of breaches >30mins only.
- 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

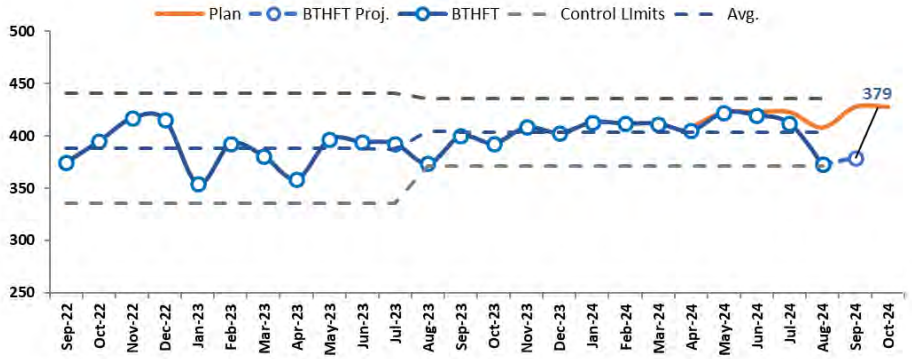
Bradford Teaching Hospitals NHS Foundation Trust

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Type 1 Performance -	65.3%	64.2%	65.1%	73.0%	75.7%	76.0%	75.3%	76.7%	75.0%	75.7%	76.8%	76.1%	73.6%
Arrival to Assessment -	00:22	00:24	00:26	00:23	00:22	00:22	00:22	00:21	00:22	00:21	00:22	00:19	00:18
Assessment to Treatment -	02:07	02:05	02:21	02:33	02:39	02:32	02:27	02:21	02:33	02:19	02:57	02:18	02:45
Treatment Length -	02:22	02:27	02:39	02:40	02:36	02:41	02:29	02:35	02:34	02:26	02:28	02:35	02:20
LoS (Discharged P'ts) -	03:49	03:53	03:46	03:06	02:56	02:58	02:53	02:54	02:59	02:56	02:47	02:49	03:12
LoS (Admitted & Discharged P'ts) -	04:42	04:50	04:45	04:04	04:00	03:56	03:49	03:46	03:56	03:38	03:44	03:41	04:12

Latest position

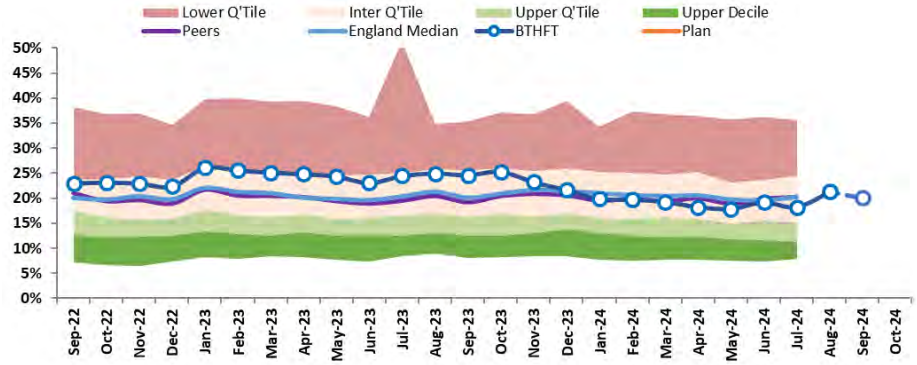
- ECS performance remains in the upper decile of Acute Trusts in England with average daily attendances coming down in August (373). Reductions in attendance have primarily been seen in both Paediatric and minor attendances although Majors have remained consistent.
- Streaming to the AECU remains consistent with year-to-date activity and continues to support admission avoidance.
- 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 3 years (previously 6).
- 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.
- Efforts are currently underway to ensure that services include the treatment of children under 2 years old and the integration of NHS 111 appointments, which are essential criteria for being designated as an Urgent Treatment Centre (UTC).
- 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

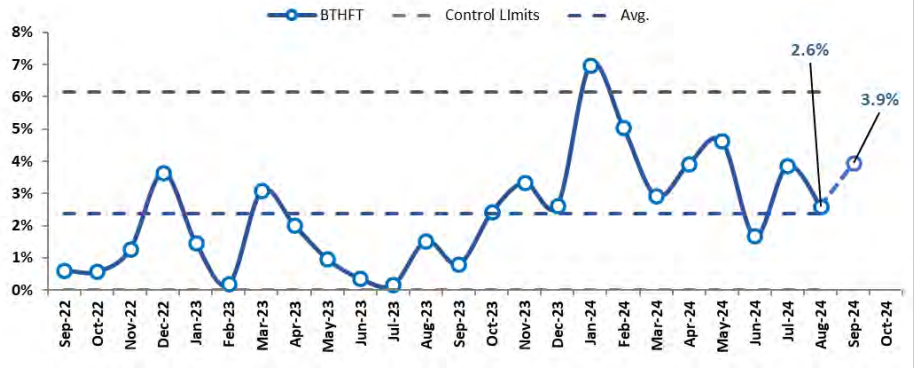
Bradford Teaching Hospitals NHS Foundation Trust

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Avg. # Daily Admissions -	98	93	95	87	81	80	84	80	81	85	81	79	76
Avg. DTA to Admit -	03:51	04:05	04:45	05:00	06:15	05:31	05:04	05:08	05:32	03:57	05:11	04:19	05:26
LoS (Admitted P'ts) -	07:31	07:38	08:01	07:33	08:23	07:55	07:27	07:21	07:59	06:24	07:35	06:53	08:12
% 12 Hour ED LoS -	5.7%	5.9%	6.8%	5.5%	6.3%	6.1%	5.3%	5.4%	6.3%	4.2%	5.4%	5.5%	7.0%
Bed Occupancy (Total)	89.1%	91.2%	92.8%	90.3%	94.5%	94.0%	93.9%	94.5%	93.6%	88.4%	89.3%	88.7%	90.2%

Latest position

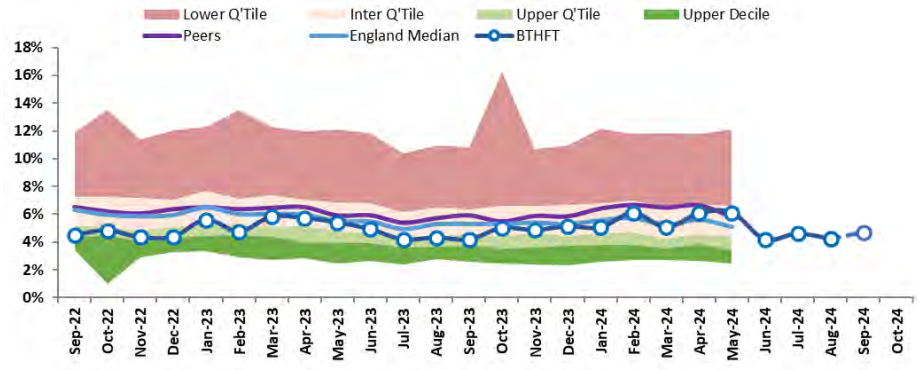
- The AECU continues to positively impact on ED and hospital admission metrics with a reduction in the average number of daily admissions continuing into August. Despite these improvements patients in the main ED can still have prolonged waits and this remains a focus for ongoing improvement activity.
- Whilst reductions in ED attendances have been observed, admissions have only marginally reduced leading to an increased conversion rate. However, this is expected as reductions were primarily in Paediatric and minor ED attendances.
- Total G&A bed occupancy remained stable at 88.7% in August with Adult G&A occupancy at 90.6%. Patient flow delays continue to impact ED length of stay (LoS) metrics.
- Within ED, the operational hub continues to provide 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 continue to attend the operational site 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

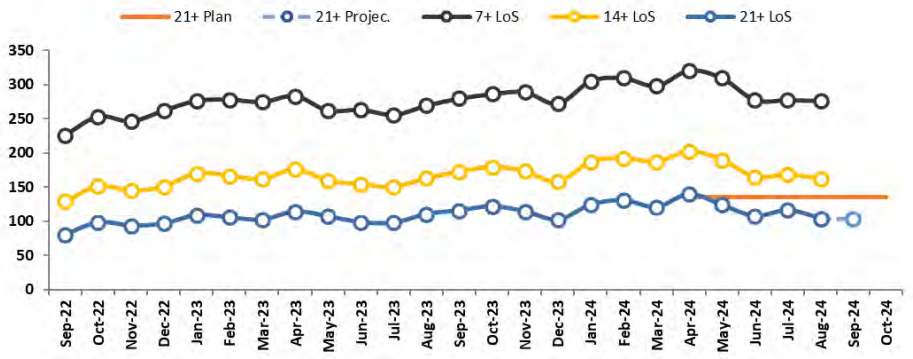
Bradford Teaching Hospitals NHS Foundation Trust

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

		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
% of P'ts with Discharge Ready Date	-	94.2%	93.2%	93.8%	94.3%	94.8%	94.8%	94.6%	94.5%	94.9%	94.6%	93.7%	94.7%	93.6%
% of P'ts Discharged on/before DRD	-	81.5%	82.1%	81.6%	80.4%	82.3%	82.4%	82.3%	83.8%	82.4%	82.8%	82.1%	81.5%	81.5%
Avg. LoS stay beyond DRD	-	3	4	5	4	4	5	4	5	5	4	4	3	2
% P'ts Not Meeting Criteria to Reside	-	14.0%	12.9%	13.3%	14.5%	12.2%	14.2%	12.0%	12.4%	13.7%	14.3%	12.5%	11.9%	12.6%
Bed Occupancy (Adult)	-	90.2%	92.0%	93.1%	90.7%	95.1%	94.7%	94.7%	96.1%	95.1%	89.4%	90.8%	90.6%	91.4%
Bed Occupancy (Paed)	-	73.4%	79.6%	89.5%	84.1%	86.1%	85.0%	83.5%	73.3%	75.1%	75.4%	70.2%	63.7%	75.3%

Latest position

- Overall bed occupancy remained steady at 88.7% in August. The number of patients with a LoS >21 days reduced to 104.
- BTHFT's strong partnerships with community, social care, and voluntary sectors are helping to alleviate pressure. The refinement of approaches at BTHFT continues to mitigate the pressures experienced by other Trusts.
- Since launching H-Fast in July the number of P1 discharges has increased to two patients per day. The program has now expanded to cover the entire Bradford Council district and is expected to increase incrementally over the next 5 weeks to up to 6 discharges per day (30 per week) - to date 47 patients have been discharged via H-FAST.
- A pilot of a discharge coordinator position was introduced on wards 28 and 29 in July to accelerate patient discharges. The presence of these coordinators has been well-received by ward staff and a review of the model will be completed in October to determine scalability across the trust.
- 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.

5. Delivering UEC Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

Ambulance Handover improvement:

- A **comprehensive mapping exercise** of the Ambulance Handover process was conducted in May 2024 with colleagues from both YAS and BTHFT. Observations during this process revealed improvement opportunities in patient safety, quality of care and operational efficiency. Ongoing work with YAS involves addressing identified issues with allocated responsible owners for the ambulance handover process.
- A Task and Finish group led by WYATT continues to work on **establishing a YAS Direct Referral Pathway to the AECU**. Process mapping insights will guide BTHFT implementation to reduce wait times and improve patient experience. A September meeting with WYATT and the ICB will determine next steps.
- A review is also underway to **streamline ambulance self-handover processes** at the front door/ reception to ease AAA congestion.

Emergency Department improvement:

- A review of the triage process is underway to **ensure that streamers follow the correct pathway**. Additionally, a proposal to trial St George's Hospital's 'Patient Check-In' app for six months is waiting to be submitted to the Executive team. This app integrates with EPR, tracks waiting patients, calculates acuity scores, and aims to halve triage time.
- Following business case approval to recruit 6 additional ED consultants, a phased recruitment plan is underway to attract and retain pre-regs. This will ensure 24/7 consultant presence in ED, improving from the current 16-hour availability. The ED team welcomes this development, recognising its **positive impact on workforce resilience**.
- The Urgent Care Centre (UCC) will continue its workstreams to enhance utilisation, develop new pathways, review triage processes, and maintain contractual arrangements with Bradford Care Alliance (BCA), which provides GP input to the UCC

Inpatient LoS and Discharge improvement:

- The clinical lead for patient flow and lead for complex discharge are supporting ward areas with no criteria to reside.
- H-FAST weekly project meetings are being held, aiming to **increase daily discharges** to six patients per day and will be given 2 discharge slots by 16th October 2024.
- The Pathway 3 DTA Trusted Assessor model is set to launch mid-September 2024 and aims to **discharge patients to independent sector providers** within 48hours of no longer meeting the criteria to reside .
- A governance review is underway to assess the feasibility of using NHS Volunteer Responders from the Royal Voluntary Service to deliver post-discharge treatment and observation (TTO) in patients' homes. This initiative aims to improve **patient flow**.
- 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 now underway.

Stroke improvement plan:

- A **'Straight to scan pathway'** is planned to launch from mid-September 2024 alongside the provision of virtual HASU beds.
- The stroke response team is now fully recruited with further plans to increase coverage by 4 hours (8am – Midnight) expected from November.
- Following the Insourcing of additional therapy the recruitment of additional Rehab workers is now underway to reduce patient deconditioning between qualified therapy sessions.

RTT and Planned Activity

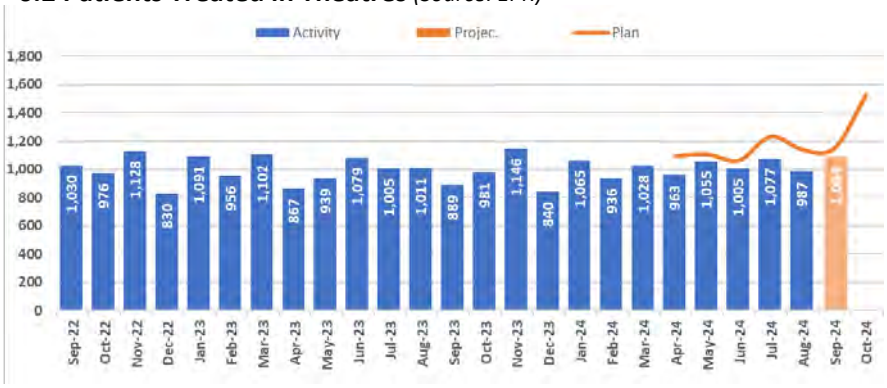
6. Inpatient Activity

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Admitted Clock Stops -	1,274	1,302	1,430	1,057	1,307	1,156	1,279	1,247	1,319	1,276	1,372	1,181	1,235
Number of lists run -	473	518	579	456	572	535	539	527	534	517	596	524	559
Patients Per List -	2.0	2.0	2.0	1.9	1.9	1.8	1.9	1.9	2.1	2.0	1.9	2.0	1.9
Capped Utilisation -	81.51%	83.29%	82.84%	80.26%	83.27%	82.71%	83.90%	85.42%	86.09%	83.19%	83.15%	82.89%	85.05%
Total Cancellations -	128	119	151	110	200	135	119	145	153	138	135	113	130
28-day Rebooking Breaches -	4	3	1	0	3	7	9	3	5	2	11	9	7
Decisions to Admit -	4,831	5,099	5,419	4,525	5,542	4,936	4,893	5,131	5,257	4,824	5,503	4,767	4,759

Latest position

- Inpatient activity delivered below plan in August 2024 in line with increased annual leave due to the summer holidays and is projected to remain stable in September 2024.
- Lists are running slightly below expected levels whilst patients per list and capped utilisation remain relatively stable in August 2024. Endoscopy unit and CDC activity is also tracking behind plan.
- The number of 28-day rebooking breaches remains high as capacity to rebook complex cases is limited.
- Theatre efficiencies aiming to increase the number of lists run and the number of patients per list will be explored as part of the Closing the Gap project. This will include an analysis of job plans to identify discrepancies with the current theatre session plan.
- A demand & capacity exercise for Anaesthetics will also identify if anaesthetist gaps are a limiting factor in the number of theatre list delivered and any opportunity for improvement.
- Day case volumes being behind plan is impacting on the closing the gap ERF opportunity and this will remain and area of focus for accelerating improvement into Q3.

7. Outpatient Activity

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Non Admitted Clock Stops -	6,514	6,891	6,933	5,461	6,810	6,230	5,909	6,474	6,589	6,255	6,713	5,699	6,090
DNA Rate -	8.35%	8.53%	8.62%	9.10%	8.16%	8.42%	8.34%	8.22%	8.52%	8.28%	7.93%	7.94%	8.52%
Follow Up Orders -	25,497	26,693	27,847	21,911	27,253	25,575	24,417	26,343	26,162	24,122	26,865	23,385	24,721
PIFU % -	1.79%	2.14%	1.91%	2.29%	1.89%	2.44%	2.48%	2.60%	2.71%	2.62%	2.60%	2.35%	2.38%
First to Follow Up Ratio -	2.62	2.69	2.70	2.60	2.61	2.61	2.53	2.52	2.50	2.49	2.64	2.54	2.50
Number of clinics run -	5,335	5,709	5,878	4,874	5,880	5,521	5,343	5,608	5,598	5,336	5,892	5,132	5,443
Patients Per Clinic -	7.9	7.6	7.7	7.6	7.7	7.6	7.8	7.8	7.9	7.8	7.9	7.8	7.5
GP Referrals -	6,764	7,262	7,330	5,554	7,423	7,049	6,979	6,888	7,379	6,629	7,474	5,985	4,620

Latest position

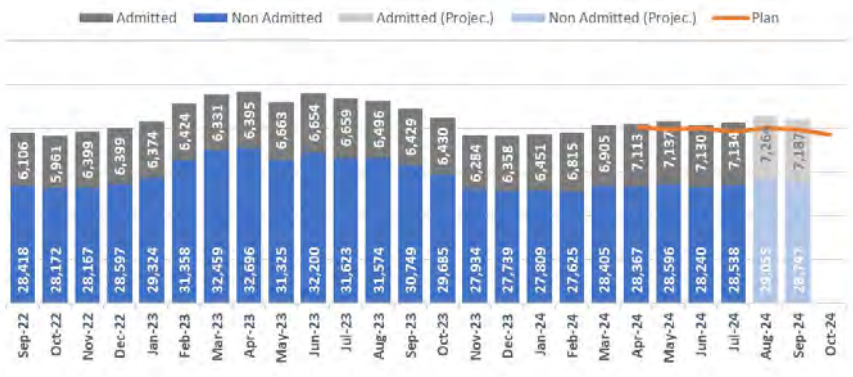
- Outpatient activity delivered above plan in August 2024 and is projected to deliver in line with plan in September 2024.
- The work to improve activity levels of outpatients with procedures in line with the planning guidance is ongoing and more services have now been included within the project.
- Patients continue to be routinely contacted via SMS as part of the waiting list management initiative aligned to the national validation toolkit recommendations. 89,231 patients have been contacted to date who meet the required criteria with 3,152 requesting discharge (3.5%).
- PIFU use has reduced slightly down in August (-0.25% to July) but remains a consistent conversation within the GIRFT programme.
- Outpatient, Day Case and Theatre improvement work has been aligned to a core workstream within Closing The Gap, with BAU improvement and GIRFT remaining in parallel.

8. Referral to Treatment

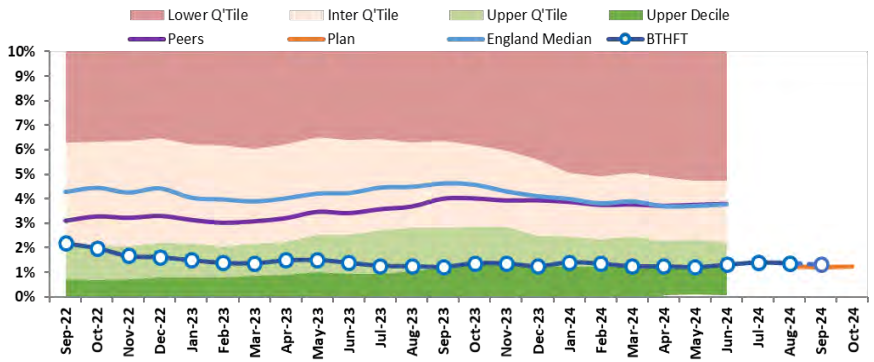
Bradford Teaching Hospitals NHS Foundation Trust

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
RTT Performance -	66.39%	66.69%	66.59%	64.60%	65.03%	65.13%	64.48%	64.35%	64.69%	64.31%	63.30%	63.16%	62.62%
Incomplete (<18) -	24,684	24,084	22,786	22,027	22,278	22,430	22,772	22,832	23,114	22,747	22,406	22,613	22,501
Incomplete (>18) -	12,494	12,030	11,431	12,069	11,982	12,010	12,542	12,648	12,619	12,623	12,992	13,191	13,433
Incomplete (52+) -	457	496	468	429	484	469	442	443	435	463	499	485	474
Incomplete (65+) -	84	92	64	63	75	67	34	58	67	75	65	55	74
Incomplete (78+) -	1	0	0	1	1	3	1	1	0	0	2	1	3
W/L Change -	-892	-1,064	-1,897	-121	+164	+180	+874	+166	+253	-363	+28	+406	+130

Latest position

- The RTT waiting list size remained above plan in August 2024 although the number of patients waiting over 52 weeks is projected to have reduced slightly in the same period. The number of patients waiting over 65 weeks decreased in August 2024 with ongoing efforts between Trauma & Orthopaedics (T&O), theatres and supporting staff to tackle issues regarding theatre capacity but is expected to increase in September 2024. Mutual aid has been offered and patients are being contacted and asked if they are happy to transfer.
- T&O, ENT and OMFS are all in recovery, with weekly meetings to review patient level data and action trackers in place.
- The T&O recovery plan continues to focus on mutual aid and improved list uptake which is expected to stabilise the position. List efficiency will be explored as part of a longer-term plan, but case complexity/duration has increased across elective and trauma lists. An arthroplasty consultant position is currently out to advert and will support longer term improvement for the specialty. Additional resource options are being presented to ETM to help address the backlog that has built up within this service.
- Oral Surgery have successfully transferred 20 patients to Leeds as part of the ongoing work with Trusts across WYATT to explore the transfer of long waiting patients.
- In support of neighbouring Trusts we have provided mutual aid for Vascular and Urology patients.

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
RTT LUNA DQ Metrics -	5,689	7,082	3,841	1,475	1,258	1,354	1,692	1,434	1,199	1,215	1,488	1,585
Correction Rate - Non RTT -	25.67%	20.06%	17.63%	20.75%	14.84%	76.76%	81.69%	42.69%	29.32%	33.91%	17.99%	13.21%
Non-RTT DQ Process Failures -	32,398	31,778	34,461	41,301	36,358	38,690	38,143	38,425	35,659	34,777	34,779	35,213

Latest position

- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.32% in August 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.
- Clearance of Non-RTT process failures is underway with technical validation of all the process failures created between 2017 and 2022 to be completed by 13th September 2024. Next stage will be to start validating 11,739 process failures created in 2023. 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 Ophthalmology on prevention of Non-RTT process failures. The new additions of process failures related to Eye CAS clinics are reducing as DQIS has improved the discharge process and work on Eye CAS booking process is underway.
- Work is underway on preventing DQ process failures related to Pre-Assessment, which is the largest cohort of DQ process failures in the trust. A new pre-assessment booking process has been agreed which includes using of to be scheduled list on Cerner to book patients for pre-assessment.
- Development of data feed and oversight process of active monitoring and endoscopy surveillance pathways is underway.

10. Delivering RTT/Planned Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

RTT and Planned Activity Improvement

- The Closing the Gap programme is working on improvements in elective service delivery across theatres and outpatient, which will impact RTT performance positively as schemes come to fruition.
- Access meetings continue weekly to review the entire RTT agenda, new dashboards are making DNA rates, discharge rates, and activity against plan more visible and accurate. These will highlight **areas of efficiency opportunity for services**, and allow them to connect over achievement with potential financial savings against CTG.
- 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. The Trust is currently calculating the impact of this delay on lost income as part of the Elective Recovery Fund.
- The implementation of the Theatre and Critical Care modules on Cerner is also due in November 2024 and should support better functionality and oversight of patients being admitted all in one place, as well as providing increased reporting functionalities.
- 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 almost all related services and actions agreed. Where appropriate cross cutting projects will be initiated to support adoption of best practice and many of these will fit within the Closing the Gap Elective Productivity workstream, for which we have established a parallel governance structure.
- As part of this we are 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. Learning from what is working across several pilot initiatives we are **mobilising additional capacity to phone patients**.
- 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.
- **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

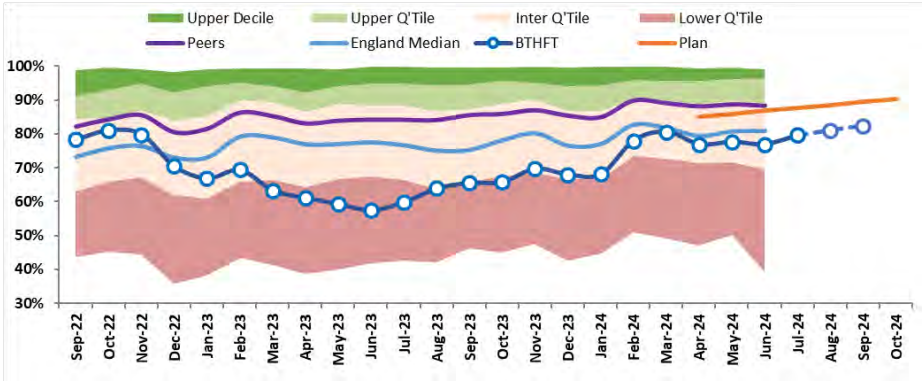
- Web-based **waiting list management tools** were successfully launched across the Corporate Access Team (CAT) and RTT tracking for all CSUs. Non-RTT tracking lists for CSUs are planned to go-live in on 17th September 2024. This will allow elective services across the Trust to track and validate all RTT and Non-RTT pathways in one place and will result in improved functionality and better oversight of pathways.
- We are developing DQ dashboard showing correction rate and DQ themes to support the 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.

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
(Phys. M'ment) Activity -	1,218	1,294	1,273	1,102	1,522	1,671	1,850	1,754	1,781	1,563	1,992	1,946	2,048
(Phys. M'ment) Performance	81.4%	70.3%	64.9%	58.2%	50.7%	61.6%	73.4%	77.1%	83.2%	74.5%	84.6%	85.5%	86.2%
(Imaging) Activity -	9,156	9,252	9,817	9,085	9,765	9,755	9,058	9,399	10,350	9,991	10,412	10,206	10,675
(Imaging) Performance -	60.1%	61.6%	69.8%	68.7%	73.2%	83.7%	82.6%	76.8%	75.7%	76.4%	77.8%	79.9%	81.2%
(Endoscopy) Activity -	1,184	1,139	1,371	1,164	1,484	1,263	1,310	1,337	1,543	1,440	1,489	1,460	1,528
(Endoscopy) Performance -	73.0%	80.3%	78.4%	90.1%	85.1%	86.0%	90.8%	77.1%	77.7%	84.2%	81.7%	80.6%	82.1%

Latest position

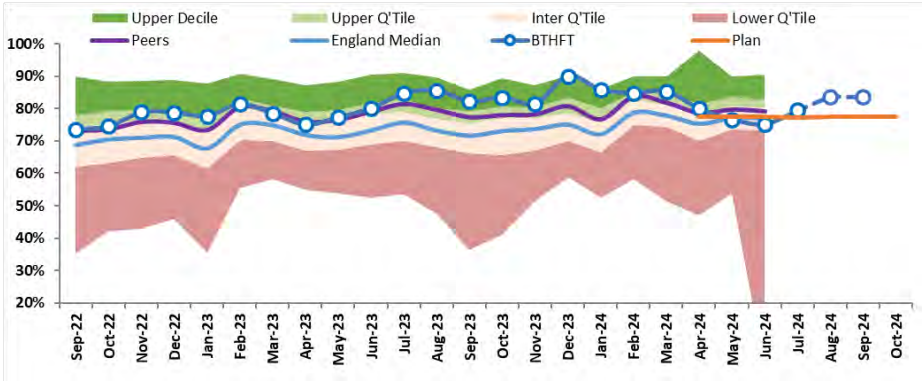
- CDC capacity is now available for Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. Process and efficiency improvements are being explored to further capitalise on this resource with recruitment to posts a priority.
- MRI capacity continued to be challenged in July due to further equipment issues including at the CDC however performance begins to recover in August. 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 but persistent sickness over the summer has hindered progress.
- Echocardiography plans are in place to ensure sustained service resilience with performance during July and August continuing to recover to summer 2023 levels of over 90%. Long term sickness will affect capacity. Extra slots have been approved across August/September which are expected to be booked in with no issue.
- Audiology continues to be challenged by gaps in clinical staffing however some improvement can be seen in July and August performance. Work to develop a long-term sustainable plan continues to support and sustain this further.

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)*

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Trust -	84.8%	85.2%	80.0%	76.6%	75.2%	79.4%	83.7%	83.5%
Breast -	96.3%	94.2%	96.2%	96.5%	96.0%	97.6%	97.5%	97.2%
Gynae -	44.2%	54.6%	54.4%	46.8%	45.8%	46.4%	75.0%	54.2%
Haematology -	52.9%	41.2%	21.4%	29.4%	33.3%	37.0%	44.4%	37.5%
Head & Neck -	84.0%	83.8%	69.5%	75.4%	72.2%	79.0%	79.1%	83.0%
Lower GI -	76.2%	76.3%	66.7%	56.7%	62.6%	65.5%	70.7%	79.7%
Lung -	84.1%	93.6%	88.9%	92.5%	88.9%	84.3%	85.7%	86.8%
NSS -	75.0%	61.1%	71.4%	95.2%	83.3%	92.3%	95.5%	80.0%
Upper GI -	80.4%	88.2%	75.9%	75.8%	85.8%	90.6%	90.5%	90.1%
Skin -	94.9%	95.1%	92.6%	86.0%	72.4%	82.8%	88.2%	81.3%
Urology -	78.6%	53.1%	54.7%	74.7%	77.9%	80.3%	84.3%	81.5%

12.3 Additional Diagnostic Phase Metrics

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
# 2WW Refs -	2,322	2,103	1,967	1,534	1,825	1,814	1,842	1,969	2,074	1,647	1,692	1,894	1,782
% 2WW Performance -	94.2%	95.6%	96.4%	93.1%	82.1%	94.8%	92.3%	86.1%	89.9%	94.4%	92.9%	93.6%	93.2%
FDS Performance -	82.1%	84.6%	81.4%	91.0%	85.7%	84.8%	85.2%	80.0%	76.6%	75.2%	79.4%	83.7%	83.5%
# Total Patients Seen FDS	2,078	1,776	1,652	1,188	1,536	1,510	1,374	1,666	1,959	1,827	1,722	1714	1865
# Undiag, unbooked >28 days -	240	301	158	283	176	217	313	318	342	212	209	176	215

Latest position

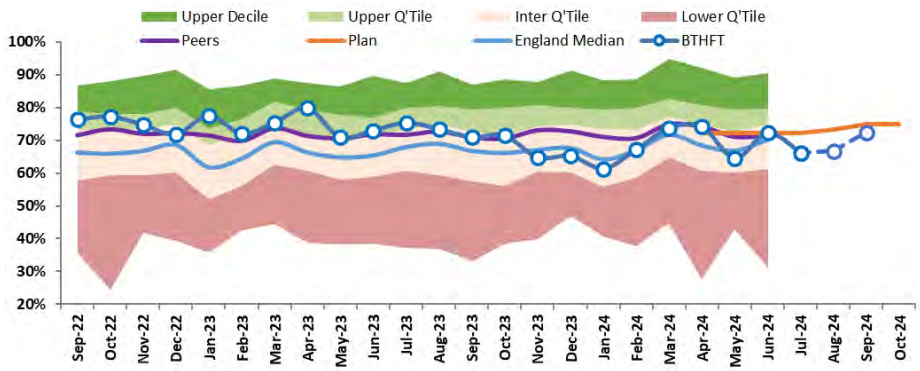
- FDS performance for July improved to above the Trust target of 77%. Histology delays are reducing having a positive impact on previously challenged tumour sites. This remains a focus for the HISTO programme along with recruitment of consultants and AP/EP demand and capacity work.
- Two week wait (2WW) performance is tracking slightly below target due to high demand in some tumour groups, but this isn't negatively impacting on the diagnostic standard.
- Skin demand has remained reduced this summer and may reduce further as the Skin Lesions Investigations Clinic (SLIC) pilot becomes embedded as BAU. The SLIC impact can be seen with performance remaining over 97% throughout the seasonal referral peak.
- 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.
- Reporting backlogs are being kept to a minimum and reporting to NHSE has been established for the forecast months.

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 70% Target

(Source: PPM)

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Trust	66.9%	74.3%	74.1%	64.5%	72.2%	66.1%	66.7%	72.4%
Breast	75.0%	82.7%	88.6%	69.1%	83.3%	92.2%	88.0%	93.6%
Gynae	25.0%	83.3%	62.5%	55.6%	70.0%	13.3%	70.0%	42.9%
Haematology	25.0%	83.3%	62.5%	55.6%	70.0%	13.3%	64.7%	58.3%
Head & Neck	33.3%	60.9%	62.5%	57.1%	35.5%	40.0%	45.8%	47.8%
Lower GI	64.3%	76.0%	73.5%	56.5%	54.5%	84.2%	63.6%	80.8%
Lung	44.4%	46.9%	60.0%	10.0%	46.2%	41.2%	43.8%	44.4%
Upper GI	81.8%	75.0%	30.8%	50.0%	61.1%	50.0%	66.7%	72.7%
Skin	84.6%	72.7%	76.7%	70.6%	87.2%	82.8%	73.1%	85.7%
Urology	78.5%	91.9%	83.3%	80.9%	82.2%	62.0%	80.0%	65.7%

13.3 Additional Cancer Treatment Metrics

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
# 31 Day Treatments	281	254	312	248	315	278	247	262	257	260	261	227	283
31 Day Performance	94.3%	91.7%	87.5%	92.7%	87.0%	95.3%	91.9%	95.0%	93.8%	91.5%	92.3%	93.8%	94.4%
62 Day Performance	73.5%	70.3%	65.8%	65.9%	60.9%	66.9%	74.3%	74.1%	64.5%	72.2%	66.1%	66.7%	72.4%
# of >62 (GP Referral)	55	66	67	53	63	53	41	62	75	56	58	55	39
# of >62 (All Types)	83	104	97	88	101	79	51	80	98	77	82	72	55

Latest position

- 31-day treatment (time from decision to treatment) performance continued below target at 92.34% for July having been impacted during holiday periods and some historic diagnostic delays. Treatment numbers are forecast to remain low during August due to further holidays which will mean the 62-day backlog increases.
- Cancer treatment within theatre remains a priority and early identification of capacity issues is in place. Head & Neck capacity is currently being reviewed but there are no other escalations at present.
- 62-day performance dropped to below the 70% target during July with the clearance of patients who had already exceeded the 62-day target due to diagnostic delays being a priority. The impact of holidays on clinician or patient availability will mean a delay in sustained recovery of performance.
- Although treatment volumes have impacted on performance against this standard, there is no single cause for this with tumour groups experiencing increased complexity, reduced capacity, 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 TBA (delayed due to integration requirements). 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 Care Co-Ordinator roles have proven successful. Further expansion is planned of these roles via the use of Cancer Alliance funding, and substantive appointment to these and FTC CNS roles has been agreed by ETM. Additionally, a successful Innovation Bid to the Cancer Alliance is providing an opportunity for CNS internships to **develop future CNS workforce** and attract nurses to these roles. Student Nurses have also commenced placements.
- Weekly One Stop Clinics for palpable neck lumps commenced 31st July 2024, which provide access to ENT, Consultant Radiologist & Ultrasound at the initial appointment. Referral forms have been revised to ensure correct patients are referred to this weekly clinic.
- The Histopathology Improving Services & Transforming Outcomes (HISTO) programme is underway, with the intention of **improving turnaround times** which will significantly impact cancer pathways. A Consultant Time Out is planned for the 6th of September and active recruitment to posts continues. ETM have supported 2 further Consultant Histopathology posts and recruitment to these is currently on-going. A business case for Extended & Advanced Practitioners is also going to be considered by ETM 9th September'.

Diagnostic Wait Times improvement

- DM01 performance for August and September is forecast to steadily improve to over 80% despite the impact of summer annual leave. NOUS and Echocardiology lead the improvement as recovery and improvement plans start to have an impact.
- The remaining challenges for sustainability of the Non-Obstetrics Ultrasound (NOUS) DM01 performance is now predominantly due to Consultant led activity, rather than sonographers. Alternative provision of specific tests are being explored.
- MRI performance continues to be a focus, however the number of patients waiting beyond 6 weeks is now on a downward trajectory month on month, and DM01 sustainable performance is anticipated within 6 months. Extra capacity for GA MRI has been approved and will help to deliver the recovery plan.
- Delivery of the **CDC programme** is now established and now working towards sustainable 7-day provision for all modalities.
- 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.9.24.12 - REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE - 10 SEPTEMBER 2024

REFERENCES

Only PDFs are attached

Bo.9.24.12 - Report from the Chair of Audit Committee Sept24.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.12

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Audit Committee

Date of meeting: 10 September 2024

Key escalation and discussion points from the meeting
Alert:
Internal Audit – the Committee received a report from the Director of Nursing on progress in addressing the recommendations in the internal audit report, Nursing Assessment and Care Plans, which had previously received Limited Assurance when reported in May 2024. Whilst recognising that the Committee members present had no clinical knowledge themselves, and noting the small sample of records tested, they were sufficiently concerned about the original findings, and insufficient evidence of improvement from the actions taken, to request that the Quality Committee give careful consideration to the findings, and assume responsibility for monitoring the improvement plan, and consider the cultural aspects of why entering important information on the care plans was not seen as an essential element of the delivery of care in every case.
Advise:
External Auditor's Annual Report – the Committee noted the contents of the report which repeated much of the previously received ISA260 report and will be publicly available on the Trust's website. The Committee noted that it had previously expressed its view on a particular aspect of the auditors' conclusions on governance risk and did not repeat the discussion at this meeting. The Committee did however reflect that there were many positives to be taken from the report which may have been overlooked in previous discussions. **Internal Audit Recommendation Tracking** – The Committee noted that there was still room for improvement in the timeliness of Executive sign-off of internal audit recommendations. The number of outstanding actions, many well overdue, was also noted and the Committee stated that it expected to see improvement in the number of significantly overdue recommendations at its next meeting **Procurement Waivers** – the Committee will take a closer look at the appropriateness of single source tender at a future meeting and was pleased that the new Chief Financial officer said he would also be looking closely at requests.
Assure:
Internal Audit – the Committee received the following reports and noted the High and Significant assurances given

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.12

Report No	Report	Final	Draft	Opinion
BH/01/2025	Infection Prevention and Control; Hand Hygiene	✓		High
BH/02/2025	COSHH Follow Up	✓		Significant
BH/03/2025	Charitable Funds / Bradford Charity – Controls Improvement Audit Stage 2	✓		N/A
BH/04/2025	Freedom to Speak up	✓		Significant
BH/05/2025	Discharge Management	✓		Significant
BH/06/2025	Board Assurance Framework and Risk Management Arrangements Benchmarking Review *(BTHFT is letter C in the analysis)*	✓		N/A

Annual Internal Audit Performance Review – the Committee noted the summarised responses of Audit Committee members and the Executive Team. Overall comments were positive about the internal audit service provided by Audit Yorkshire

Data Quality – the Committee noted the good level of assurance provided by benchmarking information of the Trust's DQMI performance compared to other WYAAT Trusts.

Overseas Visitors income – the Committee had requested the attendance of the Senior Healthcare Contracts and Overseas Manager to explore the proportionately high level of income write-off from overseas visitor treatments compared to total Trust losses. A comprehensive explanation of the systems in place was provided and the Committee took a high level of assurance that these systems and their operation worked to provide a high level of income recovery from overseas visitors and the level of losses were, to a large extent, unavoidable.

Compliance with the Risk Management Strategy – the Committee took assurance from the report and supporting evidence provided whilst noting that there were opportunities across some CSUs for further improvement in performance under the Quality Governance Framework.

Conflicts of Interest Annual report – significant assurance was provided by the report which noted that the Trust achieved 99% disclosures from decision making staff. This is very good performance compared to benchmarking information from other WYAAT Trusts.

Report completed by:

Bryan Machin
Committee Chair and Non-Executive Director
20 September 2024

BO.9.24.13 - REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE - 22 JULY 2024

REFERENCES

Only PDFs are attached

Bo.9.24.13 - Report from the Chair of the Charitable Funds Committee - July 2024.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.13

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: CHARITABLE FUNDS COMMITTEE

Date of meeting: 22 July 2024

Key escalation and discussion points from the meeting

Alert:

Charity Independence – Progress Against Plan

Progress has been delayed due to the departure of the Charity Director. The post is currently out for recruitment. It has been agreed that the case cannot progress until a replacement is in post and SA proposed that the 12-month window is started once the new Charity Director has been in post for approximately 5 weeks.

The Committee noted the update and agreed with the plan.

Advise:

Internal Investment Funds
£500k Donation for the Da Vinci Robot. The charity received £500,000 in 2023 to donate towards the new robot. Proposal to liquidate funds The Elsie Sykes Trust and Rathbones draw down request proposal was approved by the Committee.

External Investment Funds
Completion of Rathbones ERQ (Entity Risk Questionnaire). The Committee reviewed the questions and in conclusion, strongly agreed It would be preferable for the organisation to accept the risk of short-term losses to get better potential long-term gains.

Assure:

Bradford Hospitals' Charity Treasury Management & Investment Policy
MQ presented this policy for approval. The latest Charity Commission guidelines have been reflected within the document. The Committee approved the policy

Rathbones Contract
The Committee approved the recommendation to stay with Rathbones, extending the contract for 12 months, until which time the new independent charity trustees can decide on the next steps.

Operational Committee Report
The Committee discussed and noted the following:

- Work continues with the Sick Children's Trust and a Memorandum of Understanding (MoU) is awaiting sign-off for the £1.5 million for the new Neonatal Unit.
- Recruitment into the Charity Team continues, and a Charity Trust and Foundation role is being recruited to. A successful candidate was interviewed last week and is currently going through the required HR process.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.13

- The current pipeline fundraising forecast is around £351,000 in pledged donations and several fundraising activities have been carried out for the Neonatal Unit appeal

Date of meeting: 22 July 2024

Report completed by:

Altaf Sadique
Academy Chair and Non-Executive Director

September 20th, 2024

BO.9.24.14 - REPORT FROM THE CHAIR

REFERENCES

Only PDFs are attached

Bo.9.24.14 - Report from the Chair (1).pdf

Bradford Teaching Hospitals NHS Foundation Trust

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.14

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 July 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

In recent weeks I have been supporting two of our neighbouring Trusts in West Yorkshire with their Board recruitment – for Airedale DHFT I was on the external stakeholder panel for their Chair recruitment process, and for Leeds Community Health Trust I was a panel member for their recruitment process to appoint a new NED and a new Associate NED. It was a pleasure to support System colleagues in this way.

I have also now completed my introductory meetings with all key partners and stakeholders across Place and the wider System.

2. Council of Governors

- **Council of Governors meeting scheduled for 17 October 2024**

Our next Council of Governors meeting is scheduled to take place on Thursday 17 October from 4.15pm to 5.45pm. Following this the Council will hold a meeting in private to consider confidential matters.

- **Farewell to one of our longstanding Governors**

Professor Alastair Goldman, Partner Governor University of Bradford stood down from his role on 12 September following his retirement from the University of Bradford. Professor Goldman served as a member of the Council for just over five years. I have written to Alastair on behalf of the Council and the Board to convey our thanks for his service as a Governor and to wish him well in the future. We are currently reviewing the makeup of the Council of Governors and will therefore wait until that review is complete before seeking to appoint a replacement.

- **Confirmation of new Governors**

I advised in my last update to the Board of the outcome of the governor elections and the appointments of one returning governor, Ibrar Hussain, elected to represent Bradford West, and one new governor, Sharon Taylor, elected to represent Bradford South. I am pleased to advise that their pre-appointment checks are now complete and that Ibrar and Sharon have now formally joined the Council of Governors. You can see their profile information here along with that of our other Council members.

- **Feedback to the Council following Board of Director meetings**

I met with governors in July to provide an update on the items discussed at the July Board. My next session, to provide an update from our September meeting, is scheduled for 5pm on the day of our Board meeting.

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- **Governor attendance at key sessions**
  - In recent months Governors have attended the CSU (Clinical Service Unit) to Academy event on 12 September.
  - Several of our Governors will also be joining the Board and Trust staff at our 'Brilliant Bradford Awards' evening on Thursday 26th September to help recognise 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. 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. Council of Governors 'task and finish groups'

Thank you to all those Executives and NEDs who responded to my call for Board volunteers to support our Governor 'task and finish groups'. Membership has been confirmed and the meetings are now being scheduled for the delivery of the two key pieces of work; a revised Constitution and, a review of key policies and procedures related to the Council of Governors.

4. Governor Induction Programme: Site tours

A site tour has been scheduled for key areas within our BRI Estate including A&E and Ward 5, on 14 October from 1pm to 4pm. As well as our newer Governors and Non-Executive Directors; an invitation has been extended to all Governors and NEDs to attend if they wish. Details for our second site tour covering the Bradford Institute of Health Research and, our Education Service (including the Simulation Centre) will be shared shortly.

Recommendation

The Board is asked to note this report.

BO.9.24.15 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

Bo.9.24.15 - Report from the Chief Executive (cover).pdf

Bo.9.24.15 - Appendix 1 - 204.07.02 WYAAT MoU Review v1.1.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.15

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 July 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. The Ambulatory Emergency Care Unit (AECU) and front door streaming are supporting improvement in a range of KPI, however despite the improvement work some patients continue to wait longer than we would like, particularly where they need to be admitted into the hospital. Significant effort is being given to improving the experience and wait times for these patients.

The area of ED which contains the AECU and GP stream has been formally designated as an Urgent Treatment Centre (UTC). This aligns with the principles set in NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services. The UTC designation recognises the importance of this unit within the overall delivery of Emergency Care in Bradford. The confirmation of this designation was received from NHSE on the 19th July 2024.

Part of the challenge for admitted pathways relates to occupancy and the ability to discharge patients to an appropriate setting or care package. A system approach to reducing the pressure on social care is progressing. With strong internal processes we have minimised the impact and since launching H-Fast in July the number of priority discharges for discharges has become the area of focus. This programme is now being expanded to help increase these further.

Collaborative work with Yorkshire Ambulance Service (YAS) is ongoing but performance for handover times remains a pressure. Actions from the process mapping exercise that was undertaken jointly are progressing. A new handover process, approved and communicated to the teams by YAS and BTHFT

is now live and work also continues to improve the accuracy of handover data recorded by YAS and used for external oversight of relevant metrics.

Outpatient and elective transformation schemes are being supported by GIRFT further faster. This is a clinically led approach to understanding opportunities presented by identifying 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, when fully on line.

Work to reduce elective waiting times continues and whilst almost all services have continued to make positive delivery against the target to have no waits over 65 weeks, there will be some in Trauma and Orthopaedics and ENT (Ear Nose and Throat). Both areas are being intensively supported to recover the position as quickly as possible. Mutual aid from neighbouring Trusts is being used to offer patients earlier treatment elsewhere and whilst uptake has been minimal efforts persist. A similar offer of mutual aid from BTHFT has been made for Vascular and Urology patients which are being transferred to us from within WYAAT and from Sheffield.

Confidence in the Referral to Treatment (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 trying to avoid data quality issues in the first place. Web-based waiting list management tools have been implemented across the Clinical Service Units in July which are expected to improve oversight of pathways.

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 Clinics and GP led Skin Lesion Investigation Clinics 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. Diagnostic performance is improving for cancer and for more routine waits with all modalities showing progress during summer.

St Luke's Day Case Unit (SLH DCU)

The development of SLH DCU is progressing, however the expected handover date of 31 August 2024 from the contractor (Darwin Group) has not been met. A revised programme is currently being developed by Darwin Group to provide a reprofiled 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. The Trust has received the Guaranteed Maximum Price information from Robertsons, which was considered by an Extra Ordinary Board meeting on the 2nd September 2024. Based on the information provided the Trust Board approved entering into formal contract and for the development to now progress with an anticipated completion by 31st October 2025.

Revised delivery date for Theatres Anaesthesia and Critical Care Electronic Patient Record Build plus wider EPR enhancements

As Board colleagues are aware, in partnership with Airedale NHS Foundation Trust we are deploying additional functionality in our enterprise electronic patient record – Oracle Health's (Cerner) Millennium product. Initially the scheduled proposed go-live for this programme of work was the end of September 2024. Further to a series of integration testing activities (IT2) in August and a wider assessment of overall organisational readiness – both Trusts - a revised timescale has now been agreed that will see the new system operational at the end of November 2024. The programme represents a further step forward in enabling digital transformation in the Trust. This will further improve the quality of services for our patients and streamline clinical processes for our staff.

2. People

Riots, Racism and Islamophobia

We recognised the impact of the riots and rise in racism across the country and the impact on our colleagues across the organisation. On the 9th of August a special pause for peace gathering was held to offer colleagues an opportunity to come together and to send a message that we stand united against racism and Islamophobia. Colleagues gathered outside the entrance off Smith Lane under the flags showing the multitude of countries from which our workforce originates. There were messages of peace from Faeem Lal, Director of HR who delivered a message of peace from the Holy Quran and the Islamic perspective and Mel Pickup, Chief Executive reflected a message of peace from the Bible. Karen Dawber, Chief Nurse delivered a message of peace from a non-faith perspective.

Asian Heritage Month

We enjoyed a wonderful celebration on the concourse for South Asian Heritage Month. Colleagues marked the event in style with traditional costume, delicious food and beautiful henna hand painting. The celebration was organised by our RESIN network.

Pay Awards
NHS PRB

On 29 July the government announced the pay award for all NHS staff. With effect from 1 April 2024, a 5.5 per cent consolidated uplift was announced for all Agenda for Change staff on NHS terms and

conditions. In addition, it has now also been agreed that for Agenda for Change pay bands 8A and above a new intermediate pay point has been introduced.

Doctor and Dentists

For doctors and dentists the pay awards will be an uplift in salaries by six per cent, applying to:

- consultants
- specialty and specialist (SAS) doctors
- doctors and dentists in training who will also receive an uplift of £1,000
- salaried dentists, including those working in community dental services and public dental services
- contractor general medical practitioners
- salaried general medical practitioners pay ranges
- pay element of dental contracts
- no uplifts in Local Clinical Excellence Awards (these remain frozen).

All pay uplifts will be backdated to 1 April 2024.

Junior Doctors Vote to Accept Pay Deal

Junior doctors voted this week by a margin of 66% to accept the offered pay rise, on a turn out of 69%, ending the most prolonged industrial dispute in the NHS' history. The pay rise is worth an extra 22.3% on average over two years.

Staff Awards

On 26 September we hold our long service awards to celebrate remarkable levels of commitment and care from colleagues who over 30 years of service within the NHS. We also hold our staff Brilliant Bradford awards ceremony on the same day during the evening, it's an evening to celebrate the brilliant levels of care, compassion that colleagues across the organisation demonstrate to ensure our patients have the best levels of care.

Visit from the Minister of State for Care

On 17 September we hosted Stephen Kinnock MP, Minister of State for Care, who visited to hear about the work we are doing around integrated care as well as some of our specialist services. Stephen met colleagues in our Command Centre, spoke to members of our Multi Agency Integrated Discharge Team (MAIDT), and heard first-hand about the Home First Assessment Support Team (H-FAST) project at Bradford Royal Infirmary, a partnership piece of work between the NHS and Bradford Council.

3. National Updates

New ministers at DHSC

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Following the General Election on Thursday 4 July, we have a new government and this includes a new ministerial team for the Department for Health and Social Care. You can see details of the appointments below and their areas of responsibility.

- Wes Streeting MP; Secretary of State for Health and Social Care
- Stephen Kinnock MP, Minister of State (Minister for Social Care)
- Karin Smyth MP, Minister of State for Health (Secondary Care)
- Andrew Gwynne MP, Secretary of State for Public Health and Prevention
- Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health

Other key cabinet members include:

- Rachel Reeves as Chancellor
- Angela Rayner as Deputy Prime Minister
- Yvette Cooper as Home Secretary
- David Lammy as Foreign Secretary
- Liz Kendall as Secretary of State for Work and Pensions

Collective action by GPs

Following a non-statutory ballot, organised by the British Medical Association (BMA) of its GP contractor/partner members in England that concluded on 29 July, GP partners/contractors voted in favour of collective action. Seven in ten eligible members voted, with 98.3% of members voting yes, indicating that they are willing to take action. Since the result of the ballot was announced, plans have been set in place nationally, regionally and locally in response to the collective action.

The ICB is working through situations and potential risk, impacts and implications of GP collective action. The action will be different to previous industrial action by junior doctors, as the level of activity can vary by place, practice and timeline when GPs may wish to act. At place, intelligence to date suggests there has been very minimal disruption across our GP practices with system partners working through contingency plans including dealing with any surge in activity such as at local emergency departments.

Care Quality Commission (CQC) Review

In May 2024, Dr Penny Dash was asked to conduct a review into the operational effectiveness of the Care Quality Commission (CQC). The purpose of the review was to examine the suitability of CQC's new single assessment framework methodology for inspections and ratings of health and care providers.

This interim report provides a high-level summary of the emerging findings of the review in order to inform the changes needed to start the process of improving CQC. It makes 5 recommendations and is aimed at health professionals, health and social care services, academic and professional institutions and the general public.

The Trust underwent unannounced inspections of three core services – medicine, neonatal services and maternity services – in March, April and May. The draft reports have been received by the Trust and returned to the CQC following factual accuracy checks. We anticipate the reports will be published late September to early October. The Trust also underwent a well led review and we await the sharing of the draft report.

New chief nurse for England

NHS England has announced that Duncan Burton has been appointed as Chief Nursing Officer for England. A nurse of more than 25 years, Duncan was most recently Deputy Chief Nursing Officer where he led national work on the maternity and neonatal programme, workforce policies and the children and young people's transformation programme.

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.

4. Regional updates

Welcome to Shaukat Ali Khan

Welcome to Shaukat Ali Khan to the new role of ICB Chief Digital Information Officer who joins us this month and will be an NHS West Yorkshire Integrated Care Board attendee. He will be working with digital information colleagues and business intelligence teams across West Yorkshire. Shaukat brings a wealth of experience from his current role as the Global Chief Information Officer at the Aga Khan University and Hospitals in Asia, Africa and United Kingdom, where he's been driving digital strategies on a global scale. His background includes leadership roles at the University of 14 Central Asia and Novo Nordisk A/S, where he led digital transformation initiatives.

Programme director appointed for community health services provider collaborative

Becca Spavin has been appointed as the new Programme Director of the West Yorkshire Community Health Services provider Collaborative (WYCHS). Becca had been working as WYCHS Director on secondment basis over the last 18 months, but following a successful interview process, Becca will now lead the provider collaborative as its new director.

The West Yorkshire People Board

The West Yorkshire People Board, met on the 20 June 2024 to review and refresh the purpose of the Board together with key principles and strategic priorities. The People Board recognised the importance of the upcoming publication of the national Social Care Strategy as a key enabler to system wide workforce planning and transformation across the Partnership and the outcome of that strategy will signal priorities for the Board. There will also be a focus on the mental health workforce in delivering the ambitions of the Partnership and tackling inequalities.

The ICB's Director of People and members of the People Board following consultation across sectors are establishing a Strategic Workforce Forum to lead with the following purpose:

a) Oversee and drive the growth and sustainability of a health and care workforce for tomorrow, capable of meeting the needs of the population of West Yorkshire.
b) Provide leadership and consensus on determining system wide workforce transformation priorities, interventions and projects.
c) Enable strategic collaboration between partners.
d) Provide governance / assurance to the WY Health and Care Partnership.

e) Oversee the system's ability to expand and maximise placement quality and capacity across all partnership sectors.

The priorities will be set out in the West Yorkshire People Plan which will be refreshed over the forthcoming 12 months.

NHSE Regional Director, Richard Barker – message from Cathy Elliot Chair for NHS West Yorkshire Integrated Care Board

Finally, on behalf of the NHS West Yorkshire ICB Board I would like to offer thanks to Richard Barker, NHSE Regional Director (North East and Yorkshire), in recognition of his incredible contribution and commitment to the NHS. Richard is due to retire at the end of June 2024 after a 40-year career in the NHS. I thank Richard for his support and commitment to our collective work over many years and wish him well for the future. A recruitment process has begun to appoint his successor and the Board looks forward to continuing to work closely with NHSE as the regulator across the region.

West Yorkshire Combined Authority

On 4 May 2024, Tracy Brabin was re-elected as Mayor of West Yorkshire and has set out her plans to create a more prosperous region by putting local growth at the heart of her vision to give children the best possible start in life and to support parents to retrain and get back into work creating a 'region of learning'.

In addition to improving public transport, reducing violent crime, and building thousands of affordable homes, Mayor Brabin will work with councils to redesign public services including early years, adult skills and employment support.

Alison Lowe was confirmed on 14 June 2024 as West Yorkshire's Deputy Mayor for another four years, to support the Mayor to improve policing and tackle crime across the region.

5. Place updates

We stand united against all racism and Islamophobia

The Bradford District and Craven Health and Care Partnership Board demonstrated strong condemnation of recent racism and Islamophobia demonstrations observed across the country. Our support statement can be found here: Bradford District and Craven and has been addressed across West Yorkshire and through national bodies including NHS England, Local Government Association and the National Council for Voluntary Organisations.

Farewell to Key Partner Members

The Ac as One Health and Care Partnership thanked and bid farewell to some of its key partner members – Andrew Gold, Chair of Airedale Foundation Trust, David Crampsey, Medical Director of Airedale Foundation Trust, who leaves to join the Royal Free Hospital as its Chief Executive Officer, and Nancy O'Neill who retires from the Bradford District and Craven ICB.

Formal Partnership Board Meeting – 6th September

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The formal Bradford District and Craven Health and Care Partnership Board meeting took place on Friday 6 September and the papers can be found here. Members at the meeting were provided with an update on how the Listen In programme has helped either directly or indirectly influenced the work we are doing based on what local communities have told us is important to them. During this meeting we discussed how we move the way we work with our citizens, so that we encourage people to get actively involved in our shared ambitions for the communities they live in. The Partnership Board had our regular standing item on our system-wide Closing the Gap programme and we also heard an update on Bradford Council's latest financial position. Members received an update on two key local strategies – the North Yorkshire Wellbeing Strategy and the refreshed Joint Forward Plan for Bradford District and Craven. This joint forward plan describes how we will work at place, to contribute to the delivery of our West Yorkshire system's forward plan and ambitions. The next Bradford District and Craven Health and Care Partnership Board meeting takes place on 15 November.

Bradford 2025 update

We are getting closer and closer to 2025, which for us brings the excitement of Bradford taking on the mantle of UK City of Culture. On 12 September, the programme for City of Culture was announced. We know that arts and culture bring positive impacts to people's wellbeing. As a result I'm delighted to announce that we have recently recruited to a new role of creative health manager which will help support this vision. In other exciting news, the BBC has confirmed that it will be the broadcast partner for Bradford 2025. And if you didn't know already Bradford's very own Zayn Malik is the brand ambassador. Keep up to date by visiting www.bradford2025.co.uk where you can also sign up for the newsletter.

Building a Neurodiverse Friendly District: workforce and recruitment

A special event is planned in Bradford during the Healthy Minds Festival, where we will discuss strategies and initiatives for building a neurodiverse friendly district with a special focus on workforce and recruitment. The event takes place on Thursday 24 October from 10am (doors open from 9.30am) – 3pm at Margaret Macmillan Tower in central Bradford. Book your space now through Eventbrite.

Social worker recruitment campaign

Bradford Council and Bradford Care Association have launched a recruitment campaign, aimed at inspiring people across the city to embark on a rewarding career in adult social care. Titled, "Be Someone's…" this campaign highlights the crucial role social care workers play in supporting individuals in need across Bradford - because, when you work in social care, you become something to someone. We want to encourage wider sharing of this, so that we can attract people to our local health and care workforce, please do get involved.

Help for you and baby

The campaign focuses on providing clear information to families about all things they can expect from pregnancy and until their child is around two years old, including antenatal services, postnatal support and immunisations. Our local insight has involved working with communities who are either new to the country or have English as a second language. To do this we have visited community groups and have also attended English as a Second Language (ESOL) classes to test our concepts. We have also used these sessions to get a better understanding of what people know about the support that is available to women when they are pregnant and what is available to their babies once born. My ask is for colleagues, to share this campaign through your networks and community groups.

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Breastfeeding friendly scheme launched

Bradford District Care NHS Foundation Trust's Community Infant Feeding Team is launching the new Bradford District Breastfeeding Friendly scheme to support local mums to breastfeed 'here, there and everywhere'. Local organisations from cafes and restaurants, to hairdressers, shopping centres, Family Hubs, transport hubs and leisure facilities, are being encouraged to sign up to the Breastfeeding Friendly initiative, by ensuring their staff understand the importance of breastfeeding, providing a warm welcome for breastfeeding mums and displaying the Breastfeeding Friendly sign on their premises.

South Asian Heritage Month (18 July – 17 Aug)

Organisations across our Partnership, including BTHFT, have marked South Asian Heritage Month, a time to commemorate, mark and celebrate South Asian cultures, histories and communities. Mind in Bradford have led on developing resources for all partners to use. This includes stories shared in blogs and videos as well as recommendations on how you can experience South Asian culture through film, TV, recipes and books.

Pioneering research project on wellbeing into later life secures funding

Researchers from BTHFT's Bradford Institute for Health Research (BIHR) have been awarded a major grant of £892,518 from the Nuffield Foundation to establish the 'Wellbeing in Later Life in Bradford' cohort study. The research team aims to produce new findings on factors that improve or reduce wellbeing in later life, focusing on frailty, care transitions, care needs, and care networks.

Bradford independent care providers score top marks

Independent care providers, that are CQC registered, across Bradford District and Craven have topped the national table for complying with the Data Security and Protection Toolkit (DSPT). National colleagues have congratulated local care providers as we achieved a compliance rate of 93% against the national target of 70%. This means we have topped the June league table in terms of overall percentage of compliant providers! Congratulations to all teams involved, I know this has been a true partnership effort – thank you.

Awards news

- Four teams from Bradford Teaching Hospitals NHS Foundation Trust have been shortlisted in prestigious national healthcare awards. The maternity parent education team, along with additional needs navigator Naomi Hargreaves, Bradford Royal Infirmary's ward 31 and the Trust's early innovation team are all nominees in this year's Health Service Journal's Patient Safety Awards 2024. The awards ceremony is on Monday 16 September.
- Congratulations to the teams at Safe Spaces and the Multi-Agency-Support-Team (MAST). Both have been shortlisted for the Charity Times Awards under the 'Collaboration of the year' category. The winners will be announced on Wednesday 25 September.

6. Partners

WYAAT Committee in Common, 30th July

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The Chair and I attended the most recent Committee in Common (CIC) meeting on 30th July, which included a detailed discussion on the WYAAT cost review including the outputs and next steps. We received a number of reports including the Programme Executive report, collaborative report, WY HCP report and the WYAAT annual report for 2023/24. We also reviewed the WYAAT Memorandum of Understanding (MoU). The revised document includes a number of changes to reflect current legislation and operation of WYAAT in light of the approval and publication of the Five Year Strategy and to reflect the learning from the aseptics programme.

The following amendments are proposed:

- Made contemporaneous in language reflecting the July 2022 legislation e.g. removal of references to Sustainability and Transformation Partnerships (STPs) in favour of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs).
- Reference to the 'WYAAT Strategy' encompassing the development of the strategy, and delivery of the associated priorities and programmes in the annual plan rather than the 'Collaborative Programme' terminology in the originally drafted document.
- Updates to Code of Governance referenced in Section 4.1.4 to ensure the most contemporaneous guidance is referenced.
- Clarified reporting through public boards via the Annual Report (Section 6.1.5)
- Removed reference to competition and procurement compliance (section 12). Review of the updated provider licence would deem this section no longer relevant or required.
- Schedule 2 – it is recommended that the assurance framework is updated to include HR Directors and Estates and Facilities Directors' Groups in the formal governance framework.
- Schedule 2 (Section 6.8) provision to instigate a programme review when it progresses through a stage e.g. from business case approval to implementation, based on aseptics lessons learned review.
- Schedule 5 – CIC Terms of Reference (ToRs) refined in respect of our risk management approach.
- Schedule 5 – inclusion of a provision to which prevents the chairing of two collaboratives simultaneously (Section 5.4)
- Schedule 5 – broaden measures to assess effectiveness in line with committee reviews in trusts / good practice (Section 5.10)
- Schedule 5 – New section (Section 6) on extraordinary meetings based on the learning from the aseptics lessons learned exercise.
- Schedule 6 – updated with ability to communicate notices via email (Section 9).

The Board is asked to approve the revised WYAAT MoU at Appendix 1.

WYAAT Programme Executive Meeting, 6th August and 18th September

I attended the WYAAT Programme Executive meeting on 6th August where we discussed the findings of the cost review and reflected on the discussion held at the Committee in Common the week prior. We also received an update on the efficiency workstreams including a review of initial meetings and prioritisation. We received the collaborative report and HCP report and had specific discussions around LIMS deployment and specialised commissioning delegation. We received the closure report for the procurement programme and an update on non-surgical oncology.

I am also attending the Programme Executive meeting on 18th September where we have a focused session around the WYAAT service review including the drivers for this, determining scope and approach, discussing resource, leadership, stakeholder management and communication, and next steps to progress this.

West Yorkshire System Leadership Executive Group Meeting, 6th August

The West Yorkshire System Leadership Executive Group meeting was held on the 6th August and regrettably I was unable to attend due to a diary conflict with the above WYAAT Programme Executive meeting. The agenda focused around the current context to include working with the new administration, building belonging in West Yorkshire to enable system readiness, and mutual accountability.

NHS Leadership Event, 3rd September

The latest NHS Leadership Event was held in London on 3rd September and we were joined by the Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care, for the morning session which included a short Q&A. The afternoon included breakout sessions focused around winter, elective recovery and delivery of financial plans, as well as a future focus on the 10 year plan. We also discussed the emerging findings from Lord Darzi's review and had a general Q&A session with the NHS England Executive Group.

7. National Reports

Independent Investigation into the National Health Service in England

The report of the independent review of the NHS In England, undertaken by Lord Darzi was published on 12 September 2024. In July 2024, the Secretary of State for Health and Social Care commissioned Lord Darzi to conduct an immediate and independent investigation of the NHS. Lord Darzi's report provides an expert understanding of the current performance of the NHS across England and challenges facing the healthcare system. Lord Darzi has considered the available data and intelligence to assess patient access, quality of care and the overall performance of the health system. The key findings of the report were that the NHS is in a 'critical condition' and continues to struggle with the aftershocks of the pandemic. The report states that the first step to rebuilding public trust and confidence in the NHS is to be completely honest about its state, however, it was noted that the state of the NHS wasn't entirely due to what has happened within the health service, but that the health of the nation has deteriorated and that had also impacted on performance.

There were some important themes that emerged form the investigation on how to repair the NHS, and these include:

- Re-engage staff and re-empower patients
- Lock in the shift of care closer to home by hardwiring financial flows
- Simplify and innovate care delivery for a neighbourhood NHS
- Drive productivity in hospitals
- Tilt towards technology
- Contribute to the nation's prosperity
- Reform to make the structure deliver

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The full report can be accessed here: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

Recommendation

The Board is asked to review and approve the revised WYAAT Memorandum of Understanding at Appendix 1.

The Board is asked to note this report.

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

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

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

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

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

DATE 30TH JULY 2024

1. AIREDALE NHS FOUNDATION TRUST
2. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
3. CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
4. HARROGATE AND DISTRICT NHS FOUNDATION TRUST
5. LEEDS TEACHING HOSPITALS NHS TRUST
6. MID YORKSHIRE TEACHING NHS TRUST

MEMORANDUM OF UNDERSTANDING FOR WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

No	Date	Version Number	Author
1	11/10/16	1-1.4	CB/RM
2	10/11/2016	V2	Co Secs
3	14/11/2016	V3.4	CB/RM/ CG
4	17/11/2016	V3.5	Co Secs
5	5/12/2016	V4	Co Secs
6	5/12/2016	V5	Co Secs
7	6/1/2017	V6	Co Secs
8	02/2017	FINAL	Boards
9	30/07/2019	CiC review	Co Sec
10	30/07/2019	CiC Approved	CiC Members
11	27/07/2021 – schedule 2 only	CiC Approved v2	CiC Members
12	30/07/24	CiC Approved (July 24)	CiC Members

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WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Date: July 2024

This Memorandum of Understanding (**MoU**) is made between:

(1) **AIREDALE NHS FOUNDATION TRUST** of Skipton Road, Keighley, West Yorkshire, BD20 6TD;

(2) **BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST** of Duckworth Lane, Bradford, BD9 6RJ;

(3) **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** of Acre Street, Huddersfield, HD3 3EA;

(4) **HARROGATE AND DISTRICT NHS FOUNDATION TRUST** of Lancaster Park Rd, Harrogate, North Yorkshire HG2 7SX;

(5) **LEEDS TEACHING HOSPITALS NHS TRUST** of Great George Street, Leeds, West Yorkshire, LS1 3EX;

(6) **MID YORKSHIRE TEACHING NHS TRUST** of Aberford Road, Wakefield, WF1 4DG; and

(each a "**Party**" and together the "**Parties**").

RECITALS

I. In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme incorporating corporate services, clinical support services, and clinical services including ownership and commitment to collaboration as set out in the WYAAT Five Year Strategy (2024 – 2029). In particular, this MoU is intended to support the Parties' on-going work towards the delivery of more efficient acute services for patients in the WYAAT service area.

II. The Parties together form the West Yorkshire Association of Acute Trusts ("**WYAAT**") and have agreed to collaborate to bring together NHS trusts delivering acute hospital services across the WYAAT service area in delivering region-wide efficient and sustainable healthcare for patients. WYAAT will develop and deliver a collaborative approach across acute care providers. The Parties have formed a WYAAT Committee in Common ("**WYAAT CIC**") which has the specific remit of leading the strategic development of WYAAT, setting overall ambition and direction to deliver the WYAAT Strategy and programmes and initiatives for an acute provider transformation to a more collaborative model of care for the WYAAT service area, the intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYAAT Strategy**").

III. This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYAAT CIC; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for acute services in the WYAAT service area.

OPERATIVE PROVISIONS

1. **DEFINITIONS AND INTERPRETATION**

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.2.2 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF MOU

2.1 The Parties have agreed to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the WYAAT service area. The aim is for the Parties to organise themselves around the needs of the West Yorkshire and Harrogate population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYAAT in this MoU.

2.2 This MoU sets out:

2.2.1 the key objectives for the development of WYAAT;

2.2.2 the principles of collaboration;

2.2.3 the governance structures the Parties will put in place; and

2.2.4 the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph 2.4 below, this MoU shall not be legally binding.

2.4 Paragraphs 17, 19 and 20 shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2.5 Included as Schedules 6-8 to the MoU are agreements on the management of relationships for confidentiality (legally binding), conflicts of interest and sharing of information in line with competition law between the Parties.

3. KEY PRINCIPLES

3.1 The Parties shall undertake the development and delivery of the WYAAT Strategy in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2 The Parties acknowledge the current position with regard to the WYAAT and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1 The Parties agree to adopt the following principles when carrying out the development and delivery of the WYAAT Strategy (the "**Principles of Collaboration**"):

4.1.1 address the vision. In developing WYAAT the Parties seek to establish a model of collaborative care and corporate services across a network of acute hospital trusts that are focused on the delivery of high quality, sustainable acute care for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS ;

4.1.3 be accountable. Take on, manage and account to each other, the wider NHS and the WYAAT service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4 be open and transparent and act with integrity. Communicate openly with each other about major concerns, issues or opportunities relating to WYAAT and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and the Code of Governance of NHS England (April 2024) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising.

4.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6 act in a timely manner. Recognise the time-critical nature of the WYAAT Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7 manage stakeholders effectively. Ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with

the Parties' statutory duties, values and objectives.

4.1.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9 act in good faith to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1 The governance structure summarised below of this MoU provides a structure for the development and delivery of the WYAAT Strategy.

5.2 The governance arrangements will be:

5.2.1 based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements (as defined by each trust's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation), particularly in respect of delegated authority;

5.2.2 shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYAAT Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYAAT Collaborative Programme in accordance with the Key Principles; and

5.2.3 underpinned by the following principles:

i. the Parties will remain subject to the NHS Constitution, compliance with regulatory bodies and their provider licence (Code of Governance) and retain their statutory functions and their existing accountabilities for current services resources and funding flows; and

ii. clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYAAT:

6.1 WYAAT Committee in Common ("WYAAT CIC")

The WYAAT CIC will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1 progress throughout the period;

6.1.2 decisions required by the WYAAT CIC and their recommendation to respective Trust Boards for approval;

6.1.3 issues being managed;

6.1.4 issues requiring escalation to the WYAAT CIC; and

6.1.5 progress planned for the next period.

Under a standing agenda item, WYAAT CIC will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the WYAAT Director will be circulated promptly to all WYAAT CIC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The WYAAT Director will provide an Annual Report summarising achievements of WYAAT for the preceding financial year which, following approval from WYAAT CIC, will be published in the public domain.

6.2 WYAAT Programme Executive

The WYAAT CIC will hold each of the Parties' Chief Executive to account for the delivery of their sponsored workstreams within the WYAAT Strategy via the WYAAT Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYAAT Strategy in line with the Key Principles

7.1 WYAAT Committee in Common

7.1.1 The WYAAT CIC comprises senior members of the Parties and defines the strategy and holds accountability for its delivery, alongside providing overall oversight and direction to the development of WYAAT . It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of six months or three meetings, whichever is the lesser.

7.1.2 The WYAAT CIC shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

7.2 WYAAT Programme Executive

7.2.1 The WYAAT Programme Executive will provide assurance to the WYAAT CIC that the key deliverables are being met and that the development of the WYAAT Strategy is within the boundaries set by the WYAAT CIC. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1 The Parties intend that WYAAT CIC Members will each operate under a common model scheme of delegation whereby each WYAAT CIC Member shall have delegated authority to make decisions on behalf of their organisation relating to:

8.1.1 matters falling under the scope of the WYAAT CIC and agreed collaborative

programme underpinned by 'case for change';

8.1.2 the devolving of the Key Principles set out in Schedule 1; and,

8.1.3 in accordance with the WYAAT Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

8.2 Each party will reflect in its Standing Orders, Standing Financial Instructions and scheme of Delegation the authority delegated to its representatives on the WYAAT CIC.

8.3 The Parties intend that WYAAT CIC Members shall report to and consult with their own respective organisations at Board level, (noting that decisions on recommendations made by the CIC will always be made by the Boards of Member Trusts) providing the governance assurance that ensures compliance with their regulatory and audit requirements, for organisational decisions relating to, and in support of, the WYAAT Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1 If any Party has any issues, concerns, or complaints regarding the WYAAT Strategy, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2 Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3 If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYAAT, the matter shall be promptly referred to the WYAAT Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1 The Parties agree that they will:

10.1.1 disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYAAT Strategy, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYAAT Strategy; and

10.1.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3 comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYAAT Strategy but it is intended that other providers to the WYAAT service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYAAT CIC as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. REVIEW

12.1 The WYAAT CIC shall discuss and agree as a minimum:

12.1.1 the principles of collaboration;

12.1.2 the governance arrangements as set out in Section 5;

12.1.3 the scope of the WYAAT Strategy and individual workstreams;

12.1.4 the progress against the key deliverables; and

12.1.5 key decisions required in support of Schedule 4.

13. TERM AND TERMINATION

13.1 This MoU shall commence on 2 February 2017 (having been executed by all the Parties) and shall expire on termination as outlined in section 14.2 of this MoU.

13.2 This MoU may be terminated in whole by:

13.2.1 mutual agreement in writing by all of the parties

13.2.2 in accordance with Clause 15.2; or

13.2.3 in accordance with paragraph 1.5) of schedule 3.

13.3 Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with Clause 16.

13.4 In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYAAT Strategy and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYAAT CIC for the removal of the relevant Party from the MoU on a majority basis provided that:

13.4.1 reasonable notice shall have been given of the proposed resolution; and

13.4.2 the affected Party is first given the opportunity to address the WYAAT CIC meeting at which the resolution is proposed if it wishes to do so.

13.5 This MoU shall be terminated in accordance with the provision at 14.2.

14. CHANGE OF LAW

14.1 The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at paragraph 16.

14.2 In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

15. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

16. CHARGES AND LIABILITIES

16.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

16.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

17. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

18. COUNTERPARTS

18.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

18.2 The expression “counterpart” shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

18.3 No counterpart shall be effective until each Party has executed at least one counterpart.

19. GOVERNING LAW AND JURISDICTION

This MoU shall be governed by and construed in accordance with English law and, without affecting the escalation procedure set out in paragraph 9 above, each Party agrees to submit to the exclusive jurisdiction of the courts of England.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

AIREDALE NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

BRADFORD TEACHING HOSPITALS)

NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

CALDERDALE AND HUDDERSFIELD)

NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

HARROGATE AND DISTRICT)
NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

LEEDS TEACHING HOSPITALS)

NHS TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

MID YORKSHIRE TEACHING)

NHS TRUST) DATE:

Approved by those present at the meeting on 30 July 2024. Linda Pollard, Chair LTHT
Phil Wood, CEO LTHT
Sarah Armstrong, Chair, HDFT
Jonathan Coulter, CEO, HDFT
Andrew Gold, Chair, ANHSFT
'Foluke Ajayi, CEO, ANHSFT
Brendan Brown, CEO, CHFT
Helen Hirst, Chair, CHFT
Sarah Jones, Chair, BTHFT
Mel Pickup, CEO, BTHFT
Keith Ramsay, Chair, MYTT

Insert approval date

Len Richards, CEO, MYTT

Insert approval date

SCHEDULE 1 THE KEY PRINCIPLES

1. Significant financial pressures within the WYAAT service area health system, linked to increasing service demand, longer life and medical advances, require a different approach to the delivery of good health and well-being for the population of West Yorkshire and Harrogate (WYH).
2. There are significant variations in the current corporate and acute care system ranging from, for example average unit cost for trauma and orthopaedic day case activity and use of differing national providers for pathology services to differing workforce staffing solutions.
3. Through the WYAAT Strategy, the Parties' Key Principles are to achieve a sustainable, safe, high quality and cost effective acute care system across WYH, based on clear integrated and standardised models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:
   - 3.1 Achieving clinical and financial stability across the WYAAT service area health system
   - 3.2 Enhancing partnership working between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility
   - 3.3 A five step approach to collaboration which will deliver the following objectives:
     - 3.3.1 Developing a 'centres of excellence' approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, Ear Nose and Throat (ENT), maxillofacial surgery, eliminating avoidable cost of duplication and driving standardisation
     - 3.3.2 Developing WYH standardised operating procedures and pathways across services, building on current best practice and using Getting it Right First Time (GIRFT) and Model Health System data to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers.
     - 3.3.3 Collaborating to develop clinical networks and creating alliances as a vehicle (e.g. hyper acute stroke, cancer etc.) which will protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost of duplicated facilities. Using GIRFT, Model Hospital, outcome variation data and WYAAT work on sustainable services to identify the case for change for specific services, the model being based on the 'chain' concept.
     - 3.3.4 Developing workforce planning at scale to secure the pipeline of fit for

purpose staff and improved productivity, managing workforce risk at system level and supporting free movement of bank and agency staff with the aim of reducing spend on agency and reduce the administration costs of the flexible workforce.

3.3.5 Delivering economies of scale in support functions such as procurement, pathology services, estates and facilities management and other infrastructure e.g. IT.

SCHEDULE 2 GOVERNANCE FRAMEWORK

1. INTRODUCTION

The purpose of the West Yorkshire Association of Acute Trusts (WYAAT), as set out in the Memorandum of Understanding (MoU), is for the trusts to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the WYAAT service area. The aim is to organise around the needs of the West Yorkshire and Harrogate (WYH) population rather than planning at individual organisational level so as to deliver more integrated, high quality, cost effective care for patients.

2. PURPOSE

The purpose of this Schedule to the MoU is to provide a Governance Framework for the WYAAT Strategy. It provides a systematic approach to the initiation and management of the Strategy.

3. OBJECTIVES OF THE WYAAT COLLABORATIVE PROGRAMME

WYAAT's objectives are set out in Schedule 1 to the MOU.

The purpose of the WYAAT Strategy is to deliver these objectives in order to deliver more integrated, high quality, cost effective care for patients across the WYAAT service area. WYAAT programmes will design services across multiple organisations, consider innovative, collaborative models of care to improve collective outcomes and performance and make collective efficiencies.

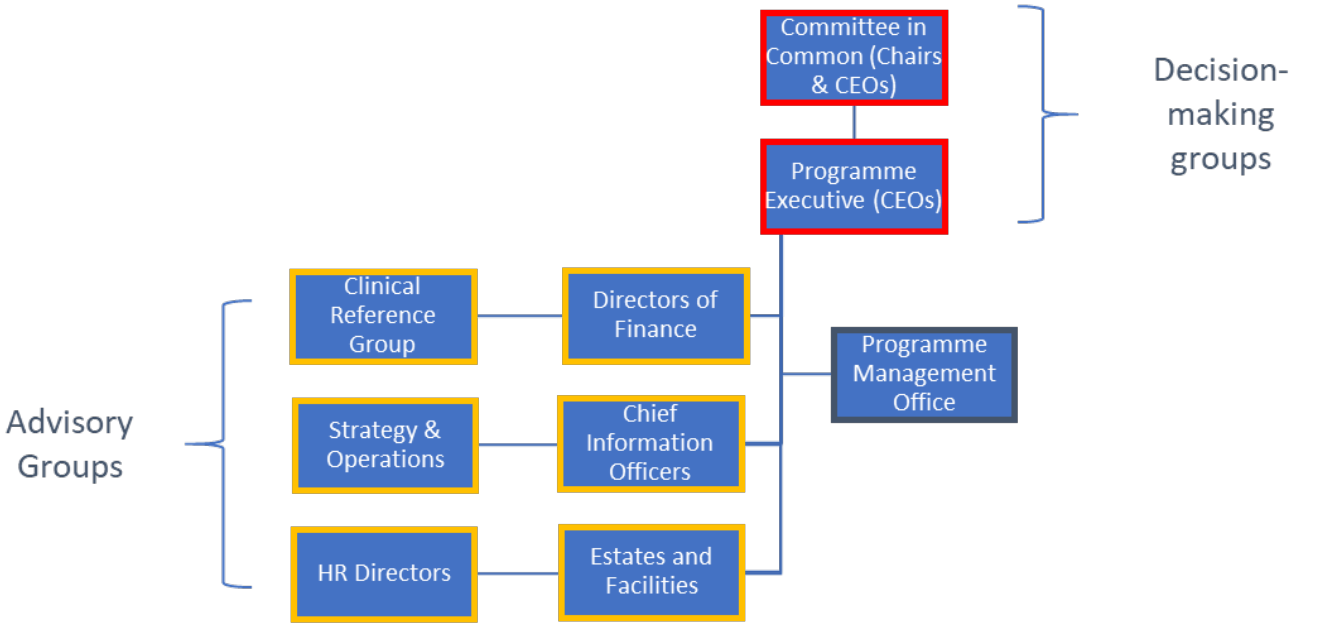
4. WYAAT STRATEGY DRIVERS

The WYAAT Strategy will be a portfolio of individual programmes covering clinical services, clinical support services and corporate services. Its priorities will be generated from a range of external and internal drivers including:

- National NHS strategies, priorities and programmes e.g. NHS Long Term Plan, The Long Term Workforce Plan, NHS Delivery plan for tackling the Covid-19 backlog of care, The NHS Patient Safety Strategy
- WY Integrated Care Board and Partnership strategies, priorities and workstreams
- NHS E Operational Planning guidance and process
- WYAAT clinical, operational, and financial sustainability priorities
- WYAAT baseline analysis of variation

5. GOVERNANCE STRUCTURE

The WYAAT MoU establishes the Committee in Common (CIC) and the Programme Executive. This Schedule establishes the governance structure below to support the CIC and Programme Executive.



5.1. Committee in Common.

5.1.1 The role and terms of reference of the CIC are set out in the main WYAAT MOU and Schedule 5 (CIC Terms of Reference) as providing strategic oversight and direction to the WYAAT Strategy. The CIC oversees delivery of the programmes, reviewing key deliverables, ensuring adherence to timescales and receiving assurance that risks are being managed.

5.1.2 The CIC consists of the Chairs and Chief Executives of the WYAAT trusts. It meets quarterly, or more frequently if required, and is chaired by one of the trust chairs for the lesser of six months or three meetings. The WYAAT Programme Director and the Company Secretary of the trust holding the Chair also attend the meetings.

5.1.3 As set out in the MoU and CIC Terms of Reference, members of the CIC shall only exercise the functions and powers of a party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that party's internal governance. Members are expected to report to and consult

with their own organisation at Board level, providing governance assurance that is compliant with their regulatory and audit requirements.

5.1.4 The CIC has no delegated powers from the trusts beyond those already held by its members under their organisation's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. In practice this means that decisions on gateway approvals for WYAAT programmes (see section 7 below) will usually be made by trust boards (or another appropriate board sub-committee in line with each trust's governance) based on a recommendation from the CIC.

5.2. Programme Executive.

5.2.1 The role of the Programme Executive is to oversee the delivery of the WYAAT Collaborative Portfolio, holding to account the Senior Responsible Owners and Executive leads for delivery of their WYAAT programme and receiving assurance that risks associated with delivery of programmes are being identified, mitigated and managed. The members of the group are the Chief Executives of the constituent trusts and the WYAAT Programme Director (non-voting). Meetings are held on a monthly basis.

5.2.2 In a similar way to the CIC, members of the group can only exercise functions and powers to the extent that they ordinarily exercise these under the governance arrangements of their employing trust.

5.3. Advisory Groups (Clinical Reference Group, Directors of Finance Group, Strategy & Operations Group, Chief Information Officers Group).

5.3.1 The Advisory Groups provide advice and assurance to the Programme Executive and CIC at gateway approval stages. They are responsible for reviewing strategic outline cases and business cases from the following perspectives and making a recommendation whether the case should be recommended to the CIC for approval by the trusts:

Group	Assurance Perspective & Considerations
Clinical Reference Group	**Quality** Clinical effectiveness and outcomes Patient safety Patient experience Clinical governance Ensuring a robust Quality Impact Assessment has been completed Ensuring a robust Equality Impact Assessment has been completed Workforce implications

Group	Assurance Perspective & Considerations
Directors of Finance Group	**Financial Sustainability** Financial benefits and costs Capital requirements Commercial, contractual, legal, tax risks and implications Financial governance
Strategy & Operations Group	**Operations & Performance** Alignment with national, ICS, place and organisational strategies Public, commissioner, system engagement and communications Operational benefits and risks Implications for performance against NHS Constitutional Standards and other performance measures Workforce implications
Chief Information Officers Group	**Information Management and Technology** Alignment with national, ICS, place and organisational IM&T strategies Cyber security Capacity and compatibility of trust IM&T infrastructure with new systems IM&T implementation, capacity and costs
Human Resources Directors Group	**Workforce** Alignment with national, ICS, place and organisational workforce strategies Workforce implications Workforce implementation, capacity and costs
Estates and Facilities Directors Group	**Estates and facilities** Alignment with national, ICS, place and organisational infrastructure strategies Infrastructure and capital requirements Estates and facilities implementation, capacity and costs

5.4. Programme Governance.

5.4.1 Each programme is led by one of the Chief Executives as Senior Responsible Owner (SRO). As a minimum each programme will also have a lead Executive Director (often a Strategy Director or Chief Operating Officer), a lead Medical Director and lead Finance Director.

5.4.2 Each programme will establish a steering group/board which meets on a regular basis. It will be chaired by the lead Executive Director and will include other lead directors and senior leaders from all participating trusts. Following approval of the Strategic Outline Case, most programmes will establish a formal programme

board, often at executive level, with representatives from all trusts and from a range of disciplines (e.g. Chief Nurse, HRD, CIO, Estates Director). Members are responsible for contributing to the successful delivery of the programme and for communicating key messages and issues to their respective organisation and feeding back any responses in return.

5.4.3 Programmes will be supported by programme and project management capacity. Initially this may be from existing resources within the WYAAT PMO, prioritised by the Programme Director, but as the programme develops dedicated resources will be provided as agreed by either the Programme Executive or CIC. The programme manager is responsible for the creation and maintenance of the: milestone plan, benefits log, risk register, quality and equality impact assessments. Each month they will produce a Highlight Report covering key activities in the month and those planned for the next; current and planned milestones; risks and issues including those requiring escalation; and benefits tracking. They are also responsible for managing the change control process.

5.4.4 Programme steering groups or programme boards are responsible for delivery of the programme across all trusts. They must ensure good trust engagement and commitment to delivery of agreed activities and integration into 'business as usual' arrangements on completion and have authority to manage the programme within the bounds of time, cost and quality agreed by the Programme Executive or CIC. Changes to the programme which exceed the agreed bounds must be escalated to the Programme Executive and, if necessary, the CIC.

6. ASSURANCE

Assurance on the progress of the Strategy overall and its constituent programmes is provided by the following:

6.1. **SRO/Programme Board/Programme Leads**. The CIC, Programme Executive and the advisory groups are able to hold the leadership of each programme to account for its delivery. They can also hold the Programme Director to account for oversight of the Strategy overall.

6.2. **Strategy Milestone Plan**. Setting out overall timescales and gateway approvals. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.3. **Strategy Risk Register**. Capturing the most significant risks on individual programmes and also common risks to multiple programmes which create a significant risk to the Strategy overall. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.4. **Benefits Map**. Shows how the outputs of the projects and programmes will lead to benefits for patients and the population of WYH. At the initial stages of programmes, the

outputs and benefits will be broadly described, but they will be more tightly defined and quantified as the programme develops through to full business case and into implementation. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.5. **Individual Programme Highlight Reports**. A monthly report describing progress, actions completed and planned milestones, risks and benefits for each programme. Maintained by each programme manager on behalf of the programme board and SRO. Provided to the Programme Executive monthly and to the CIC quarterly.

6.6. **Programme Brief and Programme Initiation Document**. These documents, approved by the Programme Director and Programme Executive respectively, ensure that new programmes are only initiated where they are in line with WYAAT's objectives and strategy, and there is a clear description of the scope of any further work to define the programme and the resources required.

6.7. **Gateway Approvals of Strategic Outline Cases & Business Cases**. Formal approval is required at each gateway to enable the project or programme to continue and to be provided with the necessary resources for the next stage. The case should be signed off by the programme board and SRO for review by the advisory groups. The advisory groups provide advice to the Programme Executive on any issues with the case and make a recommendation whether it should be recommended to the CIC. Where appropriate, for instance programmes which require DHSC or HM Treasury approval, external assurance and review of cases will also be undertaken. The Programme Executive makes a recommendation to the CIC and the CIC decides whether to recommend to trust boards that the case should be approved. If the case is not approved the programme would be closed down.

6.8. **Programme Reviews**. The CIC, Programme Executive or advisory groups may require programme SROs and programme boards to complete and provide a formal programme review at any time. A programme review will be instigated when a programme enters a new stage e.g. from business case to implementation to ensure the governance, leadership and resources are aligned to the required objectives of the subsequent phase.

6.9. **Annual Report**. While the primary purpose of the WYAAT Annual Report is to provide trust boards and other stakeholders with an annual update on the Strategy delivery, it also provides assurance to the CIC and Programme Executive about the overall progress of WYAAT and the delivery of the strategy. It is formally approved by the CIC each year and published in the public domain.

6.10. **WYAAT PMO**. The PMO is responsible for ensuring the adoption of a systematic programme approach aimed at maximising delivery. This includes identifying any interdependencies and integrating activities across different programmes and projects to avoid duplication. It maintains a milestone plan, risk register and benefits map for the overall Strategy and manages a programme assurance process to ensure all programmes are robustly established and managed. It is led by the WYAAT Programme Director who, along with the Finance Lead and Clinical Lead, is responsible for the

governance, coordination and alignment of programmes with the overall WYAAT objectives. The WYAAT Director is accountable to the Chair of the Programme Executive.

7. PROGRAMME LIFECYCLE

Each programme will follow a four stage programme lifecycle set out below. At each stage of the lifecycle there should be appropriate:

- Clinical and staff engagement and involvement (e.g. facilitated workshops)
- Patient, public, political (e.g. MPs, Overview and Scrutiny Committees, Health and Wellbeing Boards) and commissioner engagement and involvement
- Governor engagement
- External scrutiny (e.g. Clinical Senate, NHS England)
- Use of systematic, evidence based, quality improvement and change models
- Quality and equality impact assessment
- Use of a transparent options appraisal process

Stage	Description	Decision making
Initiation	**Programme Brief.** Short description of the opportunity, the rationale for it being a collaborative project, the approach that could be taken and a programme preparation plan.	WYAAT Director
	Programme Initiation Document. Description of the project: rationale, purpose and objectives, scope, desired outcomes and benefits, approach, estimated timescales and required resources. Includes initial quality and equality impact assessments.	Programme Executive
Planning	**Strategic Outline Case** Description of services, the challenges facing them, sets out the opportunity and potential benefits from changing the existing operating model. Includes quality and equality impact assessments, costs and resource estimates for developing the new operating model and the business case, likely return on investment, contribution from each trust and outline risk/gain share arrangements. Sets out the proposed governance arrangements and evaluation framework. A single Strategic Outline Case will always be completed for the whole programme.	Committee in Common **Gateway 1** CIC makes recommendation to trusts to approve the SOC and confirm their commitment to developing the OBC.

	Outline Business Case(s) Sets out the future operating model and the ways in which it could be delivered. Refines the quality and equality impact assessments, benefits, costs and timescales. Evaluates a range of options and recommends selection of the preferred option. Depending on the programme, there may be a single OBC for the whole programme, or there may be a number of project OBCs. Recommendations to trusts on approval of smaller, less complex project OBCs may be delegated by the CIC to the Programme Executive.	Committee in Common: **Gateway 2** CIC makes recommendation to trusts to approve the OBC and to confirm their support for the preferred option and their continuing participation to develop the FBC.

Stage	Description	Decision making
	Full Business case(s). A detailed description of the proposed model and associated benefits, costs and risks. Full quality and equality impact assessments. Financial and non- financial appraisal for each trust and for WYAAT in total. Sets out the investment profile, implementation plan and benefits realisation plan, including its constituent projects, activities, timescales and accountability for implementing the new model. As for the OBC there may be a single FBC for the whole programme, or a number of project FBCs.	Committee in Common: **Gateway 3** CIC makes recommendation to trusts to approve the FBC and to confirm their support for implementation and any formal agreements/ contracts required.
Implementation	**Implementation Plan** All projects and activities required to implement the programme and realise the benefits are initiated. Regular monitoring and management of progress by the Programme Board; reporting of costs and benefits; maintenance of risk register; and review and updating of quality and equality impact assessment. Includes the management of the formal change control process. Regular reports on progress to the Programme Executive and CIC.	Programme Board within delegated limits. Programme Executive or CIC where changes to the programme exceed the delegated limits.
Post implementation Evaluation	**Programme Closure Report** Once the programme has completed implementation of its constituent projects a recommendation will be made to close the programme. The report will evaluate whether the programme has delivered the outputs expected and whether these have led to the outcomes and benefits required (NB some benefits may remain to be realised by operational teams after programme closure). The report will also include a review of how effectively the programme was managed and what lessons can be learned for future programmes.	Committee in Common **Gateway 4** CIC make recommendation to trusts to approve closure of the programme.

8. RISK AND GAIN SHARING PRINCIPLES

8.1. Some WYAAT programmes (or their constituent projects) will have the potential to disproportionately benefit some participating WYAAT organisations at the expense of others. The Strategic Outline Case will set out the potential impact of the implementation of a programme or project and will describe the 'risk and gain share' model between the WYAAT members affected by the programme or project, in preparation for selection of the preferred option in the OBC. The model will be tailored

to each programme or project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYAAT service area:

8.1.1 Any losses made by a WYAAT member as a direct result of the implementation of a programme or project will be reimbursed by the other affected members.

8.1.2 The costs of implementing the programme or project will be met by the participating WYAAT members in the proportions set out in the FBC and agreed at Gateway 3.

8.1.3 The net financial benefits of the programme or project will be allocated to member trusts on a “fair shares” basis with the precise method being tailored to the programme or project. The method will be set out in the FBC and agreed at Gateway

SCHEDULE 4 - DISPUTE RESOLUTION PROCEDURE

4. **AVOIDING AND SOLVING DISPUTES**

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a '**Dispute**') when it arises.

1.4 In the first instance the WYAAT Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYAAT Programme Executive within ten Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYAAT CIC for resolution.

1.5 The WYAAT CIC shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYAAT CIC reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in clause 2.4 and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYAAT CIC or the independent facilitator, they may withdraw from the MoU at any point in accordance with paragraph 14.

1.6 If a Party does not agree with the decision of the WYAAT CIC reached in accordance with Section 4 above, it shall inform the WYAAT CIC within ten Business Days and request that the WYAAT CIC refer the Dispute to an independent facilitator in accordance with paragraph 2 below.

1.7 The Parties agree that the WYAAT CIC, on a 'Best for Meeting the Key Principles' basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYAAT CIC cannot resolve a Dispute, it may request that an independent facilitator) assist with resolving the Dispute; and

1.7.2 If an independent facilitator is selected then they shall:

i. be provided with any information he or she requests about the Dispute;

ii. assist the WYAAT CIC to work towards a consensus decision in respect

of the Dispute;

iii. regulate his or her own procedure and, subject to the terms of this MoU, the procedure of the WYAAT CIC at such discussions;

iv. determine the number of facilitated discussions which must take place within 20 Business Days of the independent facilitator being appointed; and

v. have its costs and disbursements met by the Parties.

1.7.3 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYAAT CIC may decide to:

i. terminate the MoU; or

ii. agree that the Dispute need not be resolved.

SCHEDULE 4 WYAAT DECISION MAKING

1. The Memorandum of Understanding (**MoU**) and Terms of Reference (**TOR**) for the WYAAT Committee in Common (**WYAAT CIC**) take into consideration existing accountability arrangements of participating trusts and decisions being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYAAT CIC may not be of obvious benefit to all individual participating trusts, it is anticipated that the WYAAT CIC will look to act in the basis of the best interests of the wider population by investing in a sustainable system of healthcare across the WYAAT service area in accordance with the Key Principles when making decisions at WYAAT CIC meetings.

3. There are expected to be two categories of decision making:
   - 3.1 **Mandatory Participation Decisions**. All affected WYAAT members need to participate in the initiative for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all WYAAT members reaching an agreed decision in common.
   - 3.2 **Voluntary Participation Decisions**. Participation in the initiative is consensual and voluntary, so WYAAT members will need to confirm their own commitment and involvement at key stages (Gateways) in order to ensure the Business Case assumptions (e.g. benefits, costs and risks) are robust. Only trusts participating in the initiative (the eligible constituency) will be able to vote at the decision Gateways.

4. GATEWAY DECISION MAKING

- 4.1 The WYAAT 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal. Once a trust has committed to participate at a specific Gateway it cannot withdraw until the next Gateway.
- 4.2 All programmes proposed as part of the WYAAT Strategy will require a Strategic Outline Case which will include a detailed case for change (Gateway 1). At this stage the WYAAT CIC will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider whether this a mandatory or voluntary participation programme and which WYAAT members would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

4.3 The Gateways and decision-making requirements are shown in the table below:

Gateway	Mandatory Participation Decisions	Voluntary Participation Decisions
Gateway 1 **Strategic Outline Case** (Case for Change, initial options appraisal)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 2 **Outline Business Case** (Recommendation of preferred option)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 3 **Full Business Case** (Detailed description of preferred model and implementation plan)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 4 **Programme Closure** (Confirmation that the programme has delivered the expected outputs, outcomes and benefits)	Unanimous support of all WYAAT members	Support of all participating WYAAT members

4.4 Where a unanimous decision cannot be reached initially, the dispute resolution process set out in Schedule 3 to the MoU will be used.

4.5 If a Trust does not support or vote for a proposal then it will not be bound to act in accordance with that proposal as the trusts remain independent statutory bodies under the WYAAT Strategy.

5. BILATERAL AND TRIPARTITE AGREEMENTS BETWEEN INDIVIDUAL TRUSTS

5.1. The WYAAT MoU and its schedules, including this Gateway Decision-Making Framework, do not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYAAT outside the WYAAT Strategy. It is expected that there will be transparency in developing such agreements. The associated benefits and risks of such agreements should be appropriately considered in terms of their impact on other providers and the WYAAT Strategy. The option for other WYAAT trusts to join an initiative should also be considered.

5.2. The WYAAT MoU and its schedules, and being part of the WYAAT CIC, does not preclude existing Parties alliances or existing relationships with other organisations.

5.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYAAT CIC.

SCHEDULE 5
TERMS OF REFERENCE FOR
THE WYAAT COMMITTEE IN COMMON

THESE TERMS OF REFERENCE FORM PART OF THE WYAAT MEMORANDUM OF UNDERSTANDING. DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1 SCOPE

1.1 The WYAAT Committee in Common (WYAAT CIC) will be responsible for leading the strategic development of WYAAT in accordance with the Key Principles*, setting overall ambition and direction in order to deliver the WYAAT Strategy.

2 STANDING

2.1 Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3 GENERAL RESPONSIBILITIES OF THE WYAAT CIC

3.1 The general responsibilities of the WYAAT CIC are:

i. Defining the strategy and providing strategic oversight and direction to the development of WYAAT as a provider collaborative;
ii. ensuring alignment of all Parties to the vision and strategy;
iii. formally recommending the final form of the Strategy; including determining roles and responsibilities within the workstreams;
iv. reviewing the key deliverables and ensuring adherence with the required timescales and budget;
v. Defining risk appetite and tolerances;
vi. receiving assurance that workstreams have been subject to robust quality impact assessments
vii. reviewing of the risks associated with the performance of any of the Parties in terms of the impact to the WYAAT Strategy – recommending remedial and mitigating actions across the system;
viii. receiving assurance that risks associated with the delivery of the WYAAT Strategy, and wider system risks impacting the Parties are being identified, managed and mitigated;
ix. promoting and encouraging commitment to the Key Principles;

x. formulating, agreeing and implementing approaches for delivery of the WYAAT Strategy;

xi. seeking to determine or resolve any matter referred to it by the WYAAT Programme Executive or any individual Party and any dispute in accordance with the MoU;

xii. reviewing and approving the Terms of Reference of the WYAAT Programme Executive;

xiii. agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

4 MEMBERS OF THE WYAAT CIC

4.1 Each Party will appoint their Chair and Chief Executive as WYAAT CIC Members and the Parties will at all times maintain a WYAAT CIC Member on the WYAAT CIC.

4.2 Each WYAAT CIC member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the WYAAT CIC Member is not personally present and do all the things which the appointing WYAAT CIC Member is entitled to do.

4.3 Each Party will have one vote.

4.4 The Parties will all ensure that, except for urgent or unavoidable reasons, their respective WYAAT CIC Member (or their Nominated Deputy) attend and fully participate in the meetings of the WYAAT CIC.

5 PROCEEDINGS OF WYAAT CIC

5.1 The WYAAT CIC will meet quarterly, or more frequently as required by the Committee.

5.2 The WYAAT CIC shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the WYAAT members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the WYAAT CIC into the Parties' Trust Boards.

5.3 The Parties will select one of the Parties' Chairs to act as the Chair of the WYAAT CIC meetings on a rotational basis for a period of six months or three meetings, whichever is the lesser.

5.4 The Chair of WYAAT will not simultaneously act as Chair of another Collaborative in West Yorkshire and Harrogate.

5.5 The WYAAT CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.6 No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one WYAAT CIC Member present.

5.7 Members of all Parties will be required to declare any interests which will be recorded and set out in a register and reviewed at the beginning of each meeting.

5.8 A meeting of the WYAAT CIC may consist of a conference between the WYAAT CIC Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.9 Each WYAAT CIC Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the WYAAT Strategy.

5.10 The WYAAT CIC will review the meeting effectiveness at the end of each meeting. Additionally, a survey of CIC members to assess effective will be undertaken on an annual basis. The findings of this will be reviewed by CIC in order to ensure continuous improvement.

6 EXTRAORDINARY MEETINGS

6.1 In exceptional circumstances, where a decision is required, an extraordinary meeting of the CIC can be called between the scheduled meetings.

6.2 A request for an extraordinary meeting can be instigated by any Party and must be supported by at least two further Parties.

6.3 All attempts will be made to provide five working days' notice for an extraordinary meeting, with a minimum notice period of 48 hours where there is an urgent requirement for CIC to meet.

6.4 All extraordinary meetings will comply with the provisions within these terms of reference, in line with ordinary meetings of the CIC.

7 DECISION MAKING WITHIN THE WYAAT CIC

7.1 Each WYAAT CIC Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Standing Orders, Standing Finance Instructions and Scheme of Delegation. The Parties intend that WYAAT CIC Members shall report to and consult with their own respective organisations at Board level, (noting that decisions on recommendations made by the CIC will always be made by the Boards of Member Trusts) providing the governance assurance that ensures compliance with their regulatory and audit requirements, for organisational decisions relating to, and in

support of, the WYAAT Key Principles and facilitating these functions in a timely manner.

7.2 Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, WYAAT CIC Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the WYAAT service area in accordance with the Key Principles when making decisions at WYAAT CIC meetings.

7.3 In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all WYAAT CIC Members reaching an agreed consensus decision in common in accordance with the Key Principles.

7.4 In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the WYAAT Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

8 ATTENDANCE OF THIRD PARTIES AT WYAAT CIC MEETINGS

8.1 The WYAAT CIC shall be entitled to invite any person to attend but not take part in making decisions at meetings of the WYAAT CIC.

9 ADMINISTRATION FOR THE WYAAT CIC

9.1 Meeting administration for the WYAAT CIC will be provided by the WYAAT Programme Office including responsibility for governance advice, maintaining the register of interests and the minutes of the meetings of the WYAAT CIC.

9.2 The Agenda for the meeting will be agreed by the WYAAT CIC Chair. Papers for each meeting will be sent from the Programme Office to WYAAT CIC Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

9.3 The draft minutes, and a summary report from the WYAAT Director will be circulated promptly to all WYAAT CIC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The WYAAT Director will provide a summary for sharing in the public domain.

9.4 The WYAAT CIC will produce an annual report to the Boards of all Parties.

10 REVIEW

10.1 The WYAAT CIC will review these Terms of Reference at least annually for approval by the Parties.

SCHEDULE 6 CONFIDENTIALITY AGREEMENT

RECITALS

1. The Parties together have formed the West Yorkshire Association of Acute Trusts ("WYAAT") and have agreed to collaborate to bring together NHS trusts delivering acute hospital services across the WYAAT Service Area in delivering region-wide efficient and sustainable healthcare for patients. WYAAT, as partner in the West Yorkshire Integrated Care System ("WYICS"), will develop and deliver a WYAAT Strategy to facilitate integrated methods of working across acute care providers.
2. The Parties have formed a WYAAT Committee in Common (WYAAT CIC) which has the specific remit of overseeing a comprehensive system wide integration programme to deliver the objective of an acute provider transformation to a more collaborative model of care for the WYAAT Service Area, the intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients. This "WYAAT Strategy" is to be initially developed and delivered by the WYAAT CIC.
3. The Parties are engaged in a phased approach towards developing the governance of the WYAAT collaborative working, the initial step being the formation of the WYAAT CIC for the delivery of more efficient acute services for patients in West Yorkshire and Harrogate District.
4. The Parties have entered into a protocol for managing the sharing of information to agree the ways of protecting the use of data (including confidential information) within each Party's organisation throughout the WYAAT Strategy development and delivery. The Parties have entered into a Conflict of Interest Protocol (Conflict of Interest Protocol) to govern the treatment of conflicts of interest that may arise in the WYAAT Strategy.
5. The purpose of this Agreement is to ensure that Confidential Information (as defined below) revealed to each other in the course of the WYAAT Strategy development process remains confidential and is not used by the Parties for any purpose other than the further development of the WYAAT Strategy.
6. The Parties intend this Confidentiality Agreement to be legally binding.

OPERATIVE PROVISIONS

1. Definitions

The definitions in this clause shall apply to this Agreement:

1.1 **Operational Day**: a day other than a Saturday, Sunday or a bank holiday in England.

1.2 **Confidential Information**: means

1.2.1 information (however recorded, preserved or disclosed) that is directly or indirectly disclosed, whether before or after the date of this Agreement, as part of or ancillary to:

i. the Parties responses to the WYAAT Strategy;

ii. any due diligence process for the WYAAT Strategy;

iii. any business case(s) for the WYAAT Strategy;

iv. any submission to the Competition and Markets Authority;

v. the preparation of other documents to progress and conclude the development of the WYAAT Strategy; and

vi. any post WYAAT Strategy implementation plans; or

1.2.2 the nature, content or substance of any discussions and/or negotiations taking place concerning the WYAAT Strategy and the status of those discussions and/or negotiations; or

1.2.3 information contained in any version of the Memorandum of Understanding which set out the terms upon which the development and delivery of the WYAAT Strategy will take place; or

1.2.4 information contained in any version of a WYAAT Strategy business case of any Party; or

1.2.5 any other information that the Parties agree in writing is confidential; or

1.2.6 any information that would be regarded as confidential by a reasonable business person relating to:

i. the business, affairs, patients, customers, clients, suppliers, plans, intentions, or market opportunities of the Disclosing Party; or

ii. the operations, processes, product information, know-how, designs, trade secrets or software of the Disclosing Party; or

1.2.7 any information developed by the Parties in the course of carrying out this Agreement; but does not include any information if:

1.2.8 the information is, or subsequently becomes, public knowledge other than as a direct or indirect result of the information being disclosed in breach of this Agreement or of any other undertaking of confidentiality addressed to the Party to whom the information relates (except that any compilation of otherwise public information in a form not publicly known shall nevertheless be treated as Confidential Information); or

1.2.9 a Party can establish, to the reasonable satisfaction of the other Parties, that it found out the information or the information was, is or becomes available to a Party from a source not connected with the other Parties and that such source is not under any obligation of confidence in respect of that information; or

1.2.10 a Party can establish, to the reasonable satisfaction of the other Parties, that the information was known to the Party or lawfully in the possession of the Party before the date of this Agreement and that it was not under any obligation of confidence in respect of that information (but, for the avoidance of doubt, information that was provided prior to the date of this Agreement but which is caught by Clause 1.1.2 (b) above shall be treated as information that was provided under an obligation of confidence); or

1.2.11 the Parties agree in writing that it is not confidential or may be disclosed; or

1.2.12 a Party can establish, to the reasonable satisfaction of the other Parties, that it developed the information independently of the Confidential Information; or

1.2.13 a Party can establish, to the reasonable satisfaction of the other Parties, that the information legitimately and lawfully came in to its possession otherwise than for the Purpose (as defined below).

i. **Disclosing Party:** a Party which discloses or makes available directly or indirectly Confidential Information.

ii. **Purpose:** considering, evaluating and negotiating the development and delivery of the WYAAT Strategy.

iii. **Recipient:** a Party which receives or obtains directly or indirectly Confidential Information.

iv. **Representative:** employees, agents and professional advisers (including

but not limited to accountants, lawyers and management consultants) of the Recipient appointed to assist on the evaluation, development and delivery of the WYAAT Strategy.

1.3 Clause, schedule and paragraph headings shall not affect the interpretation of this Agreement.

1.4 A person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality) and that person's legal and personal representatives, successors and permitted assigns.

1.5 Words in the singular shall include the plural and vice versa: words denoting the masculine gender include the feminine gender; words denoting persons include bodies corporate and unincorporated associations and partnerships.

1.6 A reference to a statute or statutory provision is a reference to it as it is in force for the time being, taking account of any amendment, extension, or re-enactment, and includes any subordinate legislation for the time being in force made under it.

1.7 Any obligation in this Agreement on a person not to do something includes an obligation not to agree or allow that thing to be done.

2. CONSIDERATION

2.1 In consideration of the benefits to all Parties in sharing Confidential Information for the purpose of pursuing the WYAAT Strategy development and delivery and in further consideration of each Party agreeing to pay the other Parties on demand GBP £1, the Parties agree to be bound by the terms of this Agreement.

3. OBLIGATIONS OF THE PARTIES AND REPRESENTATIVES

3.1 Each Recipient will (and will direct and procure each of its Representatives that he or she will):

i. keep the Confidential Information secret;
ii. use or exploit the Confidential Information only for the Purpose;
iii. not directly or indirectly disclose (or knowingly allow it to be disclosed) or make available, in whole or in part, any Confidential Information to any person who is not a Representative who needs to know this Confidential Information for the Purpose;
iv. take all reasonable steps to ensure that no Confidential Information is visible to, or capable of being overlooked by any person who is not a Representative who needs to know this Confidential Information for the Purpose;
v. ensure that reasonable endeavours are taken to ensure that the Confidential Information is protected against theft or unauthorised access;
vi. not alter, modify or vary any of the Confidential Information in any way;

vii. apply the same security measures and degree of care to the Confidential Information as the Recipient applies to its own confidential information, which the Recipient warrants as providing adequate protection from unauthorised disclosure, copying or use;

viii. inform the other Parties immediately on becoming aware, or suspecting, any person who is not a Representative has become aware of Confidential Information;

ix. comply with Clause 5 of the Information Sharing Agreement; and not use any previously shared information in an anti-competitive manner; and in respect of any such previously shared information, the Parties agree that this Agreement applies and the Parties agree that the Conflict of Interest Protocol and the Information Sharing Agreement shall also apply.

3.2 The Recipient may only disclose the Disclosing Party's Confidential Information to those of its Representatives who need to know this Confidential Information for the Purpose, provided that:

i. it informs these Representatives of the confidential nature of the Confidential Information before disclosure or upon signing this Agreement (whichever is the later) and obtains from its Representatives enforceable undertakings to keep the Confidential Information confidential in terms at least as extensive and binding upon the Representatives as the terms of this Agreement are upon the Parties; and

ii. at all times, it is responsible for these Representatives' compliance with the obligations set out in this Agreement.

3.3 Each Party is responsible for its Representatives' compliance with the obligations set out in this Agreement.

3.4 Representatives may only make such copies of, reduce to writing or otherwise record the Confidential Information as are strictly necessary for the Purpose and shall:

i. clearly mark all such documents as 'Confidential';

ii. ensure that all such documents supplied to him or her made by him or her can be separately identified from his own information; and

iii. use all reasonable endeavours to ensure that all copies within their control are protected against theft or unauthorised access.

3.5 If discussions in relation to the development and delivery of the WYAAT Strategy cease, or the Disclosing Party so requests in writing at any time, the Parties shall immediately:

i. return to the Disclosing Party all Confidential Information received; and

ii. destroy or permanently erase all documents and materials and any copies supplied to it or made by it or by its Representatives containing, reflecting incorporating or based on Confidential Information; and

iii. erase all of the Confidential Information from its computer systems or

which is stored in electronic form (to the extent possible).

3.6 Nothing in Clause 3.5 shall require a Party to return or destroy Confidential Information or copies that the Party is required to retain by applicable law or to be able to evidence due compliance with good governance and the proper discharge of its functions or to satisfy the rules or regulations of any applicable governmental or regulatory body to which such person is subject and to the extent reasonable to permit the Recipient to keep evidence that it has performed its obligation under this Agreement.

3.7 Each Party will establish and maintain adequate security measures (including any reasonable security measures proposed by the other Parties from time to time) to safeguard Confidential Information from unauthorised access or use.

3.8 Each Party is aware of its obligations under Clause 4.2 of the Information Sharing Agreement.

3.9 No Party shall make, or permit any person to make, any public announcement concerning this Agreement, the Purpose or its prospective interest in the Purpose without the prior written consent of the other Parties (such consent not being unreasonably withheld or delayed) except as is required by law or any governmental or regulatory body or by any court or other authority or competent jurisdiction. No Party shall make use of the other Parties' names or any information acquired through its dealing with the other Parties for publicity or marketing purposes without the prior written consent of the other Parties.

3.10 If a Party develops or uses a product or a process (other than for the Purpose) which, in the reasonable opinion of the other Parties, might have involved the use of any of the Disclosing Party's Confidential Information, the Party shall, at the request of the Disclosing Party, supply to the other Parties information reasonably necessary to establish that the Confidential Information has not been used in the development of the product or process.

3.11 The provisions of Clauses 3.5, 3.6 and 3.10 of this Agreement shall continue to apply to any such documents and materials retained by a Party, subject to Clause 8.3.

4. FORCED DISCLOSURE

4.1 Subject to Clause 4.2, a Party may disclose Confidential Information to the extent:

i. required by law (including in response to a request pursuant to the Freedom of Information Act 2000) or any order of any court or other authority of competent jurisdiction or any competent judicial, governmental or regulatory body (including the Health Select Committee and the Information Commissioner); or

ii. necessary to enable a Party to comply with any statutory function or duty of that Party or to satisfy the requirement for public accountability and good governance in the discharge of its functions, which requires disclosure of Confidential Information.

4.2 Before a Party discloses any information under this Clause 4, it shall (to the extent permitted by law) use all reasonable endeavours to:

i. give the other Parties as much notice as possible;

ii. inform the other Parties of the full circumstances of the disclosure and the information that will be disclosed;

iii. consult with the other Parties as to possible steps to avoid or limit disclosure and take those steps where they would not result in significant adverse consequences to other Parties, including considering whether any exemptions under the Freedom of Information Act 2000 apply; and

iv. where the disclosure is by way of public announcement, agree the wording with the other Parties in advance.

4.3 Each Party shall co-operate with the other Parties if it decides to bring in any legal or other proceedings to challenge the validity of the requirement to disclose Confidential Information.

4.4 If a Party is unable to inform the other Parties before Confidential Information is disclosed, it shall (to the extent permitted by law) inform the other Parties immediately after the disclosure of the full circumstances of the disclosure and the information that has been disclosed.

5. RESERVATION OF RIGHTS AND ACKNOWLEDGEMENT

5.1 All Confidential Information shall remain the property of the Disclosing Party. Each Party reserves all rights in its Confidential Information. No rights, including, but not limited to, intellectual property rights, in respect of a Party's Confidential Information are granted to the other Parties and no obligations are imposed on the Parties other than those expressly stated in this Agreement.

5.2 Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information, or the accuracy or completeness of the Confidential Information.

5.3 The disclosure of Confidential Information by a Party shall not form any offer by, or

representation or warranty on the part of, the Disclosing Party to enter into any further agreement in relation to the Purpose, or the development or supply of any product or service to which the Confidential Information relates.

5.4 Each Party shall be liable to the other Parties for the actions or omissions of its Representatives under this Agreement, as if they were the actions or omissions of the Recipient.

6. INDEMNITY

6.1 Each Party warrants that it has the right to disclose its Confidential Information to the other Parties and to authorise the other Parties to use such Confidential Information for the Purpose.

6.2 Each Party shall indemnify and keep fully indemnified the other Parties at all times against all liabilities, costs (including legal costs on an indemnity basis), expenses, damages and losses (including any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and other reasonable costs and expenses suffered or incurred by the other Parties) arising from any breach of this Agreement as a result of its breach.

7. TERM AND TERMINATION

7.1 The obligations contained in this Agreement shall take effect on the date of the Agreement and shall continue for the Term.

7.2 Subject to clause 7.2 this Agreement will be terminated:

i. If any of the Parties decide not to become, or continue to be involved in the Purpose; or

ii. on discontinuance of the development and delivery of the WYAAT Strategy.

7.3 If any Party decides not to become or continue to be involved in the Purpose it shall notify the other Parties in writing immediately. The obligations of each Party shall, notwithstanding any earlier termination of negotiations or discussions between the Parties in relation to the Purpose, continue for a period of six years from the termination of this Agreement.

7.4 Termination of this Agreement shall not affect any accrued rights or remedies to which any Party is entitled.

8. GENERAL LEGAL PROVISIONS

8.1 This Agreement, the Memorandum of Understanding, the Information Sharing Protocol and the Conflict of Interests Protocol constitute the whole agreement between the Parties and supersedes all previous agreements between the relevant Parties relating to their subject matter. Each Party acknowledges that, in entering into

this Agreement, it has not relied on, and shall have no right or remedy in respect of, any statement, representation, assurance or warranty (whether made negligently or innocently) other than as expressly set out in this Agreement, the Memorandum of Understanding, the Information Sharing Agreement and the Conflict of Interests Protocol. Nothing in this Clause 8.1 shall limit or exclude any liability for fraud or for fraudulent misrepresentation.

8.2 This Agreement shall be governed by the laws of England.

8.3 No variation or waiver of this Agreement or any part of it will be effective unless made in writing, signed by or on behalf of all the Parties (or their authorised representatives) and expressed to be such a variation or waiver.

8.4 Failure to exercise, or any delay in exercising, any right or remedy provided under this Agreement or by law shall not constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy.

8.5 No single or partial exercise of any right or remedy provided under this Agreement or by law shall preclude or restrict the further exercise of that or any other right or remedy.

8.6 A Party that waives a right or remedy provided under this Agreement or by law in relation to another Party, or takes or fails to take any action against that Party, does not affect its rights in relation to any other Party.

8.7 The Parties shall attempt to resolve any dispute between them in respect of this Agreement by negotiation in good faith.

8.8 Except as otherwise provided in this Agreement, no Party may assign, sub-contract or deal in any way with, any of its rights or obligations under this Agreement or any document referred to in it.

9. NOTICES

9.1 Any notice required to be given under this Agreement, shall be in writing and shall be delivered personally, or sent by pre-paid first class post or recorded delivery or by commercial courier or by secure NHS email with an assigned read receipt, to each Party required to receive the notice at its address as specified by the relevant Party by notice in writing to each other Party.

9.2 Any notice or other communication shall be deemed to have been duly received:

i. if delivered personally, when left at the address and for the contact referred

to in this clause on the date and at the time that the delivery receipt is signed; or

ii. if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or

iii. if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed

iv. if sent by secure email, on the date and time that a read receipt is received by the sender.

10. NO PARTNERSHIP

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between any of the Parties, constitute any Party the agent of another Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party.

11. THIRD PARTY RIGHTS

No person other than a Party to this Agreement shall have any rights to enforce any term of this Agreement whether under the Contracts (Rights of Third Parties) Act 1999 or otherwise.

SCHEDULE 7

PROTOCOL FOR MANAGING CONFLICTS OF INTEREST

IN RELATION TO THE STRATEGY FOR THE WEST YORKSHIRE

ASSOCIATION OF ACUTE TRUSTS

1. INTRODUCTION

1.1 This document forms part of the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common (CIC) and should be considered in conjunction with the overall Memorandum of Understanding and Terms of Reference of that Committee.

1.2 The members of WYAAT will adhere to the NHS England Guidance on Managing Conflicts of interest.

1.3 The objectives of this Protocol are to:

1.3.1 manage any Conflict so that the Parties are able to discuss the development of the WYAAT Strategyand make decisions on its delivery in accordance with principles of probity, fairness, non-discrimination, equality and transparency;

1.3.2 minimise the risk of a successful challenge being brought by a third party as a result of the unmanaged and undisclosed exploitation of a Conflict; and

1.3.3 ensure that the management of the Conflict during the negotiations does not prejudice the ability of any Party or Individual to continue to fulfil their role, does not undermine their ability to make decisions, and does not damage public trust and confidence in the Parties.

2. DEFINITIONS

2.1 For the purposes of this document a ‘conflict of interest’ is defined as:

‘A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold’.

2.2 A conflict of interest may be:

i. Actual – There is a material conflict between one or more interests.

ii. Potential – There is the possibility of a material conflict between one or more interests in the future.

2.3 A material interest is one which a reasonable person would take into account when making a decision regarding the use of tax-payers money because the interest has relevance to that decision.

2.4 Interests fall into the following categories:

i. Financial interests – where an individual may get direct benefit* from the consequences of a decision they are involved in making

ii. Non-financial professional interest – where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making such as increasing their professional reputation or promoting their professional career

iii. Non-financial personal interests – where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit because of decisions they are involved in making

iv. Indirect interests – where an individual has a close association ** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

v. Loyalty interests - Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

A benefit may arise from the making of a gain or avoiding a loss

** These associations may be close family members and relatives, close friends and associates and business partners.

3. CONFLICTS OF INTEREST

3.1 The Parties agree that other than being a party to WYAAT:

3.1.1 a conflict of interest (Conflict) arises when in developing and delivering the WYAAT Strategy an individual or organisation:

i. owes duties to two or more organisations and those duties are in conflict with one another; or

ii. has any financial interest, direct or indirect, in any contract, proposed contract or other matter around the WYAAT Strategydevelopment and delivery and is present at a meeting at which the contract or other matter is the subject of consideration; and/or

iii. the individuals' or organisations' ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by their involvement in another role or relationship.

iv. if in doubt, any Individual or Party concerned should assume that a potential Conflict exists.

3.1.2 applying the meaning of a Conflict to an Individual, a Conflict does potentially exist if an Individual simultaneously has a role at more than one Party or has previously had or will have a role at a Party while being employed at another as the case may be;

3.1.3 the existence of a Conflict does not in itself indicate that a person or organisation in question has done anything wrong. Where Conflicts are unavoidable they need to be managed appropriately;

3.1.4 if any Party materially breaches this Protocol then the Parties may agree to discontinue the respective Party involvement in the further discussions around the WYAAT Strategy development and delivery; and

3.1.5 this document accordingly sets out a Protocol that the Parties have agreed to adopt for the purpose of managing a Conflict.

4. PROCESS FOR MANAGING CONFLICTS OF INTEREST

4.1.1 Individuals and the Parties will adhere to the NHS England Guidance on Managing Conflicts of Interest.

4.1.2 The Parties acknowledge that they are independent statutory providers and that the intent of the WYAAT Strategy is to deliver region wide efficient and sustainable healthcare for patients, so whilst it is contemplated that there will be Conflicts, the Parties expect these to be managed in a reasonable manner to ensure the objective is met and that the appropriate Parties are part of WYAAT discussions and, where reasonable, any decisions.

4.1.3 Each individual must ensure that their declarations are up to date on the register of their own organisation in the first instance. An up to date register of interests of all Committee members will be provided to the Chair (noting adherence to Schedule 5 section 5.4) of the WYAAT Committee in Common prior to each meeting.

4.1.4 Where a Party is aware of a Conflict which:

i. has not been declared, either in the register or orally, they will declare this at the start of the meeting;

ii. has previously been declared, in relation to the scheduled or likely business of the meeting, the Party concerned will bring this to the attention of the Chair of the meeting, together with details of arrangements which have been confirmed for the management of the Conflict.

4.1.5 The Chair of the meeting will then determine how this should be managed and inform the Party of their decision. Where no arrangements have been confirmed, the Chair of the meeting may require the individual to withdraw from the meeting or part of it if appropriate. The Party or Individual as applicable will then comply with these arrangements, which must be recorded in the minutes of the meeting.

4.1.6 Where the Chair of any meeting has a Conflict, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and a deputy chair will be appointed to act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the Conflict in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the Parties present at the meeting will select one.

4.1.7 Any declarations of Conflicts and arrangements agreed in any meeting will be recorded in the minutes and the register of Conflicts for the Parties in respect of the WYAAT Strategy development and delivery. The Chair will make a decision as to whether the relevant section of the minutes should be redacted for those individuals who declared a conflict and this decision will be recorded in the minutes.

4.1.8 Where more than 50% of the Parties representatives at a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of Conflicts, the Chair (or deputy) will determine whether or not the discussion can proceed.

4.1.9 In making this decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance set out in the WYAAT CIC Terms of Reference. Where the meeting is not quorate, owing to the absence of certain Parties, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the Parties owing to the arrangements for managing Conflicts, the chair shall consult with the Conflict Leads on the action to be taken. This may include inviting on a temporary basis alternate individuals from the affected Parties to make up the quorum (where these are permitted members who are not subject to a Conflict) so that they can progress the item of business.

SCHEDULE 8

INFORMATION SHARING PRINCIPLES

IN RELATION TO THE DEVELOPMENT OF A STRATEGY FOR WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

1. INTRODUCTION

This document forms part of the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common (CIC) and should be considered in conjunction with the overall Memorandum of Understanding and Terms of Reference of that Committee.

2. DEFINITIONS

2.1 In this Agreement the following words and expressions shall have the following meanings:

2.1.1 Business as Usual: all activities undertaken by any Party in the ordinary course of business save for any activity in connection with the WYAAT Strategy development and delivery;

2.1.2 Confidential Information: shall have the meaning given to it in the Confidentiality Agreement;

2.1.3 Competitively Sensitive Information: any Confidential Information which would or might enable the recipient to alter its commercial strategy and may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contract or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Party, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions; and

2.1.4 Data: information, data and material recorded in any form and shared between any or all of the Parties including Confidential Information and Commercially Sensitive Information.

3. PRINCIPLES

The following key principles guide the sharing of data between the Parties

3.1 The Parties endorse, support and promote the accurate, timely, secure and

confidential sharing of both person identifiable and anonymised data where such data sharing is essential for the provision of effective and efficient services to the local population.

3.2 The Parties are fully committed to ensuring that if they share data it is in accordance with their legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

3.3 Where it is agreed that the sharing of data is necessary, only that which is needed, relevant and appropriate will be shared and that would only be on a "need to know" basis.

3.4 The data being shared will only be used for the purpose for which it was originally intended.

3.5 All Parties must have in place policies and procedures to meet the national requirements for Data Protection, Data Security and Confidentiality [https://ico.org.uk/for-organisations/guide-to-data-protection]. The existence of, and adherence to, such policies provide all Parties with confidence that data shared will be transferred, received, used, held and disposed of appropriately.

3.6 In line with these policies, the Parties have developed and approved a single Information Sharing Agreement to allow the sharing of non-person identifiable information to support WYAAT programmes and projects. If the Parties need to share person or patient identifiable information to support a WYAAT programme or project, an individual information sharing agreement will be put in place for each programme or project, where required, in order to ensure secure and appropriate sharing of information.

3.7 The Parties acknowledge their 'Duty of Confidentiality' to the people they serve. In requesting release and disclosure of data from other Parties' employees and contracted volunteers will respect this responsibility and not seek to override the procedures which each organisation has in place to ensure that data is not disclosed illegally or inappropriately. This responsibility also extends to third party disclosures; any proposed subsequent re-use of data which is sourced from another organisation should be approved by the source organisation.

3.8 When disclosing data about individuals, Parties will clearly state whether the data being supplied is fact, opinion, or a combination of the two.

3.9 The Parties will have in place effective procedures to address complaints relating to the disclosure of data, and information about these procedures should be made available to service users.

4. CONFIDENTIAL INFORMATION

4.1 The Parties can share information with each other and NHS England for the purpose of the WYAAT Strategy development and delivery subject to the provisions of the Confidentiality Agreement.

4.2 The WYAAT Programme Office and each Party shall maintain clear records of all the Confidential Information exchanges they are part of.

5. COMPETITIVELY SENSITIVE INFORMATION

5.1 The Parties shall not disclose to each other any Competitively Sensitive Information. The Parties acknowledge that:

5.1.1 information is not Competitively Sensitive Information if it relates to activities or markets in which the relevant Parties do not currently compete and where there is no realistic prospect that they will in future compete;

5.1.2 subject to section 6, information is not Competitively Sensitive Information if it relates to any arrangements involving information exchange and collaboration (including for the purpose of joint projects contemplated or being implemented by the Parties under WYAAT) for the purpose of Business as Usual activities; and

5.1.3 information is not Competitively Sensitive Information if it relates to activities or markets in which the respective Parties are actual or potential competitors and disclosure of the relevant information would not affect the recipient Party's commercial strategy or decisions; this may apply if, for example:

i. the information is historical, aggregated (as defined below) and/or anonymised; or

ii. the information is freely available in the public domain.

5.2 In this clause 5 "aggregated" means that the price, cost and volume of individual services or contracts for the provision of services, the subject matter of which forms or could form the basis of competition between the Parties, cannot be determined from the Data.

6. DOCUMENT CREATION

6.1 The Parties acknowledge that documents created by any Party for the WYAAT Strategy development may be required to be disclosed to the UK merger authorities.

6.2 The Parties agree to take due care and attention when creating documents (including but not limited to emails and handwritten notes) to avoid the use of language that could be misinterpreted.

6.3 If any Party is asked by external legal advisors to provide Data, any documents must be clearly marked "Privileged and confidential: prepared at the request of external legal advisers".

BO.9.24.16 - BOARD ASSURANCE FRAMEWORK AND HIGH-LEVEL RISKS

REFERENCES

Only PDFs are attached

- Bo.9.24.16 - BAF & HLRR (cover) (1).pdf
- Bo.9.24.16 - Appendix 1 - BAF - Sept 2024.pdf
- Bo.9.24.16 - Appendix 2 - HLRR.pdf
- Bo.9.24.16 - Appendix 3 - Risk on a Page Report v1.pdf
- Bo.9.24.16 - Appendix 4 - Target Mitigation Dates.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.16

Board Assurance Framework and High Level Risks

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Executive Directors Laura Parsons, Associate Director of Corporate Governance/Board Secretary Katie Shepherd, Corporate Governance Manager	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	This paper provides a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives	
Key control	Understanding the Board's risk appetite related to the achievement of the Trust's strategic objectives is a key component of the Board Assurance Framework	
Action required	For approval	
Previously discussed at/ informed by	High Level Risk Register: ETM: 22 July, 19 August and 9 September 2024 Academies: • Quality and Patient Safety Academy; 14 August and 19 September 2024 • People Academy: 9 August 2024 and 19 September 2024 • Finance and Performance Academy: 27 July 2024 and 19 September 2024 Board Assurance Framework: ETM: 16 September 2024	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

BAF – Strategic Risk

The Board of Directors has a responsibility to understand the level and type of risks being taken within the organisation. A properly functioning Board Assurance Framework (BAF) provides the organisation with an understanding of the principal risks to the achievement of its strategic objectives and should provide robust assurances over the controls in place or the action being taken to mitigate risks to an acceptable level within the Board's risk appetite.

The BAF concerns strategic risks that could impact on the achievement of the long term strategic objectives of the Trust. They can be affected by such areas as policy, people, partners, money, safeguarding, political, legal and regulatory changes, and reputation. They are identified at Board level (top down).

The risks included on the BAF, and the Board's risk appetite statement are both reviewed on an annual basis to ensure that they remain up to date, relevant and aligned with the opportunities and threats being faced by the Trust.

At the Board Development Session held on 13 June 2024, the Board considered and prioritised the risks that were included on the BAF. It was agreed that the overall number of risks would be reviewed and streamlined to remove any duplication and to ensure that the BAF is focused on the highest priority risk areas.

A list of assurance topics has been agreed with a lead director aligned to each one. The lead directors have developed the risk/s associated with each topic and the updated BAF is attached at Appendix 1 for approval.

The Board is asked to note that the initial list of assurance topics included 'patient care', however following consideration by the Chief Medical Officer, it is proposed that a separate risk is not created in relation to this topic, as ultimately all of the risks on the BAF would impact patient care either directly or indirectly.

The risks have been aligned to the Trust's strategic objectives; the Board is asked to review the alignment

and either agree or confirm any changes as appropriate.

The Board is also asked to note that a review of risk appetite is still required, this will initially be considered with the Committees/Academies in relation to the strategic objectives aligned to them, and then presented to the Board for approval in November.

High Level Risk Register (HLRR) – Operational Risk

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

At its meetings on 22 July, 19 August and 9 September, 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 July, August and September 2024 (the planned Quality and Patient Safety Academy and Finance and Performance Academy meetings for July took place during early August 2024).

The HLRR, showing all high level risks rated 15+ for June 2024, is attached at Appendix 2.

High Level Risks Report on a Page

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

The following information is included:

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

Target Mitigation Dates

Risks beyond their target mitigation date
ETM noted there were seven risks that had passed the target date for completion of the mitigating actions.

All risks have been reviewed and the target mitigation dates have been amended, with the exception of risk 396 (there is a risk to the provision of a consistent stroke service due to a number of underlying issues). This risk will be merged with risk 2618, which also relates to the stroke service.

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

New risks to the High Level Risk Register (HLRR)

Since the last report to the Board, five new risks have been accepted onto the HLRR:

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:

Meeting Title	Board of Directors		
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July 2024:						
2605	**25**	8	15 patients on daily unable to fit in for their treatment when it is due. The service is unable to accommodate any further chemotherapy until the week commencing 17th June 2024 unless there are any cancelations which are looked at on a daily basis. Without any further increase in chair or skilled nursing capacity this service cannot accommodate any more Haematology and Oncology patients.	Ray Smith, Chief Medical Officer	31 March 2025	Quality Committee and Finance and Performance Committee
August 2024:						
2604	**20**	**9**	The number of patients in the emergency department often exceeds its designed capacity and available resources meaning providing safe, timely, and efficient care to current and incoming patients becomes challenging.	Karen Dawber, Chief Nurse	1 October 2024	Finance and Performance Committee, Quality Committee
2618	**20**	**9**	If we are unable to recruit to substantive Consultant posts within Stroke then from 2nd September 2024 the only remaining consultants in stroke will be 2 agency locums (2.0 WTE), and 1 ad hoc/bank locum. Locum staff are intrinsically not a stable workforce and gaps can occur with very little notice. If we have no stroke consultants, we are fundamentally unable to provide a viable stroke service.	Ray Smith, Chief Medical Officer	31 October 2024	People Academy, Quality Committee
September 2024:						
2601	**15**	**8**	Cath lab equipment failure - Downtime of current equipment is preventing optimal numbers of patients being seen, leading to longer waits for elective PCI and pacing work, and pressure on beds due to acute waits.	Ray Smith, Chief Medical Officer	31 December 2024	Quality Committee
2630	**20**	**1**	HIV currently use an external provider, Dedalus, for their electronic patient records and data reporting. Dedalus has given notice to end contract on 31.03.25, they also gave notice in 2023 but extended for 1 year. From 1.04.25 the HIV service will be unsupported by Dedalus, this leaves too high a risk to keep using for many reasons, and they have recommended that we don't continue to use beyond the end date.	Paul Rice, Chief Digital and Information Officer	31 March 2025	Quality Committee

Risks which have been removed/closed

No risks have been removed/closed since the previous report.

Risks which have changed in score

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Two risks have changed in score since the last report to the Board:

Risk ID:	Current Score:	Previous Score:	Target Score:	Risk Description:	Lead Director:	Reason for change in score:	Academy:
July 2024:							
2542	**20**	**16**	**1**	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.	Ray Smith, Chief Medical Officer	Risk score increased to 20. Updated risk assessment reviewed and approved by HTT today given maternity fridge Blood Track failure.	Quality & Patient Safety Academy
September 2024:							
2605	**20**	**25**	**8**	15 patients on daily unable to fit in for their treatment when it is due. The service is unable to accommodate any further chemotherapy until the week commencing 17th June 2024 unless there are any cancelations which are looked at on a daily basis. Without any further increase in chair or skilled nursing capacity this service cannot accommodate any more Haematology and Oncology patients.	Ray Smith, Chief Medical Officer	Was initially scored too high.	Quality Committee and Finance and Performance Committee

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Risks beyond their review date

ETM noted there were three risks beyond its review date in July 2024, and two risks beyond the review date in August and September 2024. All risks have now been reviewed.

Change to risk description

The Board is asked to note that risk 187 (safe staffing) will be updated to remove reference to Covid-19.

Recommendation

The Board is asked to:

- review and approve the updated Board Assurance Framework; and
- confirm whether it is assured that all risks on the High Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

Meeting Title	Board of Directors		
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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients, 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 England: *Risk assessment framework, quality governance framework, code of governance*
Care Quality Commission Domain: *well led*
Care Quality Commission Fundamental Standard: *good governance*
Other (please state):

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

Board Assurance Framework – Summary

NHS Bradford Teaching Hospitals NHS Foundation Trust

Ref	Strategic Risks	Current Score & Direction of travel	Target Score	Executive Lead	Commentary (e.g. change in risk score, completed actions, reasons for any delays in actions)
Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness **Risk appetite: TBC**		**Assuring Committee: Quality / Finance & Performance**			**Overall Assurance Level 2024/25:** **Q1** **Q2** **Q3** **Q4**
1	**If** the Trust fails to address health inequalities, **then** this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven.	12	8	Director of Strategy & Transformation	
2	**If** we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services	20	12	Director of Estates & Facilities	
3	**If** Informatics are not resourced accordingly, **then** there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, adequacy and pace of delivery, **resulting in** a reduced ability for the Trust to achieve its strategic ambitions.	12	9	Chief Digital & Information Officer	
Strategic Objective 2 - To deliver our financial plan and key performance targets **Risk appetite: TBC**		**Assuring Committee: Finance & Performance**			**Overall Assurance Level 2024/25:** **Q1** **Q2** **Q3** **Q4**
4	**If** we or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, **then** we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, **resulting in** reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.	20	8	Director of Finance	
5	**If** the Trust is unable to deliver sustainable services, **then** we may not be able to deliver clinical services that are fit for the future, **resulting in** a loss of staff, and a negative impact on patient safety, experience and outcomes and an inability to deliver all requirements of the NHS operational plan	12	8	Chief Operating Officer	
6	**If** the Trust fails to implement its Green Plan effectively, **then** the Trust may fail to meet its responsibilities in relation to climate change, **resulting in** an inability to deliver sustainable healthcare.	12	8	Director of Strategy & Transformation	
Strategic Objective 3 – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion **Risk appetite: TBC**		**Assuring Academy: People**			**Overall Assurance Level 2024/25:** **Q1** **Q2** **Q3** **Q4**
7	**If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to reduce sickness absence and turnover rates, **resulting in** an adverse impact on patient safety and experience, and staff experience, wellbeing and morale. Additional vacancies and or absence could place staff under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience.	9	6	Chief People & Purpose Officer	
8	There is a risk that we are unable to achieve our ambitions on ED&I, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations. If we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, **then** we may have low levels of staff engagement and morale, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract diverse staff to work for our Trust. There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks, and including the Equality Act 2010, and specifically the Public Sector Equality Duty.	9	6	Chief People & Purpose Officer	
Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation **Risk appetite: TBC**		**Assuring Committee: Quality / People**			**Overall Assurance Level 2024/25:** **Q1** **Q2** **Q3** **Q4**
9	**If** it is not possible to fill rota gaps or provide experienced trainers, **then** we may fail to provide an appropriate learning experience for trainees, **resulting in** an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status	9	6	Chief Medical Officer	
10	**If** we fail to attract research funding and researchers to the Trust, **then** our research capacity and capability will be negatively impacted, **resulting in** a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research	6	6	Chief Medical Officer	
11	**If** we do not have robust processes for incident identification, escalation and learning **then** we may fail to learn from incidents, **resulting in** gaps in safe clinical care	12	8	Chief Medical Officer	
Strategic Objective 5 – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals **Risk appetite: TBC**		**Assuring Committee: N/A - Board**			**Overall Assurance Level 2024/25:** **Q1** **Q2** **Q3** **Q4**
12	**If** the Trust doesn't work effectively in partnership, **then** there is a risk that the Trust fails to provide the best service to patients, **resulting in** poor patient and staff experience, worse outcomes for patients and missed opportunities to address health inequalities.	8	3	Director of Strategy & Transformation	
Risk relevant to all strategic objectives **Risk appetite: TBC**		**Assuring Committee: N/A - Board**			**Overall Assurance Level 2024/25:** **Q1** **Q2** **Q3** **Q4**
13	**If** we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.	20	10	Chief People & Purpose Officer	

Heat Map – September

= current score

LIKELIHOOD	CONSEQUENCE				
	Negligible (1)	Low (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)					
Likely (4)			3 E.9(3).24.6 - Appendix 1 - BAF - C		2 4 13
Possible (3)			7 8 9	1 5 6 11 9(3).24.6 - Appendix 1 - BAF - C	
Unlikely (2)			10	12	
Extremely unlikely (1)					

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Health inequalities

Ref: 1	**Strategic Risk: If** the Trust fails to address health inequalities, **then** this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven.

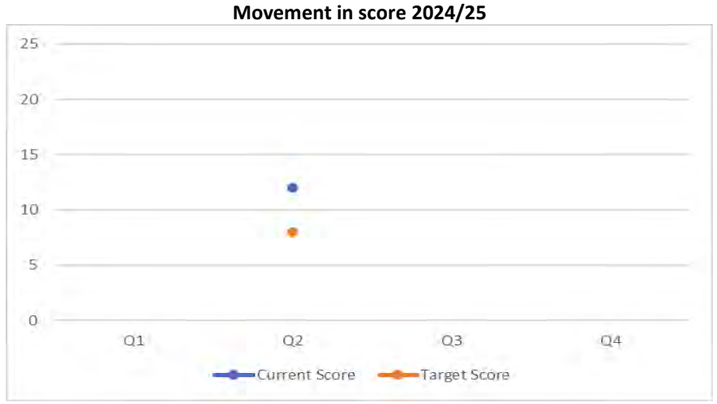
Risk Appetite: TBC

Date added: 6 September 2024

Date of last review: N/A – new risk

Lead Director: Director of Strategy and Transformation

Movement in score 2024/25



Initial Score (CxL): 4 x 4 = 16

Current Score (CxL): 4 x 3 =12

Target Score (CxL): 4 x 2 = 8

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Addressing health inequalities as a priority by providing training, adding HI to processes, setup of an HI oversight group, improve awareness. • Trust-wide Health Inequalities Action Plan being developed. • Utilising data and insight to deliver the Health Inequalities statement: Health Inequalities and Access to Care action plan to support DNA reduction, referral analysis and post referral prioritisation objectives. • Strengthening our role as an anchor organisation by exploring opportunities to procure locally, increase awareness of employment routes and opportunities (work experience, apprenticeships etc) within deprived areas, support the Living Well integration into Trust services which will help healthy eating, smoking cessation and weight management and ultimately co-design services with patients. • Examining pathways and service population profiles to understand opportunities to reduce points where inequalities could occur, utilise the Health Equity Assessment Tool to develop plans following data and pathway analysis. • Collaborating with partner organisations to strengthen our health inequalities impact particularly to work with the Reducing Inequalities Alliance, BIHR, Living Well. • Collaborating with other providers – Airedale and BDCT. • Equality Impact Assessments and EDI strategy.	**Internal** **Positive:** • EDI strategy • Health inequalities and Access to Care • Strengthening role as an anchor organisation • Connections to Equality and Diversity Council • Links to Quality Committee • A number of colleagues across the Trust have already completed the WY ICB initiative to become “Health Inequalities Fellows” **Negative:** N/A	**Independent** **Positive:** • Collaboration with Reducing Inequalities Alliance • Collaboration with Living Well • Collaboration with BIHR • National NHS E guidance, including Core20PLUS5 methodology **Negative:** N/A	**Gaps in control** Routine forum on Health inequalities Oversight of inequalities across the Trust	**Action** To gain Board approval in developing a health inequalities oversight group at the Board Development Session Trust-wide action plan being developed, which will include governance arrangements	**Timescale** Board development session in Oct/Nov 2024
			Gaps in assurance Clear definition on what we mean by Health Inequalities and an agreed method of how we are going to monitor progress against this definition.	Work with colleagues in Business Intelligence roles Gather expertise from HI Fellows to guide this	November 2024
Related risks on the high level risk register (operational risks)	**N/A**				

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Environment – estates infrastructure

Ref: 2	**Strategic Risk: If** we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services

Risk Appetite: TBC

Date added: 30 August 2024

Date of last review: N/A – new risk

Lead Director: Director of Estates and Facilities

Movement in score 2024/25

Initial Score (CxL): 5x4=20

Current Score (CxL): 5x4=20

Target Score (CxL): 3x4=12

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Infection Prevention & Control policy and processes in place, oversight through IPC Committee and Quality & Patient Safety Academy • PLACE surveys and action plans • Backlog maintenance annual condition surveys that prioritises available capital funding. • Health and Safety governance and reporting • Estates Strategy / development plan in progress • Policies and Procedures across Estates and Facilities – Estates Maintenance, Cleaning Services, etc • KPIs to monitor and manage the outputs from the policies. • Audit Yorkshire reports showing significant assurance • External oversight over sub-elements of Estates, i.e. Water Safety, Ventilation – (annual reports / surveys) • St Lukes Day Unit new build to open late 2024 • £25m successful bid for endoscopy unit progressing on site. • Main entrance BIHR – due to complete 2024 • Ward 1 Side room / PPVL project complete • Hand Theatre due to complete	**Internal** **Positive:** • IPC Quarterly Reports • PAM Report to Board September 2023 (next one due in Sept 2024) • Estates Return Information Collection (ERIC) returns show an extensive knowledge base • Health and Safety Committee reports to people academy / board. • Patient Experience Group monitoring E&F KPIs that impact the care environment **Negative:** • A deteriorating position on backlog maintenance – physical condition from last year - £93m - £102m	**Independent** **Positive:** • Meeting National Cleaning Standards • Meeting National Food Standards • Annual Inpatient Survey • Internal Audit reports: ➢ Medical Devices – Significant assurance (January 2023) ➢ Ward Accreditation – Significant assurance (April 2023) ➢ Cleaning Standards – Significant assurance (November 2023) ➢ Premises Assurance Model -High assurance (November 2023) ➢ Laundry and Linen Services – Significant assurance (February 2024) **Negative:** • Internal Audit reports: COSHH – Limited assurance (November 2023)	**Gaps in control** • 49% of the estate is non-clinical (model hospital 35%) • 7% void space -predominantly at SLH • Majority of the estate is not functionally suitable due to age. • Space utilisation is a gap in control • Clinical Services exceeding the estate physical capacity / space i.e. Skipton Renal **Gaps in assurance** N/A	**Action** • Estates strategy in development to address site utilisation and development • Space Utilisation Group to be commenced • Review of Skipton Hospital space and external options •	**Timescale** Ongoing October 2024 Ongoing
Related risks on the high level risk register (operational risks)	• **3627** – Backlog maintenance and critical infrastructure risk (current score: 20)				

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Digital and data

Ref: 3	**Strategic Risk: If** Informatics are not resourced accordingly, **then** there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, adequacy and pace of delivery, **resulting in** a reduced ability for the Trust to achieve its strategic ambitions.

Risk Appetite: TBC	**Movement in score** 	**Initial Score (CxL): 3x4=12**
Date added: 30 August 2024 **Date of last review:** N/A – new risk		**Current Score (CxL): 3x4=12**
Lead Director: Chief Digital and Information Officer		**Target Score (CxL): 3x3=9**

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Business cases/resource bids for additional team investment continues to be presented to Planning Committee, Capital Strategy with SBARs progressed to ETM for relevant approval of key roles. • A refresh of the Digital Strategy is currently underway which seeks to optimise existing resources, services, investments and technologies. • We have appointed the Trust's first dedicated cyber security manager who will be overseeing the continued optimisation and improvement of cyber security controls and arrangements. • A series of external assessments have been commissioned to assess the suitability and in some cases resilience of key services. The outcome of these shall inform future direction, work efforts and investments. • Informatics is undertaking a comprehensive review and refresh of all risks relating to its services, technologies and people. • Informatics shall be migrating to a new set of cyber security controls which will see the Trust adopt over the next 18-24 months. • As part of the digital strategy refresh, we will produce a comprehensive training agenda to ensure colleagues remain engaged, and appropriately skilled and proficient to exploit new technologies and methodologies to benefit the needs of the Trust. • Seeking investment into EPR optimisation, and residual EPR team post-AFT go live Seeking investment into Data Quality capabilities and direction	**Internal** **Positive:** Informatics Performance Group (IPG) is seeing an improved position of key IT governance activities and controls. **Negative:** Feedback from CSUs is that EPR optimisation is not progressing at the required pace, however, understand this is due to development and resources constraints owing to TACC deployment, LIMs go-live and AFT EPR.	**Independent** **Positive:** Successful ISO27001 report and outcome **Negative:** External assessment on Datawarehouse and Business Intelligence function – sub-optimal for the needs of the Trust's data and analytics ambitions	**Gaps in control** Digital and Data Transformation committee requires a re-launch with a new independent chair to monitor, and support Informatics performance. For this to work as required, a refreshed strategy (plan) will need to be delivered. **Gaps in assurance** Informatics oversight is provided by QPSA, but was recognised by the Chair that oversight on Cyber/Informatics might need additional scrutiny/appropriate oversight.	**Action** CDIO to engage with new Director of Strategy and Transformation Review of Committee TOR and work plans	**Timescale** 2 months October 2024
Related risks on the high level risk register (operational risks)	N/A				

Objective 2 - To deliver our financial plan and key performance targets
Assurance topic – Delivery of the financial plan

Ref: 4	**Strategic Risk: If** we or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, **then** we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, **resulting in** reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.

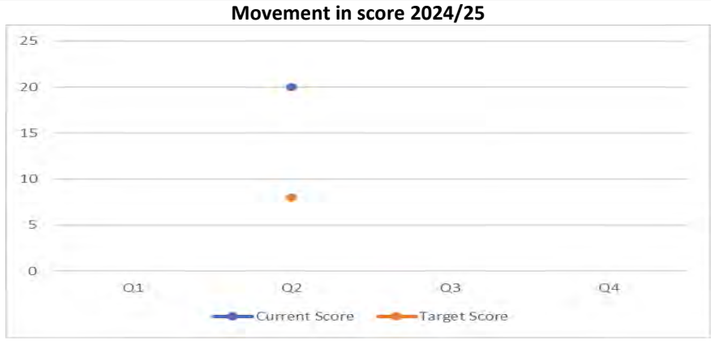
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 24 August 2024

Date of last review: N/A – new risk

Lead Director: Chief Finance Officer

Movement in score 2024/25



Initial Score (CxL): 5x4=20

Current Score (CxL): 5x4=20

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
	Internal	**Independent**		**Action**	**Timescale**
• Continued evolution of the Clinical Service Unit financial management arrangements and framework, with associated accountability and performance management framework • Introduction of the Closing the Gap (CTG) financial efficiency programme structure (ie CTG Programme Board) with workstreams focused on Workforce, Digital, Elective Productivity and Financial Controls • Communications from Executive Team to highlight the importance of delivering the financial plan and increasing the priority given to this for all Trust colleagues • Named Executive Director sponsor for every Clinical Service Unit (CSU) to support with delivery of cash releasing efficiencies and budgetary management • Increased Executive Team oversight and performance management via additional monthly CTG focused Exec to CSU meetings • Quality Impact and Financial Impact Assessment processes. • Action plan to deliver recommendations of PWC review of financial governance arrangements and efficiency opportunities • Scheme of Delegation, internal financial control environment (revised February 2023). • Financial governance and control arrangements. • Financial controls: Recruitment Approval Panel, Variable Pay Panel, Non-Pay Review Group • Budgetary Management Framework • Update to Procurement strategy, risk register and work plan • The cash & liquidity position is managed and monitored by the Cash Committee with updates provided to the Finance & Performance Academy via the monthly Finance Report and the periodic Treasury Management Report. • Close monitoring of cash forecast to ensure a timely application for external revenue support can be submitted to NHSE if required • Intensified oversight and governance of the capital programme via Capital Strategy Group and Capital Operational Group. • Look to source alternative income flows to support the investment plan that do not impact on CDEL (eg charitable donations). • WYAAT CEO-led efficiency workstreams • BDC Place Closing the Gap programme	**Positive:** • Monthly Finance report to July 2024 F&P Committee and Board – Month 3 & 4 Income & Expenditure run rate improvements vs Months 1 & 2 • Closing the Gap report to July F&P Committee highlighting progress with scheme development • Closing the Gap Scheme Scoping Documents for each workstream • Capital plan approved for 2024/25 **Negative:** • Treasury Management report to July 2024 F&P Committee highlighting forecast cash risks in Quarter 3 or 4 • CSU Monthly finance reports forecasting material overspends in many departments	**Positive:** • PWC report confirming Closing the Gap governance and programme structure is sound Internal Audit Reports: • Waste Reduction Programme – Significant Assurance (June 2024) • Financial Transactions – Significant Assurance (April 2024) • Contract Management – Significant Assurance (May 2024) **Negative:** • PWC report identified opportunities to improve financial control (outline action plan agreed at ETM 12 August 2024)	**Gaps in control** Budget holder capacity and capability to deliver a £38.9m cost improvement target in 2024/25	Budget holder training is in place, but this to be expanded with an increased focus on financial control measures and techniques for identifying efficiency opportunities. Dedicated Closing the Gap week in September 2024 giving budget holders dedicated time to focus on CTG delivery.	Quarters 3 & 4 of 2024/25 September 2024
			Gaps in assurance CSUs and corporate departments have not identified the full value of their Closing the Gap targets.	CTG governance structure Exec to CSU budget / CTG meetings	Already introduced but still maturing throughout Quarters 2 -4
				CSU named Exec sponsor roles PWC action plan	October 2024
			Ability to submit a balanced financial plan for 2025/26	CTG multi-year planning to be developed	Quarter 3
				Budget setting process for 2025/26 to commence early	Quarter 3
			Forecast to remain liquid and not reliant on external revenue cash support is dependent on timely CTG delivery of cash releasing cost reductions but this is not yet certain.	Working capital controls Cash Committee to develop further strategies to maximise cash balances	Ongoing
			The assurance that major ongoing developments within the existing capital programme will not increase in cost or slip into subsequent years, resulting in reduced CDEL and cash for future capital programme.	Capital Strategy Group and Capital Operational Group oversight	Ongoing

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

Objective 2 - To deliver our financial plan and key performance targets
Assurance topic – Sustainable services

Ref: 5	**Strategic Risk: If** the Trust is unable to deliver sustainable services, **then** we may not be able to deliver clinical services that are fit for the future, **resulting in** a loss of staff, and a negative impact on patient safety, experience and outcomes and an inability to deliver all requirements of the NHS operational plan

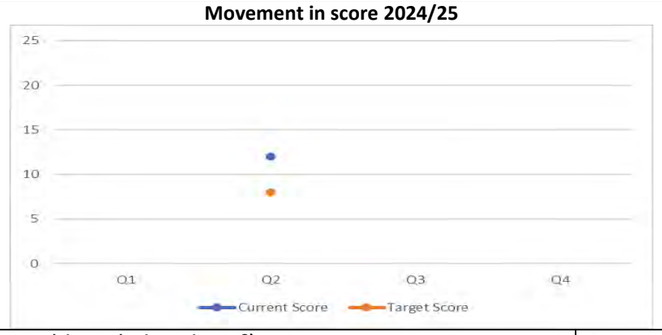
Risk Appetite: TBC

Date added: 27 August 2024

Date of last review: N/A – new risk

Lead Director: Chief Operating Officer

Movement in score 2024/25



Initial Score (CxL): 4x3 = 12

Current Score (CxL): 4x3 = 12

Target Score (CxL): 4x2 = 8

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Service planning • Operational Improvement Plan (Delivering Operational Excellence) 2023-25 approved • Act as One Programmes • Partnership work and with independent sector providers • WYAAT – Transformation Programmes, Fragile services workstream • To address workforce gaps – dedicated recruitment (national and international), regional rota • Outstanding Pharmacy Services (OPS) programme • HISTO improvement programme • Exec to CSU meetings and Accountability Framework • Hospital Management Group • NSO WYAAT Programme Director role appointed and workshops established • Creation of operational, financial and workforce plans to achieve operational planning guidance expectations 24/25. • Capital investment in infrastructure • Virtual Royal Infirmary programme • Elective Task and Finish Group established to deliver sustainable in house capacity to reduce reliance on insourcing/outsourcing • Command and control structure (Gold, Silver, Bronze) • EPRR Framework • Winter response plan • Ring fenced elective wards and capacity (at BRI site) • Closing the Gap elective recovery workstream	**Internal** **Positive:** • Act as One Updates to F&P Academy – latest July 2024 • Partnerships Dashboard – latest as at June 2024 • WYAAT ICS Programme Updates – latest July 2024 • Outstanding Pharmacy Programme update to People Academy – November 2023 Delivering Operational Excellence Plan to F&P Academy: • Cancer Performance Improvement Plan to F&P Academy – latest July 2024 • RTT Improvement Plan to F&P Academy – latest July 2024 • Urgent & Emergency Care Improvement Plan to F&P Academy – latest May 2024 • Winter Response Plan – F&P Academy – October 2023 • Performance Report to F&P – latest June 2024 **Negative:** • WYAAT reports (e.g. Non-Surgical Oncology, Haematology) • Histopathology and renal performance • EPRR self assessment core standards – 32% compliant – overall non-compliant	**Independent** **Positive:** • GIRFT reports • CQC Maternity Report (May 2023) – 'well led' improved to Good and overall BRI site now rated Good • Royal Colleges reports • Benchmarking of recovery position compared to other Trusts (Performance Report, latest June 2024) • Approach from NHSE for mutual aid support to Sheffield Teaching Hospitals Cancer Urology department • Internal audit reports: ➢ Recovery of services post Covid-19 – Significant assurance (May 2023) ➢ Patient Safety; National Standards for Cancer Patients - Significant Assurance (May 2023) ➢ Management of Patient Flow – Command Centre – High assurance (July 2023) ➢ Demand Management – Significant assurance (June 2023) ➢ Ambulance Handovers – Significant assurance (January 2024) ➢ Asset Utilisation – Theatres – Significant assurance (March 2024) ➢ Business Continuity Management Assessment Action Plan (April 2024) • Human Tissue Act assessment **Negative:** • GIRFT Reports • Joint venture – loss of UKAS accreditation • SSNAP (Stroke Audit Programme) – Dec 23 Overall 'C' Rating.	**Gaps in control** • Workforce gaps in some service areas (e.g. VIR, Histopathology, NSO) resulting in inability to maintain service provision in the longer term and shorter term gaps • Fragile services e.g. Stroke, Haematology, VIR, Histopathology, Renal • Financial challenges in 24/25 resulting in less resources to develop and transform services • Lack of certainty re: future funding allocation and national priorities • Lack of ring fenced ultra-green elective offsite facility • JAG accreditation not achieved, lack of physical capacity • Lack of funding for independent sector (IS) **Gaps in assurance** N/A	**Action** • Additional Consultant recruitment • Work with Joint Venture to streamline pathways • Increase in twilight shifts • Explore opportunity to increase chairs (6-10) at Skipton • Escalation to WYAAT and specialised commissioning • Closing the Gap programme • Working with national and regional partners to influence and input into reviews of services • Implementation of dedicated day case theatres at St Lukes Hospital. Practical completion confirmed 30/08/24. • Development of new endoscopy unit at BRI. Contractor appointed. • Work with IS and internal task and finish group to reduce reliance on IS	**Timescale** Ongoing Ongoing Ongoing Ongoing August 2024 Business case approved and programme board established. Ongoing

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

Objective 2 - To deliver our financial plan and key performance targets
Assurance topic – Environmental sustainability

Ref: 6	**Strategic Risk: If** the Trust fails to implement its Green Plan effectively, **then** the Trust may fail to meet its responsibilities in relation to climate change, **resulting in** an inability to deliver sustainable healthcare.

Risk Appetite: TBC	**Movement in score 2024/25**	**Initial Score (CxL): 4 x 4 = 16**
Date added: 4 September 2024 **Date of last review:** N/A – new risk		**Current Score (CxL): 4 x 3 = 12**
Lead Director: Director of Strategy & Transformation		**Target Score (CxL): 4 x 2 = 8**

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance**	**Actions to address gaps in controls or assurance**	
• The BTHFT Green plan outlines the action we will take to meet our obligations. The plan was developed in 2020 as a 5 year plan, although the expectation was that it would be renewed after 3 years. • Green Plan Implementation Group. The current Green Plan Implementation Group comprises of the leads for the 4 workstreams, the Exec Director of Strategy and Transformation, the Executive Director of Estates and Facilities and the Policy Manager. • Work across trust to promote good practice and share case studies. Staff engagement is important in ensuring we meet our legal obligations on reducing our carbon footprint and ensuring we are working in a more sustainable way across the trust to outline that everyone has responsibilities around sustainability. • Joint Adaptation plan with BDCT and Airedale. This plan outlines how we as a Place based partnership will respond to risks resulting from climate change. • ICB sustainability plan outlines what the ICB will do to meet its obligations on sustainability and the environment.	**Internal** **Positive:** • Annual report 2023/24 • Annual Report to Board – January 2024 **Negative:** N/A	**Independent** **Positive:** WY ICB BD&C Health & Care Partnership NHSE NE&Y CQC (outcome TBC) **Negative:** N/A	**Gaps in control** GPIG hasn't met formally since summer 2023 Engagement on sustainability/green issues across the trust is not consistent and depends on personal interest from individual members of staff	**Action** New Green Plan to be developed Membership of the GPIG to be reviewed to align with the content of the Green Plan Engagement plan to support the development and implementation of the plan Network of Green Champions to be created	**Timescale** Q4 2024/25 (dependent on publication of new guidance by NHS England) Q4 2024/25 to align with the launch of the new plan
			Gaps in assurance BTHFT Green Plan is out of date Routine data sets showing progress against the ten NHS E domains are not routinely available to monitor progress	Develop updated Green Plan	Q2/3 2024/25
Related risks on the high level risk register (operational risks)	N/A				

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

Ref: 7	**Strategic Risk: If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to reduce sickness absence and turnover rates, **resulting in** an adverse impact on patient safety and experience, and staff experience, wellbeing and morale. Additional vacancies and or absence could place staff under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience.

Risk Appetite: TBC

Date added: 13 September 2024

Date of last review: N/A – new risk

Lead Director: Chief People and Purpose Officer

Movement in score 2024/25

Initial Score (CxL): 3x4 = 12

Current Score (CxL): 3x3 = 9

Target Score (CxL): 3x2 = 6

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

- Thrive programme – to support improved wellbeing – including Leadership Conference
- HR policies and wellbeing support offers
- Occupational Health Service
- Employee Assistance Programme (EAP) provision
- Exit interview process (face to face and ESR)
- 'Stay' interviews
- Application of absence management policy
- Staff networks
- Staff survey action plan
- Civility at Work programme
- Freedom to Speak Up (FTSU) policy and processes
- Guardian of Safe Working processes
- Mediation and Staff Advocacy services
- Looking after our People Trust and Place level delivery groups in place
- People Promise Exemplar site
- Leadership pathway development
- Wellbeing conversations
- Quarterly Pulse surveys in place
- Psychology staff support offer
- Civility training
- Widening participation programme of work
- Development programmes for managers
- Development of outdoor spaces e.g. gardens
- Comms support in place to support external media exposure.

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

Internal
Positive:

- Recruitment service development with HIRE board, system optimisation and service restructure has taken place.
- CSU to Executive meetings in place
- Nursing recruitment and retention plans in place.
- Nursing & Midwifery Staffing Review – June 2024
- Workforce planning submission – Trust Board March 2024
- Turnover rates lower than the target and the position has been sustained. #
- Occupational Health / Psychological support referrals (management referrals, limited data on self referrals)
- FTSU Annual report and Quarterly Report – latest as at Q2 2024/25

Negative:

- Sickness absence rates continue to remain above target.
- Appraisal rates remain below target.
- Long lead times for Occupational Health assessments.

Independent
Positive:

- Significantly improved staff survey results for 2023 compared with the previous service, with improvements in all elements of the people promise.
- Turnover rates remains lower than the target and are sustained.
- Improvements in GMC survey data.
- Internal audit reports:
  - Just R and Overseas Recruitment (April 2024) – Significant assurance
  - Recruitment; Pre-employment checks (May 2024) – Significant assurance

Negative:

N/A

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

Gaps in control

- Insight into reasons why staff stay at BTHFT / what makes a good staff experience
- In year staff satisfaction data is limited.
- Occupational Health Service pressures
- Ongoing board issues and negative media coverage impacts staff morale.

Gaps in assurance

N/A

Actions to address gaps in controls or assurance

Action	**Timescale**
• Stay interviews to be promoted further, with central collection of data.	Q2/3
• Improvement plan for people pulse survey.	Q3/4
• Business case in development to seek further OH staffing resource to meet demand.	Q3

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

N/A

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

Ref: 8	**Strategic Risk:** There is a risk that we are unable to achieve our ambitions on ED&I, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations. If we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, **then** we may have low levels of staff engagement and morale, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract diverse staff to work for our Trust. There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks, and including the Equality Act 2010, and specifically the Public Sector Equality Duty.

Risk Appetite: **TBC**	**Movement in score 2024/25**  	**Initial Score (CxL): 3x3 = 9**
Date added: 28 August 2024 **Date of last review:** N/A – new risk		**Current Score (CxL): 3x3=9**
Lead Director: Chief People & Purpose Officer		**Target Score (CxL): 3x2=6**

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Implementation of WRES / WDES / Gender Pay Gap action plans. • Equality & Diversity Council (with focus on both workforce and population health inequalities) • Staff equality networks • Gender Equality Reference Group • Recruitment and selection training programme • Development programmes for managers including Leadership programmes. • Head of Equality, Diversity & Inclusion and team in post • Reciprocal mentoring programme • 3-year EDI Strategy in place with refreshed EDI objectives and implementation plan • NHS Improvement plan – 6 high impact actions • Implementation of Equality Delivery System 2022 (EDS) • EDI training for managers in place (including EDI related case studies, with specific focus on disability, race and LGBT+ equality, and ensuring compassionate and inclusive leadership) • Implementation of annual EDS2022 review (with focus on workforce, leadership and patient experience) • Trust Equality Impact Assessment Guidance and Template in place with EIA's completed on a regular basis with support from the EDI team. Strategy & Transformation Department leading the work on tackling population health inequalities, including developing our role as an anchor organisation.	**Internal** **Positive:** • People Dashboard: BAME overall workforce and representation at Senior Management year on year improvements – latest as at May 2024 • Gender Pay Gap – improving position – latest as at March 2023 • WRES/WDES/EDI Update report -May 2024, with some notable improvements and with refreshed action plans being submitted in October 2024 (People Academy) • HEAT assessment and training for managers implemented across the Trust (Strategy & Transformation Team) • EDS2022 review for 2023/2024: scored Achieving overall. • Winners of 2023 Nursing Times Workforce Award "Best Employer for Diversity & Inclusion" • EDI Objectives agreed for all Executive Directors • Executive Sponsors assigned to each of the Staff Equality Networks **Negative:** • Disability declaration rate • Representation at Senior Leadership levels for gender, disability and race. • People Dashboard: BAME representation at senior level– latest as at May 2024	**Independent** **Positive:** • WRES/WDES benchmarking reports: some positive comparisons. • NHS Staff survey outcomes: positive improvements in 2024 (particularly re: Harassment & Bullying) • Gender pay gap benchmarking reports [to confirm if positive or negative after publication] • Internal audit reports: ➢ NHS People Plan; Belonging in the NHS (February 2023) – Significant assurance. **Negative:** • WRES/WDES benchmarking reports some negatives around Career Development/ Representation at Senior Management levels • NHS Staff survey outcomes: some areas that require improvement • Gender pay gap: some areas that require improvement (particularly at Senior Leadership level)	**Gaps in control** • Remaining improvements to Recruitment & Selection from an EDI perspective (e.g. finalisation of managers toolkit) • Good quality, comprehensive, meaningful equality impact assessments resulting in service improvements fully embedded and aligned to our decision-making processes. • Continue to implement the 3-year EDI strategy, including the 5 key EDI objectives (which includes our ambitions to tackle wider health inequalities) • Implementation of the National EDI Improvement Plan with emphasis on good equality outcomes **Gaps in assurance** N/A	**Action** •In development •To continue to roll out the equality impact assessment guidance and proforma. •Continue targeted engagement with CSU/ departments and developing local EDI action plans/ Developing an overarching EDI Implementation plan supporting the delivery of the EDI Objectives assigned with the EDI strategy. •Working to meet the requirements **Action**	**Timescale** October 2024 Ongoing Ongoing Ongoing **Timescale**
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation
Assurance topic – Trainee development and progression (Nurses, AHPs and Doctors)

Ref: 9	**Strategic Risk: If** it is not possible to fill rota gaps or provide experienced trainers, **then** we may fail to provide an appropriate learning experience for trainees, **resulting in** an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status

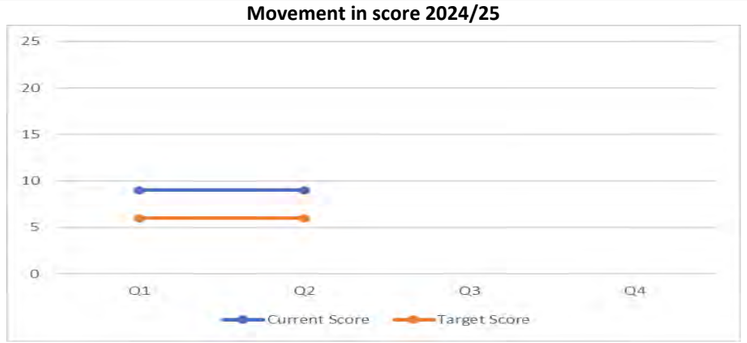
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 4 September 2024

Lead Director: Chief Medical Officer / Chief Nurse

Movement in score 2024/25



Initial Score (CxL): 4x4=16

Current Score (CxL): 3x3=9

Target Score (CxL): 3x2=6

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

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

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

Internal

Positive:

- Guardian of Safe Working Hours – quarterly reports – latest report Q1 24/25 (People Academy – July 2024)
- Appraisal & Revalidation Annual Report – latest report 23/24 (People Academy – July 2024).
- Appraisal Quality Assurance Group – annual review of appraisal quality.
- Results of appraisal feedback questionnaires.
- Annual Medical Appraisal Report / Board compliance statement September 2024

Negative:

- Guardian of Safe Working Exception reports re: missed educational opportunities or additional hours.
- GOSW hours annual report (May 2024)

Positive:

- HEE Yorkshire and the Humber Quality Interventions: Trust Update Report – 2023 – no Enhanced Monitoring Cases, two requirements closed following improvements being made.
- HEE National Education & Training Survey (NETS) – January 2024. Positive outliers for every domain.
- University of Leeds Medical School MPET Report (Annual) – October 2023 – improved scores in e.g. overall placement rating, learning environment and support.
- Improved GMC training survey results for 2024 compared to 2023. Some previous areas of concern e.g. plastic surgery and obstetrics have shown improvement across the board. We are not an outlier in any domain.
- Apprenticeship team recognised through the Bradford Means Business awards for their work across the district with young people and improved educational opportunities.
- Senior Leaders engagement event with NHSE in November 2023 – positive feedback report.

- Internal audit reports:
  - Medical Education – Significant assurance
  - E-Rostering – Junior Doctors – Significant assurance
  - Medical Revalidation – Significant assurance

Negative:

- HEE National Education & Training Survey (NETS) – January 2023 – FY1 doctors in Surgery were negative outliers.
- GMC survey 2024 BTHFT ranked 216/230 in the UK for Workload and 209/230 for Regional teaching.

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

Gaps in control

- Numbers of junior doctors on rotas

Gaps in assurance

N/A

Actions to address gaps in controls or assurance

Action	Timescale
• Lobby Deanery to increase trainee numbers.	Ongoing
• Development of Hospital at Night project.	Complete Clinical Support Workers fully recruited
• Medical student assistants	Recruited. Induction Autumn 2024

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

Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation
Assurance topic – Research capacity and capability

Ref: 10	**Strategic Risk: If** we fail to attract research funding and researchers to the Trust, **then** our research capacity and capability will be negatively impacted, **resulting in** a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research

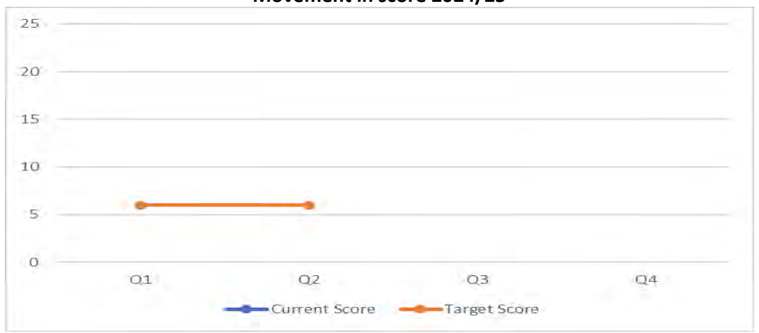
Risk Appetite: TBC

Date added: 1 April 2022

Date of last review: 4 September 2024

Lead Director: Chief Medical Officer

Movement in score 2024/25



Initial Score (CxL): 3x3=9

Current Score (CxL): 3x2=6

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Ensure research activity and involvement encouraged by providing infrastructure and support for research; this is being done in a number of ways including: • Research infrastructure – Bradford Institute for Health Research, NIHR Patient Recruitment Centre, Wolfson Centre for Applied Health Research. • Research Governance and Management Structure in place within the Trust, i.e. Director of Research, R&D Office, financial management of research, etc, which provide advice, support and leadership and oversee activity and performance. • Trust Research Strategy and Trust policy on conducting research in the Trust. • Trust Research Committee and reporting to Quality & Patient Safety Academy and Trust Board. • Strong research reputation particularly in the fields of applied health research and these teams are continually applying for grant funding. • Raising awareness of research, publicity of research successes, part of Trust induction. • All research teams have research targets and performance reports sent to them along with relevant CSU on a quarterly basis and CSUs sign off capacity and capability that can conduct new research. • New Research Strategy document completed and reported to Board. • City of Research Framework Document circulated for approval by partners. • New BIHR main entrance at build stage and to be completed by May 2024. • Research Matron, now responsible for management of Research Nurses. • Mobile Research Vehicle– funded by NIHR – to take research into communities. • BIHR - successful £8m bid for Secure Data Environment (SDE). • £5.8M NIHR funding secured for continuation of the Patient Safety Research Centre. • £5M Health Determinants Research Collaboration (HDRC) funding secured.	**Internal** **Positive:** • Quarterly Research Activity reports to Quality & Patient Safety Academy– latest August 2024. • Quarterly Research reports and presentations on research projects to Board. • Research Performance Reports for Research teams sent out on quarterly basis. • Internal annual review with each research team. • Internal audit of research. • Improvements to infrastructure / buildings. • New main entrance due to complete September 2024 **Negative:** • Unclear how the CSUs use the research performance reports to manage research activity. • Some teams are not achieving targets due to lack of clinician input due to interest/ time. • Lack of awareness that research is core business for Trust	**Independent** **Positive:** • Annual reports and reviews for projects where we are the lead organisation, e.g. NIHR programme grants, NIHR RCF annual reporting. • External Performance review meetings and annual reports for NIHR Patient Recruitment Centre, etc. • Annual review meeting with Yorkshire and Humber Clinical Research Network. • Various research finance audits. • Participant Research Experience Survey 'PRES' – positive responses. • Promotion of PRES completion leading returns target being exceeded. • NIHR quarterly 'Performance in Initiating and Delivering Clinical Research' submission 'PID submission'. • Internal Audit on Research Governance June 2024 High Assurance • Significant, repeated successful high value grant applications **Negative:** • Some research areas not meeting targets in terms of Recruitment to Time and Target.	**Gaps in control** • Promotion of research activity and raise awareness that research is a core business for Trust. • How research is promoted and managed within CSUs as Core Business. **Gaps in assurance** • Better research information to allow real time reporting and improved research activity management by CSUs and research teams.	**Action** • Trust Research Strategy and associated action plan. • CSUs' research activity to be part of the formal Trust Performance Framework • Production of research dashboard that can be accessed by Trust staff. • Promotion of ward entrance	**Timescale** Strategy approved September 2022; implementation started Ongoing Delayed; originally scheduled to be June 2022 but anticipating that achieved by March 2024. March 2024.
Related risks on the high level risk register (operational risks)	**N/A**				

Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation
Assurance topic – Learning organisation

Ref: 11	**Strategic Risk: If** we do not have robust processes for incident identification, escalation and learning **then** we may fail to learn from incidents, **resulting in** gaps in safe clinical care

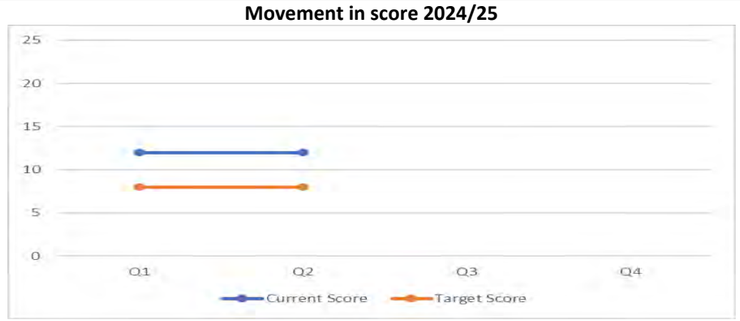
Risk Appetite: TBC

Date added: 1 April 2022

Date of last review: 4 September 2024

Lead Director: Chief Medical Officer

Movement in score 2024/25



Initial Score (CxL): 5x3=15

Current Score (CxL): 4x3=12

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Exec led weekly Quality of Care (QuOC) Panel. • Daily Trust Safety Event Huddles led by Quality Governance Team. • Weekly Safety Event Group. • Monthly Patient Safety Group. • Support CSU triumvirates in developing narrative in quality quadrant within performance balance score card. • New roles developed to support Quality Governance Framework: Quality and Patient Safety Facilitators aligned to new CSUs. • Assessment of Trust's readiness for the transition to new Patient Safety Incident Management System replacing the NRLS and STEIS. • Full-time Patient Safety Specialist in post supported by 4 senior leads. • Gap analysis complete for National Patient Safety Strategy identifying key work streams for transition to Patient Safety Incident Response Framework (PSIRF). Implementation meetings held and training undertaken for those managing incidents and investigators. • Continue with QI tests of change to support incident reporting. • Develop intranet pages for clinical negligence claims / coroner cases, Incident reporting, Risk management and Learning from Deaths. • Develop bite size training modules to support understanding of above. • Just Culture and Civility work streams / Freedom to Speak Up supported by People Academy. • Develop learning framework. • Being Open / Duty of Candour Policy updated 2021. • Incident Reporting & Investigation Policy to be reviewed to align to PSIRF form December 2023. • Participation in the West Yorkshire Association of Acute Trusts Learning Forum. • Quality Account and identification of priority areas. • CLIP report has been introduced which triangulates, complaints, litigation, incidents and patient experience data to establish further opportunities for learning. • Continue to be part of the 'Learning Together' research programme. • Monthly Quality and Safety meetings have commenced in all CSUs, most are using standardised Quality Governance Framework. The Associate Director of Quality is planning on attending in each CSU to evaluate how well embedded this is over the coming weeks. • Role of Medical Examiner who has scrutinised 100% of deaths since October 2021. • Learning from Deaths work. • InPhase commissioned as our new system to support incident and risk management. • QI training for consultants. • 'Worry and concerns' pilot. • NatSSIPs handbook updated and lead reinstated. • Improvement Strategy approved. • PSIRF policy and plan approved by Board on 16 November 2023.	**Internal** **Positive:** • Insights report – monthly – latest report as at August 2024. • Serious Incident Report – latest as at August 2024. • CLIP (Complaints, Litigation, Incidents, Patient Experience) report – quarterly • Tracking of actions from safety events overseen by Patient Safety Group. • Ward / department quality accreditation programme. • Quality Account – Submitted and approved by Board June 2024 • Medical Examiner has scrutinised 100% of deaths since October 2021. • Learning from Deaths bi-monthly reports • Deep dive review of SHMI May 2023 • Medical Examiner statutory 9 September 2024. **Negative:** Assurance programme to be re-started.	**Independent** **Positive:** • Internal audit reports: ➢ Serious Incidents – Significant assurance (May 2023) ➢ CSU Governance Structures – Significant assurance (July 2023) ➢ Safety Alerts – Significant assurance (November 2023) ➢ CQC inspection April 2024. Reports being checked for factual accuracy Sep 2024 • Commissioner review of incident investigation reports that meet the criteria under the current SI Framework. **Negative:** • External bodies feedback e.g. CQC, • Internal audit reports: ➢ Safer Procedures; NatSSIPs - Limited assurance (March 2023) But Re-review acknowledged actions now completed	**Gaps in control** • Strong lines of governance accountability through CSU, Service group. • Current Datix license to expired 2023. **Gaps in assurance** N/A	**Action** •Quality Strategy to be developed. •Implementation of PSIRF. • Renew/replace – InPhase commissioned.	**Timescale** Complete. Complete Jan 2024. Complete. InPhase has replaced Datix Jan 2024
Related risks on the high level risk register (operational risks)	**N/A**				

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

Ref: 12	**Strategic Risk: If** the Trust doesn't work effectively in partnership, **then** there is a risk that the Trust fails to provide the best service to patients, **resulting in** poor patient and staff experience, worse outcomes for patients and missed opportunities to address health inequalities.

Risk Appetite: TBC

Date added: 13 September 2024

Date of last review: N/A – new risk

Lead Director: Director of Strategy & Transformation

Movement in score 2024/25

Initial Score (CxL): 4x3 = 12

Current Score (CxL): 4x2 = 8

Target Score (CxL): 3x1 = 3

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Several members of the executive team have leadership roles outside the Trust in both the Bradford District and Craven (BD&C) Place, the regional West Yorkshire ICB and working with colleagues across the West Yorkshire Association of Acute Trusts (WYAAT). • CEO is member of the BD&C place Board. • Monthly meeting with Director of Strategy counterparts from other WY Trusts. • Director of Digital also holds the portfolio at Airedale Hospital • Head of Equality and Diversity hold a joint portfolio, acting as the lead for the Trust and the BD&C place. • Continued clinical and operational input into a range of programmes of work in the place – covering efficiency programmes and other more specialised services including diabetes, paediatrics and ageing well. • Developing joint programme of work with Airedale Hospital • Strategic Partnership Agreement (SPA) in place across the BD&C place. This agreement has been in place now for over five years and had recently been refreshed. • Number of examples of working with the local Voluntary and Community Sector in ED and Maternity in particular.	**Internal** **Positive:** • Positive culture in the executive team to engaging in partnership working and taking an active leadership role in it. • A number of senior colleagues hold roles that are designed to work across systems and organisations. **Negative:** • Demands on the time, particularly of clinical and operational colleagues can make it difficult to engage fully in system-wide or partnership work.	**Independent** **Positive:** • Strong history of working in partnership across the place, evidenced by the SPA which has been in place now for in excess of five years. • NHS West Yorkshire Integrated Care Board is recognised nationally as a leading ICB. The leadership team is stable and committed to encouraging partnership work across WY. • West Yorkshire Association of Acute Trusts is highly respected and well embedded into organisations across the region, and fosters strong partnership working. **Negative:** • Some national drivers around acute hospital performance and finance can act to drive time and focus away from strategic partnership arrangements.	**Gaps in control** Jointly developed work plan with Airedale Hospital Refreshed WYAAT strategy to help guide strategic decisions at BTHFT Need to develop relationships and associated work with Uni of Bradford, Yorkshire Clinic, Bradford Council and range of other local partners **Gaps in assurance** N/A	**Action** Meeting with Airedale exec to develop workplan. After that, develop work programme with timelines. Engage with CEOs and WYAAT leadership Meet with counterparts in organisatoins, identify areas to focus on and develop work plan.	**Timescale** October 2024 for initial meeting. Develop full plan following that. Detailed review work over the next 12 months to develop plan. To be developed over Autumn/Winter 24/25
Related risks on the high level risk register (operational risks)	**N/A**				

All strategic objectives
Assurance topic – Board leadership and governance

Ref: 13	**Strategic Risk: If** we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.

Risk Appetite:
TBC

Date added: 6 December 2023

Date of last review: 30 August 2024

Lead Director: Chief People and Purpose Officer

Movement in score 2024/25

Initial Score (CxL): 5x4 = 20

Current Score (CxL): 5x4 = 20

Target Score (CxL): 5x2 = 10

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Board and Committee/Academy structure • Committee/Academy Chair reports to the Board • Arrangements in place to ensure compliance with Code of Governance for NHS Provider Trusts and NHS Provider Licence • Suite of governance documents in place and reviewed regularly including Constitution, Scheme of Delegation, Standing Orders • Corporate Strategy sets out the objectives and ambitions of the Trust • Suite of supporting strategies • Board Development Sessions • Effectiveness reviews of Board, Committees, Academies • Appraisal process for Board members • Risk Management Strategy • Risk Appetite Statement agreed and reviewed on an annual basis • High Level Risk Register and Board Assurance Framework • Conflicts of Interest Policy and processes • NED Champion roles • Board member participation in PLACE and 15 steps visits • Board member attendance at Equality & Diversity Council • Reviews of composition of Board through NRC and Governors NRC • Fit and Proper Person checks undertaken annually • Council of Governors – quarterly meetings including holding the NEDs to account for the performance of the Board	**Internal** **Positive:** • Annual Governance Statement • Annual Report • Quality Account • Annual review of compliance against Code of Governance and NHS Provider Licence • Annual review of NED independence • Corporate Strategy annual update • BAF • High Level Risk Register • Academy/Committee Chair reports to the Board **Negative:** • BAF and High Level Risk Register – risks above target score / risk appetite level	**Independent** **Positive:** • Annual VFM assessment • Head of Internal Audit Opinion • Internal Audit reports: ➢ Organisation governance – effectiveness of Academies & reporting lines – Significant assurance (September 2022) ➢ Policy Management - High assurance (September 2023) ➢ Board Assurance – Significant assurance (February 2024) ➢ Risk Management Framework and Strategy – Significant assurance (April 2024) **Negative:** N/A	**Gaps in control** • Improvements to 'technical' governance e.g. Board/Committee/Academy arrangements • Improvements to Board 'dynamics' • Separation of SID and Deputy Chair roles • Fit and Proper Person checks to be completed in line with new framework **Gaps in assurance** • External Well Led Review to be undertaken • CQC well led inspection report to be received	**Action** • Annual Board/Academy/Committee effectiveness reviews to be completed including reviews of agendas, TORs, work plans, reporting templates • Creation and delivery of Board development programme • New SID to be appointed • Checks to be completed • Review to be commissioned	**Timescale** September 2024 12-18 months – June 2025 TBC Complete TBC
Related risks on the high level risk register (operational risks)	N/A				

All Open Risks with a current scoring of >=15 sorted by risk score - highest to lowest (as at 04/09/2024)

Risk Register Id	Legacy Id	Date of Entry	Lead Director	Risk Lead	Source of risk	Assuring Committee or Academy Summary	Description of Risk	Next review date	Rating (initial)	Consequence (initial)	Likelihood (initial)	Rating (residual)	Consequence (residual)	Likelihood (residual)	Control measures in place at the time of entering the risk on to the Risk Register	Summary of Risk Treatment Plan	Target date for implementation of mitigation	Consequence (current) - Matrix	Likelihood (current) - Matrix	Rating (current) - Matrix
2604		04 Jul 2024	Karen Dawber	Mayada Elsheikh	Risk Assessment	Finance and Performance Committee, Quality Committee	The number of patients in the emergency department often exceeds its designed capacity and available resources meaning providing safe, timely, and efficient care to current and incoming patients becomes challenging.	01 Oct 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	9	(3) Moderate	(3) May recur occasionally	04/07/2024 OPEL framework in place and YAS ambulance handover SOP in place. Existing Trust Escalation Plans, including Winter operational response plan in place. On-site and visible CSU leadership, including On-call senior manager availability for escalation. Regular escalation through the CSU management team and site operational huddle Media campaigns to encourage patients to use alternative resources such as 111, GP, pharmacy, and the Healthy Together site. In Hours AED consultant (on-site) contacts Command Centre. Command Centre contacts 1st on call manager. 1st on call manager (on site), site matron, AED consultant and AED shift leader assess situation. Command centre via the site huddle, contact the relevant CSU representatives. Assessment of need is undertaken by silver command with bronze leads. Additional GP services are now available, with a GP present from 8 a.m. to 7 days a week and an ANP when staffing allows in the adjacent UCC. The Co-located UCC. The UCC model an amalgamation of the GP Primary Care Streaming Services. GP patients will be offered a next-day appointment rather than handed back at midnight for the AED to see. Co-location of the medical SDEC into AED- SDEC has been amalgamated into the green zone with a combined EM and AIM workforce, renamed as Ambulatory Emergency Care Unit (AECU). AIM Consultant to provide in-reach into the AED. A change to the front door streaming model, and pre-triage streaming went live in December 2023 meaning earlier streaming of appropriate patients to UCC, decongesting waiting areas Weekly oversight of performance and operational response as required (ECS meeting) 24/7 Command Centre provision for operational support System escalation as required. Current SOP for speciality review of patients Ongoing work on acceptance criteria to speciality areas including but not limited to SAU, Plastics, GATU and Max Fax Patient Flow Hub is now in operation. CIC, NIC and SMIC will have situational oversight. AED new standardised plan for the management of the department in periods of extreme pressure (full capacity protocol)	1. Immediate actioning of Trust-wide comms and social media campaign to inform parents of one carer policy once surge commences and SOP triggered 2. Develop an OPEL scoring system for escalation to alert the Executive team when we are under significant pressure. (Adults and Paeds) 3. Agreement from speciality teams to accept direct referrals and for ED teams to be able to send these patients directly to specialty receiving areas on their arrival to ED, including tertiary referrals and semi-elective admissions. 4. Develop business case for 24/7 consultant cover. 5. AED Pharmacist/Tech must ensure adequate stock, assist with complex prescriptions, and suggest alternatives to reduce the burden on nursing and medical staff for medication checks, issuing of TTOs, prescription reviews, and bed waits.	01 Oct 2024	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
171	3748	15 Feb 2022	Ray Smith	Jen Green	Business Meeting	Finance and Performance Committee, Quality Committee	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.	30 Nov 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 restricted theatre availability. We have introduced a fluoroscopic PD catheter insertion service and are strongly promoting home-based renal replacement therapies, including renal transplantation. Provision of an HD service requires specialist nursing skills which can be augmented by agency or TNR nurses. In the event of a sustained loss of facility, further mitigation would be implemented (but our staffing is also stretched and this would compromise the following additional steps): Services extended into overnight/out of hours 6 or 7 days a week. Further reduced dialysis sessions Displacement of patients to other facilities potentially at some distance of travel.	14/08/24 Current risk remains. The CSU is planning to open the remaining twilight shifts from September/October. Feasibility study into possible expansion at Skipton has been requested and will be subject to business case approval and AGH not utilising the space 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	31 Dec 2024	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2605		08 Jul 2024	Ray Smith	Jen Green	Risk Assessment	Quality Committee, Finance and Performance Committee	15 patients on daily unable to fit in for their treatment when it is due. The service is unable to accommodate any further chemotherapy until the week commencing 17th June 2024 unless there are any cancelations which are looked at on a daily basis. Without any further increase in chair or skilled nursing capacity this service cannot accommodate any more Haematology and Oncology patients. Solutions provided previously: • Chemotherapy bus - provided by a charity (Hope for tomorrow) increased capacity by 4 chairs, needed two skilled staff to run this service. Requires a suitable place to put the bus due to disposal of waste. If on site, estates would need to set the bus up daily for this service to continue. If the bus was to go to a different site out of BRI/SLH it would need a driver to move the bus and emergency medical cover. • Waiting room altered to clinical treatment room - required a sink, chairs, drip stands and pump, rails, and curtains to operate as a treatment room. However, this solution was rejected due to funding. • Clinic rooms altered to clinical treatment room. Would require clinics to move to the other side if clinic space allows or move to BRI. No availability to move these clinics to other areas to allow for further capacity. These solutions have not been taken forward resulting in the same capacity with only 11 chairs for a chemotherapy unit. " style="overflow: hidden visible; color: rgb(56, 56, 56); width: 100%; background-color: transparent;">If we are unable to increase treatment space and ensure a safe skill mix of nurses on the day unit then we are unable to provide chemotherapy and immunotherapy in line with a patients scheduled treatment plan to provide lifesaving treatments; resulting in, delays to planned treatment such as neo-adjuvant, curative, and palliative chemotherapy, poor outcomes, disease progression, and deaths sooner than predicted. Prior to the move from BRI there were 12 chemotherapy chairs and 8 transfusion chairs (20 in total). Since 2019, when the service moved from the BRI site the total chair capacity has been reduced by 3 (17 in total at The Meadows). Prior to the first phase of the blood transfusion service moving to The Meadows from the BRI, the chemotherapy day unit managed the reduction to their allocated 11 chairs by using the 6 blood transfusion chairs that are now used by the transfusion service resulting in a further shortfall of 6 chairs with 11 now available for use by the service. Using the additional blood transfusion chairs enabled the daily escalation list to reduce to no patients on the list and the provision of treatment in line with their scheduled treatment plans which is no longer possible.	30/11/2024	25	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	8	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	Escalation list to manage patient prioritisation. Virtual chair used in daily scheduling to increase chemotherapy capacity. Increased nurse capacity via skilled agency staff. During clinic meetings and grand rounds patients are identified who are at risk of not receiving outpatient treatment as scheduled and are treated as ward attenders or admitted to the inpatient service at BRI to provide urgent chemotherapy to save lives. Increased skilled nursing capacity. Admitted to the inpatient service to try and treat with urgent chemotherapy to save lives. Patients admitted on to the acute ward to receive the treatment indicated on their scheduled treatment plan. Staff at all levels working outside of contracted hours to ensure treatment is provided once chemotherapy available.	14/08/24 Initial risk score downgraded to 20 after immediate risk posed to the service has been mitigated due to increased capacity on Mondays, use of pre-made chemotherapy and implementation of SACT scheduling meeting. Improvement work continues to mitigate further risk	31-Mar-25	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
290	3627	10 Feb 2021	Chris Davies	Chris Davies	Business Continuity	Quality Committee	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 maintenance is addressed additional works are required including unforeseen infrastructure failure.	06 Oct 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 Harrogate ICS for support and approval. •Enhanced investment into Backlog Maintenance Programmes of Work to reduce Critical Infrastructure Risk (CIR). Approval at ETM	31 Mar 2025	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20

2566		12 Apr 2024	Sajid Azeb	Farah Naz	Risk Assessment	Quality Committee	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.	30/11/2024	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 are provided with an hospital bed (non-pressure relieving) and oral or intravenous nutrition (where appropriate). - Patient's carers and family members are offered to stay with the patients for reassurance and familiarity to prevent increasing confusion and agitation.	05/07/2024 - the HFAST pilot is due to go live on 22nd July 2024 and we will continually review the impact as we scale up (starting with one patient and increasing gradually) 12/04/2024 • 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	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2618		19 Jul 2024	Ray Smith	Ruth Taunton-Smith	Risk Assesment	People Academy, Quality Committee	If we are unable to recruit to substantive Consultant posts within Stroke then From 2nd September 2024 the only remaining consultants in stroke will be 2 agency locums (2.0 WTE), and 1 ad hoc/bank locum. Locum staff are intrinsically not a stable workforce and gaps can occur with very little notice. If we have no stroke consultants, we are fundamentally unable to provide a viable stroke service	30/10/2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	9	(3) Moderate	(3) May recur occasionally	Service can continue at Bradford whilst ever we have locum consultant support. 2 locums at Bradford will remain able to support the on call rota, plus the maternity leave returner from Airedale.	1. Recruit an additional locum consultant to support the stroke service at the point the substantive consultant leaves 2. Appoint a consultant from another specialty within the CSU to oversee the duties of clinical lead, including risk and governance 3. Advertise for substantive consultants	31 Oct 2024	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2542		04 Apr 2024	Ray Smith	Jill Parkinson	Risk Assessment	Quality Committee	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.	19 Nov 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.	07.08.24: HTC held by videoconference 06.08.24. Once Haemobanks, which includes new kiosks, are installed the risk to the organisation will be eradicated. We cannot mitigate the risk further until Blood Track TX is implemented. Next formal HTC 12.11.24. 29.07.24: The lock on the main blood issue fridge is now fixed, therefore the fridge is now back in use. 18.07.24: The lock which is part of the blood track kiosk on the main issue fridge in pathology has now failed. This has resulted in the blood being moved into a storage fridge in the transfusion laboratory. An engineer from Haemonetics is visiting the trust WC 22nd July to review the lock and advise if it can be fixed. Reported to MHRA ref: 2024/007/018/HV1/012 IRIS: #6699. MHRA have since excluded the report from their annual report. SHOT will review it for data analysis purposes. 27.6.24: Risk score increased to 20. Updated risk assessment reviewed and approved by HTT today given maternity fridge Blood Track failure. Updated risk assessment attached. 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.	19 Nov 2024	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
607	3309	26 Nov 2018	Ray Smith	Nima Maleki	Risk Assesment	Quality Committee	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.	31 Oct 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	6/7/24 - Approval has been given for 4 additional consultants, with an emphasis on general Histopathology skills. 1 substantive and 1 NHS locum post have been immediately advertised. 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 & delays with increasing level of reported incidents.	31-Mar-25	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2630		09 Aug 2024	Paul Rice	Ruth Taunton-Smith	Risk Assesment	Quality Committee	HIV currently use an external provider, Dedalus, for their electronic patient records and data reporting. Dedalus has given notice to end contract on 31.03.25, they also gave notice in 2023 but extended for 1 year. From 1.04.25 the HIV service will be unsupported by Dedalus, this leaves too high a risk to keep using for many reasons, and they have recommended that we don't continue to use beyond the end date. In 2023 the service held meetings with Bradford EPR Team and a benchmarking exercise of need was undertaken by the service and submitted to EPR. Joint meetings were held with Calderdale and Bradford EPR teams in 2024, HIV was on track for EPR team to commence project scope in November 24, for implementation of Cerner from 01.04.25. EPR team has not agreed on a sponsor for project scoping. Due to other EPR project priorities across the wider Trust, and Airedale, HIV has been informed that there is a greater risk to HIV EPR not commencing the project scope in November or be ready to go live by 1.04.25 deadline. If HIV are unable to have EPR implemented by 1.04.25 the service cannot continue to use the Dedalus system with no contract and no backup tech support from the provider.	31 Oct 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	1	(1) Negligible	(1) Cannot believe that this will ever happen again	Dedalus in place until 31.03.25, HIV service running as normal. EPR benchmarking completed and with EPR Team.	To go out to tender for different provider, high risk of not meeting 01.04.25 deadline and costly. To move to an HIV paper-based service for booking and managing attendance, note taking, prescribing, contact tracing of lost to follow up (high risk due pre-work required, inefficiency across clinical and non-clinic, unable to report national HARS data) Exec decision to be made on risk and next steps 1. To establish a project timeline and EPR resources 2. To establish and EPR team to commence project scoping 3. To scope and produce an HIV EPR 4. EPR go live date	31 Mar 2025	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

221	3696	18 Aug 2021	Sajid Azeb	Philip Moore	Business Continuity	Finance and Performance Committee, Quality Committee	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit. The risks are specifically:- 1. a patient safety risk arising from the potential inability to provide critical medicines such as chemotherapy and total parenteral nutrition 2. a reputational risk to the organisation arising from the potential failure of, and or regulatory intervention into the, pharmacy aseptic unit. 3. A risk to organisational performance against RTT targets arising from this risk due to the potential inability to deliver treatment within specified timescales. The risk arises from the due to:- 1. The unit being almost 25 years and no longer up to current design standards. 2. The inability of the air-handling unit and associated pipework being able to deliver the required number of room air changes per hour. 3. The poor design of said pipework meaning it is impossible to satisfactorily test the integrity of the terminal HEPA filters due to leak paths of unknown origin. 4. Some of the filter housings being modified by a third party from top entry to side entry meaning the airflows immediately prior to the filter will not match the airflows the filters are designed to work with. 5. The materials and design of the unit do not support efficient cleaning of the unit - cabinets are old and damaged and the ceiling is of a modified lay in grid type formation. 6. The unit has begun to fail some of the environmental monitoring tests which means failure is more likely. 7. The MHRA and the Regional Quality Assurance Pharmacist both commented on the condition of the unit at their last regulatory inspections issuing the Trust with a Major concern and significant risk respectively.	12 Sep 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 frequency of the cleaning of the unit. In addition to this the active air sampling in the rooms was increased from quarterly to monthly. Colleagues working in the unit continue to monitor the settle plates to identify any colony forming units which would potentially indicate a further deterioration in the cleanliness of the unit. Workload - Colleagues have looked to outsource what work they can to other NHS units and third party providers. In addition to this they have looked to standardise some of the products produced meaning that the workload in the unit is such that sufficient time can be given to ensuring the unit is clean and the QMS is followed. Contingency Plans - Contingency plans are being worked up with colleagues at Airedale NHS Foundation Trust which would mean if the unit did fail and or was issued a stop notice work could be temporarily transferred to utilise whatever spare capacity ANHSFT has to offer. In addition to this colleagues from the WYATT trusts have been asked to consider if they have any capacity to support BTHFT should the unit fail. Estate Works - Colleagues from estates have visited the unit and along with advice from BTHFT's Consultant Nurse for Infection prevention and control have identified a number of actions which could be taken immediately, including some minor works, which would help to address some of the issues with the unit. Consultants have also been brought in to understand what action, if any, could be taken to address the AHU, associated pipework and filter housings. New Unit - A short-life working group has been established to manage the existing risk and to work up options as to the potential mid to long-term solutions for the unit. Such options may include, a new unit, an extensively refurbished unit, or a decision to close the unit and seek support from elsewhere. In addition to this the group will work with the units customers to build greater resilience in to their workflows in order to support the functioning of the unit and ultimately the care to the trusts patients. This group will also look to better quantify the consequences, in terms of patient care, of a unit failure / shut down.	14/08/2024 Cleaning cycles and validation in progress. 08/07/2024 EL audit report (May 2024) received for existing unit. Overall risk rating = medium risk. Temporary facility (SLH): Repairs to roof and isolator have been completed. Cleaning and validation process in place, aiming to be completed by 30/09/2024. 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	30 Sep 2024	(4) Major	(4) Will probably recur, but is not a persistent issue	16
187	3732	20 Jan 2022	Karen Dawber	Joanne Hilton	Risk Assessment	People Academy, Quality Committee	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-Nov-24	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 October 2023. 26/05/23 (JH) - Risk reviewed with further work taking place around the use of the safecare acuity and dependency tool, live staffing decisions with patient information and accuracy of data entry. There are no changes to current risk level. Recruitment event held on 25th May with 54 newly qualified nurse jobs	31 Oct 2024	(4) Major	(4) Will probably recur, but is not a persistent issue	16
109	3810	14 Oct 2022	Ray Smith	Jen Green	Risk Assessment	People Academy, Quality Committee	50 pts every week who needed OPA 8 weeks ago but not yet appointed " style="overflow: hidden visible; color: rgb(56, 56, 56); width: 100%; background-color: transparent;">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	31 Oct 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		14/08/24 - ETM requested an in depth service review which was completed by the Deputy COO with a number of recommendations. The CSU, CMO and Haematologists met to discuss the data from the review, outcome to be confirmed and will require further discussion. 06/07/24 - Demand and capacity work still underway. Further discussion at ETM on 08/07/24. Probable need to re-job plan. 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	30 Sep 2024	(4) Major	(4) Will probably recur, but is not a persistent issue	16
257	3660	25 May 2021	Karen Dawber	Kay Rushforth	Risk Assessment	People Academy, Quality Committee	• 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)	24 Mar 2025	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 required but in control. PICU bed shortages persist. Agreed scores to stay the same at present time" Update 08.04 2022 RA update in progress review date extended to end of April 22 Update April 2022 HJ Risk score remains at 12 due to impact of	01 Apr 2025	(4) Major	(4) Will probably recur, but is not a persistent issue	16

2509		16 Feb 2024	Karen Dawber	Louise Lacy	Business Continuity	Quality Committee	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	23 Oct 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 where possible to adhoc contacts from parents and carers requiring advice. Signposting 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	1. BTHFT Autism Assessment Pathway Implementation Project- ongoing changes to pathway 2. Ongoing involvement in System wide Autism pathway development	27 Dec 2025	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2549		05 Apr 2024	Ray Smith	Jen Green	Risk Assessment	People Academy, Quality Committee	There is a risk that the current NSO workforce within BTHFT and also WYAAT can't continue to support the current NSO model of care within the region, which will delay cancer treatment causing harm to patients. The delivery of NSO services has become significantly challenging in recent years due to: • growth in the prevalence of cancer • increase in treatments and complexity of treatment regimens meaning we are treating more patients and for longer • significant national vacancy levels in the Consultant medical oncologist workforce where numbers of trained specialists have been outstripped by demand • workforce pressures across all NSO professional groups including specialist nursing, SACT nursing, Advanced Clinical Practitioners and pharmacist groups The above factors not only within BTHFT have led to significant pressures across WYAAT which have been particularly acute in Mid Yorkshire. As a result, mutual aid support has been required from Trusts within the region. The support offered has been dependent on tumour site in order to protect the current service. The NSO Programme has been tasked by WYAAT to develop a robust and sustainable model for delivering NSO services across North and South sectors in West Yorkshire and Harrogate and developing a sustainable acute oncology service is a key part of this work. The Trusts in West Yorkshire and Harrogate Cancer Alliance have been divided into 2 "sectors". North - Airedale, Bradford, Harrogate and Leeds South - Calderdale and Huddersfield and Mid Yorkshire Each sector has developed their own Target Operating Model and will work to implement this model over the duration of the NSO Programme. Both sectors will work together on cross cutting themes.	31 Oct 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	• Local monitoring of waiting times with adhoc additional sessions where possible • ETM approved locum consultant • Exec sponsored involvement in NSO Programme	14/08/24 - BTHFT is supporting the demand and capacity work to describe and evidence future service provision. Business case has been drafted by the WYAAT NSO Programme Director for the North Sector. 1. Local review and response to gaps in service - Jen Green 2. Overview and support of NSO Programme - Ellie MacIver	31 Oct 2024	(4) Major	(4) Will probably recur, but is not a persistent issue	16
396	3520	08 Jan 2020	Ray Smith	Ruth Taunton-Smith	Risk Assessment	Quality Committee	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).	31 Oct 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. Clinician vacancies continue to be an issue with a further consultant going on sabbatical for 6 months. Locum recruitment ongoing with minimal success. Straight to scan pathway in process of being implemented to speed up Ambulance to Admission Times Stroke Self Assessment toolkit being completed to further identify service gaps and priorities and opportunities for collaborative work with ANHSFT • Weekly MDT breach review Meetings - Review of patient delays to ward 6 i.e. 4 hour referral from AED to Ward. • Fortnightly stroke planning meeting to monitor progress on action plan and address all issues within the department: o SSNAP o SALT o TIA o APC o Review of progress on recruitment	6/7/24 - SSNAP score D. New stroke consultant appointed. Insourcing of therapy services. Stroke responders now fully recruited. Ward 9 means no longer stroke outliers. Lag time between change in practice and change in SSNAP means likely to remain at D till October. 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 possible.	01 Sep 2024	(4) Major	(4) Will probably recur, but is not a persistent issue	16
605	3311	13 Dec 2018	Ray Smith	Jen Green	Risk Assessment	People Academy, Quality Committee	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	14/08/24 - there is no safety concerns regarding the service. There is however an ongoing issue about the service BTHFT should be providing due to lack of service specification for a local Haemoglobinopathy service. Lack of clarity means BTHFT are carrying clinical and financial risk. 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	31 Mar 2025	(4) Major	(4) Will probably recur, but is not a persistent issue	16

70	3850	29 Mar 2023	Sajid Azeb	Philip Moore	Risk Assessment	Finance and Performance Committee, People Academy	There is a risk to the patient care, staff wellbeing and trust finances arising from inadequate pharmacy accommodation. The key risk are: Aseptic Unit. The pharmacy aseptic unit is listed as a separate risk - risk 3696. Pharmacy Dispensary - The Pharmacy dispensary is cramped and can be overcrowded at busy times which increases the risk of dispensing errors. In addition to this, the cramped accommodation means the trust is unable to further automate the dispensary with the latest dispensing robots. Current dispensing robots are significantly more efficient meaning dispensing times can be further reduced and include technology such as automatic labelling which further reduces the chances of dispensing errors. The current accommodation means waiting times are longer and dispensing errors more likely than a modern automated dispensary. Pharmacy Quality Assurance / Control - The quality assurance area has recently been face lifted but like other areas accommodates more colleagues than there are spaces for. In addition to this there is inadequate storage areas to store expensive equipment which may become damaged leading to a financial risk to the organisation. There is also a lack of space for the incubators which are key to the functions of the department. Incubators are currently located in a long corridor without windows meaning the working environment is poor. The current accommodation means there is a financial risk to the organisation arising from potential damage to equipment and through staff absence resulting from the poor environment. Pharmacy Stores - The pharmacy store is currently spread across two floor levels and two separate unheated store rooms. In addition to this the layout of the building means that automation, common in other trusts, cannot be installed. The lack of automation increases the risk of stock outages and picking issues leading to an increased risk of patients missing doses of medication and potential patient harm. Equality Diversity and Inclusion - The department has numerous different floor levels, some of which are connected by ramps whilst others are connected by stairs. This means that any staff or visitors who are mobility impaired will be unable to access all areas of the department. Staff rest facilities are inadequate in that there are only two toilets for over 130 people. Office accommodation is limited meaning colleagues often need to hot desk which limits the scope for work station related adjustments. The accommodation also means that staff are less able to mix and form a coherent team leading to issues with morale impacting staff wellbeing. The current accommodation means there is a risk to staff wellbeing and trust finances through absences as a result of the poor accommodation.	12 Sep 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 14/08/2024 Cleaning validation process is underway in the temporary aseptic unit (risk 221) 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	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
30	3890	30 Aug 2023	Karen Dawber	Carly Stott	Risk Assessment	Quality Committee	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 CS to update RA next month following USS capacity meeting. 24/5/2422.05.24 Regular USS task and finish group meeting have been held and progress has been made with increasing capacity to ensure women receive scans within the expected timeframes. Ongoing audit of this is in place which demonstrates that compliance with next working days scans for women presenting with RFM is 71-74% . Capacity should further improve following completion of some of the outstanding actions on the USS task	30 Sep 2024	(5) Catastrophic	(3) May recur occasionally	15
95	3824	14 Sep 2023	Ray Smith	Farah Naz	Risk Assessment	People Academy, Quality Committee	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	04/07/2024 New medical staffing model paper will be presented at ETM on the 08/07/2024 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-Oct-24	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
512	3404	31 May 2019	Karen Dawber	Carly Stott	Escalated from Division	People Academy, Quality Committee	There is a risk that Optimal staffing levels within all areas of the maternity services not achieved due to vacancies, maternity leave, and long/short term sickness levels leading to; Patient safety concerns Ability to provide 1 to 1 care to all labouring women. Possible closure of beds and services. Patients may require divert for care at another Trust. Staff job satisfaction. Maternity unit reputation.	31 Jan 2025	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	9	(3) Moderate	(3) May recur occasionally	WTE establishment Recruitment in progress. Effective use of the managing attendance policy. Effective use of the escalation policy. Requests for Bank staff TNR and Agency. Hot desk midwife Monday to Friday office hours to support risk assessments and staff movement. On call senior midwife rota covers all unsocial hours. Senior midwifery management team/Chief nurse team	International recruitment has commenced and a number of IR midwives have started. The current vacancy against the safe staffing establishment is 11.48 WTE. This continues to be our priority recruitment figure. To achieve the funded establishment to enable MCoC as default position for all women, the current vacancy is 37.9 WTE. Daily staffing challenges persist but there has been a positive response to 'super surge' TNR rates during the last few months, which remain in place until review in the New Year. Improved offer of twilight shifts in key areas such as MAC, are having a small but positive impact. 10 of the NQM commenced their induction/supernumerary period in October and we expect that this will improve the staffing position towards the end of December when they are counted in the numbers. The remaining NQM will join us in stages between now and spring time. The first of our International Midwives arrived in November and is currently at the OSCE assessment centre in York. We are awaiting further update on a further 5 International Midwives who have offers of employment at BTHFT. Clover team is currently under review, but it is likely that 3 midwives will remain in the intrapartum areas.	31 Jan 2025	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2601		28 Jun 2024	Ray Smith	Liz Kelley	Risk Assessment	Quality Committee	Downtime of current equipment is preventing optimal numbers of patients being seen, leading to longer waits for elective PCI and pacing work, and pressure on beds due to acute waits.	01 Jul 2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	8	(4) Major	(2) Do not expect it to happen again but it is possible	Acute waits being prioritised	1.Increase in productivity in lab to be explored – all day PCI/pacing lists to start as a trial in October 2024 2.New cath lab equipment to be sought – feasibility study in development to explore various options to replace the current state or move to a 2 lab solution. 3.Expansion of lab to increase throughput to be explored Expansion of lab to increase throughput to be explored	31 Dec 2024	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

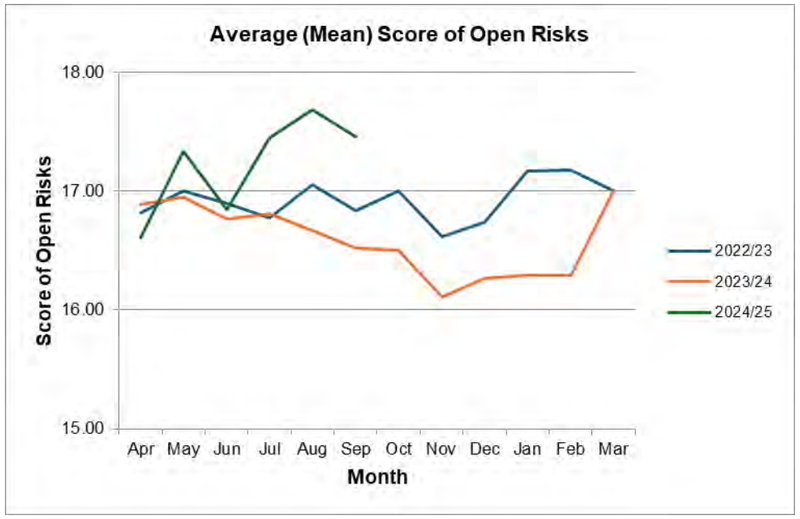
Bradford Teaching Hospitals NHS Foundation Trust

High Level Risks Report on a Page – September 2024

Total High Level Risks	24*
Aligned to F&PA	4
Aligned to QA	21
Aligned to PA	9
Aligned to Board	2

*Note some risks are aligned to more than one Academy

Movement of Risks	
New	2
Marked for closure	0
Risk score increased	0
Risk score static	21
Risk score decreased	1



Risk Overview

Consequence	Likelihood 1	Likelihood 2	Likelihood 3	Likelihood 4	Likelihood 5
5	10	15	20	25	
		30	290, 2542		
4	8	12	16	20	
			257, 109, 605, 221, 187, 396, 2549, 9, 2509	14, 607, 171, 2566, 2604, 2618, 2601, 2605, 2630	
3	6	9	12	15	
				512, 95, 70	
2	4	6	8	10	
1	2	3	4	5	

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

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

IRIS ID	Legacy ID	Date of entry	Academy	Current Score - September 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 & QC	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	31/01/2025
257	3660	25/05/2021	PA & QC	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	01/04/2025
221	3696	18/08/2021	F&P & QA	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 & QC	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	QA	20	4	30/04/2019	31/12/2019	30/04/2020	30/12/2022	31/08/2024	31/03/2025									
109	3810	14/10/2022	PA & QC	16	6	30/10/2022	08/12/2022	01/04/2023	30/09/2023	30/09/2024										
290	3627	10/02/2021	QA	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025											
171	3748	15/02/2022	QA	20	3	31/01/2023	31/01/2024	30/09/2024	31/12/2024											
14	3906	17/10/2023	Board	20	10	30/11/2023	31/03/2024	30/09/2024												
30	3890	30/08/2023	QA	15	5	31/08/2024	31/05/2024	30/09/2024												
2549	N/A	05/04/2024	PA & QC	16	4	31/03/2025	31/05/2024	31/10/2024												
2542	N/A	04/04/2024	F&P & QA	20	1	11/06/2024	05/08/2024	19/11/2024												
95	3824	14/12/2022	PA & QC	15	6	28/02/2024	31/08/2024	31/10/2024												
605	3311	13/12/2018	PA & QC	16	3	31/03/2023	31/03/2025													
70	3850	29/03/2023	F&P & PA	15	6	01/04/2025	31/05/2025													
2509	N/A	16/02/2024	QA	16	9	01/04/2024	27/12/2025													
9	3911	10/11/2023	Board	16	8	30/09/2024														
396*	3520	08/01/2020	QA	16	6	01/09/2024														
2566	N/A	12/04/2024	QA	16	12	30/11/2024														
2604		04/07/2024	F&P & QA	20	9	01/10/2024														
2605		08/07/2024	QA	25	8	24/06/2024	31/03/2025													
2618		19/07/2024	PA & QC	20	9	31/10/2024														
2601		28/06/2024	QC	15	8	31/12/2024														
2630		09/08/2024	QC	20	1	30/09/2024	31/03/2025													

Key:

Target mitigation date changed since last report

Past the target mitigation date

* Risk to be merged with risk 2618

BO.9.24.17 - BOARD, COMMITTEE AND ACADEMY TERMS OF REFERENCE AND WORK PLANS

REFERENCES

Only PDFs are attached

- Bo.9.24.17 - Academy and Committee ARs - ToRs - WPlans 2023-24 (cover) (1).pdf
- Bo.9.24.17 - Appendix 1 - Board Nominations Remuneration TOR - with track changes (1).pdf
- Bo.9.24.17 - Appendix 2 - Finance and Performance Committee ToRs with track changes (1).pdf
- Bo.9.24.17 - Appendix 2a - F&P Committee workplan (1).pdf
- Bo.9.24.17 - Appendix 3 - People Academy ToRs with track changes (1).pdf
- Bo.9.24.17 - Appendix 3a - People Academy Revised Work Plan (1).pdf
- Bo.9.24.17 - Appendix 4 - Quality Committee ToRs with track changes (1).pdf
- Bo.9.24.17 - Appendix 4a - Quality Committee Workplan (1).pdf
- Bo.9.24.17 - Appendix 5 - Board Open Work Plan 2024-25 (1).pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.17

Board, Committee and Academy Terms of Reference and Work Plans

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Renee Bullock, Chief People and Purpose Officer	
Purpose of the paper	This paper provides the Terms of Reference and work plans for the Finance and Performance Committee, People Academy, and the Quality Committee for review and approval. The Terms of Reference for the Board Nominations and Remuneration Committee and, the work plan for the Board of Directors are also included for review and approval.	
Key control	As sub-committees of the Board, the Academy and Committees form a key part of the Trust's control arrangements.	
Action reported	For approval	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	Board of Directors	11 July 2024

Background

Academy and Committee Terms of Reference

The Board Nominations and Remuneration Committee Terms of Reference were reviewed by the Committee in April 2024. These are presented for the Board's review and approval at **Appendix 1**.

In July 2024 the Board approved interim Terms of Reference for the Finance and Performance Academy, People Academy, and the Quality Academy. The Board noted that the interim terms of reference would be subject to further detailed review by the Academies prior to being presented in their final form to the Board for approval along with their associated workplans.

The revised Terms of Reference (and the associated work plans) for the Finance and Performance Committee, People Academy, and the Quality Committee are presented as follows for the Board's review and approval.

- **Appendix 2:** Finance and Performance Committee Terms of Reference and Workplan
- **Appendix 3:** People Academy Terms of Reference and Workplan
- **Appendix 4:** Quality Committee Terms of Reference and Workplan

Following on from the reviews undertaken above, the Board Workplan has been reviewed by the Chair and Chief Executive and is presented for the Board's review and approval at **Appendix 5**.

A summary of key revisions are presented below.

Board Nominations and Remuneration Committee: key revisions

- Terms of Reference

Minor updates are presented regarding the;
- Change to guidance in support of duties of the Committee following the publication of the Code of Governance for NHS Provider Trusts.
- Addition to those in attendance and providing support to the Committee (namely the Chief People and Purpose Officer and the Associate Director of Corporate Governance/Board Secretary).

- The assumption of the responsibility for communicating decisions from the Committee regarding remuneration and terms and conditions to postholders to the Chief People and Purpose Officer.

Finance and Performance Committee: key revisions

- Terms of Reference

- Name change from the 'Finance and Performance Academy' to the 'Finance and Performance Committee.'
- Several changes to the duties of the Committee to ensure they are in keeping with current strategic priorities and regulatory requirements.
- Minor changes to the membership and those 'in attendance'.
- The sub-groups reporting into the committee confirmed as:
  - Capital Strategy Group
  - Cancer Board

The Board is asked to note that reporting from the Pathology Joint Venture (PJV) has yet to be confirmed. This is proposed to take place following receipt of the next report by the Finance and Performance Committee in November 2024 - where it will then be determined which Committee/Academy the PJV will report into.

- Work plan

The Academy approved the addition of the following items under 'Estates and Facilities' reporting into the Committee:

- Premises Assurance Model (PAM)
- Estates Returns Information Collection (ERIC)
- Health and Safety Committee Update
- Annual Health and Safety Report
- Annual Fire Safety report
- Annual Security Report
- Violence Prevention and Reduction Standard
- Parking
- Accommodation
- Compliance
- Water and Ventilation (infection prevention)
- Medical Engineering

People Academy: key revisions

- Terms of Reference

- Several changes have been made to the duties of the Academy to ensure they are in keeping with current strategic priorities and regulatory requirements.
- Minor changes made to the membership and those 'in attendance'
- The sub-groups reporting into the academy are confirmed as:
  - Workforce of the Future

- Work plan

The accompanying work plan has been reviewed and updated in response to the revised terms of reference. A number of items were removed as they were no longer relevant. The work plan is now organised under the following five key headings.

- EDI (Equality, Diversity and Inclusion) Strategy

- Workforce Strategy
- People and Organisational Development Strategy
- People and Workforce Reporting
- Governance, Board Assurance framework (BAF) and Risk

Quality Academy: key revisions

- Terms of Reference

The Academy has approved the following changes
- The change of name to the Quality Committee (from Quality Academy).
- The inclusion of a clear definition of Quality based on that presented by the WHO (World Health Organisation).
- Several changes to the duties of the Committee, to ensure they are in keeping with current strategic priorities and regulatory requirements.
- Removal of references to the CSU to Academy meetings and the Annual Quality Review as these are not required within the Terms of Reference.
- Thorough review has taken place of the expected membership and attendance at the Quality Committee
- The sub-groups reporting into the committee are confirmed as:
  - Operational Chief Nurses Meeting
  - Patient Safety Group
  - Clinical Outcomes Group
  - Patient Experience and Engagement Group
  - Integrated Safeguarding Sub-Committee
  - Infection Prevention Control Committee
  - Digital & Data Transformation Committee

- Work plan

- The Quality Committee work plan has been reviewed and updated in response to the revised terms of reference.
- A number of items have been removed and one new item (Annual review of Internal Audit Plan) has been added.
- The frequency of reporting has been considered and amended as appropriate for a number of items.

Board Work Plan

The Board work plan has been reviewed and was discussed with the Chair and Chief Executive on 4 September, and the updated version is attached at Appendix 5 for approval. It was agreed that more focus is required on strategy at Board meetings and that the Board should receive a 6 monthly update on each of the Trust strategies. It was also agreed that there should be an opportunity to discuss emerging strategic issues at Board meetings.

There will also be an additional focus on partnerships through a strategic partnerships update at every other meeting.

It is proposed that the Board continues to receive CSU updates and patient stories at alternate meetings. The CSU updates will be planned further in advance to ensure a more strategic focus.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.17

Recommendation

1. Committee / Academy Terms of Reference and (where appropriate) work plans

The Board of Directors is asked to approve the changes presented to the:

- Board Nominations and Remuneration Committee Terms of Reference at Appendix 1
- Finance and Performance Committee Terms of Reference and work plan at Appendices 2 and 2a
- People Academy Terms of Reference and work plan at Appendices 3 and 3a
- Quality Committee Terms of Reference and work plan at Appendices 4 and 4a

2. Board of Directors Work Plan

- The Board of Directors is asked to approve the Board Work Plan at Appendix 5.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.17

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: Well Led
Care Quality Commission Fundamental Standard: Good Governance
NHS England Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities
Other (please state):

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

Bradford Teaching Hospitals
NHS Foundation Trust

Board Nominations and Remuneration Committee
Terms of Reference

Purpose	The Committee is responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.
Responsible to	Board of Directors
Delegated authority	The Nominations and Remuneration Committee is established under the Trust's Standing Order – Arrangements for the Exercise of Functions by delegation and is constituted as a standing committee of the Board of Directors. The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference.
Duties	• To regularly review the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors and make recommendations to the Board with regard to any changes. • To give full consideration to and make plans for succession planning for the Chief Executive and other Executive Director posts. • To agree the Non-Executive membership of an Appointments Panel to appoint any Executive Director. The panel will normally include the Chairperson and Chief Executive. The panel will have delegated authority to appoint an Executive Director. • To be responsible for agreeing an Appointments Panel to include the Chairperson which will then have delegated authority to identify and recommend a suitable candidate for approval by the Council of Governors to fill the position of Chief Executive. • To agree the job description for any Executive Director taking into account the role and capabilities required. • To determine on behalf of the Board of Directors the terms and conditions of employment and salary levels of Executive Directors in the Trust and any other Senior Managers not covered by Agenda for Change terms and conditions. The remuneration of the Chief Executive will be proposed by the Chairperson and approved by the whole body of Non-Executive Directors. The remuneration of

	Executive Directors will be proposed by the Chief Executive and approved by the whole body of Non-Executive Directors. • In undertaking this function it will:- a) Observe all statutory and contractual obligations as they affect individual postholders. b) Act in accordance with the Foundation Trust's standing orders. c) Have regard to any directions made by the Secretary of State in so far as they apply to Bradford Teaching Hospitals as a Foundation Trust. d) Have regard to the guidance in any directives on pay and conditions of employment in respect of very senior managers so far as they apply to Bradford Teaching Hospitals as a Foundation Trust. e) Ensure that regulation 5 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 is complied with in respect of any new or continued appointment. f) Ensure that in considering any starting salary over £150,000 there is a clear and documented rationale for the level of salary awarded and that an opinion from HM Treasury is sought before confirming any appointment. g) Consider the pension consequences and associated costs to the Foundation Trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement. h) Take into account the financial state of the Foundation Trust. i) Have regard to legislation on discrimination and the gender pay gap when considering levels of pay/terms and conditions. j) Ensure that remuneration is sufficient to recruit, retain and motivate Executive Directors at the level of skills appropriate to the role. k) Consider the relationship between the remuneration of these posts and that of other grades of staff employed in Bradford Teaching Hospitals in particular the layer below Board level. This may include reference to the level of pay awards granted under national pay systems e.g. Agenda for Change.

	l) Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service. m) Consider any proposal for a severance payment to be made to a Senior Manager. A 'Senior Manager' is defined as the Chief Executive or any Director who reports to the Chief Executive, whether or not they are an executive member of the Board. The Remuneration Committee will either reject the proposal or approve a business case to be sent to NHS ~~I~~England if they propose/approve a payment to be made. n) Approve the running of any MARS or Voluntary Redundancy Scheme. o) Make recommendations on any local pay arrangements not covered by national terms. p) Recommend the scope and detail to be included in the annual report concerning basic salary and elements relating to performance including an explanation of the criteria on which performance is based where necessary. q) Review appraisal outcomes for Executive Directors where there is a performance related pay element. r) Be satisfied that a risk assessment has been carried out when it is agreed that an Executive Director can leave the Foundation Trust without serving their full contractual notice. s) Work within the principles contained in the HM Treasury guidance on how to manage public funds in respect of 'special payments' and the Code of Governance for NHS Provider Trusts~~Code of Governance for NHS Foundation Trusts.~~
Sub-Groups	The Committee does not have any sub-groups.
Chairing arrangements	The Committee will be chaired by the Trust's Chair~~person~~. In their absence the Deputy Chair~~person~~, if present, will preside. If both the Chair~~person~~ and Deputy Chair~~person~~ are absent, or are disqualified from participating, such Non-Executive Director as the Non-Executive Directors present shall choose, shall preside over the meeting.
Membership	The Nominations and Remuneration Committee will consist of the Trust

	Chair~~person~~ and all Non-Executive Directors.
In attendance	The Chief Executive, Chief People and Purpose Officer and the Associate Director of Corporate Governance/Board Secretary ~~Director of HR~~ will attend in an advisory capacity. The Committee may invite other staff or external advisors to attend as required.
Conflicts of interest	The Chair~~person~~, any Non-Executive Director present or Executive Director in attendance at a committee meeting will withdraw from discussions concerning their own appointment, remuneration or terms and conditions of service.
Support	The Chief People and Purpose Officer and Associate Director of Corporate Governance/Board Secretary ~~Director of Human Resources~~ will service the Committee and provide specialist advice and information as necessary.
Quorum	This will be the Chair~~person~~ and three other Non-Executive Directors.
Frequency of meetings	For the purpose of the Annual Review of Executive Directors pay the Nominations and Remuneration Committee will meet within the first four months following the 1 April each year. The Nominations and Remuneration Committee will meet at other times for the following purposes as determined by the Chairman of the Nominations and Remuneration Committee:- • To keep up to date with relevant developments. • To review remuneration policies. • To consider proposals for changes in terms and conditions of employment. • To consider any in-year variation of salaries and terms and conditions of employment of Executive Directors. • To agree process and salaries for new appointments.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Nominations and Remuneration Committee will meet in private and record the reasons for all decisions and report these decisions to the Board of Directors as required.

	Communicating Decisions The responsibility is vested in the Chief People and Purpose Officer ~~Director of Human Resources as secretary~~ to communicate the decision of the Nominations and Remuneration Committee in writing to each postholder where it affects their pay or terms and conditions of service.
Date agreed by the Committee:	~~29 November 2022~~03 April 2024
Date approved by the Board:	~~19 January 2023~~XXX25 September 2024
Review date:	~~November 2023~~XXX September 2025

Bradford Teaching Hospitals
NHS Foundation Trust

Finance & Performance ~~Academy~~Committee

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~~Committee 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~~Committee to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The ~~Academy~~Committee may make a request to the executive management team for legal or independent professional advice. The ~~Academy~~Committee 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~~Committee'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~~Seek assurance regarding the development and maintenance of the Foundation Trust's medium- and long-term financial strategy~~.~~ • ~~Oversight and scrutiny of~~ Seek assurance regarding the development and delivery of the Foundation Trust's annual operational and financial plan and ~~integrated business~~capital plan. • Review and monitor financial plans, including the capital plan, and the Bradford District and Craven and ICS financial position, 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~~ Review the budget setting process and timetable prior to approval by the Board of Directors.

	• Approve the Budgetary Management Framework. • Seek assurance regarding the Trust's compliance with NHS contracting arrangements • Seek assurance regarding post implementation reviews of approved 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~~national cost ~~submission~~collection ensuring appropriate application of costing methodologies. • Approve and ~~keep under review~~seek assurance regarding 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~~Seek assurance regarding the operational and financial performance of the Pathology Joint Venture ~~Board~~. • ~~Oversight~~Seek assurance regarding the delivery of the Trust's procurement ~~activity (also relevant to the Learning and Improvement aspects of the Academy).~~strategy. • ~~Oversight of~~Seek assurance regarding the Trust's compliance with Emergency Preparedness, Resilience and Response (EPRR) requirements. • ~~Oversight~~Review the Trust's Winter Plan and seek assurance that appropriate arrangements are in place. • Seek assurance regarding the delivery of the Estates and Facilities function (including the completion of the Premises Assurance Model (PAM) self-assessment and Estates Return Information Collection (ERIC)). • ~~Oversight with regard~~Seek assurance regarding the Trust's performance in relation to ~~Environmental~~environmental sustainability • ~~In reviewing the assurances received,~~ and delivery of the ~~Academy will take into consideration the quality of data presented and any associated issues.~~Green Plan. • Review and monitor the delivery of the Closing the Gap and Delivering Operational Excellence programmes.

	• Review programme updates from the Bradford District and Craven Health and Care Partnership, WYAAT and the ICS to ensure that any related improvements are exploited within the Trust. • Seek assurance regarding the action taken by the Trust to address health inequalities and access to care.
	~~**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~~Committee will be chaired by a Non-Executive Director.
Membership	• Up to three Non-Executive Directors (including the Chair) • Chief Operating Officer • ~~Director of~~Chief Finance Officer

	• Director of Strategy and Transformation • Director of Estates and Facilities 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~~Committee 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~~Chief Finance Officer/Chief Operating Officer.
Quorum	A minimum of three members, including two NEDs 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~~ four clear working days in advance of the meeting.

Reporting	The Chair of the ~~Academy~~Committee 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~~Committee shall also be submitted to the Trust Board for information and assurance. The Chair of the ~~Academy~~Committee shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The ~~Academy~~Committee 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:	~~4~~14 July 2024
Date approved by the Trust Board:	~~11 July 2024~~25 September
Review date:	September ~~2024~~2025

Finance and Performance Committee Work Plan

Item	Lead	Report to Board	Notes	2024		2025										2026									
				Oct	Nov	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov
Finance and Performance																									
Winter Review/Plan	COO	x		x										x										x	
Bradford Place and ICS System Financial Update	CFO		Six-monthly				x					x					x					x			
Budget Setting Process and Timetable	CFO	x	November - annual item		x										x										x
Budgetary Management Framework	CFO		Annual							x										x					
Capital Plan	CFO	x	Jan and March updates			x		x								x		x							
Capital Update	CFO			x		x			x			x		x		x			x			x		x	
Contract Update	CFO			x				x					x					x					x		
Financial Plan / NHSE Operational Plan Submission	CFO/COO	x	Jan/Feb/Mar - inc. CTG Methodology			x	x	x								x	x	x							
Monthly Finance Report	CFO	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Pathology Joint Venture - Financial and Performance Position	CFO				x					x					x					x					x
Procurement Update	CFO							x					x					x					x		
Service Development Post Implementation Reviews	CFO				x					x					x					x					x
Treasury Management Update	CFO				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Operational Improvement Plan (Delivering Operational Excellence)	COO		Urgent & Emergency Care, RTT, Cancer & Diagnostic Performance (one per month in this order)	RTT	C&DP	U&EC	RTT	C&DP	U&EC	RTT	C&DP	U&EC	RTT	C&DP	U&EC	U&EC	RTT	C&DP	U&EC	RTT	C&DP	U&EC	RTT	C&DP	U&EC
EPRR Submission	COO	x											x										x		
EPRR Update	COO					x		x			x		x			x		x			x		x		
National Cost Collection	CFO		Annual Submission - September Annual Publication of Results - January			x							x			x							x		
Medium and Long Term Financial and Operational Strategy	CFO/COO		Annual								x										x				
Operational Highlight Report / Performance Report	COO	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Strategy and Transformation																									
WYAAT / ICS Update / Act as One Update	Act As One Programme Director			x		x		x			x			x		x		x			x			x	
Closing The Gap	DoST	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Green Plan	DoST/DoEF	x									x					x					x				
Health Inequalities & Access to Care	COO	x					x					x					x					x			
Estates and Facilities																									
Premises Assurance Model (PAM)	DoEF	x	Annual	x										x										x	
Estates Returns Information Collection (ERIC)	DoEF	x	Annual									x										x			
Health and Safety Committee Update	DoEF		bi annual		x					x					x					x					x
Annual Health and Safety Report	DoEF	x	Annual							x										x					
Annual Fire Safety report	DoEF	x	Annual							x										x					
Annual Security Report	DoEF	x	Annual																						
Violence Prevention and Reduction standard	DoEF		(two updates per year, one of which is combined with the Annual Security Report)		x					x					x					x					x
Parking	DoEF		bi annual					x					x					x					x		
Accommodation	DoEF		bi annual					x					x					x					x		
Compliance	DoEF		bi annual		x						x				x						x				x
Water and Ventilation (infection prevention)	DoEF		bi annual	x					x					x					x					x	
Medical Engineering	DoEF		Annual						x										x						
Governance, Board Assurance Framework (BAF) and Risk																									

Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary	x		x		x			x			x		x		x			x			x		x	
Finance and Performance Committee Dashboard	CFO/COO	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Annual Internal Audit Plan	Chair						x										x									
Committee Annual Report	Board Secretary	x							x										x							
Committee Terms of Reference Review and Committee Workplan	Board Secretary	x							x										x							
Committee Effectiveness Review	Chair	x						x	x									x	x							
High Level Risks	CFO/COO	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Items for Information																										
Cancer Board minutes	COO			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Internal Audit Reports relevant to the Academy (except for any limited assurance reports which go on main agenda)	Chair			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Finance and Performance Committee Work plan	Board Secretary			x	x	x	x	x		x	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x
Number of items per month (excluding the items for information)				13	13	14	11	16	14	14	12	12	14	13	13	14	11	16	14	14	12	12	14	13	13

Key:
Item reports through to Board of Directors
Planned item deferred to future meeting
Planned item cancelled and not rescheduled (state reason in notes)
Item discussed at the meeting

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: • Employee Voice - Speak up, Listen up, Follow up. To learn and improve from staff engagement activities, including Freedom to Speak Up, National Education and Training Survey, Guardian of Safe Working Hours, GMC Doctors in Training Survey and staff Surveys etc. • 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	• Workforce ~~Growth and Transformation~~of the Future

	~~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~~group will be tasked to lead pieces of work or undertake research, as necessary, 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.
Membership	• Up to three Non-Executive Directors (including the Chair) • Chief People and Purpose Officer • Chief Medical Officer • Chief Nurse 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~~Member of Pharmacy leadership team • Member of Digital ~~representative~~leadership team • ~~Assistant Director of HR/~~Head of OD • ~~Deputy Director~~Assistant Directors of HR • ~~Assistant Director~~~~Head of HR~~ • ~~Workplace Health and Wellbeing Centre Manager (only when Looking After Our People is included on the agenda)~~ • Head of Equality, Diversity and Inclusion ~~Manager~~ • ~~Deputy Chief Operating Officer~~ • ~~Director of Estates and Facilities~~ • Member of COO leadership team • Deputy Chief Nurse • Associate Chief Nurse Quality and Workforce

	• 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~~guests as appropriate • Any ~~non-~~Board member ~~NED~~that wishes to attend
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief People and Purpose Officer.
Quorum	A minimum of three members, including at least two NEDs 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~~ four 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:	~~July~~August 2024
Date approved by the Trust Board:	~~11 July~~September 2024

Review date:	September ~~2024~~2025

People Academy Meeting Work Plan

Item	Lead	Report to Board	2024 Sep	2024 Oct	2024 Nov	2025 Jan	2025 Feb	2025 Mar	2025 Apr	2025 May	2025 Jun	2025 Jul	2025 Sep	2025 Oct	2025 Nov	2026 Jan	2026 Feb	2026 Mar	2026 Apr	2026 May	2026 Jun	2026 Jul	2026 Sep	2026 Oct	2026 Nov
EDI Strategy																									
Equality Delivery System 22 (domain 2 and 3) Update	Chief People and Purpose Officer						x										x								
WRES and WDES Annual Data Update	Chief People and Purpose Officer	x								x										x					
Approval of Action Plans for WRES and WDES	Chief People and Purpose Officer	x		x										x										x	
Gender Pay Gap	Chief People and Purpose Officer	x						x										x							
Workforce Strategy																									
NHS Long Term Workforce Plan	Director of HR			x								x		x							x		x		
Guardian of Safe Working Hours Quarterly Updates	Chief Medical Officer	x		x			x		x			x		x			x		x			x		x	
Medical Appraisal and Revalidation Annual Report	Chief Medical Officer	x									x										x				
Medical Appraisal and Revalidation Annual Statement of Compliance	Chief Medical Officer	x												x										x	
Staff Appraisal	Chief People and Purpose Officer		x					x					x					x					x		
People and Organisational Development Strategy																									
People Strategy (date to be confirmed following receipt of CQC report)	Chief People and Purpose Officer	x																							
Nursing & Midwifery Staffing Establishment Review	Chief Nurse	x		x					x					x				x						x	
Nursing and Midwifery Staffing Data Publication Report	Chief Nurse		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Academy Dashboard	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Engagement	Chief People and Purpose Officer		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Pulse Survey	Chief People and Purpose Officer	x							x		x								x		x				
GMC Survey Feedback	Chief Medical Officer		x										x										x		
National Education & Training Survey (NETS) Feedback	Chief Medical Officer								x										x						
Staff Survey and Action plan	Chief People and Purpose Officer	x	x					x			x		x					x			x		x		
Management / Leadership development	Chief People and Purpose Officer				x							x			x							x			x
Outstanding programmes (tbc)																									
People and Workforce Reporting																									
Workforce Planning Submission	Director of HR	x			x		x								x		x								x
Workforce Report	Director of HR		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FTSU Annual Report	Chief Nurse	x								x										x					
FTSU Quarterly Updates	Chief Nurse			Q2			Q3			Q4		Q1		Q2			Q3			Q4		Q1		Q2	
Education Annual Report	Chief Medical Officer								x										x						
Guardian of Safe Working Hours Annual Report	Chief Medical Officer	x								x										x					
Governance, Board Assurance Framework (BAF) and Risk																									
People Academy Annual Report to Board	Board Secretary	x							x										x						
People Academy Annual Review of ToRs	Board Secretary	x							x										x						
People Academy Effectiveness Review	Board Secretary	x						x	x									x	x						
People Academy Work Plan - Annual Review	Board Secretary	x							x										x						
Annual Internal Audit Plan	Chair	x					x										x								
High Level Operational Risks	Chief People and Purpose Officer	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BAF - strategic risks relevant to the Academy	Board Secretary	x		x		x			x			x			x	x			x			x			x

Items for information only																									
Internal Audit Reports relevant to the Academy (for information only unless limited assurance reports)	Chief People and Purpose Officer		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
People Academy Work Plan	Board Secretary		x	x	x	x	x	x		x	x	x	x	x	x	x	x	x		x	x	x	x	x	x
Number of items per month (excluding the items for information)			**8**	**11**	**7**	**6**	**10**	**9**	**15**	**9**	**8**	**10**	**10**	**11**	**8**	**6**	**10**	**9**	**15**	**9**	**8**	**10**	**10**	**11**	**8**

Key:

Item reports through to Board of Directors

Planned item deferred to future meeting

Planned item cancelled and not rescheduled (state reason in notes)

Item discussed at the meeting

Bradford Teaching Hospitals
NHS Foundation Trust

Quality ~~Academy~~Committee

Terms of Reference

Purpose	**~~Academy~~Committee 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. 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 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.~~ **What do we mean by 'Quality'?**[1] Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be: • **Effective** – providing evidence-based healthcare services to those who need them; • **Safe** – avoiding harm to people for whom the care is intended; and • **People-centred** – providing care that responds to individual preferences, needs and values. To realize the benefits of quality health care, health services must be: • **Timely** – reducing waiting times and sometimes harmful delays; • **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status; • **Integrated** – providing care that makes available the full range of health services throughout the life course; • **Efficient** – maximizing the benefit of available resources and avoiding waste.

[1] World Health Organisation definition of Quality of Care

Responsible to	Board of Directors
Delegated authority	The ~~Academy~~Committee is authorised to ~~investigate~~commission or receive investigations relating to 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~~Committee to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The ~~Academy~~Committee may make a request to the ~~executive management team~~ Board for legal or independent professional advice. The ~~Academy~~Committee 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~~Committee 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 quality of 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 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 and commissioning actions in relation to the findings as appropriate.

	• ~~Oversee~~Oversight of 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~~Oversight of the Trust's objectives relating to quality priorities for inclusion in the Trust's Annual Quality Account. • ~~Have oversight~~Oversight of the development and delivery of the Trust's Improvement Strategy. • 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. • Review, challenge and assess the identification and management of risks within the ~~Academy's~~Committee'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. • Share learning with partner organisations as appropriate to promote 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 Trust's 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.

	~~• In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.~~ • Oversight of the development of a suite of metrics to measure a culture of safety, quality and improvement. • Oversight of the Nursing & Midwifery Leadership Council work programmes to ensure successful accreditation for care excellence.
	~~**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	Operational Chief Nurses Meeting Patient Safety Group Clinical Outcomes Group Patient Experience and Engagement Group Integrated Safeguarding Sub-Committee Digital & Data Transformation Committee Infection Prevention Control Committee ~~Nursing & Midwifery Leadership Council~~
Chairing arrangements	The Academy will be chaired by a Non- Executive Director.
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	• Chief Digital and Information Officer • Deputy Chief Medical ~~Officers~~Officer • Associate Medical Directors (on rotation) • Operations Directors/Deputy COO (on rotation) • Associate Director of Quality • Head of Education • Deputy Chief Nurse • Director of Midwifery • Head 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~~Deputy Director of ~~Quality Improvement~~Estates and ~~Clinical Outcomes~~Facilities ~~• 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 (on rotation) • 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.* • The Academy may invite other employees or external advisors to attend or observe as appropriate

	~~**CSU to Academy meetings:**~~ • ~~All members of Quality Academy~~ • ~~Operational triumvirate from each CSU (three or four at each meeting). Each CSU to attend at least on an annual basis.~~ ~~**Annual Quality Review:**~~ • ~~All members of Quality Academy~~ • ~~Operational triumvirate from each CSU~~ • ~~NEDs~~ • ~~Governors~~ • ~~Members including staff~~ • ~~Patient representatives~~
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief Nurse/Chief Medical Officer.
Quorum	A minimum of three members, including at least two NEDs and at least one Executive Director.
Frequency of meetings	10 times per year. 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~~four 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:	~~2 July~~19 September 2024
Date approved by the Trust Board:	~~11 July~~25 September 2024
Review date:	~~September 2024~~July 2025

Quality Committee Work Plan

Item	Lead	Category	Report to Board	Notes	2024 Sep	2024 Oct	2024 Nov	2025 Jan	2025 Feb	2025 Mar	2025 Apr	2025 May	2025 Jun	2025 July	2025 Sep	2025 Oct	2025 Nov	2026 Jan	2026 Feb	2026 Mar	2026 Apr	2026 May	2026 Jun	2026 July	2026 Sep	2026 Oct	2026 Nov
Insights Report	CMO	Assurance		Quarterly Report, (Q4 is annual report)		Q1 and Q2		Q3			Q4(AR)			Q1		Q2		Q3			Q4(AR)			Q1		Q2	
Infection Prevention and Control	CN	Assurance	x	Quarterly Report (IPC BAF to be included as an appendix)		Q2		Q3			Q4			Q1		Q2		Q3			Q4			Q1		Q2	
Equality Delivery System 2 (domain 1)	Head of Equality	Assurance		Annual Reporting					x										x								
Maternity and Neonatal Services	CN	Assurance	x	Monthly report	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Quality Committee Dashboard	CN/CMO	Assurance	x	Monthly report	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Quality Oversight & Assurance Profile	CMO	Assurance		Alternate meetings	x		x	x		x		x		x	x		x	x		x		x		x	x		x
Quality Account improvement priorities update	CMO/CN	Assurance	x	Quarterly		Q1 and Q2		Q3			Q4			Q1		Q2		Q3			Q4			Q1		Q2	
Quality Account Production Schedule		Assurance		Annual					x										x								
Annual Quality Account		Assurance	x	Annual									x										x				
Patient Safety Incident Investigations (PSII) Report		Assurance		Monthly	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PSIRF Oversight	CMO	Assurance				Q1 and Q2		Q3			Q4(AR)			Q1		Q2		Q3			Q4(AR)			Q1		Q2	
Safeguarding Adults (AR and 6 mthly update)	CN	Assurance	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.				x					AR					x					AR				
Safeguarding Children (AR and 6 mthly update)	CN	Assurance	x	Annual report in June & 6 monthly update in Dec (Dec report to include external feedback on annual report)				x					AR					x					AR				
Palliative Care Annual Report	CN	Assurance		Annual									AR										AR				
Mental Health Strategy	CN	Assurance		Annual						x										x							
Patient Experience (AR and 6 mthly update)	CN	Assurance		Annual report and 6 month update: (include PLACE AR; and outcomes from range of patient experience surveys)		x					AR					x					AR					x	
Inpatient Survey	CN	Assurance		Annual	x										x									x			
Health Inequalities	Dir S&T	Assurance		Bi annual reporting	x					x					x					x				x			
Bradford Nursing and Midwifery Professional Practice Model	CN	Assurance		Bi annual reporting					x					x					x					x			
Clinical Audit Annual Report	CMO	Assurance		Annual								AR										AR					
Clinical Audit High Priority Plan	CMO	Approval		Annual							x										x						
Compliance with National Food standards	CN	Assurance		Annual		x										x									x		
Ward Accreditation	CN	Assurance		Annual reporting							x										x						
Digital Report	CDIO	Assurance		Bi annual reporting		x					x					x					x					x	
Senior Information Risk Officer (SIRO) Report	CDIO	Assurance	x	Bi annual reporting			x						x				x						x				x
Getting it Right First Time (GIRFT)	CMO	Assurance		Annual Report								x										x					
Improvement Strategy (annual progress report)	CMO/CN	Assurance		Annual reporting								AR										AR					
Annual Review of Internal Audit Plan	CMO/CN	Assurance		Annual						x										x							
Learning from Deaths and Mortality Review Improvement Programme	CMO	Assurance		Reporting frequency three times per year	x			x				x			x			x				x			x		
Internal Audit Reports relevant to the Academy	Chair	Assurance		Monthly (as required)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Research Activity in the Trust	CMO	Assurance	x	Bi annual reporting	x					x					x					x					x		
Governance and Risk																											
Review of Quality Committee Work Plan / Terms of Reference	Board Secretary	Approval	x	Annual							x										x						
Quality Committee Effectiveness Review	Board Secretary	Approval	x	Annual						x	x									x	x						
Quality Committee Annual Report	Board Secretary	Approval	x	Annual							x										x						
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary	Assurance	x	Quarterly		Q1&2		Q3			Q4			Q1		Q2		Q3			Q4			Q1		Q2	
High Level Risks	CN/CMO	Assurance	x	Monthly	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Items for information																											
Bradford District & Craven Quality Committee (highlight report/minutes)	CN/CMO	Information		Every other month	x		x	x		x		x		x	x		x	x		x		x		x	x		x
Freedom to Speak Up (FTSU)	CN	Information	x	Quarterly		x			x				x			x			x				x			x	
Nursing and Midwifery Staffing Data Publication Report	CN	Information		Monthly	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Clinical Outcomes Group	CMO	Information		Every other month	x		x	x		x		x		x	x		x	x		x		x		x	x		x
Patient Experience Group	CN	Information		Every other month	x		x	x		x		x		x	x		x	x		x		x		x	x		x
Patient Safety Group	CMO	Information		Every other month	x		x	x		x		x		x	x		x	x		x		x		x	x		x
CSU to Academy/Committee delivery Programme & Annual Quality event 2025/26		Information		Annually					x										x								
Quality Committee Work Plan	Board Secretary	Information		Monthly	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x		x	x	x	x	x	x
WYAAT Quality and Safety Meeting Update / Minutes	CN	Information		Monthly	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Number of items per month (excluding the items for information)					**10**	**13**	**7**	**14**	**8**	**11**	**17**	**10**	**10**	**12**	**10**	**13**	**7**	**14**	**8**	**11**	**17**	**10**	**10**	**12**	**10**	**13**	**7**

Key:

Item reports through to Board of Directors
Planned item deferred to future meeting
Planned item cancelled and not rescheduled (state reason in notes)
Item discussed at the meeting

BOARD OPEN 2024-26 DRAFT

Item	Lead	Nov 24	Jan 25	Mar 25	May 25	Jul 25	Sep 25	Nov 25	Jan 26	Mar 26	Notes
STRATEGY											
Corporate Strategy	Director of Strategy & Transformation	x			x			x			
Mental Health Strategy	Chief Nurse			x			x			x	
Green Plan	Director of Strategy & Transformation		x			x			x		
Communications - Annual Update	Chief People & Purpose Officer	x									
Digital Strategy	CDIO	x			x						
Improvement Strategy	Chief Medical Officer	x			x						
Engagement Strategy	Chief Nurse		x			x					
EDI Strategy	Chief People & Purpose Officer			x			x			x	
People Strategy	Chief People & Purpose Officer										Date TBC
Strategy - Emerging Issues	All	x	x	x	x	x	x	x	x	x	
QUALITY											
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	x	
Inpatient Survey	Chief Nurse	x						x			
Adults & Children Safeguarding Annual Report	Chief Nurse					x					
Research Activity in the Trust	Chief Medical Officer			x*			x			x	*Presentation from Research Team
PEOPLE											
Equality, Diversity & Inclusion Update (WRES, WDES)	Chief People & Purpose Officer				x						Presentation
Equality & Diversity Council (quarterly reporting - update)	Chief Executive	x		x	x		x	x			
Staff Survey Results	Chief People & Purpose Officer			x							
Freedom to Speak Up	Chief Nurse				x			x			
Nursing & Midwifery Staffing Establishment Review	Chief Nurse	x			x			x			
Guardian of Safe Working Hours annual report	Chief Medical Officer				x						
Medical Appraisal & Revalidation Annual Report & Statement of Compliance	Chief Medical Officer						x				
Gender Pay Gap Report	Chief People & Purpose Officer			x						x	
Workforce Report	Chief People & Purpose Officer	x	x	x	x	x	x	x	x	x	
Healthcare Worker Flu Vaccination Best Practice Assurance	Chief People & Purpose Officer		x						x		
FINANCE & PERFORMANCE											
Finance Report	Director of Finance	x	x	x	x	x	x	x	x	x	
Performance Report	Chief Operating Officer	x	x	x	x	x	x	x	x	x	
Integrated Dashboard	All	x	x	x	x	x	x	x	x	x	
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	x						x			
Winter Plan	Chief Operating Officer	x						x			
Health Inequalities & Access to Care	Chief Operating Officer			x			x			x	
Closing the Gap	Director of Strategy & Transformation	x	x	x	x	x	x	x	x	x	
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Director of Finance		x								
PARTNERSHIPS											

BOARD OPEN 2024-26 DRAFT											
Item	Lead	Nov 24	Jan 25	Mar 25	May 25	Jul 25	Sep 25	Nov 25	Jan 26	Mar 26	Notes
Partnerships - strategic view	Director of Strategy & Transformation	x		x		x		x		x	
GOVERNANCE / ASSURANCE											
Board Assurance Framework	Chief People & Purpose Officer		x	x		x	x		x	x	
High Level Risk Register	Chief People & Purpose Officer	x	x	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief People & Purpose Officer	x						x			
Constitution - annual review	Chief People & Purpose Officer	x						x			
Self Certification of Provider Licence	Chief People & Purpose Officer				x						
NED Independence Test	Chief People & Purpose Officer				x						
Compliance with NHS Code of Governance	Chief People & Purpose Officer				x						
Well Led Review & Board Self Assessment	Chief People & Purpose Officer										Date TBC
Annual Report from Academies	Academy Chairs				x						
Annual Report from Audit Committee	Chair of Audit Committee				x						
Risk Appetite Review	Chief People & Purpose Officer	x			x						
Annual Fire Safety Report	Director of Estates & Facilities				x						
Annual Health & Safety Report	Director of Estates & Facilities	x			x						
Premises Assurance Model Progress Report	Director of Estates & Facilities	x						x			
Annual Security Report	Director of Estates & Facilities				x						
Violence Prevention & Reduction Standard	Director of Estates & Facilities				x			x			May - part of Annual Security Report
Data Security & Protection Toolkit	CDIO				x						
DPO Annual Report	DPO						x				
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Chief Operating Officer	x					x				
Use of the Trust Seal	Chief People & Purpose Officer						x				
NED Champion Roles - annual review	Chair	x						x			
Fit and Proper Person Test - annual review	Chief People & Purpose Officer				x						
COG Engagement Policy	Chief People & Purpose Officer		x								
STANDING ITEMS											
Patient Story	Chief Nurse		x		x		x		x		
Getting to know the CSUs	COO	x		x		x		x		x	
Chair's Report	Chairman	x	x	x	x	x	x	x	x	x	
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	x	
Chair's report from Academies and Committee	Academy Chairs	x	x	x	x	x	x	x	x	x	
Chair's report from Audit Committee	Audit Committee Chair	x		x	x		x	x		x	
Chair's report from Charitable Funds Committee	Charitable Funds Committee Chair		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	
Confirmed Academy and Committee minutes	Academy and Committee Chairs	x	x	x	x	x	x	x	x	x	

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

BO.9.24.18 - PREMISES ASSURANCE MODEL (PAM) PROGRESS REPORT

REFERENCES

Only PDFs are attached

Bo.9.24.18 - Premises Assurance Model (PAM) progress report - September 2024.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.18

PREMISES ASSURANCE MODEL (PAM)
PROGRESS REPORT – SEPTEMBER 2024

Presented by	David Moss, Director of Estates & Facilities	
Author	Charlotte Walker, Head of Business Management Emma Rollinson, E&F Business Administration Manager	
Lead Director	David Moss, Director of Estates & Facilities	
Purpose of the paper	Premises Assurance Model - Progress Report 2024	
Key control	Strategic Objective 1 to provide outstanding care for patients	
Action required	For assurance	
Previously discussed at/ informed by	E&F Compliance Risk Assurance Committee (CRAC)	
Previously approved at:	**Academy/Group**	**Date**
	E&F Compliance Risk Assurance Committee (CRAC)	14/08/24
	Executive Team Meeting	11/09/24

Summary & Background

The Director of NHS Estates & Facilities confirmed the requirement to adopt the Premises Assurance Model as a mandatory requirement from 1 April 2018 in a letter to all Directors of Estates on 15 March 2018.

The Trust has consistently completed application of the PAM since 2018, and to ensure an accurate baseline was established at that time, the process was undertaken with the aid of an independent 3rd party assessor to ensure impartiality.

The process was further audited in 2021 and achieved 'High' assurance status.

The NHS Premises Assurance Model (NHS PAM) is used to provide assurance for the healthcare environment and to ensure patients; staff and visitors are protected against risks associated with hazards such as unsafe premises. The NHS PAM tool provides:

- Assurance to the Trust Board, patients, commissioners and regulators regarding the safety and suitability regarding management of the estate and facilities services.
- A nationally consistent approach to evaluating NHS estates and facilities performance against a common set of self-assessment questions (SAQs) and metrics.
- Data to inform the prioritisation of investment supporting improvement opportunities.

The NHS PAM also supports the Trust to make informed decisions on the development of estates and facilities services.

Analysis

The purpose of this report is to:

a) Confirm that re-assessment of the PAM model for 2024 demonstrates maintenance of an overall rating of 'Good' for each of the five domains for the Trust:

   - Safety (Hard and Soft)
   - Patient Experience
   - Efficiency

- Effectiveness
- Organisational Governance.

b) Highlight areas of outstanding practice and improvement opportunities for each domain as a result of completing the PAM model.

c) Provide a comparison of the year-on-year overall compliance level within each domain.

Recommendation

It is recommended that the Trust Board note the key areas that have maintained an overall score of 'Good' with 'Requires minimal improvement'

Safety- Hard Facilities Management

(SH4) Health & Safety – In order to improve the score on this section, more focus is required on key areas of health and safety particularly around contractor management within E&F identified by an external audit, furthermore additional resource is recommended within the E&F Safety/Risk team and in the Capital team (in regard to CDM), currently being outsourced to a consultant.

(SH11) Asbestos- Recent RIDDOR relating capital projects team. Principal contractor failed to follow the CAR 2012 reg. 5 after a change in the project. Changes have been made to the capital projects team (change control process not followed). Awaiting Health and Safety report from Mascot to identify improvements in CDM compliance. Asbestos process in development with the AE and Asbestos manager for capital projects in line with the PMQM and RIBA stages.

(SH13) Pressure Systems - Improvement plans are in place to ensure Competent Person training, interviews and formal appointments are made in accordance with legislative requirements and best practice.

(SH19) Contractor Management- We are currently embedding a SkyVisitor electronic contractor sign in system that stores RAMs, insurances etc. Implementation of this system could improve the score. This would capture Certificates of Asbestos Awareness training from an accredited source (UKATA, ROSPA or IATP) undertaken in the last 12 months.

While the overall scores for the following SAQs were maintained, the following improvement actions have been taken to maintain status:

- **(SH14) Fire Safety** – Training & Development compliance has improved by 5% in year, from an Estates perspective we are doing everything we can to ensure training compliance continues to improve, the Trust as a whole is at 90% compliance against a target of 85% (this is an exceptional compliance rate when considering maternity/paternity, sick leave, staff turnover etc). Face to face fire safety training is now delivered annually to all staff (clinical and non-clinical).

- **(SH15) Medical Devices and Equipment**– RFID - scan for safety has been implemented across BTHFT, this is used to support asset tracking of medical devices.

Effectiveness

- **(E4) Suitable Sustainability Approach** –Green plan to be updated; HTM01-07 new requirements for infectious waste to be rolled out; budget constraints on capital build projects often means that Net Zero initiatives are difficult to fund and secondary to service delivery. Sustainability within procurement exercises is falling to the Environment & Sustainability Manager

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to assume responsibility, resource issues mean that this cannot be carried out effectively on all projects.

Patient Experience

- **(P4) Car Parking Arrangements** – following staff and patient feedback around lack of parking we are aware that there need for consistent and improved infrastructure. A business case is currently under development. We are planning for implementation and completion by Spring 2025.

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

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☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Safe
Care Quality Commission Fundamental Standard: Premises & Equipment
NHS Improvement Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities
Other (please state):

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

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.18

PREMISES ASSURANCE MODEL (PAM)
PROGRESS REPORT – SEPTEMBER 2024

1 INTRODUCTION

The purpose of this report is to provide an update and continued assurance associated with the implementation of the NHS Premises Assurance Model (NHS PAM) for Bradford Teaching Hospitals NHS Foundation Trust.

2 SUMMARY & BACKGROUND

The Director of NHS Estates & Facilities confirmed the requirement to adopt the Premises Assurance Model as a mandatory requirement from 1 April 2018 in a letter to all Directors of Estates on 15 March 2018.

The Trust has consistently completed application of the PAM since 2018, and to ensure an accurate baseline was established at that time, the process was undertaken with the aid of an independent 3rd party assessor to ensure impartiality.

The process was further audited in 2021 and achieved 'High' assurance status.

The NHS PAM is used to provide assurance for the healthcare environment and to ensure patients; staff and visitors are protected against risks associated with hazards such as unsafe premises. The NHS PAM tool provides:

- Assurance to the Trust Board, patients, commissioners and regulators regarding the safety and suitability regarding management of the estate and facilities services.
- A nationally consistent approach to evaluating NHS estates and facilities performance against a common set of self-assessment questions (SAQs) and metrics.
- Data to inform the prioritisation of investment supporting improvement opportunities.

The NHS PAM also supports the Trust to make informed decisions on the development of estates and facilities services.

3 PURPOSE

The purpose of this report is to:

a) Provide an update regarding re-assessment and level of assurance achieved within each of the five domains using the newly released updated NHS England PAM electronic platform:
    - Safety (Hard and Soft)
    - Patient Experience
    - Efficiency
    - Effectiveness
    - Organisational Governance.

b) Highlight areas of outstanding practice and improvement opportunities for each domain as a result of completing the PAM model.

c) Provide a comparison of the year-on-year overall compliance level within each domain.

d) Present a proposed programme of investment to support improvement opportunities.

4 PAM - SUMMARY OF DEFINITIONS

To aid interpretation of the NHS PAM, detailed below is a summary of the definitions for both the domains and scores.

4.1 Domain Definitions

The following provides a summary definition for each of the five domains:

Domain	Domain Statement
Safety	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the design, maintenance and use of facilities, premises and equipment keep people safe.
Patient Experience	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
Efficiency	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Effectiveness	The organisation provides assurance that its premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Governance	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

4.2 PAM Scores – Definitions

The following criterion applies when interpreting the NHS PAM scores:

Outstanding	Compliant with no action required, evidence of high-quality services and innovation.
Good	Compliant with no action required.
Requires Minimal Improvement	The impact on service users, visitors and/or staff is low.
Requires Moderate Improvement	The impact on service users, visitors and/or staff is medium. Action required to mitigate.
Inadequate	The impact on service users, visitors and/or staff is high. Action is required quickly.

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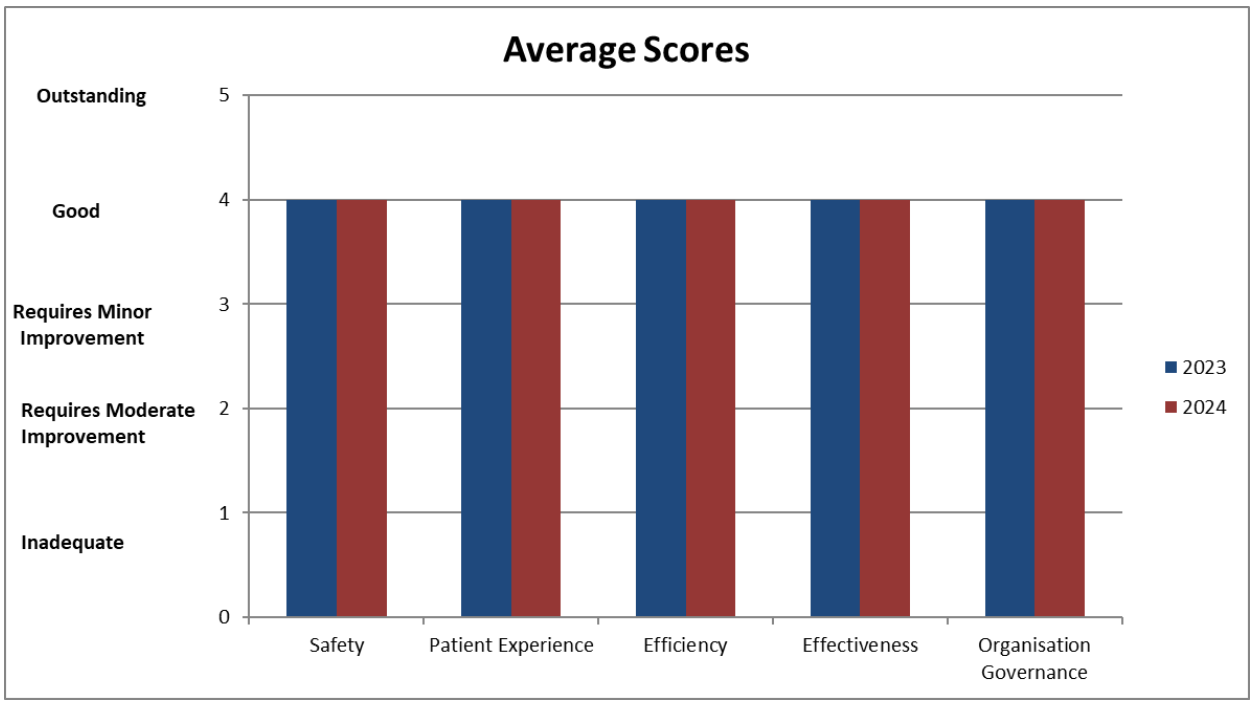
5 APPLICATION OF THE NHS PAM MODEL 2024

This section of the report provides a detailed overview in terms of scores, continued progress and implementation of NHS PAM for 2024.

5.1 Summary of NHS PAM Model 2023 – The Five Domains:



5.1.1 Re-assessment of the PAM model for 2024 confirms maintenance of an overall rating of 'Good' for each of the five domains for the Bradford Teaching Hospitals NHS Foundation Trust.

5.1.2 During the 2024 implementation cycle, improvements were achieved in the Efficiency domain; however, these improvements were not significant enough to increase the overall 'Good' rating to 'Outstanding' on this occasion.

5.1.3 Re-application of the PAM has resulted in action plans being developed for each of the self-assessment questions (SAQs) within each domain where necessary, supporting continual improvement.

5.1.4 Analysis of the DoH England PAM tool has identified several changes to the SAQs for 2024. These have been incorporated into the latest review and the amendments are confirmed as follows:

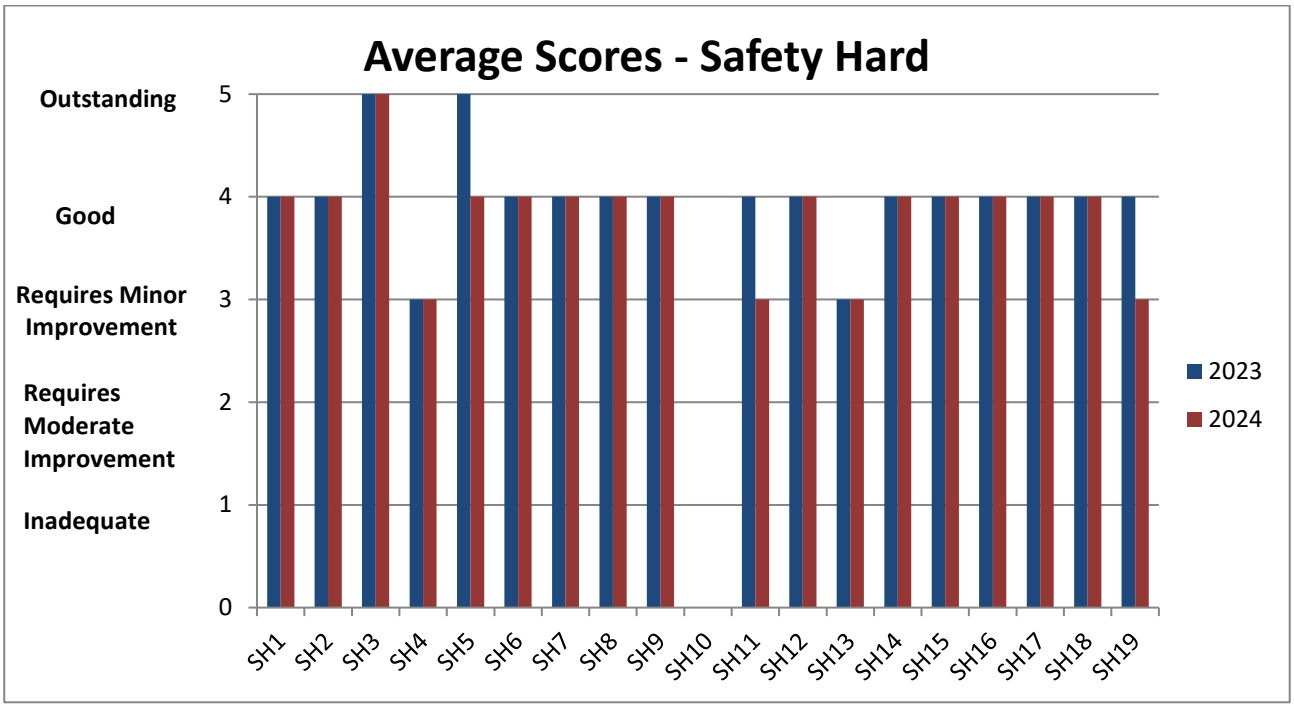
SAQ	Amendment
SH19 – Contractor Management	One additional question included within this SAQ relating to Contract Expiry.

SH20 – Healthcare Safety Investigation Branch	SAQ removed.
SS10 – Telephony & Switchboard	One additional question included within the SAQ relating to Technology replacement plan & Review process.
F3 – Capital Procurement	One additional question included within the SAQ relating to Capital Project Management.
E4 – Sustainability Approach	One additional question included within the SAQ relating to Travel & Transport.

5.2 Safety - Hard Facilities Management

The following provides a summary of the specialist areas and the SAQs that are applied:

SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:	SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:
SH1	Estates and Facilities Operational Management	SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH2	Design, Layout and Use of Premises	SH12	Lifts, Hoists and Conveyance Systems
SH3	Estates and Facilities Document Management	SH13	Pressure Systems
SH4	Health & Safety at Work	SH14	Fire Safety
SH5	Asbestos	SH15	Medical Devices and Equipment
SH6	Medical Gas Systems	SH16	Resilience, Emergency and Business Continuity Planning
SH7	Natural Gas and Specialist Piped Systems	SH17	Reporting and Implementing Estates and Facilities issues within Safety-Related Systems
SH8	Water Systems	SH18	Safety and Suitability of Community Properties
SH9	Electrical Systems	SH19	Contractor Management
SH10	Mechanical Systems e.g. Lifting Equipment. *Please note this SAQ has been addressed and included within SAQ SH12.*		



Safety - Hard Facilities Management maintained an overall score of 'Good' with 'Requires Minimal Improvement' in four key areas:

5.2.1 **(SH4) Health & Safety** – In order to improve the score on this section, more focus is required on key areas of health and safety particularly around contractor management within E&F identified by an external audit, furthermore additional resource is recommended within the E&F Safety/Risk team and in the Capital team (in regard to CDM), currently being outsourced to a consultant.

5.2.2 **(SH11) Asbestos-** Recent RIDDOR relating capital projects team. Principal contractor failed to follow the CAR 2012 reg. 5 after a change in the project. Changes have been made to the capital projects team (change control process not followed) Awaiting Health and Safety report from Mascot to identify improvements in CDM compliance. Asbestos process in development with the AE and Asbestos manager for capital projects in line with the PMQM and RIBA stages.

5.2.3 **(SH13) Pressure Systems** - Improvement plans are in place to ensure Competent Person training, interviews and formal appointments are made in accordance with legislative requirements and best practice.

5.2.4 **(SH19) Contractor Management-** We are currently embedding a SkyVisitor electronic contractor sign in system that stores RAMs, insurances etc. Implementation of this system could improve the score. This would capture Certificates of Asbestos Awareness training from an accredited source (UKATA, ROSPA or IATP) undertaken in the last 12 months.

5.2.5 While the overall scores for the following SAQs were maintained, the following improvement actions have been taken to maintain status:

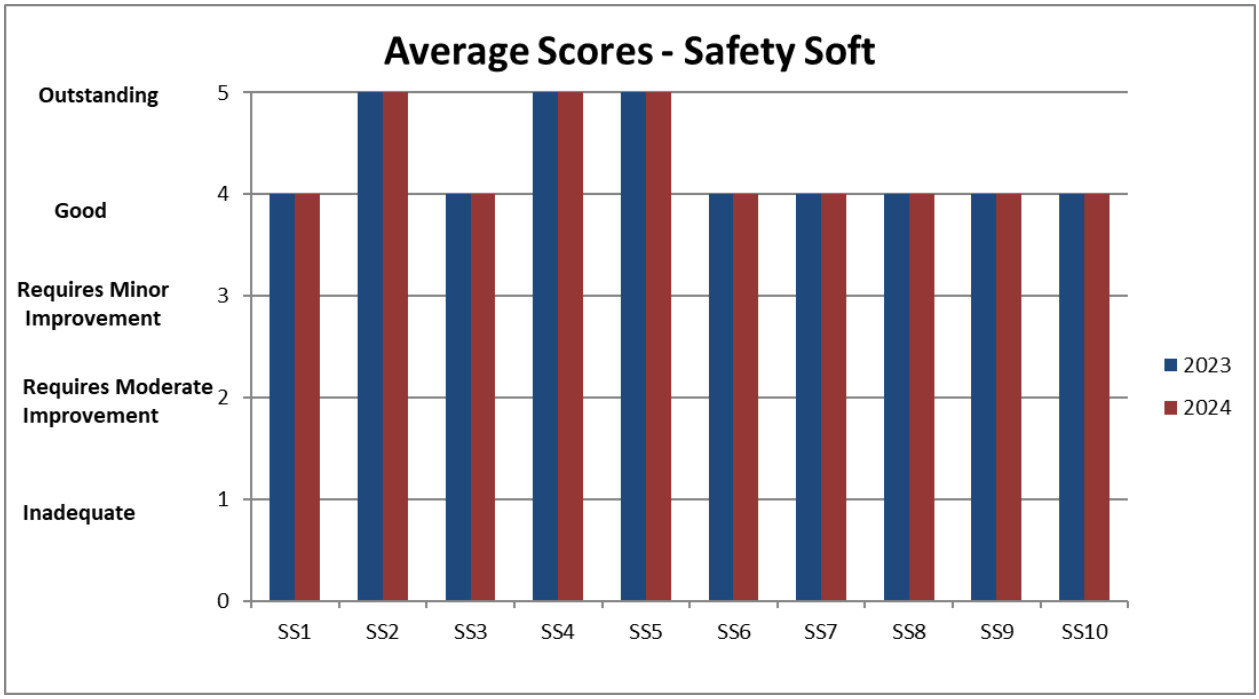
- **(SH14) Fire Safety** – Training & Development compliance has improved by 5% in year, from an Estates perspective we are doing everything we can to ensure training

compliance continues to improve, the Trust as a whole is at 90% compliance against a target of 85% (this is an exceptional compliance rate when considering maternity/paternity, sick leave, staff turnover etc). Face to face fire safety training is now delivered annually to all staff (clinical and non-clinical).

- **(SH15) Medical Devices and Equipment**– RFID - scan for safety has been implemented across BTHFT, this is used to support asset tracking of medical devices.

5.3 Safety - Soft Facilities Management:

SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:
SS1	Catering Services
SS2	Decontamination Processes
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry and Linen Services
SS6	Security Management
SS7	Transport Services
SS8	Pest Control
SS9	Portering Services
SS10	Estates IT and Building Information Management (BIM) Systems



Safety – Soft Facilities Management maintained an overall score of 'Good' with 'Outstanding' for Decontamination Processes (SS2), Cleanliness & Infection Control (SS4) and Laundry & Linen Services (SS5).

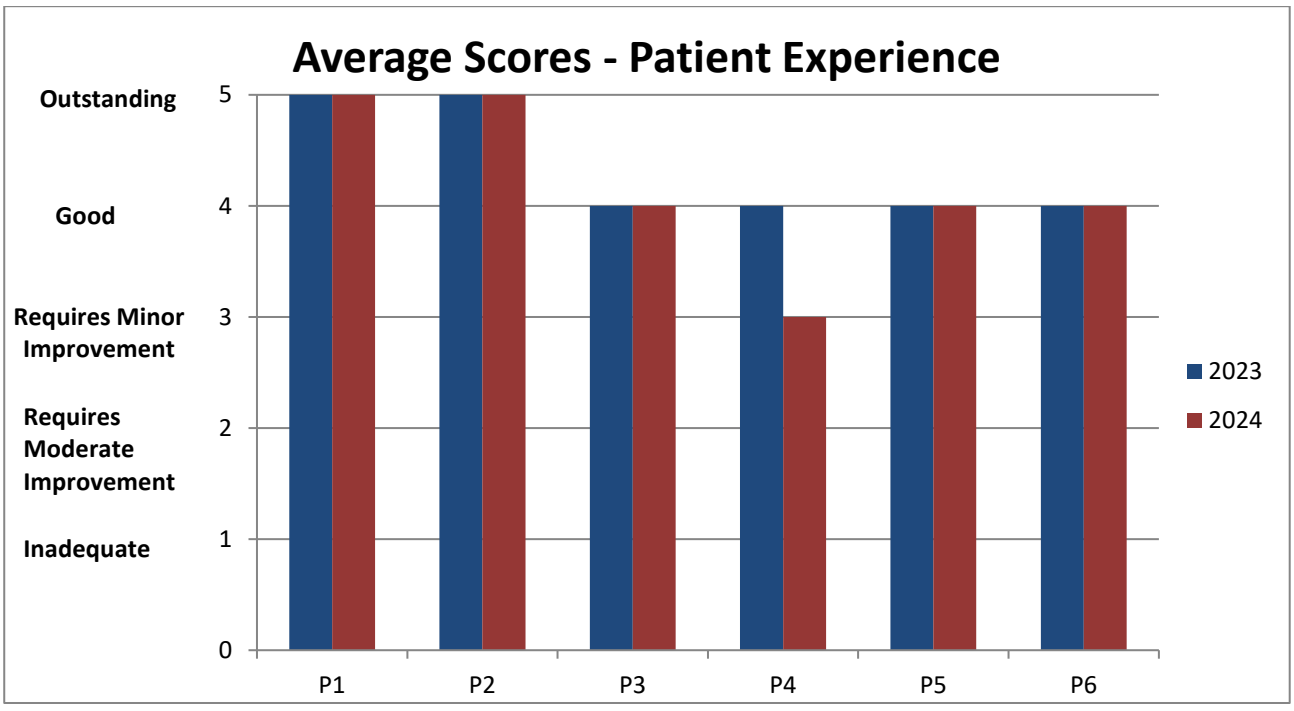
5.3.1 While the overall scores did not improve, the following improvement action has been taken to maintain status:

- **(SS1) Catering Services** - Nutritional Steering group has now developed a workplan, monitoring actions and preparing Board updates in relation to Food Standard No. 1.

- **(SS3) Recycling & Waste** – Steps are being taken to improve waste producer engagement, E&F are attending link practitioner events. Plans are progressing to increase cardboard recycling by the use of new equipment at BRI, furthermore new schemes are in development to increase better clinical waste segregation across infectious and offensive waste.

5.4 Patient Experience

SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:
P1	Engagement & Involvement of Service Users
P2	Patient Staff and Visitor Perception of Condition, Appearance, Maintenance and Privacy & Dignity
P3	Patient Staff and Visitor Perception of Cleanliness
P4	Arrangements to Meet Patient, Staff and Visitor Access and Car Parking Needs
P5	Provision of High Quality Environment in Relation to Grounds & Gardens
P6	Catering Services Provision of Adequate Nutrition and Hydration



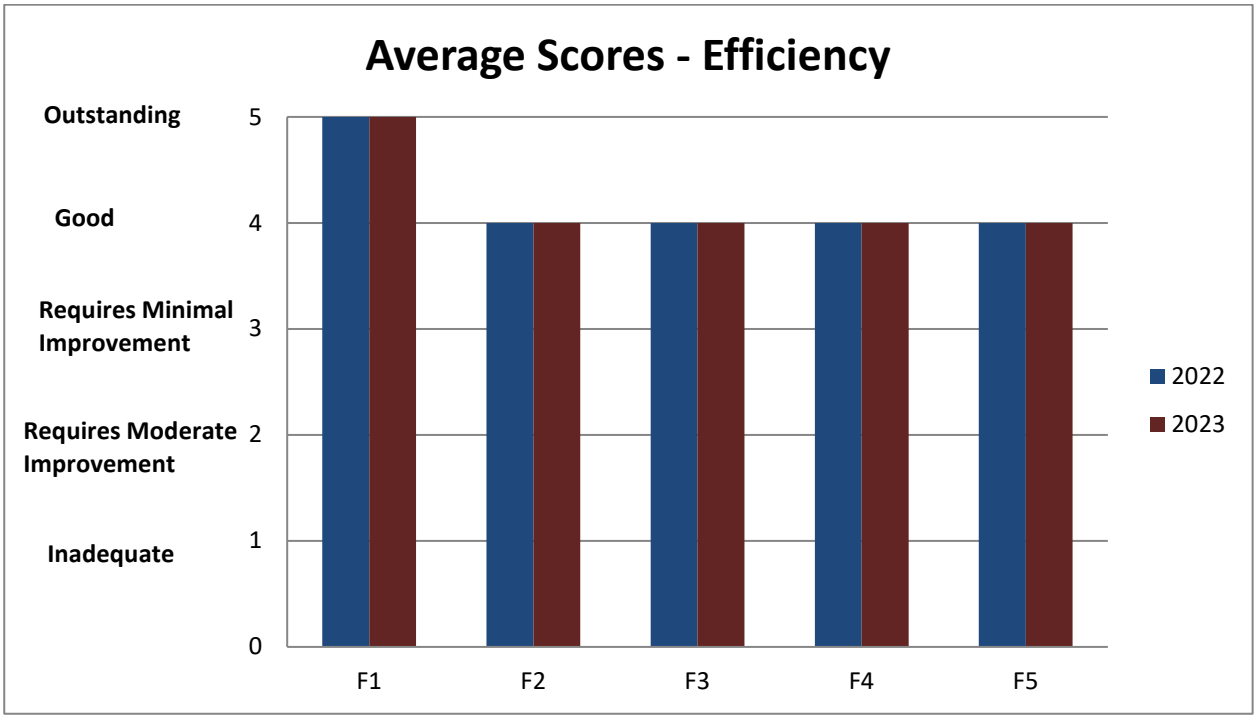
5.4.1 An overall score of 'Good' was maintained throughout the Patient Experience domain with 'Outstanding' maintained for Patient, Staff and Visitors Engagement and Involvement SAQ (P1). Requires minimal improvement is highlighted in one key area:

- **(P4) Car Parking Arrangements** – following staff and patient feedback around lack of parking we are aware that there need for consistent and improved infrastructure. A business case is currently under development. We are planning for implementation and completion by Spring 2025.

5.4.2 It is noted that all scores in relation to PLACE received through the PAM process are awarded based on the systems in place to carry out the PLACE assessments, not the outcome of the PLACE assessments.

5.5 Efficiency

SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:
F1	Management of Estates & Facilities Operations
F2	Efficiency of Estates & Facilities Services
F3	Improved Efficiencies in Capital Procurement, Refurbishment and Land
F4	Financial Controls, Procedures & Reporting
F5	Improvement & Sustainability



5.5.1 Overall the Efficiency domain maintained a score of 'Good' with 'Outstanding' within Performance Management (F1). This was supported with robust evidence such as the Estates & Facilities Directorate Key Performance Indicator (KPI) dashboard, Business Intelligence (BI) budget reports, Estates Return Information Collection (ERIC) and an established risk management structure supporting governance arrangements within the Directorate.

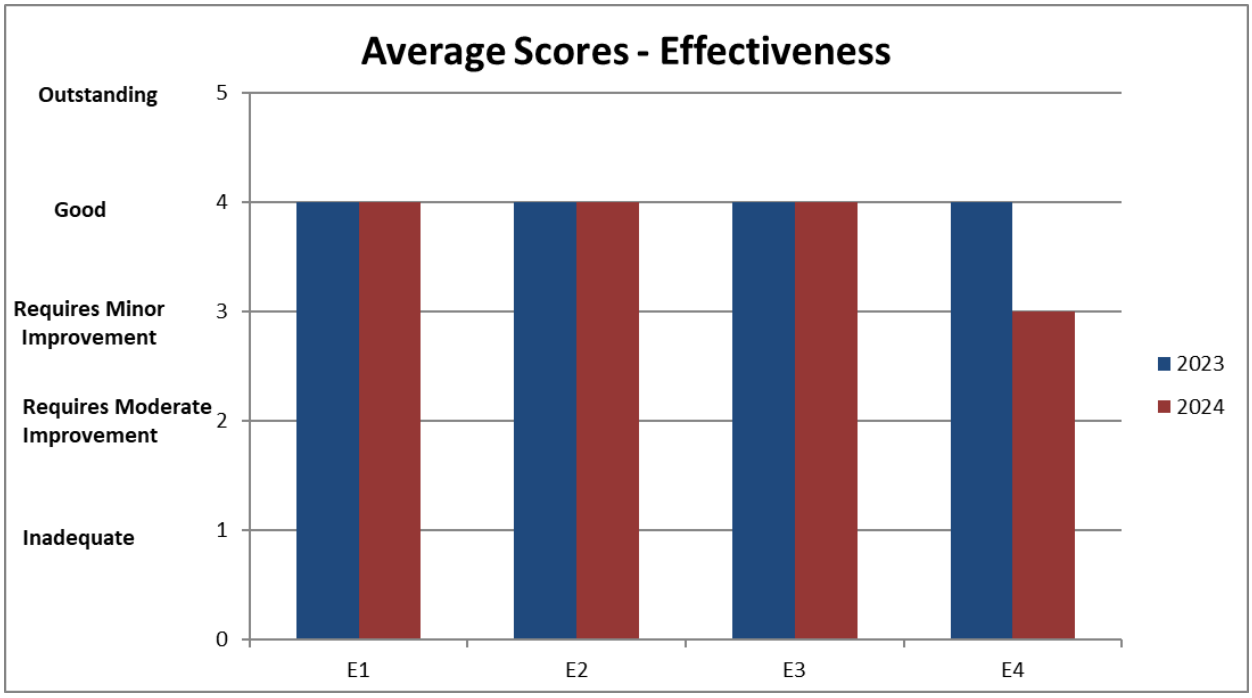
5.5.2 While the overall scores remained the same as 2023, the following improvement action has been taken to maintain status:

- **(F2) Efficiency of Estates & Facilities Services** – Estates strategy 2023-2030 has been developed. There is now an E&F representative at Waste Reduction Meetings and the ERIC & Model Hospital data is reviewed to identify further potential CIP/service improvement opportunities.

5.5.3 Scores within this domain are supported through use of various tools to analyse performance including ERIC, PAM and internal audits. Effective processes are also in place to investigate and implement improvement opportunities through partnership working with West Yorkshire Association of Acute Trusts (WYAAT), National Association of Healthcare Fire Officers (NAHFO), West Yorkshire Combined Authority (WYCA), Health Estates and Facilities Management Association (HEFMA), Institute of Healthcare Engineering and Estate Management (IHEEM), Bradford Metropolitan District Council (BMDC), Association of Healthcare Cleaning Professionals (AHCP), Healthcare Cleaning Association (HCA), National Security Membership Group (NAHS), Crown Commercial Services (CCS), Clinical Engineering Northern Region Medical Device Management Group etc.

5.6 Effectiveness

SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:
E1	A Clear Vision and Credible Strategy to Deliver Good Quality Estates & Facilities Services
E2	A Well Managed Approach to Town Planning
E3	A Well-Managed Robust Approach to Management of Land and Property
E4	Suitable Sustainability Approach



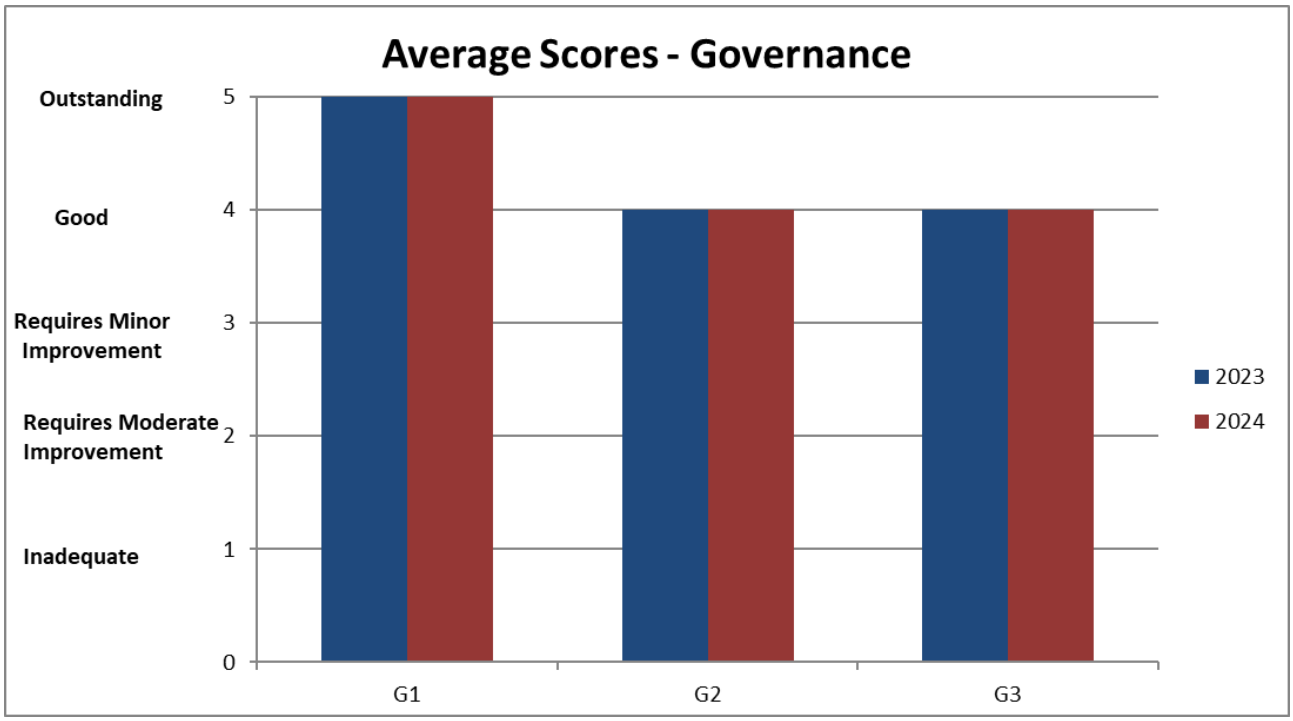
5.6.1 The Effectiveness domain maintained an overall score of 'Good' with 'Requires Minimal Improvement' for Suitable Sustainability Approach (E4).

5.6.2 The following improvement requirement has been identified:

- **(E4) Suitable Sustainability Approach** –Green plan to be updated; HTM01-07 new requirements for infectious waste to be rolled out; budget constraints on capital build projects often means that Net Zero initiatives are difficult to fund and secondary to service delivery. Sustainability within procurement exercises is falling to the Environment & Sustainability Manager to assume responsibility, resource issues mean that this cannot be carried out effectively on all projects.

5.7 Organisational Governance

SAQ Code	Self-Assessment Question – Is the Organisation safe and compliant with well managed systems in relation to:
G1	Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed.
G2	Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services.
G3	The Organisations Board has access to professional advice on all matters relating to Estates and Facilities service.



5.7.1 The Trust has an effective corporate risk management process in place and evidence provided within this section supported maintenance of a 'Good' overall organisational governance rating for 2024.

5.7.2 While the overall scores were maintained, the following acknowledgements were made:

- **(G1) Governance Framework** – The SAQ membership agreed that E&F are supporting a robust governance framework in respect of monitoring, audit and mitigation to the best of their ability.

- **(G3) Professional Advice** – The SAQ membership agreed that E&F are doing their upmost to ensure E&F related professional advice services requirements are identified and that mechanisms are in place to ensure appointment of suitably qualified staff.

6 INVESTMENT SUPPORTING DELIVERY OF ACTION PLANS

As part of the overall PAM application process, estimated costs were also developed by participants, where applicable, to give an understanding of the potential revenue and/or capital investment required to improve future PAM scores and ratings.

6.1 Revenue funding required to improve scores identified during the 2024 application of PAM are as follows:

PAM SAQ Ref.	SPECIALITY	RATIONAL FOR FUNDING	£ (+VAT)
F2	Efficiency of Estates and Facilities Services	Biometric scanning recurring licencing costs.	575.00
P4	Car Parking Arrangements	Business case for additional permanent dedicated car parking security attendants currently being progressed (May 2024). Business case required for appropriately located barriers and suitable one way system. Costs to be determined. Costs to be determined Notional costs are to be developed for BPA Accreditation (costs associated with preferred system).	TBA
P6	Catering Services Nutrition & Hydration	Ongoing costs for electronic ordering system to be identified.	TBA
SH1	E&F Operational Management	Additional funding required to increase admin support in order to roll out SFG20 - 1 wte band 4.	26,282.00
SH4	Health & Safety	Funding provided annually for statutory compliance insufficient, additional £15k per annum required	15,000.00
SH4	Health & Safety	H&S Team required 1 x band 5 to progress proactive management of risk assessments and investigations.	32,934.00
SH4	Health & Safety	Capital team require a dedicated H&S / CDM team member to undertake permit to work, assessment of RAMs etc. - band 7 (included within business case submitted in July 2023).	47,672.00
SH4	Health & Safety	Funding required annually throughout Facilities to backfill to enable staff to attend mandatory and essential training, Thrive event etc.	40,000.00
SH4	Health & Safety	Additional training budget required within Estates for external training to provide enough sessions for all staff to attend whilst maintaining service - schedules to be reviewed to provide an estimated cost	TBA

SH5	Asbestos	Funding is allocated annually through the Statutory Compliance (£60k) budget for Asbestos compliance. This needs to be uplifted to £125k p/a for training, survey & analytical costs, this does not include removal works	65,000.00
SH6	Medical Gas Systems	Funding required for training of porters on an annual basis.	4,000.00
SH8	Water Safety	Inline temperature sensors to provide temperature monitoring is required as part of the legionella control system to monitor water circulation temperatures to each primary distribution pipeline.	100,000.00
SH13	Pressure Systems	Additional costs will be incurred for double valve isolation. To be assessed as the safe working. procedures are developed - £10k per annum	10,000.00
SH13	Pressure Systems	Cost of servicing, maintaining and inspecting existing safety valves on all systems. Additional cost pressure for 2023 onwards.	5,000.00
SH14	Fire Safety	£85k Funding is allocated annually through the statutory compliance to Fire Safety. This has been reduced from £100k in previous years. Requires £100k p/a	15,000.00
SH14	Fire Safety	£20k is now being allocated annually for fire door replacement, this can only prioritise 60 minute and betterment of fire doors (repair not replace). This is not sufficient annual investment. £60k would be a more realistic investment each year	40,000.00
SH15	Medical Devices and Equipment	Maintenance contract manager required in order for Clinical Engineering to manage all maintenance contracts - AFC band 7. This risk has now been escalated to the Director of Operations for Planned Care.	50,056.00
SH15	Medical Devices and Equipment	Paper has been put together detailing medical device replacement programme - revenue investment. This is on the risk register and a business case has been rejected (evidence document SH15.8.1) - revenue investment. Risk as no structure to revenue replacement funds. This has been highlighted at multiple meetings that revenue funding will be limited in 2024/25 which will increase the risk for medical devices	TBA
SH17	Safety Related Systems	IOSH training costs to be identified for all new Estates, Facilities & Clinical Engineering manager and refresher training for Facilities managers who attended in 2019.	TBA
SS1	Catering Services	Training costs, gluten free accreditation costs (4k), Digital menu ordering recurrent costs (20k), Food safety specialist costs (10k).	34,000.00
SS2	Decontamination	When gastro expand will require 2 additional members of staff (band 2) to support extra activity & an additional wash sink (to be costed), none of which are captured in the business case	44,766.00

SS4	Cleanliness & Infection Control	Development of training in line with new National Standards for supervisors and infection clean team is currently in discussion.	45,000.00
SS6	Security Management	£10k has been allocated in 2023/24 through statutory compliance. This is not enough!	TBA
SS7	Transport	Dedicated transport manager required to ensure compliance with both waste & transport, the current arrangements are not sustainable - Band 5 (£34,581)	£34,581.00
SS10	Estates IT and Building Information Management (BIM) systems	Resilient Location - Cost of IT equipment, Licensing, etc.	TBA
		TOTAL	**619,866**

6.2 Capital funding required to improve scores:

PAM SAQ Ref.	SPECIALITY	RATIONAL FOR FUNDING	£ (+VAT)
F2	Efficiency of Estates and Facilities Services	Biometric scanning – purchase of system.	13,000.00
F5	Improvement & Sustainability	£101 million required to address the backlog maintenance of the Estate. This is on the strategic risk register and declared as part of the Estates Return Information Collection (ERIC) 2023/24 submission.	101,000,000.00
P2	Patient Staff & Visitors Perception of Cleanliness	£100k per annum required to fund PLACE improvements.	100,000.00
P6	Catering Services Nutrition & Hydration	Electronic ordering system will require funding and a business case - costs to be identified in the region of £75k to £100k	100,000.00
SH6	Medical Gas Systems	Site wide audit of medical gas system against current HTM requirements, including plant, manifolds, equipment, outlets & AVSU provision etc.	30,000.00
SH6	Medical Gas Systems	Completion of Medical Air Ring Main.	50,000.00
SH8	Water Safety Systems	Cold water tank replacement/relocation hospital street.	41,000.00
SH8	Water Safety Systems	Larger tank in NHW tank room	60,000.00
SH9	Electrical Systems	Unable to quantify the level of cost for replacement of electrical infrastructure due to backlog maintenance and poor quality of critical	TBA

		infrastructure however significant capital investment would be required to achieve compliance	
SH11	Ventilation Systems	10 year Capital Programme Replacement programme to replace all ventilation systems.	14,000,000.00
SH12	Lift Hoist & Conveyance Systems	New lift and shaft providing access to all levels including roof that is suitable for bariatric patients is required at the front of the hospital.	480,000.00
SH12	Lift Hoist & Conveyance Systems	New lift providing access to level 4 that is suitable for bariatric patients is required at Duke of York.	350,000.00
SS1	Catering Services	Additional Freezer (approx. £650k) and 3x additional I-Wave (£7k per unit), hot vending machine (£15k), implementation of digital menu ordering (£100k).	786,000.00
SS2	Decontamination	Capital Replacement - automatic washing machines are on a rolling replacement programme. Requesting funding for at least 2 at BRI as a priority in 2023/24 to mitigate risk of failure.	140,000.00
SS3	Recycling & Waste	Electrification of waste fleet requires funding to ensure compliance with Net Zero targets (2027), business case may need to be produced, cost has not yet been identified	TBA
SS6	Security Management	Additional funding will be required to improve external CCTV coverage at BRI. Costs to be determined	TBA
SS9	Portering Services	Handheld device replacement required before the end of 2024. Will need to be in line with IT update. Business case may be required and will be escalated to the risk register. Funding required - SC will send quote	TBA
SS10	Estates IT and Building Information Management (BIM) systems	A backup switchboard location is required to enable 'true' business continuity. Cost of resilient location - IT equipment, Licensing, etc. to be determined.	TBA
		TOTAL	**117,150,000**

7 CONCLUSION

7.1 Implementation of the 2024 NHS PAM provides an overall classification of 'Good' assurance regarding management of estates and facilities services for Bradford Teaching Hospitals NHS Foundation Trust.

7.2 Where gaps have been identified as part of the process, action plans have been developed to ensure that improvement opportunities are managed to achieve continuous improvement.

BO.9.24.19 - ANNUAL SECURITY REPORT (INC. VIOLENCE PREVENTION AND REDUCTION STANDARD)

REFERENCES

Only PDFs are attached

Bo.9.24.19 - Annual Security Board Report 23 24.pdf

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ANNUAL SECURITY BOARD REPORT
1 APRIL 2023 – 31 MARCH 2024

Presented by	David Moss, Director of Estates and Facilities	
Authors	Thomas Brown – Head of Security William Hall – Violence Prevention & Reduction Lead / Local Security Management Specialist Karon Snape – Head of Facilities	
Lead Director	David Moss, Director of Estates and Facilities	
Purpose of the paper	The report sets out the Trust's progress in the management of security and demonstrates the work undertaken to address current crime trends at Bradford Royal Infirmary and St Luke's Hospital sites during 2023/2024.	
Key control	Health & Safety Benchmarking	
Action required	For assurance	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Academy/Group**	**Date**
	Estates & Facilities Compliance Risk Assurance Group	14/08/24
	Health and Safety Committee	07/08/24

Key Options, Issues and Risks

This report is presented to the Executive Management Team for noting and provides assurance in relation to the management of security within the Trust during 2023/2024.

The Security Service operates 24/7 across BRI & SLH hospitals with an operational team of 17 officers rotating with 4x on shift at BRI in a 12-hour period, and 1x officer on duty per 12 hours at SLH. Previous Security papers presented highlighted service provision risks and concerns with regard to workforce, increase in demand and the requirements of staff and clinical colleagues resulting in an extreme risk being placed on the Estates & Facilities risk register.

A review of the in-house security service provided within Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), included the development of an options appraisal of the future security model required to provide continued assurance that BTHFT has appropriate security management arrangements in place to protect staff, patients and visitors and to ensure that NHS property and assets are kept safe and secure. The review identified two clear phases of work:

Phase 1 – **Mitigation of Immediate Extreme risk**

The Executive Team approved phase 1 which resulted in funded 24/7 supervision, which will become fully operational within the 24/25 period. In addition, the appointment of a Head of Security has provided oversight of the Security Service provision across the Trust.

Whilst phase 1 supported the mitigation of risk, phase 2 is an opportunity to develop the service to progress towards a more proactive and preventative approach to violence and aggression based on training, education and collaborative work across all disciplines and is aligned to the Violence Prevention and Reduction Standard (VPR). The service is currently reviewing phase two of the proposal which will be discussed further within the VPR Sub-Committee meeting which contains key stakeholders within the Trust, this phase also considers the requirement of dedicated resources in

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'hot spot' areas such as AED, as well as dedicated carparking officers to reduce vehicle crime and increase revenue streams.

There has been a continued approach to under reporting of violence and aggression and the reluctance of staff to provide statements to the police to support prosecutions. In addition, supporting clinicians with clinically related challenging behaviour in relation to physical assaults, absconding from wards and verbal violence and aggression remains a priority focus. This is evidenced from the incidents that security attend compared to the IRIS reports submitted by the clinical areas or the police response logs. There are workstreams to support underreporting areas and build confidence in the process within the Trust and externally to support colleagues and victims of crime.

The Trust has been targeted for Car crime in the reporting period, specifically integrated satellite navigation systems and figures can be seen in section 2.1. It has also been targeted for motorbike and cycle crime in the reporting period; with 2 cycles stolen and 1 motorbike.

The Security Steering Group was stood down during the pandemic and temporarily superseded by the VPR Sub-Committee which will manage and deliver the organisations obligations in relation to violence prevention and reduction and security management. During 2024/25 the Security Steering Group will recommence to support the overall security direction and support operational management of security related issues within a clinical setting around the Trust Site.

Reported violence and aggression (threatening behaviour/verbal abuse) figures for the reporting period 1 April 2023 and 31 March 2024 have significantly increased (+214) compared with previous years. This may be more reflective of the actual number of incidents staff, patients and others are faced with. The increase in IRIS reporting may in part be due to the dedicated engagement work undertaken by the Security Services to encourage reporting of incidents. Work has been undertaken within the key areas of concern following incidents highlighted, these include AED, ICU, Ward 4, Ward 17, Ward 27, Ward 28, ward 18 and Wards 30/32.

Analysis

The report provides details on the work that has been undertaken during 2023/2024 to proactively manage security within the Trust through the following key work stream areas:

- Risk Assessments
- Management of violence and aggression, including physical assault (VPR)
- Theft/Criminal Damage
- Anti-Crime work undertaken
- Anti-social behaviour reduction working in partnership with WYP.
- Working in partnership with the homeless team to reduce the number of homeless within ED for refuge.
- Proactive engagement with clinical areas

Recommendation

The Executive Management Team is asked to note and accept the content of the report, specifically:

- The number of reported incidents remaining a concern specifically in relation to clinically related challenging behaviour, physical assault and violence and aggression, as well as significant under reporting across the Trust and the lack of staff wishing to provide statements to the police to ensure that appropriate sanctions are gained where appropriate.
- A continued need to focus on engaging staff to improve reporting, intervening and de-escalating behaviours at the earliest opportunity to reduce the incidence of violence and aggression and to reduce opportunities for criminality such as theft of personal property and Trust assets to occur.

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- Review of the Phase 2 opportunity to develop the future security model to progress towards a more proactive and preventative approach to violence and aggression based on training, education and collaborative work across all disciplines and is aligned to the Violence Prevention and reduction Standard (VPR)to provide continued assurance that BTHFT has appropriate security management arrangements in place to protect staff, patients, and visitors and to ensure that NHS property and assets are kept safe and secure in the future.
- Ongoing concerns in the increase of violence and aggression within our Emergency Department and the required dedicated security resource to support reducing violence within AED, injuries to staff and wider impact on the service to patients.
- Ongoing concerns from staff due to an increasing number of thefts from our carparks and the crime taking place in the surrounding areas and the requirement for dedicated resource within the car parks focused on increasing revenue, detecting, and deterring crime ensuring property remains safe on site.
- The Head of Service - Security and, LSMS/VPR lead will continue to work on the VPR standards and report on progress on this work will be monitored through both the Health and Safety Committee and the People Academy and reported through the 2023/24 Annual Security Board report.

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)						

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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

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?	☒	☐	☒

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 SECURITY BOARD REPORT
1 APRIL 2023 – 31 MARCH 2024

1 PURPOSE/ AIM

The report sets out the Trust's progress in the management of security and demonstrates the work undertaken to address current crime trends at Bradford Royal Infirmary and St Luke's Hospital sites during 2023/2024.

2 PROPOSAL

The report provides assurance to the Executive Team about the effective management of security at BTHFT.

The report also provides details on the work that has been undertaken in year to reactively manage security through the following key work stream areas:

- Risk Assessments
- Management of violence and aggression, including physical assault
- Theft/Criminal Damage
- Anti-Crime work undertaken.

3 BENCHMARKING IMPLICATIONS

The newly published Violence Prevention and Reduction (VPR) standard has been developed in partnership with the social partnership forum. It was endorsed by the social partnership forum on 15 December 2020 and is incorporated into the 2024/25 NHS Standard Contract.

The standard delivers a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence.

The VPR Benchmark update can be seen in section 4.10

Progress on this work is monitored through both the Health and Safety Committee and the People Academy and reported through the 2024/25 Annual Security Board report.

4 RISK ASSESSMENT

During the reporting period 19 security related risk assessments were undertaken by the Security Management Team. These are monitored through the VPR Sub Committee currently whilst the Trust Security Steering Group is on hold.

Date	Assessment	Outcomes/Themes
19/06/2023	Violence & Aggression Assessment (AED)	These assessments relate to the highest reporting areas of violence and aggression highlighted in the 2022/23 period. The assessments identified the need for clinical teams to ensure early

		intervention at the first sign of challenging behaviour. Conflict Resolution Training requires putting in to practice more frequently to ensure low level behaviour is managed without escalation.
20/06/2023	Violence & Aggression Assessment (Ward 28)	Increased Security Officer and PCSO visibility in place.
20/06/2023	Violence & Aggression Assessment (Ward 27)	
22/06/2023	Violence & Aggression Assessment (Ward 4)	
22/06/2023	Violence & Aggression Assessment (Ward 31)	
13/06/2023	Horton Park Avenue (SLH) car park security assessment.	Review of security requirements for the proposed new use of Horton Park Avenue car park to support the new Day case unit build, recommendations made in relation to lighting, CCTV, security patrols and locking/unlocking times.
20/06/2023	Horton Wing Security review and risk assessment after burglary on F3, classed as an SI, IG breach.	Review of security arrangements for the upper level of Horton Wing, specifically F1 to F4 which are often not staffed out of hours. Several recommendations made in relation to CCTV on the corridor, intruder alarms, upgraded security locks, strobe/siren for area linking fire escape doors, emergency door release unts to be upgraded to the new alarming type.
26/06/2023	Security review for the Royal Visit planned for 6th July 2023.	Walk through with Royal protection team (RPT), agreed proposed route, including emergency exit and safe room, marked up plans forwarded on to the RPT and additional recces conducted in advance of the visit and on the morning of the visit.
25/07/2023	Human Tissue Authority (HTA) audit review and risk assessment support.	Review of security requirements for the mortuary to ensure compliance with the HTA recommendations, upgraded and additional CCTV, access control and intruder alarm implemented as a result of the review.

12/09/2023	Proposed endoscopy new build security needs assessment review.	Review of security requirements for the proposed new endoscopy design, access control, intruder alarm, CCTV and fire escape alarm monitoring etc.
01/11/2023	Smith Lane and Maternity car park security review in collaboration with West Yorkshire Police crime reduction officer. **(Report for review in appendix 3)**	Review of Smith Lane and Maternity car parks, recommendations in relation to replacing old crime prevention signage with new, dedicated car park staff if possible, painting the CCTV poles so they are distinguishable. Agreed levels of crime are low considering how many cars utilise the car parks on a daily basis Monday to Friday.
07/11/2023	SLH DCU security review.	Walk through of the unit reviewing the proposed security recommendations.
07/12/2023	Park Mark safer car parks assessment in collaboration with the British parking association and West Yorkshire Police.	Review of crime statistics for the previous 12 months, walk through of the car parks assessing CCTV, lighting, accessibility, cleanliness and upkeep, signage and lining, added the Maternity car park as an addition to the assessment for this year and subsequent years, all 7 car parks, 5 at BRI and 2 at SLH passed the assessment and received individual 12 month certificates.
18/01/2024	SLH E block, new clinical engineering store security assessment.	Review of security requirements for the proposed new clinical engineering store, access control, intruder alarm, CCTV and fire escape alarm monitoring etc.
23/01/2024	BIHR, proposed mobile research vehicle security assessment.	Review of security requirements for the proposed new research vehicle, vehicle security, designated parking compound and electric charging security, CCTV.
29/02/2024	SLH MRI department security review.	Review of security requirements for the MRI and mobile unit, access control, intruder alarm, CCTV and fire escape alarm monitoring and staff safety etc.
08/03/2024	GPOOH security review.	Review of security requirements for the proposed GPOOH service within OPD West, intercom and access control, CCTV

		and fire escape alarm monitoring and dedicated security resource costing provided for approval by GPOOH.

Baby, infant and child abduction testing table 2023-24		
Date	**Assessment**	**Outcomes/Themes**
28/02/2024	Women's and Newborn Unit baby abduction system test	Full system test as a result of upgraded access control throughout the unit. • Door locking mechanism operations were checked during all aspects of the test, i.e. abduction activation, break glass activation and fire alarm activation. • All staff had managed the drill with confidence and competence, particularly staff on M4 who challenged and stopped the abductor. **Learning points which have been reviewed and completed:** • Door access to be checked as no door should be able to be opened by unauthorised person. • Review of action cards including does earlier support to affected area need adding to an action card. Full security number 01274 272130 and emergency security number 01274 274837- not for sharing as this is a priority line. • Confirmation over the main maternity doors and admin corridor doors functionality and safety.

		• Review, update and circulate abduction policy especially with USS. • Check that the alarm sounds at the end of the WHU (new building). • Share case review learning with staff via lessons. • The keypad for the abduction alarm to indicate where the abduction alarm has been sounded. • Simulation of an abduction drill out of hours to compare response and that process is followed.
17/07/2023	Children's and Young Persons wards infant/child abduction test	• Ward staff had managed the drill with confidence and competence. • All staff responded quickly to the alarm and guarded the entrances to all exits within their departments • The sister on the ward was responsive, delegated tasks and provided clear instruction • Switchboard were proactive in following their actions and logging of contemporaneous notes • Relevant personnel were informed and the correct procedures within the abduction policy were followed

		• Security staff arrived 9 minutes after the activation • Door locking mechanism operations were checked during all aspects of the test, i.e. abduction activation, break glass activation and fire alarm activation. • PCSO raised the abduction directly with WYP and as a result resource was police deployed. **Learning points which have been reviewed and completed:** • Ward to ensure that all staff receives abduction training as part of their induction programme and are given access rights for lockdown where required. • Abduction plan and action cards to be reviewed to ensure any learning from the exercise is incorporated and documents signed off via existing governance arrangements. • Ensure that all security staff including agency staff and PCSO's fully familiarise themselves with the locations of wards and departments throughout the hospital and issue them with individual A4 site plans which can be obtained from the intranet. • Ensure that security control staff follow all actions on the action card including passing on the description of abductor to the responding officers and informing the Security Management Team of the live incident.

		• Ensure that security staff accurately record information on the handover log and calls for service database. • West Yorkshire Police must be informed in advance of any planned tests.

5 RECOMMENDATIONS

The Executive Management Team is asked to note and accept the content of the report and recommendations mentioned above.

6 Appendices

Appendix 1: Emergency Department Observations Report 2024
Appendix 2: West Yorkshire Police Community Support Report
Appendix 3: West Yorkshire Police crime reduction officer car park review for Smith Lane and Maternity car parks

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Annual Security Board Report 1 April 2023 – 31 March 2024

1 Management of Violence and Aggression including Physical Assault on Staff

1.1 A key measure to protect NHS staff and those who deliver NHS services from violence is Conflict Resolution Training (CRT) which is mandatory for all frontline staff. CRT provides staff with important de-escalation, communication, and calming skills to help them prevent and manage escalating situations.

1.2 The Education and Training department continue to deliver Conflict Resolution Training (CRT) face to face in line with national guidelines (refresher training is provided 3 yearly via eLearning). The Education Department report that:

- Number of staff who are compliant - number as well as percentage 95.59% (4561/4360)
- Number of staff not compliant – never done training 201

The figures for the number of staff requiring to complete this training are significantly higher as the requirement was added on for all Junior doctors as it had not been done previously.

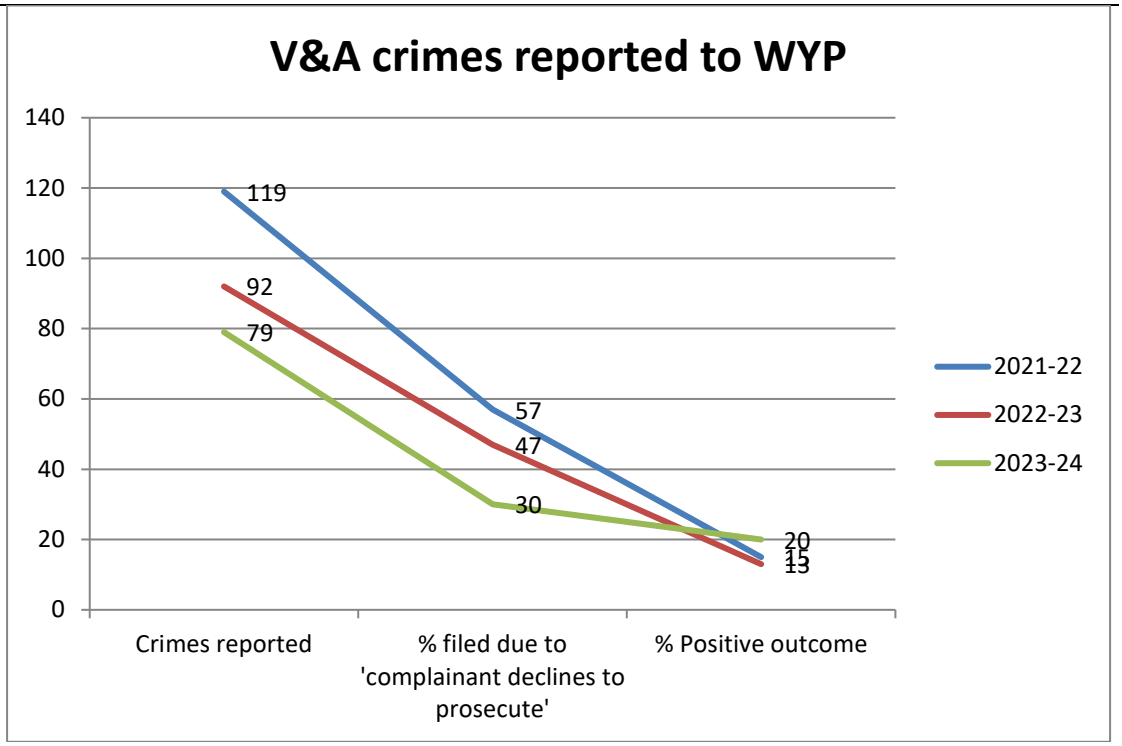
The Education team will be working on developing the training plan as part of the VPR Sub Committee with a training needs analysis taking place across all areas of the Trust.

All scheduled full CRT sessions scheduled were delivered at Trust Induction.

All refresher training is delivered via an eLearning package.

1.3 A continuing trend of staff being reluctant to report incidents on the Trust IRIS Incident Reporting System as well as a reluctance to provide victim statements to the Police after an incident remains a significant concern. Therefore, a significant number of cases that would have resulted in prosecution have to be filed by the Police as 'complainant declines to prosecute' and often the aggressor will re-attend BTHFT and reoffend and thus our incidents of violence and aggression are unlikely to reduce unless we are able to address this apathy.

1.4 This is demonstrated in the 79 crimes reported to the police between April 2023 and March 2024, where 30% of those reports were filed 'complainant declines to prosecute', as a result only 20% of crimes resulted in a positive outcome, i.e. the suspect being charged, given a caution or community resolution. This is despite the suspect's identity being known in almost all cases. See data chart below for last year's comparative figures.



1.5 With such low reporting confidence, it is likely that a significant number of violence and aggression related offences are going completely unreported to the Police and the Trust and therefore the annual statistics do not provide a realistic view of the levels of risk in relation to violence and aggression and physical assault.

1.6 The table below details the number of IRIS reported physical assaults on NHS staff by patients, visitors and public during the reporting period 1 April 2023 and 31 March 2024 compared with the previous 7 years. Whilst there is a slight increase in the number of reported assaults within the reporting period, it is likely this is a reflection of the focused work being conducted by the security management team in areas being identified following incidents and the education programme in place on best practice.

Year	Total assaults	Involving medical factors	Not involving medical factors	Criminal sanctions	Civil and administrative sanctions
2017/18	132	**121**	11	3	3
2018/19	139	**139**	0	0	2
2019/20	168	**160**	8	8	2
2020/21	174	**155**	19	14	1
2021/22	151	**132**	19	4	10
2022/23	149	**138**	11	7	20
2023/24	169	**156**	13	8	15

1.7 The number of assaults 'involving medical factors' i.e. clinically related (where the perpetrator did not know what they were doing, or did not know what they were doing was wrong due to medical illness, mental ill health, severe learning disability or treatment administered) remains a significant factor in this year's reporting on physical assaults.

1.8 Of the 13 physical assaults that were not clinically related, therefore categorised as 'intentional' the perpetrators received a mixture of adult cautions, community resolutions, prison sentences, community service, fines, and court costs as well as compensation to the victims.

1.9 The table below shows the IRIS reported violence and aggression (threatening behaviour/verbal abuse) figures for the reporting period 1 April 2023 and 31 March 2024 compared with previous years. The numbers reported have significantly increased (214) in year and this may be more reflective of the actual number of incidents staff, patients and others are faced with. The increase in IRIS reporting may in part be due to the dedicated engagement work undertaken by the Security Services to encourage reporting of incidents. Work has been undertaken in areas following incidents highlighted these include AED, ICU, Ward 4, Ward 17, Ward 27, Ward 28, and Wards 30/32.

V&A	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Total	456	341	304	298	273	280	494

1.10 The table below highlights the 5 highest reporting areas for violence and aggression during the reporting period:

Area 2023/24	Physical Assault	Threatening Behaviour	Verbal Abuse	Total
Emergency Department	36	52	141	**229**
Ward 27	25	12	14	**51**
Ward 17	14	6	1	**21**
Ward 28	12	6	0	**18**
AMU 4	10	6	3	**19**
Total	**97**	**82**	**159**	**338**

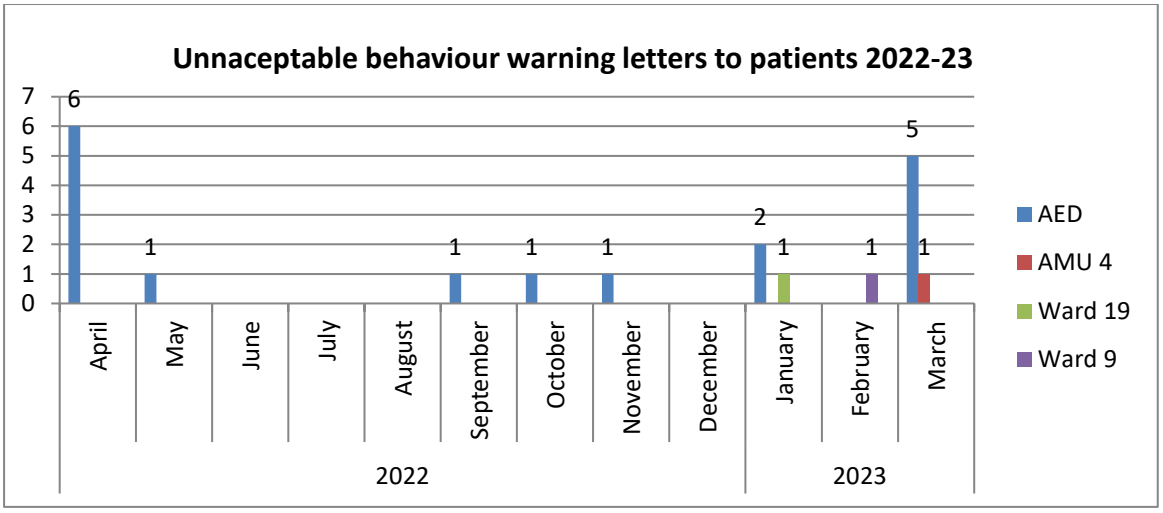
1.11 The statistics highlighted identify some important areas to target and suggests significant under reporting. The Security Management team will continue to support these areas to ensure incidents are appropriately reported, dealt with accordingly and training needs identified.

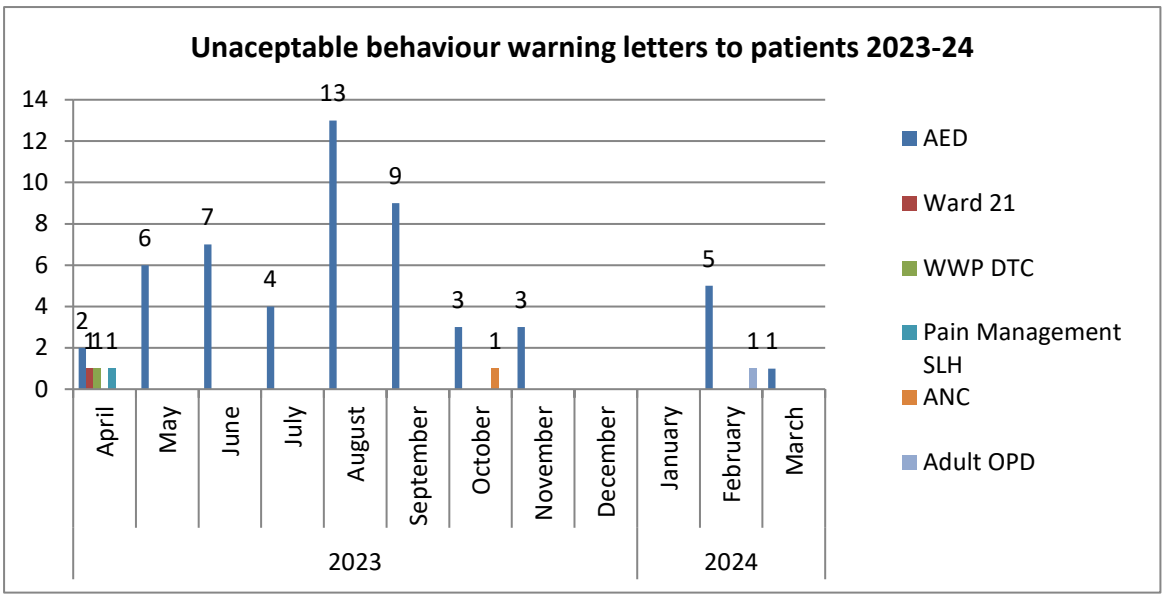
1.12 The Security Management Team are working with the AED Leadership Team to ensure that 'warning' letters are issued to patients attending and being verbally abusive to staff to reduce the numbers of verbal abuse, threatening behaviour, and physical assaults, as a result of this several unacceptable behaviour warning letters have been issued to patients.

Work with the AED leadership team has been undertaken within the 2023/24 year with observation within ED taking place of patient and clinical interactions, a proactive review of incidents taking place and the information flow of incident reporting and follow ups.

This included additional patrols within AED by the Security team and on site PCSO that saw a reduction in incidents and calls during their presence at peak times. It also identified the need for a floor walker from the medical team to be able to monitor patients within the reception and waiting areas.

There has been a dedicated action plan put in place to support the AED team with Security advice and recommendations with some outstanding into the 24/25 year. The Security Management Team recommended and supported the purchasing of Body-Worn CCTV to support reducing violence and aggression. Further training on mental / emotional wellbeing, conflict and breakaway training, adjustments to CCTV cameras in and around AED to improve coverage and support prosecutions of incidents. Full report can be seen in **Appendix 1**.





1.13 The security management team continue to support AED by completing Anti-Social behaviour Diaries which help staff record the relevant information for both frequent and regular attenders who abuse the services and where appropriate the Trust considers withdrawal of treatment and/or banning, Criminal Behaviour Orders (CBO) imposed by both the hospital and West Yorkshire Police (WYP). There are a number of patients that currently have WYP anti-social behaviour interventions, either yellow warning letters or final (red) warning letters, one of these patients who was a frequent attender when not in custody has received a five year CBO which expires on 30/01/2029 with the following conditions:

- Not to enter or remain within the grounds and premises, including car parks, of the Bradford Teaching Hospital NHS Trust, when refused entry or asked to leave by any member of staff.

1.14 The challenges highlighted in the data trends highlight the importance of:

- Understanding the reasons why staff are reluctant to report and provide statements in relation to violence and aggression. Ongoing work is being undertaken with relevant areas when this has been highlighted to educate staff or review further with the police on support available. Some under reporting is due to staff being a victim of domestic abuse, same community groups and lack of trust in any action being taken.
- Working with Education to review the training requirements for staff caring for patients displaying clinically related challenging behaviour often leading to physical assault.
- The continued engagement of clinical teams to improve the prevention and management of violence and aggression

1.15 The new Violence Prevention and Reduction Standard will be an important factor in the future management, prevention and reduction of violence and aggression across the Trust.

2. Car Crime / Theft

2.1 During the reporting period the Trust car parks have seen a decrease in the level of reported car crime to the previous year, outlined in the table below.

Year	Theft of vehicle	Media system Sat-Nav	Catalytic converter	Number plate	Tools	Wing mirror	Total
2021/22	0	9	7	1	1	0	18
2022/23	4	15	2	4	0	1	26
2023/24	1	12	0	0	0	0	13

(Information provided by WYP)

2.2 Whilst the Trust and WYP would like to eliminate car crime of this nature, it is worth pointing out that car crime within the Trust car parks is exceptionally low, considering the number of site users and geographical span of the car parks and reflects the continued improvement from the past when figures were significantly higher.

2.3 Low level car crime is attributed to a number of initiatives which have been undertaken in partnership with West Yorkshire Police to combat these types of car crime, such as:

- Assessment of the car parks security measures in collaboration with West Yorkshire Police crime reduction officer
- Hi-visibility police patrols (PCSO's) and additional hi- visibility security patrols to act as a deterrent
- Additional security staff in March to deter the national target of satellite navigation systems and catalytic converters.
- Adhoc police patrols through the car parks in marked vehicles to act as a deterrent.
- Assessment completed identifying the needs of dedicated carparking officers to reduce crime and increase revenue of carparks from ticketing.

2.4 In December 2023 the Trust retained the Park Mark Safer Car Parking Award for 'C' Block and Horton Wing Pay and Display Car Parks at SLH and BRI main entrance, accessible entrance, Smith Lane, and Maternity Car Parks. This scheme is managed by the British Parking Association with the aim of the scheme to:

- Reduce crime and the fear of crime within parking facilities
- Provide guidance on how to establish and maintain a safe and secure environment through the introduction of proven management processes, physical measures and site security systems.
- Raise awareness to those who use the car parking facilities that the operator has considered and where appropriate taken action to reduce crime within the parking facility that they have chosen to use

Cycle and motorbike theft

2.5 During the reporting period the Trust cycle storage areas have seen an increase in the level of reported thefts of both cycles and motorbikes, 1 theft of cycle at SLH and 1 cycle and 3 motorbike thefts from BRI.

Year	Cycle	Cycle tyre	Motorbike	Total
2021/22	0	0	1	1
2022/23	2	1	3	6
2023/24	2	0	1	3

2.6 Unfortunately, the perception of crime is always worse than the experienced level and based on this perception global communications have been sent out throughout the year providing advice to reduce car crime and provide staff reassurance.

2.7 The Security Management team are working closely with WYP to continue deterring and investigating whenever there is a spike in vehicle, motorbike and cycle crime offending at the BRI within the reporting period, this is a wider issue across West Yorkshire, and we remain low compared to the local community.

2.8 The PCSO team continue to monitor reported vehicle, motorbike, and cycle crime on the Hospital site daily and work in partnership with the security team to provide a visible deterrence across the site.

2.9 The Police are of the opinion that persons who commit such crimes are (in the vast majority of cases) drug motivated offenders. Any crime spikes are likely because of one (or two at most) local offenders having been released from prison/moved onto this patch'/relapsed on drugs. Currently there are no outstanding suspects linked to the recent reports at the hospital.

2.10 The Trust continues to create opportunities for theft to occur by leaving windows open, doors wedged open, allowing tailgating, and leaving assets insecure and in view, allowing opportunist thieves to enter staff/authorised areas and remove personal property and Trust assets. Security continue to engage accordingly with the areas who are seen to be allowing these behaviours to continue and we also look to carry out further engagement and education on best practice in the coming year with Senior Supervisors, engagement stalls and communication plan.

2.11 Theft of patient property features regularly, and staff are reminded to encourage patients to leave valuables at home or request for family to take home for safe keeping. The Security Management team continue to work with those areas where crime reporting is higher. The Police Community Support Officers patrol all areas in an attempt to deter criminal activity and highlight to the clinical teams the opportunities they present to thieves. We have also trialled some secure property bags on higher reporting areas which has seen a reduction in crime from this introduction.

2.12 Safe and secure storage at ward level remains an issue as the Trust actively encourages patients to bring in electronic items such as phones and laptops by providing free Wi-Fi, however, the patient has nowhere to safely secure these items as they leave the ward for tests.

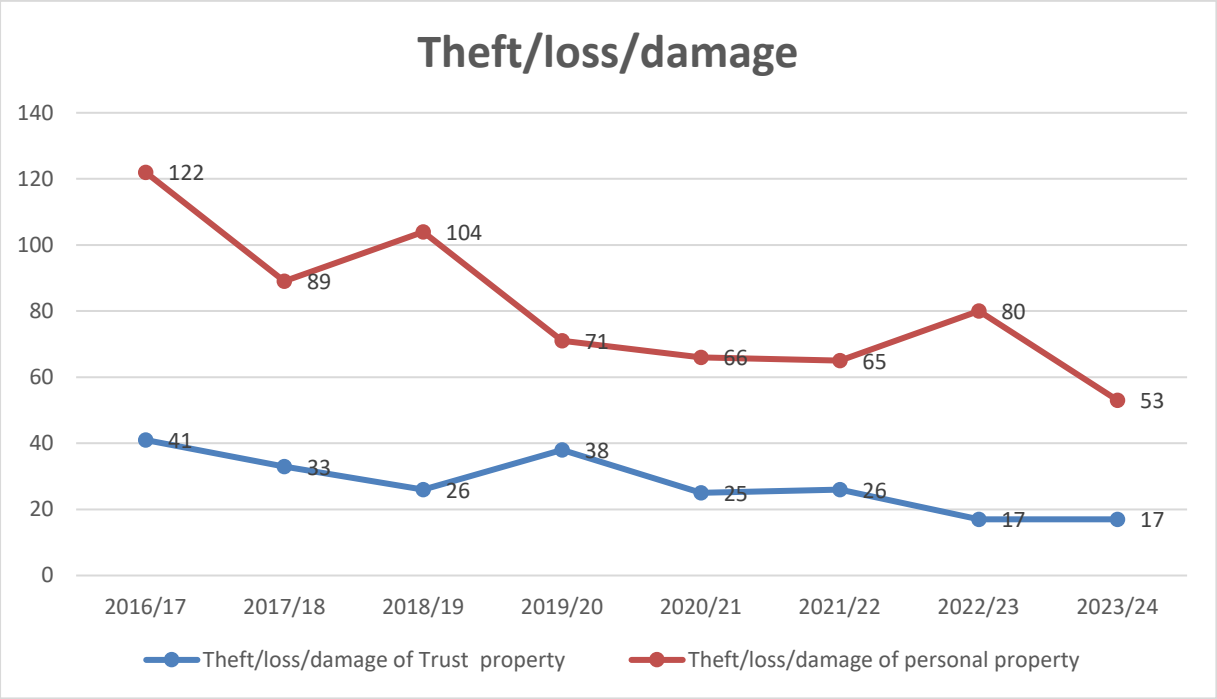
2.13 The Patients Property and Valuables procedure is not always adhered to by clinical staff when either admitting or transferring a patient or after a patient has deceased, this impacts on investigations when allegations are made in relation to missing items of property and the Trust often compensates patients or relatives for missing items. It would be recommended that further education at ward level is undertaken around procedures supported by Security.

2.14 Staff are being reminded to encourage patients to leave valuables at home or request family to take home for safe keeping. The PCSO's patrol the 'hot spot' wards to help deter criminal activity and also educate and highlight crime prevention to the clinical teams.

2.15 The LSMS is currently supporting the Patient Property Task & Finish Group with reviewing the current systems and processes in place and there are trials in progress with recommended police approved (used by WYP in their detention suite) property bags and a system developed by the Trusts IT department for recording and photographing patient's property that is kept or handed over for safe keeping. The group will make recommendations after the trial concludes.

2.16 The table below shows comparative data for the previous 7 years in relation to theft/loss/damage. There has been a decrease in the overall number of reported incidents of

theft/loss/damage of personal property which has decreased by 27 from last year. The amount of theft/loss/damage of Trust Property remains the same as the previous year.



3. Anti-Crime work undertaken to tackle and prevent crime in general

3.1 A significant amount of work has been undertaken in year and some of this is highlighted below:

- The security management team supported the development of the Women's and Children's Unit abduction lockdown system which has recently been upgraded and integrated in the new fire alarm system. Further enhancements have been identified to make it clear which area the abduction alarm has been activated along with additional strobes and sirens in areas to ensure all staff are alerted. This has been discussed with the Unit who are taking this forward via their risk assurance group.

- Continuing focus and collaboration with wards/departments to ensure there are management plans in place for patients who exhibit signs of violence and aggression to minimise the risk of staff being assaulted whilst carrying out their duties. This includes a weekly walk around between Adult Safeguarding and the Security Management Team.

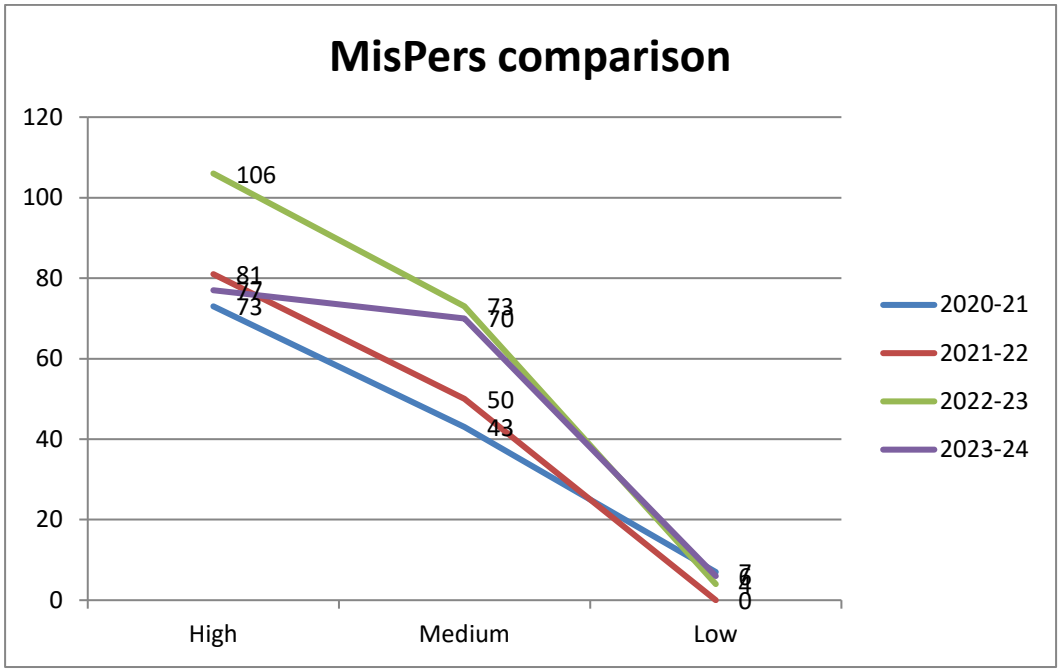
- Continuing progress on the planned upgrades in relation to access control, intruder alarms and CCTV surveillance systems which benefits the organisation by providing the security team with the most up to date tools to carry out their duties, minimising the amount of time taken to proactively monitor alarm events in real-time and use smart search features to help find missing patients in a timely manner. This is expected to be implemented within the 24/25 period and a technology plan developed for future improvements in technology as part of the ongoing maintenance scheme.

- Adhoc security consultation and recommendations for access control, CCTV and intruder alarm installations within refurbished wards and new build projects to deter or detect criminal activity specifically in relation to theft.

- Working with the homeless Team to reduce the number of homeless patients using the hospital as a place of refuge. The increase of removing homeless from the Trust site when found and also reporting to the police if persistently creating anti-social behaviours.

- Working with WYP ASB team to actively monitor, target and reduce the number of patients exhibiting anti-social behaviour within the organisation.

- Working with WYP to reduce the number of patients reported as 'missing' (153 in the reporting period compared to 183 in the previous year). The Security Management Team works with specific ward staff identified as inappropriately reporting/not following the protocol to re-educate and reduce inappropriate reporting to the police, the number has decreased this year.



- Working with the clinical teams on wards/departments that have been targeted for theft/loss/damage of personal and Trust property

- The Trust continues to work in partnership with West Yorkshire Police and the security management team will work with them to develop a 2024/2025 hospital policing plan based on the crime trends of 2023/2024.

4. Violence Prevention and Reduction Standards

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.19

4.1 As outlined in the Violence Prevention and Reduction Standard introduced in 2021, the Trust is required to review its status against the standard and provide Board assurance that they have been met twice a year.

4.2 Since the last update attendance at the meetings improved with engagement from key stakeholders, the workstreams have been reviewed including the reporting structure to further improve engagement and progress. The VPR group is now classed as a sub-committee instead of task & finish group for reporting purposes from the workstreams.

4.3 Three distinct key areas requiring focus to achieve Violence Prevention and Reduction across the Trust have been identified and implemented to progress VPR, categorised as follows:

1. **Clinically related challenging behaviour (CRCB)**
   Where the patient did not know what they were doing or did not know what they were doing was wrong due to medical illness, mental ill health, severe learning disability, substance abuse withdrawal or treatment administered. This category is currently managed by the clinical teams with limited support from security. This area has been a significant factor in previous years reporting on physical assaults on staff.

2. **Visitors/Public non-patient related behaviour**
   This relates to non-patient violence and aggression from/to visitors and the public where there are no clinically related factors and managed by the security and police teams.

3. **Staff on staff behaviours (Civility, H&B etc)**
   This relates to staff-on-staff incidents which are managed through HR processes within the Trust currently.

   It was previously recommended that these 3 areas required significant focus and senior leadership to support engagement and compliance to the VPR.

1. Clinically related Challenging Behaviour is led by the Chief Nurse supported by the Chief Nurse team. These types of incidents are generally because of underlying clinical conditions, the preventative measures, or risk reduction measures are often clinically/treatment related. This focus group will review the 'patients who pose a risk pathway', MH, LD, Alcohol, substance abuse, decision making, management planning, enhanced care pathways/models and assessments, security ward-based observations, physical intervention etc.

2. Visitors/Public – non patient related behaviour is led by the Deputy Director, Estates and Facilities supported by the Security Management Team.
   This group will review the data relating to 'intentional' rather than clinically related behaviours to review the current strategies in place and assess how effective they are in managing this group of attenders. Often those involved in these types of incidents are not requiring clinical care.

3. Staff on staff is led by the Director of HR and supported by the HR Business Managers.
   They are responsible for reviewing available data relating to incidents and to review the effectiveness of current policy, procedures with representation from the focus and workstream groups. These types of incidents are more likely to be reported through HR

processes than security reporting routes. This group are responsible for supporting the development of the Violence Prevention and reduction Strategy and related policies.

In addition, there are key workstreams identified to support the focus groups.

a) Education and Training - led by the Education Manager
(Review delivery of CRT, breakaway, restraint, undertake training needs analysis, including MH training requirements). The Trust needs to ensure that the training delivered is targeted to the needs of the Trust and is risk based.

b) Metrics and data validation - led by Head of Non-Clinical Risk
(Pulse survey, staff survey, risk incidents, complaints, SI, number of physical assaults, verbal, threats, ASBO's behaviour agreements, warning letters, treatment withdrawal, prosecutions, etc) this is to ensure we improve reporting mechanisms to enable best effective use of data to target resource and reduce incidents. The organisational risks associated with Violence and Aggression will be assessed and shared with appropriate stakeholders

4.4 The VPR Lead is working across all focus and workstreams to enable the update of the overall workplan and submission of the twice-yearly updates.

4.5 The new structure and workstreams has been discussed and agreed at the meeting in May 2024 and will enable improved engagement and progress.

4.6 Commissioners are also expected to undertake compliance assessments as part of their regular contract reviews, twice a year as a minimum, or quarterly if significant concerns are identified.

4.8 The violence prevention and reduction standard employ the Plan, Do Check, Act (PDCA) approach, an iterative four-step management method to validate, control and achieve continuous improvement of processes.

4.9 There are a number of indicators within each of the PDCA sections that need to be achieved to enable the organisation to be fully compliant against the standard.

4.10 The table below shows the Trusts current benchmark position in relation to the VPR standards.

Section	Indicators	Compliant Jan 2023	Non compliant 2023	Compliant Jan 2024	Non compliant 2024	Section rating
Plan	14	5	9	6	8	Partially compliant
Do	11	7	4	8	3	Partially compliant
Check	12	5	7	7	5	Partially compliant
Act	6	1	5	2	4	Partially compliant
Total	43	18	25	23	20	
					Overall rating:	Partially compliant

5. West Yorkshire Police – Police Community Support Officer report 2023-24

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.19

5.1 The Trust currently fund 50% of the equivalent of 2.45 full time Police Community Support Officer (PCSO) posts. The full sum of funding provided is used in ensuring a consistent Policing presence at the Bradford Royal Infirmary. The PCSO team is dedicated to tackling both NHS and Police partnership issues and providing reassurance to patients, staff and visitors to the Hospital site through a highly visible and easily accessible presence.

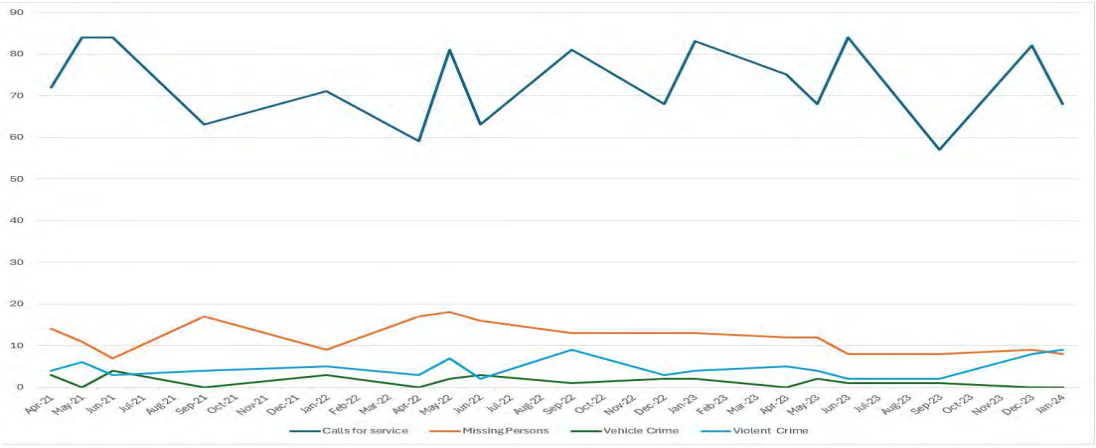
The role of a Police Community Support Officer continues to be a good fit for the Policing requirements of the Bradford Royal Infirmary. The three-team rota worked by the BRI PCSOs ensures a visible Policing presence during the hours of peak demand and continue to provide value for money to the NHS & Police.

As with PCSOs posted in any area, it is hard to quantify many outputs; the role of a PCSO is to prevent and deter crime, as such it is impossible to measure what doesn't occur. A fantastic example of this is the continued low level of offences of theft on Hospital wards. Crime statistics in this area continue to remain low for the reporting period so the offence type does not feature on this report which represents an overwhelming success following Police action against offenders in previous years and a continued robust Trust Policy.

There is clearly still a partnership need to address reporting confidence in staff working from the Hospital, including agency/covering staff, particularly for incidents of violence, work in this area has commenced overseen by PS Milner and William Hall and will be supported through bespoke tasking to the Hospital based PCSOs and planned training inputs.

The below chart mapping 3 years of data clearly illustrates sustained low levels of both call and crime demand, even when accounting for the lower demand during and immediately following the COVID-19 pandemic. It is a clear indication that the Policing and NHS partnership at the Hospital is a continued success.

Consistency continues to be key to problem solving and demand reduction work at the Bradford Teaching Hospital Trust.



Please refer to the full PCSO annual report for detailed information. **See appendix 2.**

6. 2024/25 Security Workplan

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.19

- The Trust continues to work in partnership with West Yorkshire Police and the security management team will work with them to develop a 2024/2025 hospital policing plan based on the crime trends of 2023/2024 as identified in the tables within the report, this will include:

    - Addressing the proactive element of security in year specifically working with the Police to reduce violence and aggression and theft.
    - Working with WYP ASB team to actively monitor and target individuals exhibiting anti-social behaviour
    - Undertaking risk assessments in the 5 high reporting areas of violence and aggression
    - Adhoc input in relation to security recommendations for new build and refurbishment projects throughout the organisation
    - Adhoc input at MDT meetings for complex patients exhibiting signs of violence and aggression
    - Baby Abduction Testing (Women's and Children's Unit)
    - Child/infant Abduction Testing (Children & Young person's wards)
    - Supporting the Safeguarding Adult Team to address the gaps in relation to the management of clinically related challenging behaviour, specifically in relation to the acute assessment areas, clinical teams and education to support the appropriate management of those patients with underlying mental health, alcohol and drug related problems, including the appropriate management and care of a patient in a state of distress, looking at crisis management, restraint and enhanced supervision for clinical and security staff (as outlined in the paper presented to the Executive Management Team in January 2021)
    - Quarterly seasonal security awareness tabletop advice sessions, supported by WYP
    - Continue to deliver reporting confidence sessions in collaboration with WYP and witness care from the courts to high reporting areas within the Trust
    - Violence Prevention and Reduction (VPR) Task and Delivery Group
    - Continual review (twice annually) of the Trust status against the Violence Prevention and Reduction Standard

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda item	Bo.9.24.19

Appendix 1

ED Observations Report - March 2024

Appendix 2

BRI Policing Report 2021 - 2024.docx

Appendix 3

EVA Site Survey Letter BRI Maternity V

EVA Site Survey Letter BRI SMITH LAN

BO.9.24.20 - ANNUAL DATA PROTECTION OFFICER REPORT

REFERENCES

Only PDFs are attached

Bo.9.24.20 - Annual IG-DPO Report 202324.pdf

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda Item	Bo.9.24.20

Annual Information Governance and Data Protection Officer Report

Presented by	Jenny Pope, Head of Information Governance and Data Protection Officer	
Author	Graeme Holmes, Information Governance Manager Jenny Pope, Head of Information Governance and Data Protection Officer	
Lead Director	Paul Rice, Chief Digital and Information Officer/Senior Information Risk Owner	
Purpose of the paper	Information Governance and DPO Annual Report	
Key control		
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**
	NA	

Key Options, Issues and Risks

The purpose of this report is to update the Board on the Information Governance programme, confirming the results of the Data Security and Protection Toolkit assessment for 2023/24 and internal audit outcome. It provides an overview of the arrangements in place to manage information risks and compliance in the year ahead and to provide a progress summary of the activities undertaken by the Information Governance service in-year. The report includes the opinion of the Data Protection Officer (DPO) as a separate addendum

Analysis

A Work Plan is in place that encompasses the Data Security and Protection Toolkit requirements, plus general IG activities which encompass UK General Data Protection Regulation and Data Protection Act compliance related actions and improvements.

There was 1 externally reportable incident to the ICO (Information Commissioners Office) in 2023/24.

The position of the Trust and the level of compliance with IG related legislation and standards is good. This can be further improved by continuing to building on the heightened awareness brought about by critical activities during the pandemic and increasing awareness of the Trust's expansive Digital, Data Intelligence and Insight agenda during and after. The IG Service will continue to deliver a rolling programme of enhancements and checks. Where necessary supported by improvements to policy, procedures and guidance and the right tools and advice for staff. This enables colleagues to carry out their duties in accordance with best practice IG standards. A revised Training plan and staff needs analysis was carried out in 2024 in response to the changed requirements in the DSPT meaning compliancy flexibility for all NHS Trusts delivering mandated training. The updated Trust Training Plan includes a change to training target to align it with other Mandatory training within the Trust at 90%. This amendment was approved at IG Group , Mandatory Training Group and by the SIRO in June 2024. IG training compliance at year end stood at 90% NB training compliance was measured in a DSPT year which runs 1 July to 30 June (not 1 April to 31 March).

Recommendation

The Board is asked to:

- Receive and note this report
- Be satisfied that the Head of IG and DPO role is being effectively planned and discharged to provide the Board of Directors and Trust with the appropriate information and assurances regarding compliance with the UK GDPR and Data Protection Act.

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda Item	Bo.9.24.20

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			
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)	No variance.					

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?		X	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐		X

Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments		X
Quality implications		X
Resource implications		X
Legal/regulatory implications		X
Diversity and Inclusion implications		X

Regulation, Legislation and Compliance relevance
NHS Improvement: (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
Other (please state): UK General Data Protection Regulation (GDPR) and Data Protection Act 2018

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)

Meeting Title	Board of Directors		
Date	25 September 2024	Agenda Item	Bo.9.24.20

1 PURPOSE / AIM

This report is to update the Board on the Information Governance programme, confirming the results of the Data Security and Protection Toolkit (DSPT) assessment for 2023/24. It provides an overview of the arrangements in place to manage information risks and compliance in the year ahead and a progress summary of the activities undertaken by the Service in-year.

2 BACKGROUND / CONTEXT

It is good practice for Board to be sighted on Information Governance (IG). The DPO is responsible for ensuring that the application of data protection and confidentiality legislation is consistently observed and any weaknesses in current practices are identified and remedied where possible.

The Trust is required to undertake an annual DSPT assessment to provide assurance to the Board and external bodies of good practice IG and data security and that personal information is handled correctly. The DSPT is a structured assurance framework and provides a basis for compliance with national security standards, and overarching UK GDPR and Data Protection Act principles.

During 2023/24 the DPO and IG Service provided advice on data protection and confidentiality across the Trust. Common themes continue to be information sharing and assessing privacy risks. Clarity around internal and cross-organisational information sharing has continued to be a key focus. An IG Improvement (Work) Plan informs this and other activities the team will progress throughout 2024/25.

In summary we have seen progress but this has been limited in some areas and there are further improvements to be made.

3 MONITORING AND COMPLIANCE

The DSPT assessment provides assurance of good practice i.e. that an Information Governance framework is in place with the necessary controls, governance, and policies. It takes the form of an online assessment tool produced by the Department of Health and hosted by NHS Digital. It draws together the relevant Information Governance management legislation and national guidance under a single framework designed to enable an organisation to implement the relevant standards. It enables the Trust to measure its performance through an annual self-assessment and report upon levels of compliance against a set number of assertions based on the National Data Guardian's 10 data security standards.

For 2023/24 the Trust was required to measure itself against 34 Assertions (2 are non-mandatory) in total and 108 mandatory evidence items. Organisations can only achieve a final overall outcome of Standards Met by providing evidence against all mandatory items. There is no Red Amber Green (RAG) rating.

The IG Manager alerts the Head of IG and SIRO to any high risks, that is where the completion of certain actions are critical to Standards Met, and where there are concerns they may not be completed. The IG service worked with the relevant service area leads across the Trust to evidence the assessment.

Prior to completion the Trust's internal auditors, Audit Yorkshire reviewed a sample of mandatory assertions' evidence within a cross-section of the criteria. The approach and scope of the internal audit review was thorough and as in depth as in previous years despite their review of the same sample. The SIRO and Trust received a report against DSPT progress, and provided approval prior to the 30 June submission, which included the Internal Audit Report.

The audit outcome was that the Trust has attained overall risk assessment across all 10 NDG Standards' as 'Substantial', and an 'Assurance level as 'High'. There were 3 Low level Recommendations made and accepted.

General Data Protection Regulation/Data Protection Act

The General Data Protection Regulation (GDPR) that came into force on 25 May 2018 is supported by the UK Data Protection Act (2018), which updated the Data Protection Act (1998). Compliance with key legislation, such as the UK GDPR, Data Protection Act (DPA) 2018 and Freedom of Information Act 2000 (FOI) is regulated by the UK Information Commissioner's Office (ICO).

Internally, the Digital and Data Transformation Committee received assurance on IG.

Access to Records under the DPA (Subject Access) and FOIA is not managed by the IG Service. The Access to Health Records Team manages Subject Access Requests / requests under the DPA. The right of access to health records is governed by rules set out under the Data Protection Act. Requests must be processed under their own individual merit and Data Controllers consider whether each request meets the lawful requirements for provision. Many are straightforward. Those that are more complex often require expert review to ensure the confidentiality rights of the data subject (and any associated 3rd parties) are maintained. Safeguarding rules are also often applicable within this work. Input from the IG Service is provided to the Access to Health Records Team (ATHR) wherever appropriate..
Since April 2023 to end March 2024 the ATHR Team have completed 2,032 requests.
Our IT colleagues confirm improvements to cyber security are continuous. A number of external assurances are sought and received throughout each year. The Head of IT and team provide separate assurances to the Digital and Data Transformation committee(s) and SIRO routinely on the controls and actions in place and being progressed.

Privacy by Design

The Trust has controls in place so that it does not embark on new or changed processes without having considered privacy impact and staff have become more aware of the need for Data Protection Impact Assessments (DPIAs) for example. DPIAs capture rationale, risks, assurance of security, and legal basis for processing. The IG Service has provided assistance so that other teams can complete these as well as possible, has provided support and guidance to address confusion about when and where they are needed, and has oversight of / and reviews completed assessments. The quality and timeliness of these is not always as it could be still. It continues to work with services Trust-wide to help ensure such requirements are considered at the outset in line with Privacy by Design principles under UK GDPR.

Face to face IG audits or 'spot checks' that take place alongside such controls were limited in 2023/24. However, a combined programme of spot checks and virtual questionnaires were used which was acceptable.

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4 RAISING THE PROFILE/SUPPORTING TRUST SERVICES

The Information Governance service has worked to provide an accessible forum for information rights and good practice advice and support to Trust services representing a variety of clinical and corporate areas. It has provided specialist advice regarding data sharing and encourages confidence in handling personal information safely. The team has worked hard to keep pace with the challenges associated with increasingly complex scenarios and requests for advice, not only due to legislative and national changed requirements but also in relation to Digital developments and the associated IG requirements. The Service routinely receives requests for advice and direction on a variety of work streams; most notably with regard to new initiatives, new suppliers, new partners and the data sharing, data processing, Data Protection Impact Assessment and contractual elements which underpin each. There was no significant shift in the nature of enquiries overall.

Requests from staff for advice and guidance are an indicator of awareness; they continued at pace and involve more with more complex questions. Tools and controls are in place such as policy and procedures, contract clauses, and templates. IG has a rolling programme of work that includes development and refinement of existing documentation and the creation of new resources that form the backbone of our IG controls. We have made inroads to improve our Data Protection Impact Assessment tools, and work began to refine and further align our Sharing and Processing Agreement templates with other Trusts' examples, in particular Airedale Hospital NHS Foundation Trust (ANHST) given our joint IG service. The new Training Plan joint arrangements brought training needs and requirements in line for each Trust where previously there were slight differences.

5 TRAINING AND AWARENESS

Mandatory training compliance was 90% prior to the end of June 2024 DSPT submission.

A revised Training plan and staff needs analysis was carried out in 2024 in response to the changed requirements in the DSPT meaning compliancy flexibility for all NHS Trusts delivering mandated training. The updated Trust Training Plan includes a change to training target to align it with other mandatory training within the Trust at 90%. This amendment was approved at IG Group, Mandatory Training Group and by the SIRO in June 2024. Training compliance is measured in a DSPT year which runs 1 July to 30 June (not 1 April to 31 March).

IG training is available in several different formats to suit individual needs. The primary training all staff complete is national e-learning provided centrally, but where appropriate staff may attend a trainer-led classroom session or complete a workbook and video. The interactive face to face classroom sessions were cancelled during the pandemic and have not resumed, though ad-hoc training has been delivered via MS Teams where requested.

Following changes to the national training compliance requirements set out within the DSPT, the Trust now needs to ensure that all staff have an '*appropriate understanding of information governance and cyber security*'.

This means we now have more flexibility to set local training targets that are proportionate to different roles, and to adopt a range of different methods to deliver that training.

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6 INCIDENTS

During 2023/24 191 IG incidents were reported by staff, an increase of approximately 13.7%.

All are disseminated to the Caldicott Guardian, and IG in real time, as they are reported. This enables the service to respond promptly as necessary. The majority reported were lower level 'minor' incidents or near misses. All were assessed and advice given on further mitigating actions or investigations where necessary.

More serious incidents are assessed and judged whether externally reportable according to criteria based on likelihood and impact of harm on the data subject(s). Externally reportable incidents like this must be reported to the Information Commissioner's Office within 72 hours where they meet the criteria. The Trust had 1 during this period, which involved a number of staff accessing records of a victim of a serious crime. This was reported to the ICO and CQC and appropriate disciplinary action was taken by HR. The ICO took no action.

The maximum penalty that can be imposed on organisations for serious breaches is 20 million euros (or 4% of annual turnover) for the most serious breaches of Data Protection Act (individual rights and 3rd country transfers) and up to 10 million euros (or 2% of annual turnover) for standard infringements (administrative requirements).

During 2023/24 the ICO imposed in total £14.8m in monetary penalties. None were imposed on a Trust.

Again, as previously, far more non-health related companies than public sector were affected by enforcement action. The majority were marketing / retail sector related. The largest, high profile, fine related to £12,700,000 for TikTok.

7 INFORMATION SHARING

The Trust has a responsibility to work with partners to minimise the burden of data collection and ensure that it uses information effectively to support the overall aims of health and social care. 2023/24 again saw organisations increasingly looking towards future shared care models or collaborative working and the IG Team received multiple requests to develop or contribute to 'patch wide' or 'purpose specific' Data Sharing Agreements and similar. The team reviewed a total of 51 DPIAs and 46 Sharing Agreements (inclusive of DSAs, DPAs and Research Collaboration Agreements)

The team has worked to improve and align its templates and agreements, including consideration of multiple variations in use by or available to other organisations.

The National Data Opt Out Programme does not affect sharing for direct care. It offers patients the opportunity to make an informed choice about whether they wish their personally identifiable data to be used only for their individual care and treatment or also used for research and planning purposes. Patients and the public who decide they do not want their data used for planning and research purposes will be able to set their opt-out choice online. The Trust lead is the Head of Information and confirms there is a process is in place to carry out Opt-out requests.

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8 INFORMATION ASSETS

Work took place to update policies and procedures. We continued to work with business units to help ensure IG requirements are considered at the outset in line with Privacy by Design principles under UK GDPR. The Trust's information assets, what happens to them, and the controls surrounding them, inform a multitude of other areas. Thus, the role Information Asset Owners (IAOs) play in ensuring such controls are in place remains key to our information asset management framework and mitigating information risk.

Further work is needed to engage with IAOs to help them understand their own and the Trust's obligations. Training helps to provide assurance to the SIRO on the security, reliability, and integrity of assets plus reinforces their responsibilities and accountabilities. A new information asset register (IAR) was developed by IT colleagues that will provide improvements to the annual validation exercise and simplify completing the register for IAOs during 2024/25. This work was delayed in 2023/24. Mapping work did take place so progress was made but limited as some developments / further changes could not be made.

9 RISKS

The SIRO and IG Team monitors and reports incident related and other Information Governance related risks reported on the Trust risk register routinely. Current Risks are the Risk of IG Breaches, Risk related to limited IG Team resources across BTHFT and AGHT and the risk of failure to complete the Data Security and Protection Toolkit (DSPT). The SIRO is responsible for overseeing the development and implementation of information risk strategy. The SIRO is supported in this by the IG team and by Information Asset Owners (IAO) within each business area. The IAO is responsible for managing information risks to the assets within their control. This may involve developing business continuity plans as well as documenting their personal data information flows and conducting regular risk assessments. The IG team support IAOs in achieving these objectives. The above mentioned delay to roll out of the new register meant process and arrangements remained unchanged in 2023/24 in terms of the tools and activities required for validation of assets.

10 NETWORKING AND COLLABORATION

The Information Governance landscape has continued evolving, less due to the changes in data protection legislation and more in relation to the increasing focus on NHS digital aspirations.

Externally, the DPO contributes proactively to the IG sector sharing of advice, guidance and working practices in relation to the application of new legislation and general data protection compliance. The DPO and IG Team regularly contributed to and work alongside peers at Bradford District Care Trust, the regional (North Yorkshire and Humber) and National SIGN (Senior IG Network), other Trusts, and the Yorkshire and Humber Care Record programme.

The North Yorkshire and Humber Directors of Informatics IG sub-group remains a key group and national and regional level. It's well established monthly meetings have continued and include respected representation by senior professionals from across the North with the emphasis on IG in a health and care setting. The key issues and themes are often repeated as they remain challenging for organisations and as changes in national guidance or requirements are issued, so during the course of the year have again included:

- Information sharing / agreements and surrounding processes
- Increased use of and demand for digital technologies in the NHS advanced by the pandemic, and the required IG elements and assurances.

National NHSE DPO webinars have been valuable as well as when there have been new or changed IG requirements the national team have guided and advised, for example when the Trust team have had to implement or provide assurance against changed requirements.

Internally, the Head of IG / Data Protection Officer and IG Team are represented at various groups and committees such as the Digital SMT and Heads of Service groups, including Digital and Data Transformation Committee.

The Information Governance Service has worked to develop shared or aligned protocols and training in line with the ever involving data security and protection agenda, and the expanding digital agendas of both Trusts.

The Head of IG manages the Service. The team consists of an IG Manager at both locations, supported by 1 x IG Officer (1.0) at BTHFT.

Whilst progress has been made, it is slower than desirable. The size of the Service and the complexities and disparities of existing processes in some areas means there is more to do. The accumulated effect of stretched resources hinders progress. BAU activities have been the focus by necessity and these have been challenging again. Required activities are included within a 'joint' IG Improvement (Work) Plan to ensure the programme of work at each Trust is set in the context of a shared IG Service. A risk assessment is in place around the IG Service and its capacity and resource needs and consideration being given to IG Team establishment / resource requirements.

11 FUTURE PLANS AND KEY ACTIVITIES

The Information Governance landscape continues to evolve. We must continue to respond to the challenges faced by changing working practices in order to ensure that we keep pace with the ever-changing information society we work in. Going forward, this will only become even more demanding. National developments will have a bearing on the direction of the Information Governance programme. IG requirements and advice in relation to digital developments and use of safe digital technologies for example is an area that will only grow and yet there is still some confusion and inconsistent messages on the subject.

Our IG Service catalogue will help provide clarity for staff across services, sites and Trusts. It will help inform and clarify reporting requirements both assurance and performance. The Team will continue to develop and deploy a range of communication methods and materials to engage and support staff including use of newsletters and presentations and consider all avenues for staff IG training.

Areas for continued development this year still include

- Data Protection by Design and Default principles; including register of processing activities mapping
- Ensuring we have a strong understanding of our processing activities and work with IAOs to keep our information assets register and data flows up to date and correct and that when needed, DPIAs and other agreements are in place.

- Working collaboratively with other organisations and our IG colleagues to share best practice, develop shared practices, processes and documentation.

12 SUMMARY

The Trust has a robust process for managing IG and the associated responsibilities that come with our commitment to adopt best practice processes and procedures in order to protect patient and Service users' information.

The Trust received a favourable Internal Audit opinion of its DSPT assessment review. It has made improvements across the Trust in terms of raising awareness of IG, though training required fresh impetus once more, in implementing and updating the required new and existing policy and procedures, and compliance with UK GDPR / Data Protection legislation.

The IG Service has a dynamic plan to refresh and improve compliance with the DSPT standards and other non DSPT IG improvements. Evidence for many of the assertions is refreshed as part of established daily business or monitoring activities throughout the year though this needs to take place much earlier in some cases. Some objectives are more challenging and for this reason are constantly targeted as being key areas and will receive early oversight. 2024/25 brings a significant change to the DSPT which will be introduced in September 2024 as a new CAF aligned model. The team will advise the Business on the new process.

The IG Service will continue to work with other NHS organisations in our Region sharing good practice, and to aim for an integrated approach.

13 RECOMMENDATIONS

The Board is asked to receive and note this report and satisfy itself that the Data Protection Officer role is being effectively planned and discharged to provide the Board of Directors and Trust with the appropriate information and assurances regarding compliance with the UK GDPR and Data Protection Act 2018.

It is asked to support plans to ensure that the Trust is equipped and supported to be able to face the challenge presented by a new CAF aligned DSPT model for 2024/25, and that it continues to strive to improve and embed IG best practice into routine working practice across the Trust.

BO.9.24.21 - USE OF THE TRUST SEAL

REFERENCES

Only PDFs are attached

Bo.9.24.21 - Use of the Trust Seal.pdf

Meeting Title	Board of Directors		
Date	25.9.24	Agenda item	Bo.9.24.21

Report on the Use of the Foundation Trust's Seal

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Sheridan Osbourne, Corporate Governance Officer	
Lead Director	Reneé Bullock, Chief People and Purpose Officer	
Purpose of the paper	To provide a summary of the use of the Foundation Trust Seal during the period 15 September 2023 to 18 September 2024	
Action required	For assurance	
Previously discussed at/informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Background

In accordance with the Trust's Board of Directors Standing Orders (Section 8.4) '*A report of all sealings and signatures of documents as a deed shall be made to the Board by the Secretary to the Foundation Trust as and when required. The report shall contain details of the seal number, the description of the document and the date of sealing or signature.*'

The last report was presented to the Board of Directors on 21 September 2023.

Appendix A details the use of the Trust seal between 15 September 2023 – 18 September 2024. This includes entry numbers 370-382.

Recommendation

The Board of Directors is asked to receive and note this information.

Meeting Title	Board of Directors		
Date	25.9.24	Agenda item	Bo.9.24.21

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)						

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

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

Regulation, Legislation and Compliance relevance

NHS Improvement: (please tick those that are relevant)

☐Risk Assessment Framework ☐Quality Governance Framework

☐Code of Governance ☐Annual Reporting Manual

Care Quality Commission Domain: Choose an item.

Care Quality Commission Fundamental Standard: Choose an item.

NHS Improvement Effective Use of Resources: Choose an item.

Other (please state):

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

Meeting Title	Board of Directors		
Date	25.9.24	Agenda item	Bo.9.24.21

Appendix A

Bradford Teaching Hospitals NHS Foundation Trust

Report on the Use of the Foundation Trust's Seal – 15 September 2023 – 18 September 2024

Set out in the table below is a summary of the capital schemes and other documents that have been sealed during 15 September 2023 – 18 September 2024. This includes entry numbers 370 to 382.

The Board of Directors is asked to receive and note this information.

Entry Number	Item/Scheme	Date
370	Contract with RBR Roofing Ltd for the upgrade and replacement of roof coverings and insulation at Ward 15 (roof) BRI	26.9.23
371	Contract with Whitaker & Leach for the refurbishment of the existing CT scanning suite at St Lukes Hospital	22.11.23
372	Contract with Whitaker & Leach for the conversion of existing kitchen into a haematology transfusion room at Eccleshill Community Hospital	30.11.23
373	Contract with Walter West Builders Ltd for the conversion of the existing CDU to minor hand surgery unit on Level 1 at BRI	7.12.23
374	Underlease for part of Undercliffe Health Care Centre, BD2 4RA	25.3.24
375	Underlease for part of Westbourne Green Community Health Centre, BH8 8RA	25.3.24
376	Contract with Code Building Solutions Ltd for works associated with the BIHR main entrance	25.3.24
377	Sub-contractor collateral warranty for Ward 1 isolation rooms. Contract with Northern Mechanical Services Ltd	9.5.24
378	Sub-contractor collateral warranty for Ward 1 isolation rooms. Contract between Peter Hope Structures Ltd, Walter West Builders Ltd & BTHFT	9.5.24
379	Short form contract with Classic Lifts Ltd for lift refurbishment on Horton Wing, St Lukes Hospital	9.5.24
380	Sub-contractor collateral warranty for radiology room 6. Contract between Northern Mechanical Services Ltd, Walter West Builders Ltd & BTHFT	9.5.24
381	Sub-contractor collateral warranty for radiology room 6. Contract between Peter Hope Structures Ltd, Walter West Builders Ltd & BTHFT	9.5.24
382	Main contract agreement between BTHFT and Morgan Sindall Construction & Infrastructure Ltd in relation to the development of outstanding maternity scheme – Phase 1	9.5.24

BO.9.24.22 - ANY OTHER BUSINESS

BO.9.24.23 - ISSUES TO REFER TO COMMITTEES/ACADEMIES OR ELSEWHERE

BO.9.24.24 - REVIEW OF MEETING

BO.9.24.25 - DATE AND TIME OF NEXT MEETING

BO.9.24.26 - CONFIRMED ACADEMY MINUTES

REFERENCES

Only PDFs are attached

- Bo.9.24.26 - Confirmed People Academy minutes 3rd July 2024.pdf
- Bo.9.24.26 - confirmed People Academy minutes 9 August 2024.pdf
- Bo.9.24.26 - Confirmed QPS Academy Minutes - 2 July 2024.pdf
- Bo.9.24.26 - Confirmed QPS Academy Minutes -14th August 2024.pdf
- Bo.9.24.26 - confirmed Minutes FP Academy 4 July 2024.pdf
- Bo.9.24.26 - Confirmed minutes FP Academy 24 July 2024.pdf

Bradford Teaching Hospitals NHS Foundation Trust

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 3 July 2024	**Time:**	09:00 – 11:00
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 (RB)		
In Attendance:	- Sally Scales, Director of Nursing (SS) - John Bolton, Deputy Chief Medical Office (JB) - Catherine Shutt, Assistant Director of HR/ Head of OD (CS) - Sarah Freeman, Director of Nursing (Operations) (SF) - Sara Hollins, Director of Midwifery (SH) - Samia Hussain, Associate Director of HR (SHu) - Georgi Dyson, Assistant Director of HR (GD) - Faye Alexander, Head of Education (FA) - Raquel Licas, Deputy Chair, RESIN (RL) - Amanda Grice, Workplace and Wellbeing Centre Manager (AG) - Jacqui Maurice, Head of Corporate Governance (JM) - Amandeep Singh, Partnership Lead (AS) - Ruth Haigh, Equality, Diversity and Inclusion Manager (RH) - Sean Willis, Associate Chief Nurse Quality & Workforce (SW) - Amanda Limbert, Head of Service for workforce information and flexible workforce (AL) *In attendance for their items only:* - Jade Stephenson, Matron (JS) - PA.7(1).24.7 - Laura Parsons, Assistant Director of Corporate Governance / Board Secretary (LP) - PA.7(1).24.12 - Mark Hindmarsh, Director of Strategy and Transformation (MH) - PA.7(1).24.16 - Jason Joy, Head of Communications (JJ) and Sarah Smith, Communications Manager (SSm) - PA.7(1).24.17 - Sarah Waite, Leadership and Team Development Manager (SWa), Debbie Jackson, OD Manager (DJ), Julie Snellgrove, OD Practitioner (JS) - PA.7(1).24.18		
Observer	- Karina Edwards, Internal Audit Manager, Yorkshire Audit		

Agenda Ref	Agenda Item	Actions
PA.5.24.1	**Apologies for Absence**	
	• Altaf Sadique, Non-Executive Director • Karen Dawber, Chief Nurse (represented by Sally Scales, Director of Nursing) • Ray Smith, Chief Medical Officer (represented by John Bolton, Deputy Chief Medical Officer) • Laura Parsons, Assistant Director of Corporate Governance / Board Secretary (represented by Jacqui Maurice, Head of Corporate Governance)	

PA.7(1).24.2	**Declarations of Interest**	
	No interests were declared.	
PA.7(1).24.3	**Minutes of the meeting held on 22 May 2024**	
	The minutes of the meeting held on 22 May 2024 were approved as an accurate record. The Academy noted the outcome regarding the following action: • PA24008 – PA.2.24.13 – Gender Pay Gap. This item has been deferred to September 2024. Action to remain open.	
PA.7(1).24.4	**Matters arising**	
	Correction to submission of WRES/WDES data: RH informed members there was a discrepancy to the WRES/WDES submission, which related to the recruitment and selection data, which was presented at the previous meeting. The data has now been rectified and was submitted to NHSE by their deadline of 30th May 2024. The data analysis now indicates a slight deterioration in our performance since last year, but this does not change our position, or the level of focus which will be given to recruitment and selection in the refreshed action plans. The academy noted the update.	
	Assurance	
PA.7(1).24.5	**Nursing and Midwifery staffing data publication report**	
	SW highlighted the following key points from the report: • There has been a consistent improvement in fill rates. • Reduction in vacancies, including the band 5 roles and this is due to international recruitment and retention plans. • Workforce gaps in HCA recruitment, but recruitment has moved to monthly. • Harm data is consistent. • Red flag reporting has reduced. SW informed members that the aim is to reduce the HCA vacancy position and retention will be monitored closely over the next six months, as international recruitment is not an option currently. KW asked what is done around role content which could impact on productivity and ensuring staff have time to fulfil their roles? SW advised that Sarah Freeman is working on a piece of work called 'confirm and challenge' with CSUs to ensure the right skills are applied at the right place and supporting staff at work ensuring rosters are filled appropriately. AS asked whether the new overseas nurses can be surveyed to get a view on their experiences. SW confirmed that feedback is collected on a regular basis and SW agreed to bring a report back in a couple of months' time. CS and RL led on an engagement event in June, which was open to all international colleagues The session provided an informal way to connect, share stories and experiences and learn about life and work at BTHFT. RL will be analysing the feedback and will meet up with RB and SW to discuss the feedback received and	

	draw up an action log. **Action**: SW agreed to share the feedback report, based on international nurses and their experiences at the trust. The Academy was assured by the report.	(PA24016) Associate Chief Nurse
PA.7 (1).24.6	**Nursing and midwifery staffing establishment review**	
	SH and SW provided an overview of the Nursing and midwifery staffing establishment review and informed members that the establishment review is carried out twice yearly. The paper summarised the outcomes of the recommendations and those were: • 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. • 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. • Establishment change requests which have not been supported at this time are Ward 23, Ward 28, AMU 1, AMU 4. • A safer staffing review will be undertaken, using the updated validated Safer Nursing Care Tool (SNCT) to determine optimal nurse staffing levels and need for enhanced care. • Prioritising and reducing vacancies in areas where additional staff requests have been made. • To continue to support the services proposal, to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care. • An additional consultant midwife post to the structure, but due to the financial constraint there is no significant risk to the service and the vacancy will be on 'hold' until 2025/26. The Academy was assured by the report.	
PA.7(1).24.7	**Nursing and Midwifery recruitment and retention data**	
	JS joined the meeting to present the Nursing and Midwifery recruitment and retention data. JS took the paper as read and provided a summary. JS advised that twenty staff members have left the ICU department in the previous year, but twenty-five new starters have commenced employment in the department. The bed is base is 16, but 8 are level 3 beds – one to one care and 8 level two beds which is 1 to 2 care ratio. There have been some challenges in the department which are due to low staffing numbers and staff leaving the trust, due to overworking during Covid, abuse from patients and several staff left due to retirement, which has also impacted on the closure of some beds. Other challenges have been associated with the recruitment of overseas staff and ensuing staff have been fully trained, where overseas staff are on a longer training package compared to locally trained nurses. The Academy was assured by the report.	

PA.7(1).24.8	**People Academy Dashboard**	
	GD introduced the dashboard, noting that there has been a slight reduction in the number of bullying and harassment cases reported. The non-medical appraisals have fallen below the 85% target, but this is on an upwards trajectory and HR Business partners will be supporting the non-clinical areas to increase compliance. Sickness levels continue to fall which is currently at 5.36% and again HR Business Partners are supporting managers. Staff turnover is at its lowest and agency use has reduced in non-clinical areas. The Academy was assured by the report.	
PA.7(1).24.9	**High level risks relevant to the academy**	
	GD advised that there were three new risks on the risk register which are 605, 2509 and 396. Two risks have reduced in score, which are risk numbers 447 and 39. Two risks have passed their target mitigation dates, which will be reviewed by the exec lead as soon as possible. The Academy confirmed their assurance that all relevant key risks have been identified, reported to the Academy and are being managed appropriately. The Academy was assured by the report.	
PA.7(1).24.10	**Industrial Action update**	
	GD advised that the junior doctors strike action took place on 27 June – 2 July, there was an increase in the number of junior doctor's bank shifts during the strike period. A message was circulated from Mel Pickup, thanking clinical and non-clinical staff for their continued support during the strike action. JB informed members that during previous strike actions, A&E figures have been low, but during the last strike period, A&E saw the second highest record of attendances ever reported. The trust is getting better at mitigating the effects associated with strike action. There were no significant harms reported during the strike action due to the lack of medical cover and services were delivered safely.	
PA.7(1).24.11	**Revised Terms of Reference and workplan**	
	JM advised that as reported in the paper, drew attention to the following interim changes to the Terms of Reference. • Membership of the Academy is to be amended to refer to the Non-Executives and the Executives only. All others will be in attendance. • The quorum for meetings will be at least two NEDs and one Executive Director. JM advised that these would be shared with the Board of Directors in July following approval. The Academy further noted that a more detailed review was scheduled to take place prior to September board with any further changes to the ToRs and the workplan presented to Board for approval. JB suggested if the 'Deputy Chief Medical Officer' could be added to the membership list.	

	Action: JM would propose the addition of the Deputy Chief Medical Officer to the membership list for the people academy at the more detailed review scheduled to take place. The Academy approved the proposed interim changes to the Academy Terms of Reference which would now be presented to Board for approval in July.	(PA24017) Head of Corporate Governance
PA.7(1).24.12	**Board Assurance Framework - strategic risks relevant to the Academy**	
	LP joined the meeting to present the Board Assurance Framework and informed members that the BAF is currently under review and was also reviewed by an external consultant, who has undertaken a wider review of the Trust's governance arrangements, where some recommendations have been made. At a previous board development session, the BAF risks were reviewed and prioritised. LP will be meeting with the Trust Chair to consider a new proposed BAF, and the aim is to reduce the number of total risks to avoid duplication and to ensure that the risks are prioritised appropriately. Once a new BAF has been considered it will be presented to this academy for review and will also be shared with the Board of Directors for approval. The Academy was assured by the update.	
PA.7(1).24.13	**Medical appraisal and revalidation annual report.**	
	The report was taken in the main as read. JB highlighted the following key areas of note: • Every doctor who must maintain a licence will need to be validated by the GMC every five years. Recommendations for validation are dependent on an annual appraisal yearly, within the five years. The paper outlines the trusts success with the process and the trust has a robust system in place to conduct and record appraisals. • At 31st March 2024, 514 doctors had a prescribed connection with the Trust. • For the financial year of 2023-24, 498 doctors received an outcome measure 1 – completed appraisal, 16 doctors were allocated an outcome measure 2 – approved missed appraisal and there has been no outcome measure 3 appraisal – unapproved missed. • There were 83 revalidation recommendations for the period 2023-24. This included 5 recommendations to defer revalidation based on insufficient evidence. The academy noted the recommendations highlighted in the paper and, that the report will also be shared with the Board of Directors. The Academy was assured by the update.	
Learning and Improvement		
PA.7(1).24.14	**Workforce Civility update**	
	SHu and RH provided a brief update on all civility work that is currently underway in the trust.	

	• communication campaigns, posters etc. • Launch of the Trust's mediation service, this includes five trained workplace mediators. • The staff advocacy A workplace civility programme board has been established in December 2021, which has 20 members from across the Trust. • A Civility Advisory panel has been developed which includes 15 members of staff, who are provided with a safe space to share their experiences around civility and this has helped shape a lot of the work of the programme. • Workplace civility toolkit has been developed, which provides resources to support individuals who have experienced, witnessed or accused of civility and how to address the issues on an informal basis. This has been reviewed and relaunched with the tools from the Psychology department around self-compassion, reducing extreme emotions and de-escalation strategies. Positive feedback has been received on the toolkit. • The trust has worked with Collingwood learning to develop some drama-based training videos (based on the lived-experience of Trust staff). The videos have been used in training and are also available on the Thrive webpages. • A 'live' action drama-based training event was hosted for manages with Collingwood learning, based around the case studies used in the videos to provide learning for managers in more detail, this was very well received. • The workplace civility training has been developed including bespoke approaches for certain departments. • The People Charter has been developed and utilised in recruitment, development days etc. • Rolled out service has been refreshed, 5 staff members have been trained to strengthen the service. • Harassment and bullying policy is being reviewed, with a focus on early informal resolution, the policy will be renamed the 'respect, civility and resolution policy', once approved. The academy was asked what more could be done to add value to this agenda. A discussion took place and members suggested using data which indicated where the issues are, hotspots and, areas of focus. The academy noted the update.	
PA.7(1).24.15	**NHS Staff Survey action plan update**	
	CS and DJ introduced the report and highlighted the following: • There are 16 actions which have been developed in the plan, these have been identified through engagement following intensive analysis of the results. • Civility has been embedded in the actions identified in the plan. • The team have received numerous enquiries about de-escalation and customer service training, specifically from non-clinical staff. • Reward and recognition awards – a celebration evening will be	

	taking place in September, where the event will be funded by sponsorship and not the trust. • Having a voice – refreshing Thrive Live where two events will be taking place each month, Exec Directors will be attending the events and positive feedback has been received about this. • Raising concerns – giving timely feedback and the team have collaborated with the freedom to speak up team, to review the process to enable staff to speak up with confidence and review the approach and impact. • Heathy Food – ensuring staff have access to healthy nutritious food 24/7. AS queried whether there is any scope for personalised development plans with regards to nutritious foods, have the existing companies who are on site considered offering adequate food service for out of hours? DJ stated that personalised development will be considered in the management offerings as well as the offerings for progression routes. With regards to AS query to healthy food DJ mentioned that conversations have taken place with existing companies on site and feedback will be provided once this piece of work has been completed. The academy noted the update.	
PA.7(1)24.16	**Closing the Gap: impact on our people**	
	MH joined the meeting and informed members that he is the Exec lead for the closing the gap piece of work, where the trust has to achieve the financial saving target of £40m. MH referenced the Fisher's personal transition curve and explained that as well as staff feeling anxious, nervous, this also brings opportunities as this allows staff members and teams to work in different ways to reduce savings. MH also alluded to the trust 'values' and highlighted all the work currently underway which was addressed in the presentation, ensuring the values are being addressed whilst working through the project. Five workstreams have been established to cover the large pieces of work, which will drive the changes and improvements and pulling staff and resources together, to work through the challenges. All CSUs have been allocated an Exec sponsor to them, where the Executive responsible for that particular area will meet with the team to ensure they are fully supported, offer guidance to work through the challenges, priorities and cost saving efficiencies. Resources will be available monthly for staff to access, to support staff with morale as well as sharing examples of best practice and how staff contributions are impacting to the overall position of the organisation. An evaluation will be carried out of the trust schemes and position, as well as the programme to indicate that we are listening, reacting, respond and that we are making improvements in the programme, ensuring there is transparency, fairness, consistency and that	

	clarity has been given to our staff. AS suggested when communication is circulated if messages can be circulated with regards to the history of this piece of work, position update describing why 'closing the gap' has been developed so that staff can understand it better. AS also mentioned that we must be mindful of the gender pay gap and equal pay legislation and these cannot be disregarded of the cost improvement plan. MH confirmed that messages are cascaded via let's talk, the intranet, digital and verbal communication. The Academy was assured by the report.	
PA.7(1).24.17	**Internal communications strategy**	
	JJ and SSm joined the meeting and introduced the internal communications strategy. The current communication strategy is at a point where it needs to be refreshed, reflecting the changing communication challenges and opportunities available. In order for the strategy to be a success, JS welcomed ideas, participation and feedback from colleagues in helping to shape the communications strategy. For the strategy to be successful improvements needs to be made to the internal contact list and team structure, the team will be working closely with the HR team and IT team in order to review, assess and improve the contact, circulation lists and structure charts. Global emails will be assessed to improve its functioning process, work is underway with the IT team to investigate new options for emails, to make it more engaging and innovative. Prior to Covid a monthly core brief was shared across the trust which included information relating to performance, position and achievements, which staff members found very useful. The team would like to introduce this, as the information was previously shared with teams as part of team/departmental meetings and this added context, why certain activities were taking place. An editorial group of colleagues will be established to help forward plan Let's Talk with a mix of human-interest stories, lifestyle pages and corporate news. JJ and SSm welcomed feedback, comments and ideas to help improve and shape the communications strategy. The Academy noted the report.	
PA.7(1).24.18	**People awards and conference**	
	SW and JS joined the meeting and provided an update on the People awards and conference. In previous years the trust has held award events to celebrate and recognise the hard work of our staff, which recognised and brought awareness to the fantastic work across the trust. The presentation proposed the following:	

	• To host a celebratory event on Thursday 26 September. • To identify funding for the event, via sponsorship from local businesses. • To hold two events on the same day • The first event will a be a long service award ceremony from 2-5pm, (times now changed to 12.30pm - 3.30pm), for staff who will have achieved 30 years in the NHS. • The second event will be the staff awards, which will be an evening staff awards event, where the excellent contribution from individuals and teams will be celebrated and appreciated. • There are seven categories for the awards and the presentation referenced each category. • The nomination period will run from 8 July – 9 August, the nomination forms and process will be accessible via the intranet pages and communication will also be circulated via Let's talk. • The judging period will run from 12 – 16 August. • The finalists will be announced week commencing 19 August. • The judging panel will consist of an executive director, non-executive director, staff network member and a patient. (patient / patient experience team member). • A let's talk article will be published w/c 8 July which will have details about the awards, as well as links to the nomination forms. There was an ask for academy attendees to promote the awards event within their team and directorates and to consider if there are any individuals or teams, that should be nominated for an award. The Academy noted the report.	
PA.7(1).24.19	**Any other business**	
PA.7(1).24.20	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.7(1).24.21	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.7(1).24.23	**Date and time of next meeting**	
	9 August 2024, 10:00 to 11:00	

Items for Information		
	Internal audit reports relevant to the Academy	
PA.7(1).24.23	• BH452024 – Pre-employment checks • BH472024 – E-job planning This item was shared for information only.	
PA.7(1).24.24	Staff story - Outstanding theatre services review document (from action PA24001 at 31.01.24 meeting) This item was shared for information only.	

ACTIONS FROM PEOPLE ACADEMY – 3 July 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	09.08.2024	This item is on the agenda. Action closed
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	09.08.2024	In the first cohort 2 physios and 1 OT are expected to qualify in 2025. The dietetics 1st cohort commenced in 2024. Currently it is too early to report on the number of apprentices in Therapies taking up employment with the Trust. Action closed.
PA24017	03.07.2024	PA.7(1).24.11	**Revised Terms of Reference and workplan:** JM would propose the addition of the Deputy Chief Medical Officer to the membership list for the people academy at the more detailed review scheduled to take place.	Head of Corporate Governance	09.08.2024	To be presented for consideration at the second review meeting on 5 August 2024. Action closed.

PA24008	22.02.2024	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	25.09 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 deferred to September.
PA24016	03.07.2024	PA.7(1).24.5	**Nursing and Midwifery staffing data publication report:** SW agreed to share the feedback report, based on international nurses and their experiences at the trust**.**	Associate Chief Nurse	25.09.2024	
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

PEOPLE ACADEMY MINUTES

Date:	Friday 9 August 2024	**Time:**	10:00 – 12:00
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 (RB) - Karen Dawber, Chief Nurse (KD) - Ray Smith, Chief Medical Officer (RS)		
In Attendance:	- Faeem Lal, Director of HR (FL) - Catherine Shutt, Assistant Director of HR/ Head of OD (CS) - Sarah Freeman, Director of Nursing (Operations) (SF) - Samia Hussain, Associate Director of HR (SHu) - Faye Alexander, Head of Education (FA) - Raquel Licas, Deputy Chair, RESIN (RL) - Jacqui Maurice, Head of Corporate Governance (JM) - Amandeep Singh, Partnership Lead (AS) - Sean Willis, Associate Chief Nurse Quality & Workforce (SW) - Amanda Limbert, Head of Service for workforce information and flexible workforce (AL) - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) - Rachel Pyrah, General Manager to CDIO Office (RP) - Justine Carroll, HR Business Partner (JC) - Jane Kingsley, Lead Allied Health Professional (JK) *In attendance for their items only:* - Rashi Gupta, Therapy Assistant (RG) for agenda item PA.8.25.5. - Susan Franklin, Associate Chief Nurse for Quality Improvement/Freedom to speal up Guardian (SF) for agenda item PA.8.24.8 - Georgina Hewitt, Lead Pharmacist (GH) for agenda item PA.8.14.11 only.		
Observer			

Agenda Ref	Agenda Item	Actions
PA.8.24.1	**Apologies for Absence**	
	• Altaf Sadique, Non-Executive Director • Laura Parsons, Assistant Director of Corporate Governance / Board Secretary (represented by Jacqui Maurice, Head of Corporate Governance) • Georgi Dyson, Assistant Director of HR • Jo Hilton, Director of Nursing/Deputy Chief Nurse • Sonia Sarah, Equality, Diversity and Inclusion Manager (SS) • Adele Hartley Spencer, Director of Nursing (Operations) (AHS)	
PA.8.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.8.24.3	**Minutes of the meeting held on 3 July 2024**	
	The minutes of the meeting held on 3 July 2024 were approved as an accurate record.	

	The Academy noted the outcome regarding the following actions: • PA24014 – PA.4.24.21 – Review of National Education & Training Survey (NETS) Feedback. This item was on the agenda. Action closed. • PA24015 – PA.5.24.5 – Therapies Workforce Plan. Update on the log noted. Action closed. • PA24017 – PA.7(1).24.11 – Revised Terms of Reference and workplan. Update on the log noted. Action Closed.	
PA.8.24.4	**Matters arising**	
	There were no matters arising.	
PA.8.24.5	**Staff Story – Positive Progression at BTHFT**	
	RG joined the meeting and provided some background in her progression at the trust. RG joined the trust in 2022 as a PPE Assistant after graduating in India as a Physiotherapist, RG did not have the qualifications required to pursue her career in Physiotherapy in the UK, hence taking up the post in the PPE hub. Whilst RG worked in the PPE hub her team members as well as the CEO encouraged RG to take up a career in her qualified area and RG made links with the head of service for Physiotherapy. RG successfully secured a Therapist Assistant position in the Medical Therapy team and whilst working in that role RG was encouraged to apply for her HPCP registration, which she pursued in 2023 and successfully gained her registration. RG successfully applied for the post of Physiotherapist, securing a position in the Neuro and Stroke team. RG explained that she gained support from her peers/colleagues and senior managers who supported her through her progression journey. She described the interview process as very daunting. The recruitment process was new to her and she had to adjust to the culture of the trust. RG shared that she enjoys her role, working with the patients on the ward and thanked everybody who has supported her on her progression journey. RB mentioned that CS and KH were undertaking a review of our trust recruitment, progression, policies and processes – having learned from RG's experience. KD and AS encouraged line mangers to hold conversations with their staff members during their 1:1 and appraisals on career progression and how the trust can support individuals through progression routes. The Academy noted the update.	
PA.8.24.6	**Workforce Growth and Transformation**	
	SW referred to the report which was taken as read and highlighted the following: • Apprenticeships are reviewed in detail. • Job descriptions will be reviewed, in particular when staff are struggling to apply for senior positions in the organisation.	

	• Understanding and recognising 'equivalent experience' to qualifications for band 8A's and above. • A new way of CPD allocation in the new year to support staff to gain access to higher education qualification. • Conversations are ongoing regarding career conversations and reverse mentoring. • A programme supported by NHSE for our region has been launched, the closing date is 15 August and senior staff have been encouraged to apply to the course. Some of our staff members have completed the course and positive feedback has been received. KD pointed out that an area to focus on is for staff members on bands 6 and 7 who would like to progress to senior positions, as a gap has been identified in these staff groups. KH agreed to meet with CS and SW to discuss this further. **Action:** KH agreed to meet with CS and SW to discuss those staff members on bands 6 and 7 who would like to progress to senior positions, as gaps have been identified in these staff groups. The Academy noted the update.	(PA24018) Head of Equality, Diversity & Inclusion
PA.8.24.7	**Review of National Education & Training Survey (NETS) Feedback**	
	FA introduced the report. She informed colleagues that the NETS feedback was presented in April and that on the back of the survey there was a request to review some of the feedback and statistics compared with local trusts. The report summarises results from various locals trusts across WYAAT and in the North East and Yorkshire region. FA drew members attention to the following key points: • Compared to the national average and benchmarking against other Trusts, BTHFT stands out as a top performer within WYAAT and among other teaching hospitals in the region. • All learners were asked if they would recommend their Trust for training. BTHFT is performing well, with only 9% of learners unlikely to recommend it. Compared to Trusts within WYAAT, BTHFT's results are mid-range. However, among teaching hospitals in the region, BTHFT is the top performer for this question. • The nursing results show a moderate interest in employment, with 49% of students indicating they plan to apply for a post at BTHFT upon qualifying. This figure is slightly below that of some other Trusts in the region. • Work needs to be undertaken where learners were asked if they plan to apply for a post within the Trust. This area scored low and requires some focus. FA will work closely with the University of Bradford to identify where the graduate students are applying to after qualifying. There are also opportunities for the Trust to work closely with Bradford University to highlight our career development plans ensuring the University is aware of our recruitment timeline.	

	• SW and FA have agreed to work together to ensure that all the work the Trust is carrying out is shared with Bradford University. RS stated that we need to understand the barriers to why qualified staff do not apply to Bradford and also suggested that, if capacity allows, we can introduce/develop a recruitment pack for learners in their final year highlighting the careers and development opportunities at the Trust. The Academy noted the update.	
PA.8.24.8	**FTSU Quarterly Report**	
	SF joined the meeting to provide an update on the Q1 quarterly report. SF drew members attention to the following: • Recruitment campaigns are underway to recruit new FTSU ambassadors. • With regard to FTSU e-learning training; an internal audit review will be carried out on the management of FTSU across the Trust. The following up training module - Speak up, listen up - is not mandatory but the national guardian has asked all senior leaders to commit to undertake the training. Three Board members have completed the 'follow up' training and 4% of staff have completed the 'speak up' training. SF encouraged members of the Academy to complete the training. KD proposed that the training is mandated for Execs and Non-Executives and also suggested mandating the 'speak up, listen up' training for staff members on bands 8A and above. KW agreed that she would include KD's proposal in her Chair's report to the board. • FTSU month is in October and this year the focus is on 'the power of listening'. • 22 concerns have been raised in Q1 – which has seen the highest number of concerns raised around 'inappropriate attitude' and 'behaviours'. • The highest group of reporting concerns were made from registered nurses and midwives. **Action**: It was agreed for KD to propose mandating the FTSU e-learning training for Non-Executive Directors and Executive Directors as well as staff at Band 8A and above. The Academy noted the update.	(PA24019) Chief Nurse
PA.8.24.9	**Thrive Live update**	
	CS explained that Thrive Live was launched several years ago. Some reflection and learning has taken place and as a result of this Thrive Live was relaunched in July with some new additions. The new format includes subject matter experts who will be present at the session to answer relevant questions. Two events have taken place, the first one in Education and the second event in Research. In total across both sessions, 89 participants attended, which is a large improvement compared to previous numbers. Some themes have been specific to both	

	sessions and others to the individual session. Feedback shared indicates that having subject experts at the sessions worked well, as well as also having an Executive member present. Both sessions have taken place face to face, but consideration has been given to a hybrid approach. The sessions have been planned to take place monthly for the course of the year at BRI and St Lukes and planning is underway for sessions in 2025. CS asked colleagues if they would consider hosting a session in their departments. Colleagues were advised to contact the Organisational Development team. The Academy noted the update.	
PA.8.24.10	**Higher Programme Board**	
	CS provided an overview of the higher programme board, which has three aims. The aims are: • To improve the overall recruitment of colleagues • To improve the overall recruitment process of candidates • To reduce the average time from advert close to start date, to below 59 working days. Time to hire has reduced from 126.5 days to 90 days, this has seen a good improvement but there is a further push to reduce this further to achieve the target. There have been some changes to standardise recruitment timetables and agree start dates with the recruitment team. Work has commenced to introduce interview standards. There will be a maximum of five questions and examples will be shared with different grades and bands. One of the questions will be an EDI question, two will be skill based and two will be competency based. Work is also underway to review generic job descriptions and person specifications to simplify these. The Academy noted the update.	
PA.8.24.11	**Outstanding Pharmacy Service**	
	GH joined the meeting and provided an update on the programme of works in the Outstanding Pharmacy Service. GH is the lead for the Education and Training workstream. Since the programme has been developed the team have been looking at making improvements around education and training. The team identified a lack of training, support, resources and awareness for line managers (in particular new line managers). To address this issue the team has introduced regular line manger catch ups, which take place once a month where line managers can raise any questions or concerns. All line mangers within the	

	department have the opportunity to attend the meetings. The team has also identified that a lot of delays within the department are to do with issues relating to errors or problems with prescription requests before they reach the department. As a result of this a one-hour teaching session has been introduced on day two of nursing preceptorship training on medicine management. Feedback is captured based on the learning from the session and learners have stated that it has helped significantly with their knowledge and confidence about the topic. The team are considering similar teaching sessions for junior doctors to support them with prescribing. In addition, a small credit card size instruction card has been developed instructing medial staff how to correctly prescribe drugs. The department has created a conference calendar, ensuring staff within the department are aware of key conferences and staff have been encouraged to attend these. A competency matrix has also been developed so that staff can identify their own development needs, to support improvement of the overall staff skill mix. Where there has been difficulty to recruiting to some roles the JDs and PSs have been reviewed which has proven positive as some of the roles have been filled. The Academy noted the update.	
Assurance		
PA.8.24.12	**People Academy Dashboard**	
	CS introduced the dashboard and highlighted the following: • Mandatory training is improving month my month, Overall, Trust compliance continues to be above the Trust target of 85% and has stayed above 90% over the last several months. All CSU's continue to achieve above the 85% target. 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. • Monthly turnover rate is 9.95%, this is a slight increase since May. • There has been an overall decrease in agency use. • The disability declaration rate is improving and currently sits at 4.9%. • Contacts with the staff advocacy service have reduced and is the lowest since 2018. KW queried the slight increase in absence and staff turnover and asked whether there was a rationale that led to the increases. SHu wasn't aware of the reason behind this but agreed she would explore this and will provide an update at the next meeting. FL agreed that the sickness absence is higher compared to other Trusts and generally around this time of the year, absence is generally high. SHu assured the academy that the HR team are	

	developing a piece of work to support managers with sickness absence. **Action**: SHu agreed to provide an update on sickness absence, in particular the increase in sickness absence, data, targets etc at the October meeting. The Academy was assured by the report.	(PA24020) Associate Director of HR
PA.8.24.13	**People Academy ToRs and Work Plan**	
	JM advised that as reported in the paper, drew attention to the following changes to the Terms of Reference: • The People Academy will remain in its current format as an 'academy' • An additional section has been added to the 'improvement ' section of the ToRs • There have been some minor changes to the membership and those in 'attendance' where members of leadership teams can attend the meeting. With regard to the work plan: • Several items have been removed and the remaining items have been grouped under 5 key headings. • It was agreed to remove 'Nursing Recruitment and Retention Plan' from the workplan and KD and JM agreed to discuss 'Workforce Growth and Transformation' outside of the meeting. **Action**: KD and JM agreed to discuss 'Workforce Growth and Transformation' outside of the meeting. Subject to any changes regarding workforce growth and transformation, the Academy approved the revised ToRs and workplan as described in the paper.	(PA24021) Chief Nurse & Head of Corporate Governance
PA.8 24.14	**High level operational risks**	
	CS advised of the following: • The target mitigation dates for risk numbers 257 and 512 have been extended. • There are no new high-level risks reported or any changes to the risk scoring. • Risk 187 is beyond its review date which is being updated. The risk description will also be updated to remove reference to Covid, to ensure the risk is more reflective of the current context. The Academy was assured by the paper.	
PA.8.24.15	**Workforce Report**	
	CS introduced the report and highlighted the following key areas of note: • The staff in post headcount has increased from 6,779 to 7,331. • There has been a slight reduction in turnover May from 9.87% to 8.99%.	

	• Year to date absence rate is 5.79%. The main reasons for sickness absence are stress/anxiety and depression. • Mental health awareness week: A number of promotions and activities took place across the Trust showcasing clubs associated to physical and mental health. • Equality diversity and human rights week: Promotion of staff networks and celebratory events took place. • Band 5 recruitment event: 59 posts were offered to newly qualified nurses and the Trust is expecting 100 newly qualified nurses to start in the next 6 months. • Thrive Hive has launched: *(As previously reported under separate agenda item).* The Academy was assured by the paper.	
PA.8.24.16	**Guardian of safe working hours – Quarterly report**	
	RS presented the Q1 report for 2024/25. The Academy noted that the 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the board to provide assurance that doctors and dentists in training are working safe hours. Key points noted were: • 54 exception reports were reported in the quarter, 48 of these were related to hours/working patterns, 5 were relating to education and 1 to the service support available to the trainee. In addition, 2 reports were flagged as an immediate safety concern and these were investigated individually by the Guardian of Safe Working. • In Q1 there were 54 exception reports. In total 66.5 additional hours were reported. • The highest number of reports and additional hours came from trainees in Plastic Surgery covering specific gaps in rotas and the issues raised are currently being addressed. The Academy was assured by the paper.	
PA.8.24.17	**Any other business**	
	CS informed the Academy that the nominations for the Brilliant Bradford awards are now closed. 235 nominations across all categories have been received and judging will take place next week. KD informed colleagues that an extraordinary 'Pause for Peace' is taking place today and encouraged as many members as possible to attend. KD also encouraged managers/colleagues to check-in with colleagues to ensure that they are safe at work, or whether any support can be offered for those that need it. RL reminded members that it is the South Asian Heritage month and an event will be taking place in the main concourse at BRI, on Wednesday 14 August from 12pm to 2pm to celebrate the occasion.	

	AS informed colleagues that he has received concerns from staff in respect of 'closing the gap' with regards to health and safety issues and the recruitment freeze of non-clinical posts and overtime reduction and how this is impacting staff. AS commented that it will be helpful to know if service managers are picking up similar concerns and that the necessary risk assessments are being carried out. KD informed members that a process is followed before any vacancies are frozen and this also includes a risk assessment. A variable pay panel meeting takes places every Friday and vacancies are also submitted to the weekly Executive team meetings for Executives to approve/refuse the vacancies. KD assured colleagues that most vacancies are approved and asked AS to share the health and safety concerns raised with him so that they can be addressed and resolved in a timely manner, AS agreed to share the concerns with KD and RS. **Action**: AS agreed, to share the health and safety concerns raised to him with KD, so that they can be addressed and resolved in a timely manner.	(PA24022) Partnership Lead
PA.8.24.18	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.8.24.19	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.8 24.20	**Date and time of next meeting**	
	19 September 2024, 14:00 to 16:00	

Items for Information		
PA.8.24.21	Report/minutes from Health and Safety Committee	
	This item was shared for information only.	
PA.8.24.22	Nursing and midwifery staffing data publication report	
	This item was shared for information only.	
PA.8.24.23	Internal audit reports relevant to the Academy	
	This item was shared for information only.	

ACTIONS FROM PEOPLE ACADEMY – 9 August 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
PA24008	22.02.2024	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	25.09 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 deferred to September. Sept 2024 – a workshop session has been held with the gender equality forum. Update from the session to be presented to People Academy in November 2024 (added to agenda). Action closed
PA24016	03.07.2024	PA.7(1).24.5	**Nursing and Midwifery staffing data publication report:** SW agreed to share the feedback report, based on international nurses and their experiences at the trust**.**	Associate Chief Nurse	25.09.2024	
PA24022	09.08.2024	PA.8.24.17	**Any other business:** AS agreed, to share the health and safety concerns raised to him with KD, so that they can be addressed and resolved in a timely manner.	Partnership Lead	25.09.2024	AS has referred the safety concerns to KD. Action closed

PA24018	09.08.2024	PA.8.24.6	**Workforce Growth and Transformation:** KH agreed to meet with CS and SW to discuss those staff members on bands 6 and 7 who would like to progress to senior positions, as gaps have been identified in these staff groups.	Head of Equality, Diversity & Inclusion	23.10.2024	
PA24019	09.08.2024	PA.8.24.8	**FTSU Quarterly Report**: It was agreed for KD to propose mandating the FTSU e-learning training for Non-Executive Directors and Executive Directors as well as staff at Band 8A and above.	Chief Nurse	23.10.2024	
PA24020	09.08.2024	PA.8.24.12	**People Academy Dashboard**: SHu agreed to provide an update on sickness absence, in particular the increase in sickness absence, data, targets etc at the October meeting	Associate Director of HR	23.10.2024	
PA24021	09.08.2024	PA.8.24.13	**People Academy ToRs and Work Plan:** KD and JM agreed to discuss 'Workforce Growth and Transformation' outside of the meeting.	Chief Nurse & Head of Corporate Governance	23.10.2024	
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	

QUALITY AND PATIENT SAFETY (QPS) ACADEMY - ASSURANCE MEETING MINUTES

Date:	Tuesday, 2nd July 2024	**Time:**	1pm to 3.30pm
Venue:	Microsoft Teams Meeting	**Chair:**	Professor Louise Bryant Non-Executive Director / Chair
Present:	- Professor Louise Bryant (LB), Non-Executive Director / Chair - Mrs Julie Lawreniuk (JL), Non-Executive Director - Dr Ray Smith (RS), Chief Medical Officer		
Attendees:	- Mr John Bolton (JB), Deputy Chief Medical Officer / Operations Medical Director - Mrs Sara Hollins (SH), Director of Midwifery - Mrs Sarah Freeman (SF), Director of Operations (Nursing)		
In Attendance	- Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District Care Health and Care Partnership - Ms Jacqui Maurice (JM), Head of Corporate Governance - Ms Judith Connor (JC), Associate Director of Quality - Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes - Mr Mark Hindmarsh (MH), Director of Strategy and Transformation, in attendance for agenda item QA.7(1).24.4 - Mr Nazzar Butt (NB), Moving to Outstanding Lead, in attendance for agenda item QA.7(1).24.14 - Mr Nicholas Rushton (NR), Patient Safety Manager - Ms Sally Scales (SS), Director of Nursing representing Professor Karen Dawber (KD) - Ms Sarah Turner (ST), Assistant Chief Nurse Vulnerable Adults and Safeguarding Adults, in attendance for agenda item QA.12.23.12 - Ms Liz Ward (LW), Named Nurse Safeguarding Children, in attendance for agenda item QA.12.23.13 - Ms Linda Preston, Minute-taker		
Observers	- Alastair Goldman, Partner Governor - Karina Edwards, Internal Audit Manager, Audit Yorkshire		

Agenda Ref	Agenda Item	Actions
QA.7(1).24.1	**Apologies for Absence**	
	- Professor Karen Dawber, Chief Nurse (represented by Sally Scales, Director of Nursing) - Karen Walker, Non-Executive Director - Adele Hartley-Spencer, Director of Operations (Nursing) - Kay Pagan, Assistant Chief Nurse for Informatics - Laura Parsons, Associate Director of Corporate Governance / Board Secretary in attendance for agenda item QA.7(1).24.11 only (represented by Jacqui Maurice, Head of Corporate Governance - Sughra Nazir, Non-Executive Director - Dr Paul Rice, Chief Digital and Information Officer - Dr Deborah Horner, Deputy Chief Medical Officer - Joanne Hilton, Deputy Chief Nurse / Director of Nursing	

QA.7(1).24.2	**Declarations of Interest**	
	There were no declarations of interest.	
QA.7(1).24.3	**Minutes of the Meeting Held on 22nd May 2024**	
	The minutes of the meeting held on 22nd May 2024 were approved as a correct record of the meeting. With regard to the action log, the following updates were provided. • QA24007: Academy ToRs. These have been added to the agenda for this meeting. Action closed. • QA23017: Adult Safeguarding. ST advised that the Missing Person Protocol Policy is aligned to the way in which the Police prioritise risk and has been recirculated around the Trust, which has seen a decrease in the number of inappropriate reports to the Police. As a result of the Right Care Right Person (RCRP) work there is also now improved dialogue with Police and mental health Trust colleagues. Action closed.	
QA.7(1).24.4	**Matters Arising**	
	• Items to Escalate from the Chief Nurse/Chief Medical Officer In relation to the recent five day Junior Doctor industrial action which ended at 7am this morning, RS advised that as previously a significant amount of planning work was undertaken resulting in the affected days being managed safely with no incidents of harm occurring as a result of the strike. Approximately 30% of elective in-patient operating was stood down, together with around 20% of out-patient activity which included some out-patient cancer appointments. All elective cancer operations went ahead as planned. There was no evidence of a reduction in A&E attendances throughout the five days, and 1st July 2024 saw the second highest ever daily number recorded at 506. The number of Junior Doctors who participated in the strike action varied between 69% and 76%. RS expressed his thanks to all those colleagues involved in the planning and those who stepped up to cover the gaps including nursing staff, other clinical staff and non-clinical staff, to which LB concurred. • Equality Impact Assessment Process MH introduced the circulated presentation around the Closing the Gap programme and reiterated the desired achievements of the process. He talked through the flowchart explaining how the impact assessment process will work and the supporting documentation to be used. He then gave an outline of the information and support available to colleagues on the intranet of the Closing the Gap programme.	

	JL asked what the timescale is for moving through the process. MH confirmed the Quality Oversight Panel meets on a weekly basis. The current hindrance being seen in relation to the process is around staff being clear about what they are trying to achieve, what the potential financial savings which might arise are, and engagement around this with colleagues. JL also questioned what the impact on quality may be and how difficult decisions will be made when there is a need to choose between safety and quality. MH said he believes the process will assist in making those judgements as conversations will be undertaken with the CSUs around quality and safety, and the conclusions which need to be made to avoid an impact on safety and minimise any effects in terms of quality. SS commented the Closing the Gap programme will be a challenge initially for the CSUs and support will be required for them to deliver its objectives. MH agreed and reiterated the work will be done in conjunction with colleagues and they will be listened to and supported. JB advised the first pre-meeting of the panel had taken place during which there was an acknowledgement of the need to not cause a delay in progression of the programme, and a prioritisation process is therefore being implemented. He noted the process is one of learning as it goes along, and there is also an awareness of the requirement of the assessments to highlight where risk exists so they can be escalated for further considered discussion. RS added it is acknowledged that safety cannot be compromised. With regard to quality, it is accepted there will be some impact in order to achieve the savings required. However balanced decisions will be made as appropriate to obtain the most value in terms of financial savings with the least impact on quality of care for patients. JC agreed and noted the quality improvement methodology states the requirement to identify the measures which demonstrate success, but equally to look at measures with unintended consequences. LB thanked MH for his presentation and he then left the meeting. There were no additional matters arising or further issues to escalate.	
QA.7(1).24.5	**Quality and Patient Safety Academy Dashboard**	
	RS discussed the newly formatted circulated dashboard and noted the following: • The first four slides in the presentation are for education purposes and explain the differentials between variation special cause and common cause, and how to interpret a Statistical Process Control (SPC) chart.	

	• Slide five provides a summary for the latest period. The information contained on this slide is then examined in more detail in the graphs contained within the dashboard pack. • Some of the slides are still in development, eg the Crude Mortality Rate graph. However as can be seen the rate is decreasing which provides some assurance that the Summary Hospital Mortality-Level Index (SHMI) shows that we do not have excess deaths. SHMI is a rolling 12-month process and is reported quarterly in arrears, and therefore any changes can take a short while to be displayed on the graph. • On slide seven the labelling is to be corrected on the first graph (Structured Judgement Review - SJR) as it shows numbers of deaths month by month and should therefore be a run chart rather than a SPC chart. The SJRs scoring three or above graphs will have further information and narrative added going forward to provide context. JC added that it has been agreed that a graph depicting incidents still open over 30 days will be included as a measure on the dashboard as part of the Patient Safety Incident Response Framework (PSIRF) assurance. It is anticipated this graph will be included from next month. NR then advised with regard to the SJR metrics, the previous ones reported referred to the Medical Examiner Service rather than the Trust's learning from deaths process. The summer months of 2022 which showed 0% were shortly after the restart of the SJR process, and also the Mortality Review Improvement Group (MRIG) did not exist at that time. The number of SJRs being completed were low and Hospital Onset Covid Infections (HOCI) and Coroner deaths were also being picked up which had an impact on the figure. As a result of processes changing in the last two years, the twelve-month rolling chart demonstrates that quality of care within SJRs has improved. It is proposed to provide the Assurance Academy meetings with the crude mortality rates and SHMI, and the Learning and Improvement meetings with the SJRs and thematic analysis and supporting context. LB commented she found the new dashboard very clear, easy to read and informative, and expressed her thanks to everyone involved in its formation. The Academy noted the information discussed.	
QA.7(1).24.6	**Quality Oversight and Assurance Profile**	
	JC presented the Quality and Oversight Profile which is an accumulation of all the activities which have occurred around patient safety incidents, alerts, external reporting, CQC enquiries etc for the reporting period. She highlighted:	

	• In relation to safety incidents (SI), she noted the period being reported on is 1st May to 31st May 2024 and not 1st March to 31st March 2024 as shown on slide four, and likewise on slide five the period for externally reported incidents is May 2024. • A deeper dive has been undertaken into the CQC enquiries which is included in the Annual Insights Report. The CQC have moved into their single assessment framework and changed the way they engage with the Trust. Previously the monthly enquiry log was received which had a four-week response time, and any outstanding issues being discussed at the engagement meeting with the CQC. Following the restructure of the CQC prior to Christmas and the appointment of a different engagement lead, the process has changed and ad-hoc enquiries are now received with very tight turnaround times, which can place a burden on the quality team and clinicians who need to investigate the concerns raised. At present the Trust is regularly receiving multiple queries from different Inspectors in relation to the same matters. • There is a backlog of Inquests at the Coroner's Office, and it has been agreed we need to be given at least six week's notice to ensure clinicians have time to re-arrange or cancel any planned activities. Recently this notice period has not always been given, and it is believed this is due to quite a high turnover of staff at the Coroner's Office which has resulted in Inquests being relisted. The issue is being followed up with the Coroner's Office. • There are no risks to note from any of the safety incidents reported. • Patients requiring care under a Section 136 within the A&E department were not recorded in the past. However, we have introduced some documentation to support a clear process in terms of staff responsibilities and highlight that the Police must not leave individuals in the Trust's care; they are responsible and accountable for the patient whilst they are with us. These instances are also now recorded on IRIS, our incident reporting system. In relation to the CQC ad-hoc enquiries, JL asked if we now receive more enquiries than was the norm, and if we receive a report back once we have responded. JC advised it is unusual to receive such a high number of enquiries and with such short turnaround times and this is as a result of the change in CQC processes. She further advised that a confirmation email is received from the CQC when they are closing an enquiry. Further to a comment from LB, JC confirmed other Trusts are experiencing a similar scenario. RS commented the new report format is helpful, easy to understand and navigate, and LB agreed.	

	The Academy was assured following the presentation of the approach taken in that it links in with the work of the Academy into assurance, learning and improvement in relation to quality and patient safety incidents.	
QA.7(1).24.7	**Patient Safety Incident Investigations (PSII) and Legacy Serious Incident (SI) Report**	
	JC noted the format of the report will change going forward as the final legacy serious incidents have concluded. She highlighted: • Since the report was written there has been an update in terms of how Maternity and Newborn Safety Investigations (MNSI) will be recorded going forward. The Strategic Executive Information System (StEIS) will be closed down along with the National Report and Learning System, and replaced by the Learning from Patient Safety Events Platform (LFPSE). We have also been advised there will be a new taxonomy which is taxonomy LFPSE 6, and this will become into being in the next four to six weeks. Therefore, any incident which would be recorded on the StEIS system for MNSI will now automatically go through the LFPSE system. • Two legacy SIs were closed during the reporting period and three MNSI investigations are in progress. The Trust does not have a jurisdiction on how long the investigations take as this is determined by an external body hosted by the CQC. The Director of Midwifery's team works very closely with MNSI to ensure accurate information is provided and any recommendations and actions required by the Trust are undertaken. Challenges to any of these are made where appropriate. • This month the Trust received a concern following an Inquest where the Coroner asked for our response in terms of a patient death as he felt there should have been a higher level of investigation in addition to the usual learning from deaths and mortality processes. The Coroner requested the Trust specifically consider if duty of candour had been exercised, and following open and candid discussions with the clinical team involved it has been recognised that further work is required in respect of clinicians' understanding around their responsibilities under the legislation, and how this is applied with regard to openness and transparency with patients and families, and the recording of such within EPR. A plan has therefore been put in place and a response has been sent to the Coroner detailing this which has been accepted. It is felt there is not a risk to the Trust at the present time, however further work will be done with the clinicians over the coming months.	

	• Going forward the report will also include the number of after action reviews undertaken, how many multidisciplinary team meetings are held, and any other activities which sit outside of the PSII process and identify the learning from patient safety incidents. The Academy noted the report and confirmed they are assured the Trust has processes in place to identify, investigate, improve and learn from patient safety investigations.	
QA.7(1).24.8	**Patient Safety Incident Response Framework (PSIRF) Oversight Guidance**	
	Whilst the oversight guidance is included in the Complaints, Litigation, Incidents and Patient Experience (CLIP) insight report, JC noted the report comprises mainly of the CLIP report and also moves into the insight arena. As part of the transition into PSIRF at the beginning of the year there was a requirement to ensure the work previously undertaken was captured, however consideration was also needed as to how data was assessed from a much wider learning perspective.	
QA.7(1).24.9	**Complaints, Litigation, Incidents and Patient Experience (CLIP) – Quarters 3 and 4 and Annual Report**	
	JC noted the circulated report brings the data together for the purpose of learning, improvement and assurance, and is the beginning of the step change with regard to the way the Trust uses the data to provide a richer insight and inform us how we continue to provide good quality of care. The aim is to be able to demonstrate how the Trust uses the learning to inform the improvement work going forward, and share examples of good and excellent practice across the organisation. JC commented work is still to be done on the report, particularly around claims which are currently very narrative driven rather than from a data perspective. JC then gave an overview of the circulated report and noted: • The number of reported incidents is not outwith national figures which is around 1,000 incidents per month. Work remains to be done to ensure all incidents are being reported appropriately. • Whilst there are currently 434 open clinical claims against the Trust these will not all result in settlement, and some will close once the evidence has been gathered and submitted to NHS Resolution. RS queried if the triangulation capabilities available in the InPhase system are yet being used. JC stated a condition of the procurement process was that like for like modules only were able to be purchased and therefore we do not have the Insights capability available at present.	

	In terms of damages payments for claims, JL asked if it is known how the figure benchmarks against other Trusts. JC said the Trust receives a Getting It Right First Time (GIRFT) report around claims each year and the information is also provided by NHS Resolution. She continued that the majority of high value claims are in relation to maternity cases, however the Trust is not an outlier when compared to other Trusts. RS added the occurrences which led to the settled claims did not all take place in one year, rather the claims were settled in the one year, and therefore the value of settled claims can differ substantially from one year to the next. He also noted the Trust pays for insurance to cover for the cost of claims rather than the damages payments coming out of our budget. With regard to the number of complaints which have not been resolved in six months, SS commented the current figure of 49 seems quite high and some of these may progress to claims. LT said work is to be done with the Patient Experience Team to gain an understanding of the data in the Insights report and the learning and improvement work being done. Simplification of the complaints process is also being looked into. The Academy noted the content and was assured following the discussions. The Academy also approved the changes reflected in the report for quarter four and confirmed the reporting period as quarterly.	
QA.7(1).24.10	**High Level Risks Relevant to the Academy**	
	The paper circulated prior to the meeting was presented by RS. He highlighted: • There are currently 16 risks aligned to the Academy with a score of 15 or above. • None of the new risks on the High Level Risk Register (HLRR) are new risks, however they have been added to the HLRR due to their increase in score. Risk 605 is past its target mitigation date and is also listed as a new risk to the HLRR. The increased score is as a result of a recent Haemoglobinopathy peer inspection commissioned by the UK Haemoglobinopathy Forum, who is in turn commissioned by the British Haematological Society which does not carry any statutory authority. The Trust is a local Haemoglobinopathy service, with Leeds being a specialist Haemoglobinopathy service, and Sheffield and Manchester are jointly a Haemoglobinopathy co-ordination centre. Local centres are not usually inspected and there is no service specification or inspection criteria for such centres to be measured against, however due to pressure from the National Thalassaemia Society a request was made for an inspection to take place.	

	As a result of the inspection an initial safety concern was noted recommending a Haemoglobinopathy Consultant should be appointed, which is not the norm for a local centre, and it would undoubtedly prove difficult to fill the role. Further discussions have therefore taken place and it is generally accepted the recommendation was superfluous. With a view to resolving the risk, our good working relationship and the assistance we receive from the red cell expert Consultant in Sheffield will continue. In addition, as future haematological job plans become available and there is potential for new appointments to be made, consideration will be given for time for haemoglobinopathy services to be included in job plans. A high level of haemoglobinopathy support however is currently provided to our patients, and this is at a greater level than would be expected of a local centre. • In relation to risk 396, the CQC were particularly interested in the Stroke Service and the input of therapies to it, which is the reason for the escalation of the score of this risk. The current Sentinel Stroke National Audit Programme (SSNAP) rating, which looks at how soon various actions / assessments / processes take when a patient presents on-site, is C. Ruth Taunton-Smith, General Manager is leading much of the work being undertaken looking at where improvements can be made, and this is being done in conjunction with Airedale General Hospital (AGH) who the service is shared with. RS continued that the scoring of SSNAP is to be changed and at the present time the new scoring system is shadowing the traditional one. The criteria on the new system are far more rigorous and also include new items such as 'what proportion of patients have a mechanical thrombectomy?', which is a specially commissioned service and in WYAAT is only available in Leeds, and our score may therefore be affected by such matters. • Regarding risk 171, RS stated discussions are taking place with Specialist Commissioning and system-wide meetings are being held looking at capacity for renal dialysis. There are currently approximately six months' worth of capacity (14 slots) remaining and around three net increases to our chronic dialysis programme each month. Leeds Teaching Hospitals are also in a similar position. RS will provide an update at the next Academy meeting. Following a query from JL regarding risk 2509, RS advised the Trust is involved in providing some of the assessments and the service has experienced pressures for a while. RS confirmed it is regularly discussed at the System Quality Committee, however he will discuss with KD on her return regarding the Academy's oversight and visibility of the risk.	QA24014 Chief Medical Officer (RS) QA24015 Chief Medical Officer / Chief Nurse (RS/KD)

	With regard to risk 221, JM provided an update from Saj Azeb, Chief Operating Officer, in that until a permanent unit is in place a temporary aseptic mobile unit has been installed and handed over to the Trust at St Luke's following a lengthy period of estates related work by the supplier. The final works involved the commissioning of isolators which required testing and signoff. It is anticipated the mobile unit will be functional by the end of August / beginning of September 2024 following signoff of all necessary compliance standards. The Academy was content with the report and was assured the relevant key risks are being identified, reported to the Academy and managed appropriately.	
QA.7(1).24.11	**Board Assurance Framework – Strategic Risks Relevant to the Academy**	
	LP provided a verbal update as the Board Assurance Framework (BAF) is currently in the process of being reviewed to ensure the risks included are correct and up to date. Some recommendations have also been received for consideration from a Governance Consultant who has undertaken a review of the Trust's Board and Committee arrangements, risk and the BAF. She continued that the BAF was discussed at the Board Development session on 13th June 2024 where the Board was asked to prioritise the 17 risks currently included. The number of risks is to be reduced down to around 10 to make the BAF more manageable, allow focus to be given to the key risks to enable the Trust to achieve its objectives, and remove any duplications. LP is therefore going to work with the Trust's Chair and Audit Committee Chair to develop the new BAF which will be presented to the Academies and Board of Directors for signoff. The Academy noted the update provided.	
QA.7(1).24.12	**Safeguarding Adults Annual Report (Including Update on Right Care, Right Person)**	
	ST took the circulated annual report as read, and introduced the slide presentation. She highlighted: • A decreasing picture of compliance in relation to level three training had been seen, however this was in part due to the reporting system. A piece of work has been undertaken with education to address this resulting in re-levelling of staff and an increase in the number of people with this training level requirement. • An increase in requests for engaging with multi-agency reviews has been seen. No training in this regard has taken place for a number of years so this was arranged through the partnership, and two Trust members of staff attended. • ST's chairing of the regional Criminal Justice and Mental Health meetings gives an opportunity for an acute Trust voice to be heard as this area has a significant impact on acute care.	

	SS recognised the whole safeguarding agenda is broadening and increasing every year, and the importance of the Academy receiving the report and the continual learning taking place. With reference to the increasing complexity of cases, LB asked how the learning is brought through from amongst others the Hospital Independent Violence Advocate (HIDVA), and the Independent Sexual Violence Advocate (ISVA) to increase the knowledge and learning of our staff more generally. ST advised information is disseminated through the Safeguarding Adults sub-group as domestic abuse is a standing agenda item, and also via the safeguarding champions and the Intranet. Work is also undertaken in conjunction with the Safeguarding Children team as appropriate. With regard to the recommendations contained in the report ST commented there is a desire to make the Additional Needs Care Navigator post a permanent position, however consideration needs to be given to this whilst recognising the current financial status of the Trust. Similar conversations are also taking place at partnership level with regard to the HIDVA role. The Academy was assured that the Trust is meeting its statutory duties and delivering high quality care for vulnerable adults and demonstrating learning and improvement.	
QA.7(1).24.13	**Safeguarding Children Annual Report**	
	LW introduced the Safeguarding Children annual report and discussed the headlines and key achievements. She discussed the new arrangements and offerings in terms of training and how it is delivered. The offer for level three training has increased with the traditional face to face 2 hour sessions and by utilising lunch and learn sessions, virtual and simulation sessions etc. With regard to development, one of the team members who is now a permanent member of staff comes from a child and adolescent mental health service background, and her role is being developed to be the advocate for children's mental health. She also worked closely with ST when there were concerns with regard to children with mental health issues placed in Bradford from out of area and who are accessing the Emergency Department (ED). LB thanked LW for the update and report provided. The Academy was assured that the Trust is meeting its statutory duties and delivering high quality care for vulnerable children and demonstrating learning and improvement.	
QA.7(1).24.14	**15 Steps Assurance Programme**	
	NB provided an update on the 15 Steps Assurance Programme and potential areas for review and improvement as detailed in the circulated paper.	

	In relation to broadening out the programme with Place colleagues, SS asked if conversations have taken place with the Patient Experience Team as it needs to be 50% patient led. NB said he has had discussions with Karen Bentley, Assistant Chief Nurse in relation to the PLACE leads and noted the guidance mentions the programme can be incorporated as an additional component to the Place inspection. It is hoped to have a meeting with Place colleagues to discuss this further. LT noted her agreement and offered her support to NB in engaging patients and their families / representatives in the programme. SS also noted the need to not make the visits too onerous as they then fail to achieve their objectives. NB commented the visits should be no more than 40 minutes in total and he will bear SS' comments in mind. The Academy noted the report and update provided.	
QA.7(1).24.15	**Maternity and Neonatal Services Update**	
	SH introduced and discussed the circulated presentation and report. She advised the Academy there were two neonatal deaths in May 2024 and not three as shown in the report, as one of the deaths did not meet the criteria for reporting. In relation to the actions from the completed investigations, SH noted: • With regard to managing inductions one of the ward midwives is leading on a great deal of quality improvement work, and this has been recognised at the recent Midwifery and Nursing Awards where she was commended on the work undertaken. • There are still some challenges with personalised care plans due to our digital capabilities, and work continues to attempt to make progress in this area. This is an outstanding Ockenden action. • One of the points the Trust did not agree with in the MNSI report was around the need to have a paper proforma for recording telephone triage calls. The Trust advised MNSI we now operate a paperless service utilising a checklist in EPR for parental post-natal calls, and therefore it is felt the recommendation should be that this is followed by the midwives. Meetings with parents are offered to discuss any concerns, and are also used to advise them that whilst we acknowledge the MNSI report, there are some points within it with which we do not agree. If the offer of a meeting is declined it is clearly noted where disagreement with MNSI exists, and this is archived along with the timeline, completed report and other investigations undertaken should progression to a litigation occur or the matter require further exploration in the future.	

	This process has been approved by the Quality of Care Panel (QuOC). The Academy noted the contents of the report and supporting documentation, and feel assured that the Trust is providing high quality maternity and neonatal care delivered with kindness, and demonstrates learning and improvement in relation to maternal and neonatal incidents.	
QA.7(1).24.16	**Revised Academy Terms of Reference and Workplan**	
	JM discussed the circulated documentation and the proposed interim changes to the Quality and Patient Safety Academy which will be presented to the Board of Directors in July 2024. A fuller review of the Terms of Reference and Workplan will take place shortly, following which an update will be provided to the Academy prior to being presented to the Board of Directors for approval in September 2024. In addition to the information provided, JM advised that since the ANHH Consulting review and following a discussion between the Trust's Chair and Chief Executive, it is proposed to rename the Academy to the 'Quality Committee'. The Academy provided approval of the proposed interim changes.	
QA.7(1).24.17	**Any Other Business**	
	There was no other business to discuss.	
QA.7(1).24.18	**Matters to Share with Other Academies**	
	There were no matters to share with the other Academies.	
QA.7(1).24.19	**Matters to Escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
QA.7(1).24.20	**Date and Time of Next Meeting**	
	The date of the next meeting has changed to Wednesday, 14th August 2024, 1pm to 3.30pm.	
	Annexes for the Quality and Patient Safety Academy **Annex 1 – Documents for Information**	
QA.7(1).24.21	**Quality Account 2023/24**	
	Noted for information.	
QA.7(1).24.22	**Bradford District and Craven Quality Committee (Highlight Report and Minutes)**	
	Noted for information.	
QA.7(1).24.23	**Freedom to Speak Up (FTSU) Annual Report 2023-24**	
	Noted for information.	
QA.7(1).24.24	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	

QA.7(1).24.25	**Internal Audit Reports Relevant to the Academy**	
	Noted for information. • BH/40/2024 Risk Management Framework and Strategy – 23rd April 2024 • BH/41/2024 Data Security and Protection Toolkit – 7th May 2024 • BH/46/204 Consultant and SAS Doctors Job Planning – 15th May 2024 • BH/50/2024 Clinical Audit Stage Two, Control Improvement Audit (CIA) – 6th June 2024	

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 2nd July 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	No feedback received. Action closed.
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	Included in the May Chair report to the Board of Directors on 11 July. Action closed.
QA24014	02.07.24	QA.7.24.10	**High Level Risks Relevant to the Academy** Risk 171 – Renal Services Capacity RS to provide an update following Specialist Commissioning and system-wide meetings looking at capacity for renal dialysis.	Chief Medical Officer	August 2024	Work underway to optimise the 4 pillars of renal care; namely chronic kidney disease, acute kidney injury, dialysis and transplant. Recognised as a high priority area for the ICB. On-going plans to assess and manage renal services across the ICB rather than at individual Trust level. Action closed.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24015	02.07.24	QA.7.24.10	**High Level Risks Relevant to the Academy** Following a query from JL regarding risk 2509, RS advised the Trust is involved in providing some of the assessments and the service has experienced pressures for a while. RS confirmed it is regularly discussed at the System Quality Committee, however he will discuss with KD on her return regarding the Academy's oversight and visibility of the risk.	Chief Medical Officer	August 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 to this, however, BTH is in the hands

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						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.
QA24016			(Next number)			

QUALITY ACADEMY
MINUTES

Date:	Wednesday, 14th August 2024	**Time:**	1300-1530
Venue:	Microsoft Teams Meeting	**Chair:**	Professor Louise Bryant Non-Executive Director/Chair
Present:	- Professor Louise Bryant (LB), Non-Executive Director/Chair - Mrs Julie Lawreniuk (JL), Non-Executive Director - Ms Karen Walker (KW), Non-Executive Director - Professor Karen Dawber (KD), Chief Nurse - Dr Paul Rice (PR), Chief Digital and Information Officer (part meeting) - Dr Ray Smith (RS), Chief Medical Officer		
Attendees:	- Ms Faye Alexander (FA), Head of Education - Ms Jane Kingsley (JK), Lead Allied Health Professional - Mrs Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing - Ms Judith Connor (JC), Associate Director of Quality - Mrs Kay Rushforth (KR), Associate Director of Nursing for Children and Neonatal Services - Mr Kez Hayat (KH), Head of Equality, Diversity & Inclusion/Assistant Director, HR - Ms Leah Richardson (LR), Patient Safety Specialist - Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes - Mrs Sara Hollins (SH), Director of Midwifery - Dr Yaseen Muhammad (YM), Nurse Consultant / Director of Infection, Prevention and Control		
In Attendance	- Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District Health and Care Partnership - Ms Jacqui Maurice (JMa), Head of Corporate Governance - Ms Denise Stewart (DS), Quality and Patient Safety Facilitator - Ms Sarah Hartley (SHa), Quality and Patient Safety Facilitator - Ms Linda Preston, Minute Taker		
Observers	- Alastair Goldman, Governor		

Agenda Ref	Agenda Item	Actions
QA.8.24.1	**Apologies for Absence**	
	- Ms Sughra Nazir (SN), Non-Executive Director - Mrs Adele Hartley-Spencer (AHS), Director of Nursing – Operations - Ms Karen Bentley (KB), Assistant Chief Nurse, Patient Experience - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Ms Julie Baker (JBa), Quality and Patient Safety Facilitator - Ms Sally Scales (SS), Director of Nursing: Programme Lead for Magnet	

QA.8.24.2	**Declarations of Interest**	
	There were no declarations of interest. With regard to agenda item QA.8.24.17 however, LB mentioned she is a member of the Executive of the Faculty of Medicine and Health at the University of Leeds which has links with Bradford Institute for Health Research (BIHR), and therefore she does have oversight of health research but no financial interest.	
QA.8.24.3	**Minutes of the Meeting Held on 2nd July 2024**	
	The minutes of the meeting held on 2nd July 2024 were approved as a correct record. The meeting reviewed and agreed the following updates and outcomes in relation to these actions: QA24010: **Serious Incident (SI) Report** – agreed this action to be closed. QA24011: **High Level Risks, Risk 2542** – agreed this action to be closed. QA24014: **High Level Risks, Risk 171** – agreed this action to be closed. QA24015: **High Level Risks, Risk 2509** – KD said the risk is also on the Integrated Care Board (ICB) Risk Register and input comes from various sources. It was agreed the Children Clinical Service Unit (CSU) will be invited to the next meeting so the Academy can gain an understanding of the actions being taken to mitigate the risk. Action closed.	
QA.8.24.4	**Matters Arising**	
	RS referenced the recent BMA notification around GP's dissatisfaction with their contracts, and advised they have agreed a collective action which came into effect on 1st August 2024 to implement one or more of 10 options. Of these the ones which are likely to affect the Trust the most are in relation to the number of referrals received, and the number of patients attending at the Accident and Emergency Department (A&E). In respect of the latter of these RS explained GPs now have the option of restricting the number of patient contacts they have during each day to 25, and also to refrain from engaging with the Advice and Guidance System which they are encouraged to refer to for patients presenting with certain symptoms to ascertain if they can be managed in a primary care setting. A further option for GPs is to not restrict any referrals or investigations to secondary care for consultations which may increase the number of outpatient attendances being requested. RS noted however no impact from the 10 options has yet been seen by the Trust and engagement with our primary care colleagues remains good. In relation to blood stocks and the notification from the Blood and Transplant Service of amber alert being entered for O^+ and O^- blood stocks due to a national shortage, RS advised donors have	

	been approached to donate wherever possible, and the Trust is also required to undertake a number of actions such as limiting the amount of blood held on site, and consider postponing any non-urgent procedures which may require significant group O blood transfusions. All theatre lists have therefore been reviewed and the impact of this has been relatively small, with the affected operations to be rescheduled as soon as possible. The most recent information received advised national stocks of O^+ and O^- blood are both now beyond six days' supply which is the normal level, and it is anticipated the amber alert will be withdrawn after the upcoming bank holiday. The Academy noted the update provided.	
QA.8.24.5	**Review of Quality Academy Terms of Reference and Work Plan Prior to Submission to Board in September**	
	JM introduced the papers and discussed the proposed key amendments to the Academy's Terms of Reference and Work Plan. The list of sub-groups reporting into the Committee is still to be finalised, as is the attendee list, and these will be circulated when available prior to submission to the Board of Directors. Discussion took place around the removal of the Patient Safety Incident Response Framework and it was agreed this item should remain on the Work Plan for quarterly activity reporting. JK noted an item needs to be added to the Work Plan around compliance in relation to national food standards and she will liaise with JM outside of the meeting in relation to this. JM will then circulate the updated Work Plan to LB, RS and KD for further review. LB added she has requested the Quality Dashboard is presented to each meeting of the Committee. The Academy approved the proposed changes to the Terms of Reference and Work Plan.	QA24016 Head of Corporate Governance (JMa)
QA.8.24.6	**High Level Risks**	
	RS introduced the circulated documentation and further advised: • Risk 2605, score 25 – the target date needs adjusting as 24th June 2024 is the date the risk was added to the Register. The issue relates to the capacity of the service at The Meadows Haematology and Oncology Day Unit at Eccleshill whereby following their first chemotherapy session, patients are added to a reserve list for their further sessions rather than these being scheduled when treatment first commences. Work is ongoing to mitigate this risk and some services such as iron infusion have been moved out of The Meadows back to BRI which has freed up more capacity. As of this week however there are no patients on the reserve	

	list and the risk score will be reduced to 20. It is hoped it will be possible to decrease the score to 16 in the near future as the position is significantly improved. LB asked what measures are in place to prevent the risk escalating in the same way in the future and RS said it is a system problem, and conversations are being held with ICB colleagues in relation to this. LB asked if this risk is linked to risk 2549 around the challenges to deliver non-surgical oncology services. RS confirmed they are separate risks as 2605 is specifically around the delivery of systemic anti-cancer treatment (SACT) at The Meadows Unit. Risk 2549 is a wider risk and the review being undertaken within WYAAT is looking at how delivery of non-surgical oncology can be done differently, and the staffing challenges currently being faced. • Risk 2542, score 20 – funding for new transfusion kit across the Trust has been secured. Implementation of the new HaemoBank fridges will take several months due to the education and estates considerations involved. Once this has been achieved the score for this risk will be reduced to 1. Furthermore RS commented that since the last Academy meeting the Trust's main blood flood fridge also failed which contributed to the increase in score of this risk. The failure was caused by a door locking fault which has now been repaired. In light of this it is anticipated the risk score will reduce back down to 16. • Risk 187, score 16 – JH advised the description is being updated to remove the Covid element, and the score and mitigation date will also be amended. The Academy confirmed they are assured that all the relevant key risks have been identified and reported to them, and are being managed appropriately.	
QA.8.24.7	**Legacy Serious Incident (SI) and Patient Safety Incident Investigations (PSII) Report**	
	LR gave an overview of the circulated papers and noted there was one PSII declared in the reporting period under the emerging theme category of care and treatment of patients with learning disabilities, and one ongoing Maternity & Newborn Safety Investigation (MNSI) report. There are no investigations out of date and two MNSI reports were closed. Following a query from LB regarding the emerging theme, LR advised there is an indexed patient and other cases which have been identified. A system PSII is being undertaken in relation to the indexed patient in conjunction with colleagues from Bradford District Care Trust (BDCT), and an independent consultant will also sit on the investigatory panel. KD added we are aware more people with learning and physical	

	disabilities are surviving into adulthood, however the adult trained nurses have not necessarily been exposed to their often complex needs in the same way as children's nurses and therefore often struggle to do their roles. A review is therefore being undertaken to also cover transition from children to adult services. KD also stated it was previously agreed the MNSI report would be included in the maternity section. Therefore, the shared reports were published in April and May 2024 and have been reported through the maternity report and also shared with the Board of Directors. They will continue to be reported through the maternity report going forward.	
QA.8.24.8	**Briefing Note – Never Event 2024/2217**	
	JC introduced the circulated documentation and highlighted how swiftly the investigation and learning from the event was undertaken, with all actions being completed with confidence. It was agreed that assurance for PSIIs will be reported in the same way to the Academy going forward. The Academy confirmed they have a high level of confidence and therefore assurance with regard to this Never Event.	
QA.8.24.9	**Patient Safety Incident Response Framework**	
	LR introduced the circulated slide presentation. She highlighted the implementation of the Patient Safety Incident Response Framework (PSIRF) continues, however she confirmed incidents are being reviewed daily and going through the Trust's governance processes which have been aligned to the PSIRF, with relevant escalations made in line with the Patient Safety Incident Response Plan and national guidance. The two new improvement programmes are now well established and work is ongoing in relation to Medicines and Blood Transfusion. Incident data checks have been checked retrospectively due to a gap being identified. This has now been completed and data checking will continue going forward. JC added further work is required around the learning and this being embedded across the Trust. The model used in Dorset is being referred to as a basis for LR and LT to use when refreshing our plan. Following a query from KW, it was confirmed the learning is also reported back to the Quality Academy. The Academy approved the proposals in terms of PSIRF reporting.	
QA.8.24.10 & QA.8.24.11	**Quality Improvement Programme Update** **National Patient Safety Improvement Programme Update**	
	LT explained the Quality Improvement Programme is realigned to the Trust's improvement priorities set out in the Quality Account. One of the key areas of this around deteriorating patients is the work around Martha's Rule.	

	With reference to the circulated presentation, LT discussed the background to Martha's Rule, and the Phase 1 pilot which commenced on 20th May 2024 and is being led by NHS England involving 143 organisations. LT provided an update on the Trust's current position and the work being done with regard to the different components of the project. In relation to the Worries and Concern Pilot, LT advised wards 7 and 9 have been able to demonstrate compliance with the patient reported measure that at least once a day (and usually more than once during a 24 hour period), information relating to a patient's condition is being captured directly from patients themselves and their family, and is readily accessible to those who require it. With regard to access to the Critical Care Outreach Team for Trust staff, JL asked if that is now in place and LT confirmed it is. LT advised from July 2023 to August 2024 there have been 27 referrals to the Critical Care Outreach Team via the patient wellness questions, of which four required additional care and were re-admitted to ICU. LT continued data for the Relatives Line is available covering the last six months, and there were around 10 calls specifically relating to patients with families who had concerns around deterioration. RS said following the Trust expressing an interest and being selected to represent the North East and Yorkshire region in the Worries and Concerns pilot, Bradford is very much seen as the standout group and passed on his congratulations for the work done which JH reiterated. JH added Martha Mills' mum had noted with her care that whilst there were elements where the nurses had listened to the family, the issues arose with the communication between the nurses and the doctors and this is the area where improvements are required, especially around empowering nurses to feel able to make challenges where necessary and having the necessary tools to be able to do this. She suggested a visit is made to the University of Bradford to discuss Martha's Rule and patient wellness with the student nurses, and LT confirmed she will follow this up. KH acknowledged the consideration and importance of the Equality, Diversity and Inclusion (EDI) implications, the accessible information standard, capturing information, and internal communications to raise awareness eg screensavers etc. He then discussed his personal lived experience being the parent of a child with a complex condition and the requirements and challenges faced by him and his family. KW asked how it is being communicated to families that their worries and concerns, knowledge, feedback and advice is welcomed in relation to their family member. LT stated a mindset shift has been seen on those wards which have adopted, embedded and are sustaining use of the patient wellness questionnaires. They also lead to improved conversations with	

	patients around how they are feeling, and documentation of those conversations.	
QA.8.24.12	**Clinical Audit Annual Report**	
	LT discussed the circulated paper around the national clinical audit programme which was taken as read. KD expressed concerns that not all CSUs embrace the programme in the same way and undertake local audits to improve their own local practise. Discussion took place around the Clinical Outcomes Team challenging and supporting the CSUs effectively to identify areas to focus on, and to acknowledge that audits are to be used as a method of improvement.	
QA.8.24.13	**Infection Prevention and Control Quarterly Report**	
	YM introduced the circulated presentation and stated the data included is always up to four months out of date and therefore does not reflect the current status when looking at comparisons with other Trusts. YM noted there have been improvements on some of the graphs shown, and also highlighted: • Covid numbers are decreasing again following a recent peak. • The Trust has had no attributable MRSA Bacteraemia in the last four months. • Since the last peak in April 2023, the number of C. diff Infections has remained at a stable level. • With regard to Trust attributable Pseudomonas Bacteraemia, there has been one per month in the last three months. • There were four Trust attributable MSSA Bacteraemia in two months including in Oncology and Renal. Meetings have taken place to look into the reasons behind this and improvements have now been seen. • Trust attributable Klebsiella Spp. Bacteraemia numbers have increased however remain better than many other Trusts in the region. • Trust attributable E.coli Bacteraemia numbers are now at a stable level following some recent increases, with the reasons for some of the infections being outside of the Trust's control. YM then discussed the areas where improvements made by the Trust have had a positive impact, such as the Hydration Improvement Project on the care of the elderly ward. • Educational fun initiatives in relation to infection control such as a hand hygiene day and infection control week are continuing. With regard to the hand hygiene audit LB expressed her congratulations on a high level of assurance being attained. KD advised there has been an increase in incidences of MRSA	

	colonisations in the Women's and New Born unit across a range of areas. All relevant processes, notifications and tests were undertaken and all the babies have now gone home except one who remains in hospital for other reasons. Further details will be provided in the next Infection Prevention and Control (IPC) report presented to the Academy. It was agreed this agenda item is presented to the Academy for assurance rather than approval as shown on the agenda. The Academy confirmed they are assured that progress is being made against the work programme, and risks are highlighted and actioned.	
QA.8.24.14	**IA Report BH382024 – Medical Records Deletion and Destruction of Electronic Patient Records – Low Assurance**	
	PR advised that through dialogue with other Trusts he has confirmed that the organisation is not an outlier in respect of the low assurance audit outcome regarding a current and comprehensive medical records deletion and destruction policy. He discussed the circulated paper which outlines the actions already undertaken and those planned. A further update will be provided once the work has been completed. Following a query from LB, KD confirmed a risk has been added to the Risk Register, has been reviewed by the Executive team, and is scheduled for a final review. The Academy confirmed they are assured that work is progressing as necessary with regard to this issue.	
QA.8.24.15	**Maternity and Neonatal Services Update**	
	SH introduced the slide presentation and provided the following further information: • With regard to the two maternal deaths, one is currently being investigated jointly with BDCT however it does not meet the Maternity and Newborn Safety Investigations (MNSI) reporting criteria. The second death is likely to be attributed to sudden adult death syndrome (SADS). The case has been referred to MNSI who are undertaking a further investigation, and the Academy will be advised of the feedback received. • Both issues raised within the MNSI Escalation of Concern letter are not considered to have directly contributed to the patients' deaths, however the learning gained is being taken on board. Following the meeting held with MNSI on 30th July 2024 a review of how the Maternity Early Warning Score (MEWS) system was recording was undertaken, and confirmation has been provided that the current system and guidance marry up. An agreement was made at the meeting that our improvement plan in response to the case would be fed back, and this has now been provided to MNSI. A response following a further	

	MNSI panel meeting is now awaited. In relation to the second escalation of concern, SH advised the case is in relation to consultant attendance and the results of an audit undertaken whereby the consultant did not go into the A&E at the time of the event (though she was looking at the case remotely), and it was noted this did not contribute to the deterioration of the patient. This has highlighted that whilst the Trust is effective at responding in incidences when consultants are required to attend on the labour ward, the guidance requires tightening in relation to expectations when a pregnant woman is deteriorating in another part of the hospital. This response has been provided to MNSI who have confirmed they are assured, and the next steps to be taken are appropriate. KD offered holding 'masterclasses' for members of the Academy who require further information to increase their knowledge of items reported to them and this was welcomed. PR advised the Academy John Anderson has been appointed as one of the Associate Chief Clinical Information Officers (CCIO) and this strengthens the level of clinical engagement in Informatics decision making across the Trust. With regard to the midwifery staffing report, LB inquired what the context of the many red flags contained in it is, and SH advised the midwives are now highlighting when there are issues which need addressing so monitoring and remediation actions can be undertaken which has led to improved reporting. LB also asked if there will be a future update advising that many posts have been offered to the newly qualified midwives which will therefore alleviate some of the red flagged items. SH said the new intake of staff in October will mean the Trust has successfully recruited to the funding establishment, and it is hoped this will resolve a number of the staffing challenges and reduce bank and agency staffing spend.	
QA.8.24.16	**Magnet4Europe Update**	
	In the absence of SS, JH discussed the slide presentation providing details of the Magnet4Europe Research Programme looking at the work of American hospitals and bringing it into Europe and the Trust. JH highlighted the culture change element of the initiative is huge and focus is therefore being given to shared governance and involvement of nurses and midwives in care, decision making and priorities for the organisation. A further challenge has been around benchmarking information for nursing and midwifery metrics via a national vendor, and this was discussed with the NHS England Chief Nursing Information Officer who visited the Trust last week. JH also noted a significant element of the strategy is focussed around workforce and the retention of staff. PR added Helen Balsdon, Chief Nursing Information Officer and Jules Gudgeon, National Chief Midwifery Information Officer who	

	are part of the Transformation Directorate visited the Trust last week. Aspects of the research pedigree of the organisation and the impact of the Magnet programme were incorporated into the discussions, and Helen positively referenced these on LinkedIn following her visit. KH asked if there was an opportunity to align some of the activity with the Nursing and Midwifery Equity Programme which has recently been launched. JH said the leadership element is a key objective of the Nursing and Midwifery Strategy, and it is hoped all the nursing and midwifery leaders who have been on the programme will be able to help support/sponsor other members of the organisation. JH and KH will discuss this further outside of the meeting.	
QA.8.24.17	**Research Activity in the Trust – Update**	
	RS introduced the documentation which has been provided for the Academy's information rather than assurance as noted on the agenda. He highlighted: • Handover of the entrance extension for the Bradford Institute for Health Research is expected at the end of August 2024. • Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) was the highest recruiter to the National Institute for Health and Care Research (NIHR) studies in the whole of the country. • The patient recruitment centre is going through the process of re-applying for the investment award. There are more applicants on this occasion than previously resulting in a more competitive process. RS will update the Academy once it is known if the application has been successful. • The Trust has been shortlisted for a Health Service Journal (HSJ) award in relation to IPC community health checks work in conjunction with BIHR. The health check events are held largely in Mosques as a place where communities gather, and offer all members of society basic health checks for conditions such as diabetes and hypertension. The sessions are very well attended, bring people together and provide those who may not normally visit primary health care, access to the services they offer. LB expressed her thanks for the information provided to the Academy. ***Post Meeting Note***: *It was subsequently agreed following the meeting that Research Activity in the Trust would be reported to the Committee for assurance, as opposed to for information.*	
QA.8.24.18	**Any Other Business**	
	PR advised following a critical gateway review the planned Electronic Patient Record (EPR) system go live for Airedale NHSFT (ANHSFT) which is linked to BTHFT in relation to theatres, anaesthesia, critical care work and other elements, has been	

	rescheduled to the third weekend in November. The appropriate governance channels will be utilised to ensure the relevant colleagues in the Trust are aware, and replanning strategies are underway as required. PR's support for the recommendation to delay the go live date was ratified by the Executive Team at their meeting on Monday 12th August 2024. KD expressed her support and advised she has reached out to the ANHSFT Chief Nurse and offered shadowing opportunities for their staff with BTHFT nurses or other staff using EPR.	
QA.8.24.19	**Matters to Share with Other Academies**	
	There were no matters to share with the other Academies. KW and LB agreed sharing of the Patient Safety Incident Response Framework (PSIRF) information should be considered further at the bi-monthly meeting with the Trust's Chair.	
QA.8.24.20	**Matters to Escalate to the Board of Directors**	
	It was agreed the new risk entered on the High Level Risk Register in relation to chemotherapy (risk no 2605) should be brought to the attention of the Board of Directors.	
QA.8.24.21	**Date and Time of Next Meeting**	
	Thursday, 19th September 2024, 1100 – 1330.	
	Annexes for the Quality and Patient Safety Academy	
	Annex 1 – Documents for Information	
QA.8.24.22	**Patient Safety Group Minutes**	
	Noted for information.	
QA.8.24.23	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.8.24.24	**Clinical Outcomes Group Minutes**	
	Noted for information.	
QA.8.24.25	**Patient Experience Group Minutes**	
	Noted for information.	
QA.8.24.26	**West Yorkshire System Quality Group Meeting Minutes**	
	Noted for information.	
QA.8.24.27	**Safeguarding Children, Young People and Adults at Risk in the NHS – Publication from NHS England**	
	Noted for information.	
QA.8.24.28	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.8.24.29	**Internal Audit Reports Relevant to the Academy**	
	• BH/01/2025 – Infection Prevention and Control: Hand Hygiene	

	– 17th July 2024 • BH/02/2025 – COSHH Follow Up Report – 1st August 2024 The above reports were noted for information.	

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 14TH AUGUST 2024

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24002	28.02.24	QA.2.24.5	**High Level Risks** PR reflected on previous conversations concerning material risks related to the Trust's alliance in pathology with Fordham and the programme of WYAAT migrating to Clinicist. The Trust is reliant to Leeds in relation to two elements of the programme around blood science and microbiology. The programme has been responsible for considerable delays, however, the project go-live is June for Leeds elements resulting in consequences for the Trust. PR agreed to reconsider the consequences and processes and provide further detail to the QPSA regarding the implications around these delays in Leeds against the original trajectory resulting in the Trust being later in the process than initially anticipated.	Chief Digital and Information Officer	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

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						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.
QA24016	14.08.24	QA.8.24.5	**Review of Quality Academy Terms of Reference and Work Plan Prior to Submission to Board in September** JK noted an item needs to be added to the Work Plan around compliance in relation to national food standards and she will liaise with JM outside of the meeting in relation to this. JM will then circulate the updated Work Plan to LB, RS and KD for further review.	Head of Corporate Governance	September 2024	03.09.24: JM confirmed the Work Plan has been updated, re-circulated and a further review has been undertaken with RS, KD and JC. Action closed.

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	4 July 2024	**Time:**	09:00-11:00
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director (JL)
Present:	- Zafir Ali, Non-Executive Director (ZA) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - John Bolton, Deputy Chief Medical Officer & Medical Director - Ops (JB) - Sarah Freeman,Director of Nursing, operations (SF) - Mark Hindmarsh, Director of Strategy & Transformation (MHi) - 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) up to 10.30am - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - James Taylor, Deputy Chief Operating Officer (JT) - Rachel Waddington, Deputy Director of Operations Planned Care (RW) from 10am		
In Attendance:	- Laura Parsons, Board Secretary (LP) for agenda item FA.7(1).24.8 - Helen Farmer, Act as One Programme Director (HF) for agenda item FA.7(1).24.9 - Jacqui Maurice, Head of Corporate Governance (JM)		
Observing:	- Karina Edwards, Internal Audit Manager, Audit Yorkshire - Raquel Licas, Staff Governor		

No.		**Action**
FA.7(1).24.1	**Apologies for Absence**	
	The following apologies were noted: - Adele Hartley-Spencer, Director of Nursing (Operations) (AHS) - Matthew Horner, Director of Finance (MH) - Ellie MacIver, Deputy Director of Operations for Cancer & Diagnostics (EM) Absent: - Joanne Hilton, Director of Nursing/Deputy Chief Nurse (JH) - Sughra Nazir Non-Executive Director (SN)	
FA.7(1).24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.7(1).24.3	**Unconfirmed Minutes of the Meeting held 22 May 2024**	
	The minutes of the meeting held on the 22 May 2024 were approved as an accurate record.	
FA.7(1).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	

No.		Action
	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. Verbal update to be provided at the May meeting. 22/05/24: MH explained this is still evolving and will be shared once available. 04/07/24: CSm said things have evolved since this action was agreed and there is no formal expectation to respond to the set of actions as each Trust is addressing it's own deficit and ours is through the Closing the Gap programme. It was agreed that this action is closed and a new action is opened for the Academy to receive an update following the PwC review of the Trust's governance structure as part of the whole West Yorkshire Association of Acute Trust (WYAAT) review which is expected to be completed mid-July with a report going to the Committee in Common and WYAAT Chief Executives which will determine next steps. Action closed.	Acting Chief Financial Officer FA24012
	Assurance	
FA.7(1).24.5	**Finance & Performance Academy Dashboard**	
	JL reminded colleagues that the dashboard provides a single view of the F&P Academy indicators aligned to the Trust's Strategic Objectives. Throughout the meeting members of the Academy have the opportunity to review and challenge the elements of the dashboard presented relevant to the Academy Terms of Reference. SA and CSm confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting.	
FA.7(1).24.6	**Revised Academy Terms of Reference and Work Plan**	
	JM advised that the documents show the initial changes that were proposed at a meeting in May 2024 by the Academy Chair, Director of Finance and Chief Operating Officer when they met to consider a number of key questions with regard to the Academy's operation, terms of reference (ToR) and workplans in response to the review of the Trust Governance arrangements undertaken by ANHH Consulting. A Board development session took place on 13 June where the full Board discussed feedback with the Academy Chairs and Executive leads. Some interim changes were agreed in relation to the Academies, and it was also noted that an in depth review of the ToR and work plans would be undertaken with Academy Chairs and Lead Executives. Recommendations will be presented to the next Academy meeting for ratification prior to approval being sought at the Board of Directors in September 2024. The proposed interim changes for the ToR of the Finance & Performance Academy are detailed in Appendix 1. JM referred to the current workplan which is presented at Appendix 2 and explained the changes which include the reporting on 'Estates and Facilities' items and 'Environmental Sustainability' that have been added to the work plan. The format and frequency of the reporting will be confirmed	

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	as part of the in-depth review. ZA referred to the quorum section of the ToR and asked if the reference to two NEDs is in addition to the Chair. JM confirmed two NEDs are required which includes the Chair. ZA asked if the name of the Finance and Performance Academy will be changed to Finance and Performance Committee as alluded to by the Trust Chair at a Board Development session recently. It was agreed that this will be reflected in the next set of changes. MHi queried the term "Bradford Improvement Plan" within the ToR and JL explained this was previously the Finance Improvement element but is now covered within the Closing the Gap Programme. This will be reflected within the ToR. A discussion took place in relation to the inclusion of the Trust Improvement Strategy within the ToR and it was agreed that this will be reflected within the next set of changes. The Academy approved the proposed interim changes to the Academy ToR and the work plan noting that the next set will include the changes agreed above which will be presented at the next Academy meeting.	
FA.7(1).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 Executive Team Meeting (ETM) on 24 June 2024 in relation to high level risks. JL noted no risks had been added, closed or changed in score since the last report. The Academy was assured by the update.	
FA.7(1).24.8	**Board Assurance Framework – Strategic Risks Relevant to the Academy**	
	LP advised that the 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.	

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	This will be followed by approval from the Academies and final sign off at a Board meeting. The Academy noted the update.	
	Learning & Improvement	
FA.7(1).24.9	**Act as One Programme Update**	
	HF presented the item and explained that a number of schemes continue to be delivered through the Act as One system programme approach. HF talked through the presentation highlighting the progress and next steps in relation to the programmes. HF referred to the Home First Assessment Support Team (H-FAST) pilot which is due to commence in the Trust on 21 July. The aim of the pilot is to support people to be discharged from hospital back to their own home within 24 hours of not meeting the criteria to reside. This has been piloted in Airedale with some very positive outcomes. HF reported that work has commenced on reviewing a number of service specifications across the partnership throughout 2024/25. There is a plan to undertake a deliberative event in September on Closing the Gap which will involve wider stakeholders and members of the public. MHi highlighted the references within the presentation to women's health initiatives and was pleased to note this is being progressed and delivered through the programme. MHi was keen to support this work along with other colleagues. ZA was pleased to see the various initiatives within the programme and asked if a communications strategy is in place to ensure the initiatives reach those that would benefit from them and also whether benefits are being realised and captured appropriately. HF explained that specific colleagues are dedicated to the various initiatives to both publicise them and capture the outcomes. System wide listening events also take place to cover various themes where people can provide feedback. This helps identify challenges and supports us to understand where services can be improved. In addition to this a quality and equality impact assessment is being launched to go alongside all closing the gap schemes where there is a direct impact on patients which is linked closely to communication and engagement. The Academy noted the update.	
FA.7(1).24.10	**Closing the Gap**	
	MHi presented the item and explained that the presentation includes the first Closing the Gap (CTG) dashboard showing progress and delivery across all 206 schemes. To date £22.9m of potential savings have been identified against the £38.9m required which is 59% of the target identified for 2024/25. It was important to recognise the huge amount of work from	

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	colleagues across the Trust to get to this amount but there is still a lot of work to do to scope all the schemes as well as continue to identify further savings. All identified schemes have a risk rating associated to help determine the likelihood of delivering the full value of the schemes. Of the £22.9m identified £12.5m are low risk therefore likely to be delivered, £5.5m are medium risk which is a confidence level of delivering 60% and £4.9m are high risk where the confidence in delivering the full value is approximately 30%. Therefore it was important to recognise the risk of deliverability of the identified schemes. The number of schemes identified is increasing month by month which demonstrates that staff are thinking about where savings can be made. MHi explained the governance arrangements and how this is being embedded across the Trust from workstream groups through to the Board of Directors as detailed within the presentation. The Academy discussed the rounded approach to reporting on the CTG programme across Academies and through the Board. In terms of staff engagement MHi talked through the actions taken to date including executive sponsor meetings, go live of the intranet page and an article in Let's Talk. Going forward a number of engagement initiatives are planned including a monthly CTG publication as well as a video spotlight on individual schemes. MHi talked through the challenges to the delivery of the programme and next steps as detailed within the presentation. ZA asked how deliverable the target is and how the Trust is benchmarking on CTG against other Trusts in the region. MHi explained that although the target is very challenging all opportunities are being explored in order to meet the target as best as possible. CSm advised that in terms of benchmarking and the level of savings the Trust is trying to make it is relatively comparable to other trusts within the region with all trusts facing very substantial challenges. The Trust is an outlier in its position at Month Two with being £2m off plan with others either on plan or less off plan, however all Trusts are in deficit. ZA asked if there are examples of where savings have been realised along with details of impact assessments. MHi confirmed this detail is available for various schemes and this can be made available if required. MHi provided assurance that clinical input forms a big part of the impact assessments prior to schemes being approved to ensure there are no unintended consequences. In terms of governance ZA asked at what level are checks and balances taking place to validate the savings being made. CSm said the actual savings delivered are validated by the finance team and CSm was confident that the monthly reported position is accurate and these are true savings. In terms of the forecasting element the finance team continue to work on the forecasts and analysing the plans to ensure they are as robust as they can be but it was important to note that they are just forecasts and risks remain as to the deliverability of these.	

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	JL was pleased 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 remains high. It was agreed that an update is also provided to the Governors on the CTG programme to ensure they are also kept informed of progress. The Academy noted the update.	Director of Strategy & Transformation FA24013
FA.7(1).24.11	**Operational Improvement Plan – Referral to Treatment (RTT)**	
	JL welcomed RW to present the update on the operational improvement plan in relation to referral to treatment (RTT) performance. RW referred colleagues to the presentation and explained that the slide pack starts with the usual opening slide demonstrating transformation, pro-active performance and business as usual elements and now with the addition of the Closing the Gap workstream which focuses on elective recovery and will influence the RTT performance. RW explained there are seven CTG actions that will be addressed for RTT which fit into the operational excellence strategy headings of transforming the delivery of outpatient appointments, improving theatre efficiencies and reducing outpatient follow ups. Many of the actions that were previously transformational have now progressed to business as usual. RW talked through the workstreams to be delivered in the current financial year to transform outpatient appointments. These will be led by Deputy / Associate Directors of Operations and will include the following: - To increase clinic sessions delivered, review job plans and productivity - To reduce Did Not Attend (DNA) rates - To increase outpatient procedures - To improve first follow up ratios across clinics - To increase theatre sessions delivered - To increase patient per list - To increase endoscopy and cath-lab productivity RW referred to the proactive performance slide which demonstrates the projects that are now live or about to go live. The proactive performance management workstream has evolved to be more influential in improving RTT performance. RW provided examples of some of these including a demonstration of the waiting list tracking app which is due to go live this month. The app has the ability to provide accurate and live data instantly. RW commended the BI team and NS in particular for their support in implementing this dynamic tool which will help manage waiting lists much more effectively. NS added that the collaboration with colleagues from the Access team has also contributed hugely to the success of the app. The business as usual workstream continues to operate and the RTT improvement focus has shifted to the 52 week clearance ahead of March 2025 in line with national guidance. There are various elements which will	

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	support achievement of this ambition as listed within the presentation. In terms of recovery various improvement actions are being taken with specific areas to work towards achieving the national targets. Close tracking is in place for Trauma and Orthopaedics as well as Ear, Nose and Throat specialty to achieve the 65 week position. The Trust has an ambition to remain within the top quartile nationally across each key performance indicator and for RTT the Trust is performing well and maintaining this position as demonstrated in the presentation. SA thanked RW and the team for all the hard work they have done and continue to do to get to this position. SA also wished to commend the Access Team on the work they have undertaken to address the data quality issues for waiting lists. Data quality was previously escalated to the risk register following which a prevent, correct and clear model was established and implemented to address the issues. SA visited the Access Team the previous day and was met by an enthusiastic and hard working team who were extremely proud of their achievement of the huge improvements made to the waiting list. Although there is still work to do SA was pleased to note the confidence and assurance we now have on data quality metrics. SA referred to the positive outcome in relation to 104 and 78 week wait positions but highlighted that the 65 week position remains a challenge. It is unlikely that the Trust will achieve 0 patients waiting 65 weeks by September but all efforts will be made to work towards this. It was worth noting that the Trust is the only one in WYAAT that does not have an LLP or cost per case model which does make consultants reluctant to come forward due to personal financial implications but the CTG target and the Trust's financial position does mean there is a fine balance to address between finances and quality. The Academy was assured by the update.	
	Performance	
FA.7(1).24.12	**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: - 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 28% when compared to the same time last year. Collaborative work is ongoing with YAS, mapping the ambulance handover process has now	

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	been completed with issues identified and owners allocated. A new handover process, approved and communicated to the teams by YAS and the Trust has also recently commenced. It was important to note that performance over the last two weeks has improved significantly – this is not included within the report due to being July data. SM confirmed that in the last week the average handover time has been 17 minutes, which is better than the Trusts 18 minute annual planning target and it was the best in WYAAT which is a brilliant achievement. This is despite the junior doctors industrial action. - Emergency Care Standard (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. Work is continuing to look at further opportunities to improve ECS performance with workstreams in place to achieve improved utilisation, develop new pathways, review triage and contractual arrangements with Bradford Care Alliance (BCA) who provide the GP input. - 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 daily average number of patients with a length of stay (LOS) of over 21 days reduced to 124 in May 2024 with further improvements forecast in June to 108. 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. - In terms of Referral to Treatment (RTT) CSt recently attended a North East & Yorkshire Operations Delivery event and the Trust was either in line or ahead of every best case example that was presented on the day. This was for the RTT, diagnostic and urgent and emergency care standards. It was very positive on the day to see the improvements that have already been made by the Trust and how we benchmarked against other Trusts. - In terms of Diagnostics 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. DM01 performance for May 2024 was 77.63% which is an improvement on April's performance but is slightly behind the expected improvement trajectory. 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 but CSt noted that we have now started to see the position recovering. - For Cancer performance the two week wait performance was below the target position of 86.06% in April but this is expected to improve yet remain below target into May due to the continued Bank Holiday period and sustained high referrals particularly in Breast. Breast services continue to seek to run additional clinics to manage sustained referral volumes into the summer and are working closely with Radiology to support extra sessions. In terms of skin services demand CSt reported that the dermatology hubs have now gone live which has resulted in a decrease in skin referrals – this was a particular pressure last summer.	

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	In terms of the Faster Diagnosis Standard (FDS) performance remains above target and in the upper decile nationally. CSt explained that as most of the delays are for Skin it does not always impact the reported FDS because the decision to treat will be before the "patient informed" date, however, patient experience is impacted negatively and the improvement plans will address this. CSt reported that 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. A case has been submitted to the Cancer Alliance for additional cancer pathway navigator roles for every tumour group. These roles have proved to be very successful in supporting patients to have a shorter journey and encourage them to come to appointments. If successful this will be of huge benefit. The new cancer IT system (Civica) is currently in project scoping phase with a planned go live of September. This will also 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. SA provided some further insights into the current pressures and the impact on performance including attendance to the Accident and Emergency Department (AED) which has been particularly high with some of the busiest days on record occurring over the last week. SA referred to the recent media coverage in relation to emergency care at the Royal Shrewsbury Hospital which highlighted concerns for patient care. Following this all Trusts were issued with a letter from NHSE seeking assurances in relation to patient care. The letter will be reviewed at ETM. The main ask is to review the requirements to implement the actions that were outlined in an earlier letter from NHSE in relation to urgent and emergency care recovery at year two. Prior to this a letter was received last year which was about the steps that need to be taken to recover emergency care performance following which the year two letter was issued which highlights further actions to be taken to address the two main elements around improving the overall emergency care four hour performance as well as category two ambulance handovers. In order to achieve this the two areas of focus are to maintain the bed base through patient flow as well as ensuring there is capacity for ambulance handovers. SA provided some examples of how the Trust is ensuring this is achieved through the work with intermediate care around good flow out of hospital, the work in relation to productivity and all the work that is being undertaken with regards to same day emergency care and admission avoidance The letter also asks that basic standards of care are maintained in line with CQC standards and safety walkabouts are undertaken to ensure visibility. Executive colleagues join the daily Safety Huddle to maintain an oversight and this is then fed into the daily Executive Huddle as well as an overview of performance from the previous day and issues experienced overnight. SM added that the actions required are not just for the Trust but also a system wide requirement. It is important to recognise that there are	

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	challenges system wide as discussed in previous meetings such as intermediate care beds, virtual services that support flow and admission avoidance have a couple of services that only have temporary funding arrangements such as the React Team and the Alcohol Care Team all of which support the work that the Trust does within emergency care. These services are facing financial challenges which will impact the Trust. JL was encouraged to see the highlight report which demonstrates the Trusts approach to improving through learning from others. The Academy was assured by the update.	
FA.7(1).24.13	**Performance Report**	
	Covered at the preceding item.	
FA.7(1).24.14	**EPRR Update**	
	SA referred colleagues to the suite of papers which are shared with the Academy as per the NHSE comments from last year's core standards review to ensure a robust governance process is being followed by the Trust. The suite of papers include a number of appendices as follows: - An updated EPRR work plan is attached at Appendix 1 which provides an overview of the progress made on the workplan for 2024-25. - A Trust Key Performance Indicator tracker (KPI) which includes the status of business impact analysis (BIA) plans, business continuity plans (BCP), that was implemented in September 2023 is attached at Appendix 2 and this shows the activity that has taken place over the last few months on the current number of BIAs and BCPs that are in date, being reviewed or to be written, there are still some number to be written. Current position is that we are 31% of approved BCPs and with 33% of BCPs in draft/requiring review. - The NHSE core standards action plan is attached at Appendix 3. This has progressed with twice monthly meetings held with West Yorkshire Integrated Care Board (WYICB) to assist in completing the large number of partially compliant standards. To note that as we are reliant on WYICB to provide information on a large number of good practice guidelines from other Trusts and plans that require the ICB to complete, this is not progressing as quickly as anticipated. This action plan is also being monitored by Audit Yorkshire. Currently the Trust position has moved from 32% compliant to 55% with 34/62 now compliant. - The learning identified tracker is attached at Appendix 4 and this shows where progress has been made on exercises, debriefs and incidents and this is updated once the exercise/training has been delivered. - The Chemical. Biological, Radiation, Nuclear (CBRN) risk assessment was updated following comments from NHSE and is attached at Appendix 5 for noting. - Internal Audit have produced their report on Business Continuity Management Assessment Action Plan which is attached at Appendix 6 and it has stated there is significant assurance gained from the audit with one minor action relating to external information and plans and policies not being available.	

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	JL was pleased to note that necessary work is being undertaken for EPRR and was assured by the internal audit report that has given significant assurance in this area. The Academy was assured by the update.	
	Finance	
FA.7(1).24.15	**Monthly Finance Report**	
	CSm presented the item and explained that in the annual plan re-submission in June 2024, NHSE required all providers to re-phase their plans to ensure the Year to Date (YTD) plan at Month 2 was exactly aligned to YTD actuals. The formally reported position for Month 2 was therefore a £6.5m deficit against a planned £6.5m deficit resulting in zero variance to plan. This position is reflected in Table 1a. The remainder of the Month 2 report will report on the position against the original annual plan as this provides more insight into the Trust's true financial position against its own planning assumptions. Reporting in subsequent months will be based on the revised plan phasing. CSm highlighted the following: - The Trust has reported a £6.5m Income and Expenditure (I&E) cumulative deficit at Month 2 which is £2.3m worse than planned. The in-month deficit in Month 2 was £3.5m which is a £0.5m deterioration on the Month 1 position. CSm reminded the Academy that the plans for Quarter 1 were less challenging than they are in later months in the year which is a cause for concern. There are however a number of non-recurrent costs in Months 1 and 2 which contribute to the position which will not continue into future months. CSm talked through the key drivers that have contributed to this position as detailed within the slides. - In terms of the planned monthly deficit CSm reported that this becomes increasingly challenging as the year progresses. The improvement shown from Month 8 onwards reflects the phasing of the additional £5m stretch efficiency target. - In a scenario where the Month 2 YTD I&E position were to continue for the remainder of the financial year, the year end deficit would be £38.8m, which would be £24.8m below plan. However, this is not reflective of current forecasting assumption but is presented in the report to highlight the scale of the potential risk. - CSm referred to the CTG programme as described by MHi earlier in the meeting. The risk adjusted forecast delivery of savings for the full year 2024/25 is £22.9m as at Month 2. This would result in a £15.9m shortfall against the annual £38.9m CTG target. CSm talked through the value of schemes and risk to delivery as detailed on slide two and reported that a total of £45.6m of unadjusted opportunities have been recorded as deliverable within 2024/25. The Trust's risk adjustment methodology reduces this down to a £27.5m opportunity based on the assessed maturity and likelihood of delivery of each of the schemes. CSUs have also provided their own forecasts for delivery against the schemes, including start dates, and this results in a lower figure for actual forecast delivery of £22.9m. The focus of the Closing the Gap programme is to support Workstreams and CSUs to develop and implement their plans further so that confidence in scheme delivery and	

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	consequently the level of forecast savings improves on a month to month basis. - In terms of presenting a fully reliable forecast outturn position CSm said it was too early in the financial year to provide this but slide three does provide a range of high level scenarios based on the run rate to Month 2 which take into account a very limited number of variables. CSm asked the Academy to note that there are not sufficient robust numbers on the forecast delivery to provide assurance at Month 2 that the Trust will deliver the financial plan therefore this is currently a significant risk. However all the necessary structures are in place and work is underway to mitigate this as best as possible. - CSm asked the Academy to note that none of the forecast scenarios presented include an 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. The reported position assumes recovery of 100% of the ERF funding included in NHS contract plans for 2024/25. There is therefore a risk that this income position may deteriorate once fully coded activity information is available. - MQ provided an overview of the cash position and reported that the opening cash position is £64.2m and the current forecast is for the cash position to be reduced by £47.2m down to £17m by the end of the current financial year. This is on the assumption of an I&E deficit of £14m, capital expenditure of £42.8m and full delivery of the CTG programme of £38.9m. It was important to highlight that the £22.9m identified for the CTG was important to deliver otherwise cash will go down to £1m which will result in liquidity and cash flow issues. It was important to note that the deterioration of cash over the last two months demonstrates the risk of entering cash flow problems in the current financial year meaning that a request for revenue cash support may need to be made to NHSE. The Academy was not assured that the 2024/25 financial plan would be delivered but were assured about the work that is underway to mitigate this risk. The Academy noted the risk to the delivery of the plan and the associated risk to the Trust's liquidity and cash position should the financial plan not be delivered.	
FA.7(1).24.16	**2024/2025 Capital Plan**	
	MQ presented the report and explained that the purpose of the paper is to inform the Academy of the proposed five year capital programme and seek approval for this programme and to note the indicative position for future years. On 14 March 2024 the Trusts Board of Directors delegated the final approval of the 2024/25 capital programme to the Finance and Performance Academy. The only change since then is the addition of the UEC capital allocation of £2.0m that the Trust was awarded for UEC performance during 2023/24. The Academy is asked to note that these programmes will form the basis of the operating plan submission to NHS England. MQ requested that the Academy approves the Trust's outline five-year capital programme from 2024/25 to 2028/29 noting:	

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	- The overall quantum is likely to change as the WYICB agree capital funding each year. - It could be subject to change if NHSE impose further capital controls that we are not currently aware of. - If the income and expenditure position is not in line with plan. - The contingency pot of £1.0m and UEC allocation of £2.0m is to be allocated is discussed and approved at the next capital strategy group in July. The Academy approved the 2024/25 capital plan for £42.8m noting that a few of the numbers may need to be updated as the plan develops.	
FA.7(1).24.17	**Any Other Business**	
	There were no further items of business to discuss.	
FA.7(1).24.18	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.7(1).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.7(1).24.20	**Date and Time of the Next Meeting**	
	24 July 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 4 July 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FA24009	27/03/24	**FA.3.24.17**	**Health Inequalities & Waiting List Analysis:** As there is an increased level of understanding of health inequalities and the waiting list, 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	
FA24012	04/07/24	**FA.7(1).24.4**	**Matters Arising:** Academy to receive an update following the PwC review of the Trust's governance structure as part of the whole WYAAT review which is expected to be completed mid-July with a report going to the Committee in Common and WYAAT Chief Executives which will determine next steps.	Acting Chief Financial Officer	24/07/24	
FA24013	04/07/24	**FA.7(1).24.10**	**Closing the Gap Update:** It was agreed that an update is also provided to the Governors on the CTG programme to ensure they are also kept informed of progress.	Director of Strategy & Transformation	24/07/24	
FA24011	22/05/24	**FA.5.24.12**	**Pathology Joint Venture – Financial Position:** Next report to include 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.	Chief Financial Officer	27/11/24	
FA24014						

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	24 July 2024	**Time:**	08:30-10:45
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director
Present:	- Julie Lawreniuk, Non-Executive Director (JL) - Zafir Ali, Non-Executive Director (ZA) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - Joanne Hilton, Director of Nursing/Deputy Chief Nurse (JH) - Mark Hindmarsh, Director of Strategy & Transformation (MH) - Shaun Milburn, Deputy Director of Operations, Unplanned Care (SM) - Michael Quinlan, Deputy Director of Finance (MQ) - Terri Saunderson, Director of Operations (TS) - Chris Smith, Acting Chief Financial Officer (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - James Taylor, Deputy Chief Operating Officer (JT) - Rachel Waddington, Deputy Director of Operations Planned Care (RW)		
In Attendance:	- Ellie MacIver, Deputy Director of Operations for Cancer & Diagnostics (EM) – in attendance for agenda item FA.7(2).24.9 only - Jacqui Maurice, Head of Corporate Governance (JM) - John Pointon, Deputy Director of Estates (JP) for agenda item FA.7(2).24.15 - Leah Pollard, Service Improvement Lead (LPo) for agenda item FA.7(2).24.9		
Observing:	- Kate Lavery, Lead Cancer Manager for agenda item FA.7(2).24.9 - David Wilmshurst, Governor		

No.		**Action**
FA.7(2).24.1	**Apologies for Absence**	
	The following apologies were noted: - Sughra Nazir Non-Executive Director (SN) - Ellie MacIver, Deputy Director of Operations for Cancer & Diagnostics (EM) – in attendance for agenda item FA.7(2).24.9 only - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) - John Bolton, Deputy Chief Medical Officer & Medical Director - Ops (JB) - Sarah Freeman,Director of Nursing, Operations (SF) - Adele Hartley-Spencer, Director of Nursing (Operations) (AHS) - Neil Scott, Head of Business Intelligence (NS)	
FA.7(2).24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.7(2).24.3	**Unconfirmed Minutes of the Meeting held 4 July 2024**	
	The minutes of the meeting held on the 4 July 2024 were approved as an accurate record.	
FA.7(2).24.4	**Matters Arising**	
	The Academy reviewed the action log and the following actions were	

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	updated: - FA24009: **Health Inequalities & Waiting List Analysis** - As there is an increased level of understanding of health inequalities and the waiting list, 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. Item covered at agenda item FA.7(2).24.14. Action closed. - FA24012: **Matters Arising** - Academy to receive an update following the PwC review of the Trust's governance structure as part of the whole WYAAT review which is expected to be completed mid-July with a report going to the Committee in Common and WYAAT Chief Executives which will determine next steps. CSm advised that the final report was received on 23 July and provided a summary of the content. A written summary of the report to be presented to the September meeting of F&P. - FA24011: **Closing the Gap Update** - It was agreed that an update is also provided to the Governors on the CTG programme to ensure they are also kept informed of progress. Item covered at agenda item FA.7(2).24.8. Action closed. - FA24013: **Pathology Joint Venture – Financial Position** - Next report to include 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. This has now been captured within the Finance & Performance Workplan. Action closed.	
	Assurance	
FA.7(2).24.5	**Finance & Performance Academy Dashboard**	
	JL reminded colleagues that the dashboard provides a single view of the F&P Academy indicators aligned to the Trust's Strategic Objectives. Throughout the meeting members of the Academy have the opportunity to review and challenge the elements of the dashboard presented relevant to the Academy Terms of Reference. SA and CSm confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting.	
FA.7(2).24.6	**Revised Academy Terms of Reference and Work Plan**	
	JL presented the item and explained that following an in-depth review of the Academy's operation, terms of reference and workplans in response to the overall review of the Trust governance arrangements a number of changes are presented for approval as follows: - A name change from the 'Finance and Performance Academy' to the 'Finance and Performance Committee.' - Several changes to the duties of the Committee to ensure they are in keeping with current strategic priorities and regulatory requirements. - Minor changes to the membership and those 'in attendance'. - Estates and Facilities to be included within the remit of the Committee. Additional recommended amendments are included as track changes within the Terms of Reference at Appendix 1 and a copy of the revised terms of reference, with no track changes is included at Appendix 2.	

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	The Academy approved the proposed amendments to the Terms of Reference and the work plan prior to their submission to the Board of Directors in September 2024 for Board approval.	
FA.7(2).24.7	**High Level Risks Relevant to the Academy**	
	JL reminded colleagues of the Academies responsibility to review, challenge and assess the risks presented to ensure that the Academy is assured that all relevant key risks have been identified and reported and are being managed appropriately. The Academy noted the matters raised by the Executive Team at its Executive Team Meeting (ETM) on 22 July 2024 in relation to high level risks. JL noted no risks had been added, closed or changed in score aligned to this Academy since the last report. ZA asked what the overall financial deficit risk score is as he could not find the information on the PDF version of the papers due to the formatting. JL confirmed this risk was 25 and asked JM if the Excel version could be included in the meeting papers for future meetings and JM agreed to also send the Excel version to all. If there are any items to raise colleagues are asked to let JL know. MQ suggested it was worth exploring whether ETM should consider making the cash position risk a separate risk to the overall finance risk. The Academy was assured by the update.	Head of Corporate Governance FA24014
	Learning & Improvement	
FA.7(2).24.8	**Closing the Gap**	
	MH presented the item and reminded colleagues of the Closing the Gap (CTG) savings target of £38.9m. The forecast delivery for 2024/25 is £25.06m which is equivalent to 64.4% of the target. Each individual scheme within the forecast delivery figure has been risk rated for how deliverable it is believed to be. 53% of the schemes have been rated as low risk, 26% as medium risk and 21% as high risk. MH reported that the number of schemes identified have increased since Month 1 to Month 4 and currently stand at 273 ideas generated from colleagues across the Trust – these vary in terms of their value but this does demonstrate the positive engagement from colleagues. It was important to note that some of these still need to be allocated with a value and risk rating for delivery. MH talked through the programme governance as detailed within the presentation and advised that this is now in place and updates are provided at the various meetings. Workstreams are in place for elective productivity, workforce, medicines management and financial controls and these are areas that are cross cutting across a number of departments rather than being individual schemes allocated to particular Clinical Service	

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	Unites (CSUs) and departments. Two forums have been established to support the CTG programme. The first is the weekly Variable Pay Panel Meeting which is chaired by SA to review variable pay requests and the second is the Clinical Oversight Group (COG) which reviews the impact of each scheme from a safety and quality perspective. MH advised that some changes have been made to the scheme scoping document including simplifying the high level impact assessment following feedback. Engagement continues across the Trust including CSU sponsor meetings and CTG focus meetings with CSUs. The intranet page is being kept up to date and a CTG specific bulletin is due to be published by the end of the month. Presentations have been delivered to all Board Academies, the Hospital Management Group and the Council of Governors to keep colleagues informed of progress. One of the challenges is converting ideas into delivery and this is currently one of the main areas of focus along with reducing the deliverability risk of the existed costed schemes. It is also important to keep colleagues motivated and encouraged to deliver the savings. In terms of next steps the focus is now on costing and delivery of identified schemes, delivering updated communications, reviewing and implementing the PwC recommendations and strengthening connections with Bradford District & Craven Place Partners. JL referred to the 273 schemes which is fantastic but asked if there is the capacity to translate the ideas into savings. MH said it is very much a team effort with expertise and engagement from clinical, pharmacy, procurement, operational and transformation team colleagues as well as the CSU's themselves. Each scheme varies in terms of the input needed to make it deliverable but there is confidence that the vast majority of them already have a value against them and will be prioritised in terms of which need delivering earlier than others. The Academy noted the update.	
FA.7(2).24.9	**Operational Improvement Plan – Cancer & Diagnostic Performance**	
	JL welcomed EM to present the update on the operational improvement plan in relation to cancer and diagnostic performance. EM referred colleagues to the presentation and highlighted the following: - Key performance indicators are on a good trajectory but the Cancer 62 Day First Treatment performance remains a challenge with Haematology and Head and Neck being the main pressure points. - A Haematology and Oncology improvement programme is in place to provide a reset and refocus of the service. The programme includes process mapping of pathways and reallocation of admin processes from consultants to appropriate colleagues. Chemotherapy is a particular area of concern and now features on the high level risk register. There are capacity constraints on the service such as chair space, nurse staffing and aseptic production. A number of actions are	

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	in place to manage the risk in the short term and long term solutions are also being explored. - Phase one of the Cancer IT System will go live on 1 October when the Trust will move from the spreadsheet tracking process to being able to track and monitor patient pathways live. This will provide clearer visibility of patient pathways. Phase two is expected to go live in March 2025 which will bring further improvements including a digital remote monitoring system to support personalised stratified follow-up pathways. - The One Stop Clinic for palpable neck lumps is going live on 31 July and this will be a weekly clinic with access to ENT, Consultant Radiologist and Ultrasound. - An agreement has been reached to pool the Head & Neck diagnostic surgery which will help reduce pathway delays. - Collaborative pathway work is planned with MSD in relation to Head & Neck and Breast pathways. This is through a 12 month collaborative working agreement which is free and a workshop is planned to take place in Quarter 3 to map pathways for the two specialties. - A cancer timeout session took place on 21 June which was very well attended with excellent engagement. EM talked through the feedback received and the outputs from the session. - In terms of diagnostics EM advised that the Community Diagnostics Centre (CDC) is now up and running and the next step is to move this to a 7 day working model. Enabling works for the Endoscopy Unit are ongoing and it is expected to open in Quarter 3 of 2025/26. The new unit will enable JAG accreditation as it will address the current ventilation issue and will also increase room capacity from 6 rooms to 8 rooms. EM welcomed LPo to present the update on the Histopathology Programme which has been in place for six months now. LPo highlighted the following points: - The Histopathology Programme is a structured improvement programme to bring clarity, governance and accountability in order to improve Turnaround Time (TAT) for when the specification is taken from a patient to when the report is available to the requesting clinician. - The national recommendation for 7 day TAT (fast track patients) is to be at 80% with the Trust performing at 20%-30% for the past 6-7 months. The national recommendation for the 10 day TAT should be 90% and the Trust has been performing at approximately 30%-40%. Work is underway to improve the performance and there is a long way to go to meet the national targets. Factors influencing the TAT include an increase in demand, significant workforce constraints from the consultant body within the lab workforce and outsourcing which impacts processes further. - The impact on cancer performance as a result of delayed TAT is typically breaches between 17%-27% for the Faster Diagnosis Standard (FDS) which is on average 70-80 patients per month and the biggest patient group impacted is Gynae and Breast specialties. For the 62 Day standard breaches are typically between 13%-16% which is on average 10-15 patients per month and the biggest patient group impact is Skin and Head & Neck specialties.	

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	- In terms of what is working well LPo explained that the improvement programme has provided a wider understanding and acknowledgement of the internal and external influences on Histopathology. A Breast Task and Finish group has been established including Executive Director input to help address the wider issues within Histopathology as well as efficiency and process improvement opportunities. Approval has been received for 2 whole time equivalent Consultant posts and clinical prioritisation of Histopathology cases has also improved. - It was important to note that challenges still remain with workforce recruitment being the biggest challenge. Outsourcing is another area of concern as this has both a quality and financial impact. Clinical time and availability to help influence and support change is also a challenge. A number of actions are in place to help address the challenges including recruitment and retention. One of the next steps is to develop a collaborative approach between clinical, operational and transformation teams. Contracts and Service Level Agreements (SLAs) with outsourcing companies will be reviewed to improve quality and reduce spends. ZA referred to the Trust TAT performance which is very low against the national recommendation and asked if a root cause analysis has been undertaken in order to understand the issues and put the required actions in place to help improve performance. EM felt that the main root cause is capacity due to workforce issues and explained that whilst the workforce has remained stagnant or even reduced the requests for histopathology have tripled and this has caused the biggest pressure as recruitment has been difficult causing bottlenecks within the laboratory which is impacting on the patient pathway. The recruitment issue is faced by other Trusts too and EM was aware of others within WYAAT with workforce challenges but there is no specific benchmarking available to demonstrate this. SA added that all the improvement programmes are based on understanding the entirety of the pathway and not just around achieving the target as it is important to recognise that diagnostics, pathology and histopathology play a huge part in the pathway. SA highlighted that the work being undertaken by LPo is helping to identify issues such as workforce and capacity gaps as well as processes that can be streamlined to improve the pathway further. MH referred to clinical prioritisation that takes place in relation to the samples that are sent to the laboratory for testing and asked if there was a particular way of measuring that. EM explained that the referral form is currently being updated to make it clear whether a sample is routine, urgent or fast track and this will be used to prioritise the samples accordingly. MH highlighted that he was aware that a huge amount of work has been undertaken to make the service safer for patients as well as improving the overall performance of the service and asked EM to provide insight into this. EM explained that Bradford has a model whereby consultants report on particular tumour sites as opposed to generalist reporting for all sites. This could cause delays in reporting when there are colleagues on any type of leave. In order to address this the two new posts that are being recruited to will be allocated generalist reporting but with a special interest in particular tumour sites which should help address some of the delays.	

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	LPo added that the Chief Medical Officer is working with LPo to engage with consultants about the workforce model and how this should look in order to incorporate generalist reporting. JL was interested in understanding the impact from the improvement work on the trajectory and the timescale as the current performance is a long way away from the required standard. EM was unable to provide a realistic trajectory at this stage due to the uncertainty in relation to recruitment and when posts will be filled but will certainly provide this going forward once posts had been recruited to. JL provided a personal example of a relative who is currently undergoing treatment and from the patient perspective felt it would be beneficial for patients to also understand the pressure and challenges being faced particularly in relation to chair capacity and short notice changes to treatment times and asked if anything has been shared with patients. EM said that feedback has been taken from patients about the service but the current challenges and pressures had not been shared with patients which EM agreed to pick up with the team. SA reported that a new risk was added to the risk register for chemotherapy with a rating of 25 and this was discussed and accepted by ETM earlier in the week. Since the risk was added to the risk register some improvements have been made such as capacity improvements, use off the shelf chemotherapy rather than producing it and also better utilisation of chairs on Mondays. It was important to point out that when the level of chemotherapy demand and the number of chairs available at the Trust to the population size in Bradford is compared to neighbouring organisations it is significantly under chaired from a capacity point of view. SA provided details of the work being undertaken at WYAAT level in relation to a business case for non-surgical oncology. Ben Roberts who is joining the Trust as Chief Financial Officer in the coming weeks is involved in this work from a financial perspective as is SA himself as the Chief Operating Officer Lead for non-surgical oncology at WYAAT. This will be presented to the Committee in Common and WYAAT Chief Executives in October this year and will describe the overall need in relation to non-surgical oncology and SA will ensure that the needs of our Trust are built into it. SA provided an update to the Academy in relation to the Endoscopy programme and reminded colleagues that the programme was signed off by the Board and is currently working to a guaranteed maximum price. The price is expected back from the contractors early August and will be presented to the Board for approval before the programme can be progressed to the next steps. It is expected that this will be a maximum of £25m. If approved to progress then the unit is expected to open up in October or November 2025. The Academy was assured by the update.	
	Finance	
FA.7(2).24.10	**Monthly Finance Report**	

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	CSm presented the item and highlighted the following: - The position at Month 3 is a deficit of £7.9m against a planned deficit of £8.1m which is broadly in line and slightly ahead of the plan. CSm asked colleagues to note that this is the revised plan following a request by NHS England (NHSE) to rephase the plan following submission of the final version. All providers were asked to match the Month 2 actual position to the Month 2 planned position in the revised plan to show a zero variance at Month 2. - The key headline for Month 3 is the very significant improvement in the run rate of Income and Expenditure (I&E). During June the Trust posted a deficit of £1.5m which represents a significant improvement on the April and May deficits which were £3.0m and £3.5m respectively. The improvement in the monthly run rate in June is £1.75m compared to the preceding two Months. This run rate improvement is attributed in large part to the impact of additional financial controls that were introduced during Quarter 1, together with increased budgetary control within the CSUs and corporate departments and increasing contributions from the CTG programme as schemes begin to be implemented. - It was important to note that there is a key risk to the reported position of £7.9m deficit at Month 3 and this relates to the Elective Recovery Fund (ERF). The ERF is paid on a variable basis for elective activity including first outpatient activity and a couple of other areas of activity. This cannot be reported on reliably at the moment as there is no baseline from NHSE and it is yet unclear on what exactly will be counted through the system. Some internal analysis has been undertaken for an estimate of the elective recovery fund and this is also inconclusive as there is a backlog in coding of our clinical activity. Although the activity from Month 1 is mostly fully coded well, the Month 2 and 3 activity is not yet fully coded therefore estimates have been put in place to provide an estimated ERF value for those months. - CSm wished to provide some positive news in relation to the activity plans that were submitted. These demonstrated that the Trust would deliver the targeted £91m of ERF activity which is the 107% target. Upon factoring in more up to date coding activity from the end of the last financial year and the start of the current one, the case mix suggests that delivering the activity plan would give an extra £3m income than planned for. This is all subject to getting up to date with the coding before being fully confident but none the less a potentially positive outcome. - CSm highlighted the run rate improvement in Month 3 across most departments and added that income and non-pay also improved for Month 3. The Academy was assured by the update.	
FA.7(2).24.11	**Treasury Management Update**	
	MQ presented the item and explained that the aim of the Treasury Management Report is to provide an overview of the Trusts cash and liquidity position, investment strategies and financial risks exposures. The Treasury Management policy requires the Trust to hold enough cash to fund eleven days of operations. MQ highlighted the following key points:	

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	- The 2024/25 cash plan reports that cash will fall by £47.2m from an opening balance of £64.2m to a closing balance of £17.0m. The 2024/25 cash plan assumes a net cash investment of £42.8m in the capital programme and receipt of £17.2m of PDC/TiF towards capital, £18.8m reduction in capital payables, an I&E deficit of £14.2m and that the CTG programme is fully delivered releasing £38.9m of cash benefit. - The Trust has a planned operational expenditure of £594.3m for 2024/25 and as such will need to hold a minimum cash balance of £17.9m. However as it is looking like the cash balance is going to be short going forward MQ has been in discussions with NHSE and other NHS Trusts and it looks like the minimum cash balance may be £1m which needs to be confirmed by NHSE but is a dramatic drop from £17.9m. NHSE have confirmed that it maybe that support cannot be requested until the cash position is £1m which makes it extremely tight. It is very important to be accurate in cash forecasting but it was important to note that the Trust may only have a minimum cash balance of £1m plus capital payable which is approximately £1.5m. - The year-to-date cash is £1.2m behind plan and this is mainly due I&E working capital being lower than plan in particular payables. The Trust has reduced the accruals for Annual Leave (£0.9m), Bank Staff (£0.8m) and Research and Development (£1.5m). Forecast cash is expected to be £2.8m lower than plan. - As referred to during the CTG agenda item another £13.8m of savings need to be identified within the current financial year otherwise the Trust is forecasting a closing cash balance of £1.7m. £5.2m of the identified savings target within the CTG tracker are classed as high risk to being delivered this financial year, £6.5m are classed as medium risk and £13.4m of the savings target are classed as low risk. If these are not generating a cash releasing benefit by the 31 March the Trust will require revenue cash support to remain liquid. In MQ's opinion the Trust will be between the orange line as detailed on slide 6 (£3.3m) and the red line (£19.3m) in terms of cash releasing benefits. If that is the case then it is likely that the Trust will require cash support from NHSE for Quarter 3 and 4. The position may change if the numbers improve in terms of achieving the CTG savings which will give cash releasing benefits but this is the outlook currently. - If revenue support is required then this needs to be requested on a quarterly basis in advance and the next timeline is early September for cash support for Quarter 3 which needs to be a Board approved request. MQ is liaising with Corporate Governance colleagues to ensure the correct governance framework is followed in order to be prepared to make the request if it is required. If cash support is requested then spending restrictions will be imposed on the Trust. MQ provided an example of another Trust that made a request for this and only received 25% which caused a significant challenge therefore it was important for the Academy to note that if the Trust is in this situation then we will be asked to provide a cash improvement plan. It was important to note that any revenue support takes the form of Public Dividend Capital (PDC), with no set repayment date, but attracts a dividend payable at the current rate (3.5%). ZA asked if there is anything else that can be done to counteract applying	

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	for cash support from NHSE. MQ emphasised the need to be forecasting more clearly on the CTG challenge and if cash releasing benefits can be taken from the CTG programme and we understand the position then we can also understand the scale of the cash deficit and what that means in terms of managing capital and working capital in the balance sheet. CSm added that delivering the CTG plays a key part in avoiding a request for revenue from NHSE but in addition to that cash management processes and getting Trust debts repaid by managing the supplier payment terms effectively will also help. Ultimately the biggest bill is for salaries and the priority is to ensure that this can be paid each month on time without fail. It was also important to note that the Trust is not alone in this position and there are other partners from WYAAT who are already in receipt of cash support and operating under this regime which is a real struggle from week to week. The Trust is doing it's best to avoid being in that situation and the best way to achieve that is to deliver the CTG programme. TS asked if there will be sufficient time to halt some of the capital works activity without incurring expenditure if the Trust does end up making the request for support in September and do we need to consider prioritising capital works now. MQ said a lot of the capital programme work is committed but there is a contingency pot of £3m which we may get asked to reduce to £0m. However there is a list of capital works for £30m which will need to be risk reviewed and prioritised. There is also some opportunities for working capital such as pre-payment and these may be able to be reduced as well as reducing the inventory balance. As the Academy is not meeting again until September it was agreed MQ, CSm and JM to consider whether a short, extraordinary meeting is required in August to agree the governance framework in case a request needs to be made to NHSE in order to ensure the Board is sighted with the required information to make the decision. The Academy was assured by the update.	Acting Chief Financial Officer FA24015
FA.7(2).24.12	**Bradford Place and ICS System Financial Update**	
	CSm provided a verbal update and advised that the Month 3 update for the Integrated Care System (ICS) is not yet available but the Month 2 position has been reported to be on plan. Risks are being flagged by the Directors of Finance from the various organisations in terms of the phasing of the plan and the challenge being much harder later in the year than it is at the beginning of the year. The scale of the risk in relation to phasing is huge with the plan for Month 2 for the ICS and providers as a totality being a deficit of £39m and the plan for the year a deficit of £50m. CSm advised that NHSE are introducing a new investigation and intervention regime to provide dedicated support to systems through some management consultancies. This support will be aimed at ICS's that are falling behind on their financial plans and meet certain high priority criteria. So far eleven systems have been identified for this targeted support from the consultancies and the expectation is that other ICS's will fall into this as the year progresses. Given the scale of the numbers and the phasing challenges there is an expectation that our ICS is likely to fall into the	

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	regime at some point. As alluded to earlier a PwC review has already taken place which was commissioned by WYAAT and the suggestion is that if we fall into this regime then a consultancy will expand on that review as well as look at the Integrated Care Board (ICB), mental health providers and community health providers who were not part of the PwC review. The expectation is that the report will provide more specific recommendations but would build on the PwC review but there is no confirmation at the moment that we will be part of the regime. At Place level a lot of work is continuing in relation to CTG and a detailed service review template has been submitted by Airedale NHS FT which looks at all aspects of services to identify where efficiencies and consolidation might be possible. This is being reviewed the following week at a meeting with respective Chief Operating Officers, Finance Directors and the leads from the Act as One Programmes to see how far that can be taken forward. The System Finance and Performance Committee has agreed to appoint a consultant who is an experienced ex NHS manager to support the project for a month and get it off the ground. In terms of the WYAAT efficiency workstreams CSm explained a long list of efficiencies were developed from an all Executive Team Meeting to review opportunities and ideas from other systems. There are 105 items on the list which are broken down into six priority areas to be reviewed over a thirteen week process by six working groups led by Chief Executives with support from other Executive colleagues from across the system. The aim is to rule in and rule out items from the long list and agree which ones can be implemented immediately and which ones require further analysis before implementation. The Academy noted the update.	
	Performance	
FA.7(2).24.13	**Operational Performance Highlight Report**	
	The report was taken as read and SA wished to share some positive news which was received earlier in the week. Formal notification has been received that the Trust has been designated as an Urgent Treatment Centre (UTC). This is part of a national programme and SA wished to commend SM and colleagues within the Urgent & Emergency Care CSU who undertook a huge amount of work on this. SA explained the benefits of moving to a UTC recognised site which will have a set of standards which have to be met providing a consistency of service offers. From a recording point of view activity can continue to be captured as Type 3 Activity as it allows for patients to be streamed into the UTC. CSt reported that the Trust will not achieve the 65-week KPI standard but the connectivity to the work being undertaken in relation to the waiting list, CTG and inequalities will contribute to improving the overall waiting list position going forward. The Academy was assured by the update.	

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FA.7(2).24.14	**Health Inequalities & Waiting List Analysis**	
	CSt presented the report and highlighted the following key points: - Data continues to be analysed and there is no particular change in terms of the patterns that are seen of patient attendances and pathways. In summary there is a variance in terms of referral priority but once patients are referred there is a fair equity of offer and the data shows no evidence of variance in clinical prioritisation of surgical waiting lists for CORE20 patients and treatment dates are given fairly within priority grouping. - In order to support the work to reduce health inequalities data needs to be linked to tangible actions but this cannot be done in isolation. This needs to be done as part of the Act as One agenda with colleagues across the Place, particularly primary care colleagues as a lot of what is being observed is how patients are referred to Trust services and the differences from the various community groups. There are four key areas within the action plan which will focus on reducing inequalities and these are: o Data and insight: Improve internal use of data to drive actions and link with external partners such as Bradford Institute of Health Research to enhance/ advance analysis o DNA reduction: Progress CTG workstream with a focus on this agenda and link with Place colleagues to coordinate stakeholder engagement o Referral analysis: Progress work with Cancer Alliance and PCN coordinators and reducing inequalities group across place to devise specific actions o Post referral prioritisation: Ensure Learning Disability (LD) prioritisation continues and enhance weekly oversight and identify other cohorts that would benefit from similar prioritisation by using segmentation analysis and the plus five elements of the core 20PLUS5. JL commended the great work being undertaken within this area and asked if any tracking is undertaken in terms of improvement and if this has impacted positively. CSt explained there are two tangible outcomes that can be tracked and these are the impact on LD and the difference that is being made in relation to the gap on the DNA rate for CORE20 and non-CORE20 patients. The other actions which link with the work that is being undertaken with primary care partners is in the tentative stages of development therefore any specific tracking has not yet been done to measure the other outcomes but this will be developed over time. SA added that the next stage is to link the elements of outcome, experience and access together to see whether that provides a richer data source to track outcomes and this is something that MH and his team can lead on. The Academy was assured by the update.	
FA.7(2).24.15	**Estates Procurement Internal Audit Report (BH482024)**	
	JP presented the item and explained that the report explains the reasoning behind the conclusion of limited assurance of the Estates Procurement	

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	Internal Audit Report and a summary of the work that is being undertaken to mitigate any risks. JP made the following key points: - A Measured Term Contract (MTC) agreement was awarded in July 2022, following a full competitive tender process, and covered a two-year period with one designated contractor. This allows the contractor to undertake repairs, maintenance, and minor new building works at an agreed, contracted fixed price based on a pre-tendered schedule of rates. The MTC pre-tendered route is utilised if the work requires fast track construction or there is a genuine rationale precluding a competitive tendering exercise, an MTC quote is obtained in line with the pre-tendered schedule of rates, and meets Estates internal financial thresholds of between £250.00 excl. VAT and £99,999.99 excl. VAT. - The MTC route was chosen for an element of works related to the car park enabling works, undertaken to mitigate overall impact to losing car parking provision both during and post construction of the new Day Case Unit (DCU) at St Lukes Hospital (SLH). The DCU Project Board approved works at a value of c.£94k (all costs excluding VAT), within the SFI limit and was not expected to increase/change. - Following a review of the car park works at DCU with key stakeholders a decision was taken by the DCU project board to increase the scope of work to respond to historic (the area previously used as a car park) welfare/security areas of concern around that area, increasing the cost to £197k. The governance procedures implemented to oversee cost and procedure were followed by the project board and deemed affordable within the overall DCU project budget. However, the audit identified that this increase in cost, which breached the Trust imposed limit of £99,999.00 under SFI's, did not get 'flagged' and reported to the Estates and Facilities Compliance, Risk & Assurance Group (CRAG) Group. Thus identifying a potential risk "that this can potentially lead to the inappropriate awarding of funds to a supplier which does not provide value for money". - The Management Response with regards to governance and oversight are being addressed and are summarised as follows: a) Estates Management are aware of this breach in procedure and learning has been identified. To prevent the risk of a repeat of this situation, an escalation process has been introduced. b) The MTC works cost tracker and procedure, maintained by the Estates Business Management Team, has been amended to highlight variance between the initial MTC instruction and forecast final cost as the works are delivered. This will allow all cost increases to be flagged and monitored, escalated as required. c) The MTC Meeting agenda now includes a standing agenda item 'Potential Increased Costs – Existing Instruction'. d) In addition, following recent discussions with Finance Colleagues, the imposed SFI limit of £99,999.00 is understood to be being reviewed to ensure the imposed limits reflect circumstance – advice from finance established that this instance did not break the law in regard breach, but did breach the imposed SFI threshold. e) All Estates staff have been reminded of the requirement to ensure segregation of duties in the commission and authorisation of procurement transactions. f) The Business Management Team closely monitor each MTC	

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	instruction through its life cycle and will return any MTC instructions for re-approval if governance rules have not been followed. ZA raised the point that the requisition should not be raised by the same person who is approving it therefore checks and controls should be in place to avoid this. MQ advised that segregation is built in for the iProc system which is used within Procurement and would expect the same is in place for the Estates system. MQ suggested that the Estates department may want to consider using the iProc system as opposed to their internal system currently in place as iProc has all the sufficient grip and control in place which will not allow the SFIs to be breached. The Academy was assured by the update.	
FA.7(2).24.16	**Any Other Business**	
	There were no further items of business to discuss.	
FA.7(2).24.17	**Matters to Share with Other Academies**	
	JH agreed to share the concerns in relation to histopathology and cancer and particularly the recruitment challenges with the People Academy.	
FA.7(2).24.18	**Matters to Escalate to Board**	
	JL advised that any relevant matters would be escalated to Board via the formal Finance & Performance Academy Chair report including the finance cash position as well as the risk to delivering the CTG schemes.	
FA.7(2).24.19	**Date and Time of the Next Meeting**	
	25 September 2024 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 24 July 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FA24014	24/07/24	**FA.7(2).24.7**	**High Level Risks Relevant to the Academy:** - To circulate the Excel version of todays paper to all. If there are any items to raise colleagues are asked to let JL know. - To include the Excel version of the risk register in the meeting papers for future meetings.	Head of Corporate Governance	24/07/24 25/09/24	
FA24015	24/07/24	**FA.7(2).24.11**	**Treasury Management Update:** MQ, CSm and JM to consider whether a short, extraordinary meeting is required in August to agree the governance framework in case a request needs to be made to NHSE in order to ensure the Board is sighted with the required information to make the decision.	Acting Chief Financial Officer	31/07/24	
FA24012	04/07/24	**FA.7(1).24.4**	**Matters Arising:** Academy to receive an update following the PwC review of the Trust's governance structure as part of the whole WYAAT review which is expected to be completed mid-July with a report going to the Committee in Common and WYAAT Chief Executives which will determine next steps.	Acting Chief Financial Officer	25/09/24	CSm advised that the final report was received on 23 July and provided a summary of the content. A written summary of the report to be presented to the September meeting of F&P.
FA24016						

BO.9.24.27 - CONFIRMED AUDIT COMMITTEE MINUTES

REFERENCES

Only PDFs are attached

Bo.9.24.27 - confirmed AC mins - 21.5.24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

CONFIRMED AUDIT COMMITTEE MEETING MINUTES

Date	Tuesday, 21 May 2024	**Time**	14:10 – 17:00
Venue	Virtual Meeting – MS Teams	**Chair**	Bryan Machin, Non-Executive Director

Present	• Bryan Machin (BM), Non-Executive Director and Chair • Zafir Ali (ZA), Non-Executive Director
In Attendance	• Matthew Horner (MH), Director of Finance • Michael Quinlan (MQ), Deputy Director of Finance • Steve Moss (SM), Counter Fraud, Audit Yorkshire • Paul Hewitson (PH), External Audit, Deloitte • Nick Rayner (NR), External Audit, Deloitte • Karina Edwards (KE), Internal Audit, Audit Yorkshire • Helen Higgs (HH), Internal Audit, Audit Yorkshire • Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary • Jacqui Maurice (JM), Head of Corporate Governance • Mel Pickup (MP), Chief Executive for A.5.24.21only • Faeem Lal (FL), Director of HR for A.5.24.11c only • Saj Azeb (SA), Chief Operating Officer for A.5.24.23 only • Steve Amos (SAm), Emergency Planning Manager for A.5.24.23 only • Adam Griffin (AG) Deputy Chief Digital & Information Officer for A.5.24.24 only • Ray Smith (RS), Chief Medical Officer for A.5.24.11b only

No.	Agenda Item	Action
-	**Private meeting with Audit Committee members, Internal and External Audit**	
A.5.24.1	**Apologies for absence** • Richard Maw (RM), Counter Fraud, Audit Yorkshire • Mohammed Hussain (MH), Non-Executive Director (authorised absence)	
A.5.24.2	**Declarations of interest** No interests were declared.	
A.5.24.3	**Minutes of the meeting held 22 April 2024** The minutes of the meeting held on 22 April 2024 were approved as a correct record subject to the two updates to Zafir Ali's initials within the minutes.	
A.5.24.4	**Matters arising** The following actions were confirmed as closed as indicated on the action log. • A24025 – Review of meeting – action closed • A24023 – Audit Committee annual report to Board – action closed • A24022 – IA report BH382024 – action closed	

	• A24021 – Policies and procedures of ensuring acceptable data quality – action closed • A24020 – Single Source Tenders – action closed • A24017 – Counter fraud progress report – action closed • A24016 – Draft internal audit plan 2024/25 – action closed • A24015 – Draft internal audit plan 2024/25 – action closed • A24014 – Audit recommendations assurance & evidence -action closed • A24013 – Follow up of internal audit recommendations – action closed • A24012 – Internal audit progress report – action closed • A24011 - Internal audit progress report – action closed • A24009 – External audit annual plan 2023/24 – action closed • A24007 – Audit committee annual self- assessment – action closed • A24019 – Schedule of losses and special payments – action closed **Updates were provided with regard to the remaining actions as follows:** • A24024 Any other business: Two documents require signature of AC Chair in relation to HFMA sustainability exercise. MH to arrange for this to take place. Action to remain open. • A24010 Internal audit progress report: The IT business continuity forms part of the wider EPRR process and feeds into that via the Quality Academy. Action closed. • A24008 External audit annual plan 2023/24: 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. Action to remain open. • A24018 Schedule of losses and special payments: 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. • 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.5.24.5	**Revised external audit annual plan 2023/24** Further to the action (A24009) relating to the Value for Money risk of significant weakness raised at the previous Audit Committee meeting NR confirmed that after discussion with management a form of words was agreed that was acceptable to the Deloitte audit team and quality reviewers. LP referred to the statement on page 33 relating to the Code of Governance and clarified that this has been to the Board for assessment, and it was discussed at the previous Audit Committee meeting. NR explained that this was a timing issue relating to the production of the report. The Committee noted the update provided.	
A.5.24.6	**Use of External Audit to provide non-audit services (standing item)** There was nothing to report on this item.	
A.5.24.7	**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. Eight finalised reports have been issued since the last meeting: one high	

	assurance report, three significant assurance reports and, three limited assurance reports. Two audits remain outstanding as part of the planned 2023/24 work; Procurement (Estates) which is likely to be a limited assurance report and the Waste Reduction Programme - which is likely to be a significant assurance report. An updated progress report, final IA Annual Report and the Head of Internal Audit Opinion will be presented to the June Audit Committee in line with the workplan. There were no management changes and the KPI's remain unchanged since the last meeting. A summary, on page 5 of the report, provides an overview of the work completed throughout the year with the overall opinions for each of the individual reviews and the number of associated recommendations. BM referred to the payroll audit wording on page 24 relating to the opinion being provided on a payroll department which is not run by the Trust. KE confirmed that the wording should say 'the payroll department within the Foundation Trust' and agreed to update this. The Committee noted the report and the assurance provided.	Internal Audit A24026
A.5.24.8	**Follow up of Internal Audit recommendations** KE provided an overview of the current position in relation to internal audit recommendations and the progress made which is shared with MH who then shares with the executive team. The system has recently changed from Pentane to K10 and the responsibility for updating audit recommendations sits with each of the executive assistants to ensure updates are provided in a timely manner. Due to the changeover in the system, there may be updates that haven't pulled through, but it was hoped that this would catch up shortly. It was envisaged that all recommendations will have a current update going forward and this will be monitored. MH confirmed that the report had recently been discussed at the ETM meeting and it was noted that some of the updates may have missed the report deadline but should be picked up in future reports. The Committee noted the report and the assurance provided.	
A.5.24.9	**Draft Annual Head of Internal Audit Opinion** KE provided an overview of the key outcomes of the work undertaken by internal audit which supports the organisation's annual report and accounts and specifically the annual governance statement for 2023/24. KE confirmed that Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. In response to a question raised KE stated that KPI's and any amendments to the internal audit programme are routinely reported to the Audit Committee throughout the year ZA referred to the 7 limited assurance opinions relating to patient facing	

	areas. He felt that the plan for 2024/25 needed to be flexible to undertake more patient facing operational types of audits to provide broader assurance to the organisation. KE advised that the internal audit plan presented to the April Audit Committee shows that clinical governance and quality have been allotted 160 days of the 542 total days allocation – approximately 30% of the plan. Any proposed changes to the plan in year, and the list of backup audits, takes into consideration patient focussing audits. ZA suggested that the themes from the recommendations could be included within the report to highlight areas of weakness to help the organisation improve. HH concurred that this would indeed add value to the plan and would be included in the 2024/25 plan. The Committee noted that there is nothing, in terms of the audits yet to complete, that is likely to change the Head of Internal Audit Opinion therefore, the Committee concluded, t the Annual Governance Statement should include the significant assurance statement.	
A.5.24.10	**a. Draft Internal Audit Plan 2024/25** KE advised that the draft plan being presented also includes further mapping details relating to the strategic objective and relevant strategic risk, as requested by the Audit Committee in April 2024. This will ensure that when the BAF is reviewed it will be clear where the assurance is expected from the internal audit process during 2024/25. The Committee approved the draft Internal Audit Plan 2024/25 **b. Internal Audit auditable areas** KE stated that the paper provides an analysis of the areas that have been audited over the last three years, as requested by the Audit Committee in April 2024, to ensure that there are no areas omitted on the 2024/25. ZA felt that the paper provided assurance on what has previously been audited and ensures that no duplications are made which will ensure that the plan can be flexed as and when required. BM drew attention to the consent audit that last took place in 2021/22 with limited assurance which does not seem to be factored into the plan for 2024/25. The Cyber security audit, although external assurances have been given, is not included in the internal audit plan for 2024/25. KE confirmed discussions had taken place with Adam Griffin, Deputy Chief Digital & Information Officer and it was agreed that this would not be included in the 2024/25 plan. Data security and protection will form part of the Cyber Awareness Framework (CAF) which will have much more cyber focus going forward, but KE said she was happy to amend the plan if required. BM felt that once we have established which committee/academy will be overseeing Cyber Security they may wish to add this to the internal audit plan for 2024/25. Any consideration to changes to the plan in year towards more patient focused audits could include revisiting consent. The Committee noted the reports and the assurance provided.	

A.5.24.11	**Limited assurance internal audit reports** **a. BH432024 – Nursing Assessment & Care plans – limited assurance** Item deferred to September due to the unavailability of the Chief Nurse to attend this meeting. **b. BH462024 – Consultant & SAS doctors job planning** RS joined the meeting. He advised that the two internal audits BH462024 and BH472024 are interlinked. He noted that the timing of the audit, with the job planning being in a state of flux, would be a driver to try and improve and identify any potential issues. RS explained that all Consultants (approximately 400), and SAS doctors have a job plan which is rolled over from year to year unless there are any particular changes made to it. This is a significant undertaking for the Clinical Directors from each CSU to ensure all job plans are up to date. During 2022 'Allocate' the new electronic system wide planning platform was implemented along with the re-start of job planning after the pandemic. A target of 80% compliance had been set to ensure all job plans are signed off by the 31st March 2024 which, as shown in the recent audit, has not been achieved. Recent discussion at ETM highlighted some unintended consequences which, given the financial challenges we are facing at the moment, require demand and capacity remedial action. Management agreed that job planning needs to be undertaken in conjunction with a service review which will allow us to understand capacity, demand and staffing issues. RS confirmed that most of the actions outlined in the audit have been completed and the aim is to have all job plans, taking into account the service as a whole, up to date and signed off within the last 12 months to reach the target of 80% compliance. ZA queried the figures within the report of 23 Consultants identified as not having a job plan. RS confirmed that these refer to Consultants who have started recently in the Trust who have a generic job plan for their post which will require review once in post. It may be that the auditors did not have visibility on these, and this is being investigated further by John Bolton, Deputy Chief Medical Officer who felt that these may relate to bank staff or new employees rather than any substantive member of staff. **c. BH472024 – E-Job Planning** KE provided an overview of the limited assurance report and the work ongoing to ensure all Consultant and SAS doctors job plans are inputted into the system. FL joined the meeting and provided his update on the position to date. FL advised that all Consultants and SAS doctors have job plans but it is best practice to ensure they are reviewed on a regular basis and this forms part of the piece of work around 'closing the gap' to review them in more detail to ensure they are still relevant and applicable. A much deeper dive into job planning will be undertaken to prioritise key areas to ensure plans are updated. It was envisaged, that by the end of the year, we will be in a much better position, and it would be beneficial to have another audit next year to track progress made. Management's proposal is to focus on specialties which are a priority for review by the Trust and then to review the job planning process therein. MH felt that further review of the timelines	Chief Nurse A24027

	is required to ensure the job plans are aligned to the capacity and demand work that will be undertaken by management. It was suggested that the People Academy should review progress on job planning and completion percentages throughout the year via the workforce report to provide assurance for the organisation. People Academy Chair to be advised.	Board Secretary A.24028
A.5.24.12	**Policies and procedures for all work related to counter fraud, bribery and corruption** SM confirmed that a revision of the Anti-Fraud, Bribery and Corruption policy had taken place, although this is not due for review until May 2025, which noted that the policy stands up to scrutiny and reflects current practice. The Conflict of Interest Policy is also up to date, with no issues to highlight, and is due for renewal in February 2025. The Committee noted the report and the assurance provided.	
A.5.24.13	**Counter Fraud Annual Report 2023/24** SM referred to the Counter Fraud annual report which summarises the work undertaken in the previous year (with the vast majority of the content already provided in the progress reports to Audit). The report contains a draft of the Counter Fraud functional standard return which highlights the Trusts position against the standard compliance levels. The Trust complied with most standards apart from requirement 3 concerning the risk management component. SM stated that this is probably one of the hardest standards to achieve but steady progress is being made and he was confident that the Trust will score green in a years' time. The report also provides an overview of other work undertaken by Counter Fraud including their costings for the year. ZA drew attention to the number of investigations that have taken place in year and the low figures relating to redress and sanctions. He questioned the comparison with other similar sized Trusts and whether we have appropriate plans in place to support the redress. SM confirmed that benchmarking data is provided in the progress reports provided to the Audit Committee. There are a decent number of referrals made within the Trust and these can only be taken so far if the evidence is not available to support the allegations. The conclusion of each case is discussed with MH on the most prudent course of action required to take the investigations forward either through a criminal route or an HR route. MH felt that the Committee would benefit from receiving a more detailed update on what internal sanctions were imposed for each of the investigations and suggested this is provided in the progress reports at future meetings in line with the workplan. BM referred to the masterclass sessions that are provided by Counter Fraud which are available to all Audit Yorkshire clients. SM noted that the attendance figures had been higher in the past and work is ongoing to promote these sessions throughout the Trust and wider.	Counter Fraud A24029

	The Committee noted the report and the assurance provided.	
A.5.24.14	**Draft Counter Fraud Annual Plan 2024/25** SM provided an overview of the draft plan and highlighted the planned 90 days allocated to the counter fraud work for the coming year. The vast majority of days are dedicated to pro-active work looking at more awareness work, master classes and face to face presentations to promote the Counter Fraud service. Work continues on the fraud risk descriptors with the 5 most commonly seen across Audit Yorkshire clients in 2023/24 relating to working whilst sick, falsifying timesheets, falsifying their CV, changing bank details and dishonest travel/expenses claims. Twenty investigation days have been allocated to fraud investigations and the pursuit of sanctions and redress and any changes or increases to the number of days will be discussed with the Director of Finance. The planned work will help the Trust comply with the standards and help us to achieve a green overall score for next year's return. The Committee approved the draft Counter Fraud Annual Plan 2024/25	
A.5.24.15	**Counter Fraud Self Review Tool** The Trust is required to submit their Counter Fraud functional standard return annually. The Trust's overall score is green with one amber score (standard 3) which has not affected the overall score and is on target for full compliance next year. SM confirmed that MQ is the Trust's Counter Fraud Champion and meets regularly with RM to discuss ongoing investigations and training and development. The Committee noted the report and the assurance provided.	
A.5.24.16	**Counter Fraud progress report** SM provided an update on the position to date and gave an overview of the current and concluded investigations. Future updates will be provided at the September meeting. One alert pertaining to a mandate fraud attempt in Scotland has been circulated along with two newsletters for information. SM confirmed that the Trust had not been subject to a mandate fraud attempt, but this was happening elsewhere across Audit Yorkshire clients and work continues to highlight the messages particularly to credit payment staff. The Committee noted the report and the assurance provided.	
A.5.24.17	**Exception reports: Schedules of losses and special payments** There was nothing to report on this item.	
A.5.24.18	**Trust compliance with Standing Orders, Standing Financial Instructions/Scheme of Delegation (standing item)** There was nothing to report on this item.	
A.5.24.19	**Suspension of Standing Orders/Standing Financial Instructions (standing item)** There was nothing to report on this item.	

A.5.24.20	**Other assurance functions (standing item)** There was nothing to report on this item.	
A.5.24.21	**Annual Governance Statement (AGS)** MP joined the meeting to present the AGS for approval. MP provided an update on how she satisfies herself that all points, listed within the paper, are identified and met. MP drew attention to the section within the AGS that covers information governance in relation to one externally reportable incident, reported in the last financial year, where personal data has been compromised but no action was taken against the Trust. We continue to maintain a strong emphasis on staff awareness and compliance with the rules in order to protect the integrity of patient and colleague information to reduce the risk of breaches. In relation to the provider licence, the Board carefully considered the requirements of section 4 (governance arrangements), in light of the resignation of the former chairman and concerns raised by him, and concerns raised by three Non-Executive Directors. This has particularly impacted on board relationships and dynamics. On balance, the Board concluded that these issues did not sufficiently affect the control and governance of the Trust to require us to declare non-compliance, because the Board, Academies and Committees have continued to operate control processes and decisions have been made where needed. Both board mechanics and board dynamics have been considered by the Board and it was felt that the mechanics have worked although the dynamics were not perfect. The CQC has not highlighted any breaches following their recent inspections although the final report is still awaited. In conclusion, MP advised, there were no significant internal control issues identified which have caused an impact on the completion of the AGS. It was noted that there are some parts of the AGS, relating to the Head of Internal Audit Opinion, which will need to be finalised after this meeting. BM noted that he had sent some typographical updates to LP and an additional paragraph on the EPRR and the AGS has been updated accordingly. The Committee approved the current draft of the AGS subject to any final amendments which will be presented at the Audit Committee on 20th June.	
A.5.24.22	**Partnership arrangements: implications for the Audit Committee** LP advised that there were no updates to report.	
A.5.24.23	**Business Continuity and EPRR** SA and SAm joined the meeting and provided an overview of the Business Continuity and EPRR position to date. NHS England requires all NHS organisations to annually assess their ability to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations. The submission is signed off by the Finance & Performance Academy and then the Board of Directors.	

	SAm provided an update on the enhanced requirements for submitting evidence against the core standards which requires the Trust to submit substantial amounts of evidence, via an online portal. This is a regional request from Yorkshire and Humber and is in additional to the NHS England national requirements. The results show the Trust was fully compliant with 20 out of 62 core standards and partially compliant on 42 core standards which gave us a 32% compliance rating compared to last year's 86% rating. The benchmarking data shows that we had comparable scores with other Trusts in the Yorkshire and Humber region. The Trust has been working closely with West Yorkshire ICB to produce an action plan and there has been a marked improvement in our compliance with the current scores at 31 fully compliant and 31 partially compliant. A recent internal audit has taken place which provided significant assurance, with one minor recommendation. SA, as the executive lead for EPRR, is required to attend the West Yorkshire Local Health Resilience Partnership at quarterly meetings throughout the year as this is a core standard requirement. Due to numerous WY/Place policies and procedures being out of date, this affected the Trust compliance for some core standards. Once these documents have been signed off at West Yorkshire level and are received, these can be used to base our internal plans on or allow us to become fully compliant with additional core standards. A deep dive exercise was undertaken relating to exercise and training and our overall score from the submission was 1 out of 10 compliances. Improvements have been made and the compliance rating is now 6 out of 10. There have been 17 periods of industrial action since the last report to the Audit Committee with support being provided by the Emergency Planning team to run the command and control meetings and writing the operational plans. Internal investigations and lessons identified form part of the action plan and debrief relating to any incidents that arise. NHS England requires the Trust to undertake a minimum of 1 tabletop exercise per year, 2 call cascades and a live exercise every 3 years. A number of different incident response training and exercise tests have taken place in year with lessons learnt and action plans produced. Staff training continues throughout the Trust which links into the EPRR training needs analysis. We continue to work collaboratively with the ICB, Bradford Council and other local health emergency planning leads to ensure we receive early notifications of incidents in the area. Work continues to progress the core standards and continuing to support the increase of business impact analysis and business continuity plans throughout the Trust. BM noted that there is no longer a requirement for this report to be provided to the Audit Committee as it is already discussed via the Finance & Performance Academy three times a year.	

	The Committee noted the report and the assurance provided.	
A.5.24.24	**Cyber Security** AG joined the meeting and provided an overview on the current state of cyber security in the Trust along with the ongoing improvement plan. AG referred to the draft business plan which makes very clear objectives and plans around cyber security throughout the Trust and the ongoing metrics relating to IT firewalls which are configured to block any suspected inbound network traffic automatically. The Trust has revisited the National Cyber Security Centres "10 Steps to Cyber Security" best practice framework and assessed itself against each of the metrics. The self-assessment shows that the Trust continues to have strong technical protection although there is limited evidence to confidently inform a position on User education & awareness, hence an amber-red rating. A third-party training provider has been procured to provide all frontline staff on cyber response handling and management. ZA queried if the new Cyber Assessment Framework replaces the '10 Steps Cyber security assessment'. AG confirmed that there is a rich tapestry of guidance models and frameworks available and it's the Trust's responsibility to choose the ones that are most practical and appropriate for our organisation. In terms of best practice ZA suggested that it might be beneficial for AG to look at the National Cyber Security Centre website to determine if the '10 Steps Cyber security assessment' has been superseded. The ISO 27001 assessment provided assurance, the Trust has the correct, controls, staff, and processes in place to manage IT Security. An Internal Audit was undertaken in 2022 to provide further assurance, which carried a Significant Assurance opinion. AG drew attention to the improvements planned for the coming year: • The first Cyber Security Manager will be in post, and this will mark a step change in our management and provision of cyber security arrangements. • The tenable cyber vulnerability system will become embedded within the Trust which scans the technical estates from an internal perspective and an external perspective effectively mimicking that the attackers would do. • Different metrics and ways of measuring security and cyber performance have been established and will be reported via the academies in due course. The Committee felt assured that the Trust has appropriate and robust arrangements in place for managing the cyber security risk proven in the external assurances being sought. The guidance from the new HFMA handbook is unclear as to where the oversight of cyber security, from a governance perspective, should sit. LP confirmed that a discussion, to review the academy/committee terms of reference and workplans, will take place at the June Board development session where cyber security, along with other functions, will be discussed.	Deputy Chief Digital & Information Officer A24030

	The Committee noted the report and the assurance provided.	
A.5.24.25	**Draft Annual Report 2023/24** LP provided an overview of the annual report which has been produced in line with the Annual Reporting Manual published by NHSE which will be submitted by the deadline of 28 June 2024. Changes made by the Board of Directors have been included with the paper which will be coming back to the 20th June Audit Committee prior to final approval at the Board of Directors on the 25th June. The Committee noted the report and the assurance provided.	
A.5.24.26	**Audit Committee Annual Report 2023/24** BM gave an overview of the report which reflects the work of the Audit Committee for 2023/24. ZA noted that within the report he is listed as Deputy Chair within the Terms of Reference which needs to be removed. LP agreed to update the report. The Committee approved the report which will now be submitted to the Board in July.	Board Secretary A24031
A.5.24.27	**Audit Committee Annual Self-Assessment** BM confirmed that he had reviewed the new HFMA handbook with LP. There are a small number of areas where the Committee is considered to not be fully compliant and comments and proposed actions are included for discussion. The Committee felt that this was a fair assessment of where we are at the moment on process. It was agreed that assessment, in terms of effectiveness, should be included as part of the annual governance cycle to inform the end of year processes which lead to the production of the Annual Governance Statement. The Committee agreed the proposed actions to address those areas marked as not compliant and agreed the proposal to not complete the effectiveness checklist for 2023/24.	Board Secretary A24032
A.5.24.28	**Annual review of AC terms of reference and workplan** BM highlighted the proposed amendments in relation to the Terms of Reference which are mainly procedural. All amendments as proposed within the paper were approved. BM agreed to reflect these changes in his Audit Committee report to Board in July 2024. BM highlighted the proposed amendments to the Audit Committee workplan and these were approved. The subject of cyber security as discussed at A.5.24.24 will be discussed at the June Board Development session. BM was assured that the terms of reference for this committee, as it sits in the Trusts governance, are in accordance with the practice of the HFMA handbook. The Committee approved the terms of reference and workplan for approval by the Board of Directors in July 2024.	Chair A24033

A.5.24.29	**Annual Reports 2023/24** The Committee were assured that the Academies have performed their functions in line with their terms of reference during 2023/24. The Committee noted the reports and the assurance provided.	
A.5.24.30	**Any other business** There were no matters raised.	
A.5.24.31	**Matters to share with other committees/academies** The People Academy to review progress on job planning and completion percentages throughout the year for assurance.	Refer to A24028
A.5.24.32	**Matters to escalate to the Risk Register** There were no matters identified to escalate to the high-level operational risk register.	
A.5.24.33	**Matters to escalate to the Board of Directors** • The Audit Committee terms of reference and workplan for approval at July Board. • Audit Committee Annual Report to be presented for approval at the July Board.	
A.5.24.34	**Items deferred to subsequent meetings** BH432024 – Nursing Assessment & Care plans – limited assurance deferred to September.	
A.5.24.35	**Attendees for subsequent audit committee meeting** • The AC would continue with the practice of Executive attendance on a rotational basis. • September meeting: Paul Rice, Chief Digital & Information Officer regarding Data Quality • September meeting: Julie Ward, Senior Healthcare Contracts & Overseas Manager with regard to Overseas Visitors presentation • September meeting: Karen Dawber, Chief Nurse with regard to limited assurance IA report BH432024	
A.5.24.36	**Review of meeting** BM commented that it had been good practice for attendees to join the meeting to present and explain their perspectives on different areas to aid the committee's considerations.	
A.5.24.37	**Date and time of next virtual meetings:** • 20 June 2024 (extraordinary meeting accounts sign off) • 10 September 2024 • 19 November 2024	

Action log from the Audit Committee Meeting held 21 May 2024

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
			A24035		
21.5.24	A.5.24.28	**Annual review of AC** BM highlighted the proposed amendments in relation to the Terms of Reference which are mainly procedural. All amendments as proposed within the paper were approved. BM agreed to reflect these changes in his Audit Committee report to Board in July 2024.	**Chair** **A24033**	September 2024	ToR's to be presented at Board in July for approval. Action closed.
21.5.24	A.5.24.27	**Audit Committee annual self-assessment** It was agreed that assessment, in terms of effectiveness, should be included as part of the annual governance cycle to inform the end of year processes which lead to the production of the Annual Governance Statement.	**Board Secretary** **A24032**	September 2024	In future all academy/committee effectiveness reviews will be undertaken in April so that they can inform the AGS. Action closed
21.5.24	A.5.24.26	**Audit Committee Annual Report 2023/24** ZA noted that within the report he is listed as Deputy Chair within the Terms of Reference which needs to be removed. LP agreed to update the report.	**Board Secretary** **A24031**	September 2024	Updates actioned. AC Annual report to be presented at Board in July for approval. Action closed.
21.5.24	A.5.24.24	**Cyber security** In terms of best practice ZA suggested that it might be beneficial for AG to look at the National Cyber Security Centre website to determine if the '10 Steps Cyber security assessment' has been superseded.	**Deputy Chief Digital & Information Officer** **A24030**	September 2024	The 10 steps is just one of many available sets of guidance to help organisations protect themselves in terms of cyber. The 10 steps will always remain relevant and will complement BTHFT's approach to cyber. We adopt additional standards on top of the NCSC's 10 steps which provides a broader, and deeper set of controls for the protection of BTHFT's information assets e.g. ISO27001,

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
					CyberEssentials+, Action closed.
21.5.24	A.5.24.13	**Counter Fraud annual report 2023/24** MH felt that the Committee would benefit from receiving a more detailed update on what internal sanctions were imposed for each of the investigations and suggested this is provided in the progress reports at future meetings in line with the workplan.	**Counter Fraud A24029**	September 2024	Information to be included in progress reports going forward. Action closed
21.5.24	A.5.24.11	**Limited assurance internal audit report** BH472024 – E-job planning - It was suggested that the People Academy should review progress on job planning and completion percentages throughout the year via the workforce report to provide assurance for the organisation. People Academy Chair to be advised.	**Board Secretary A24028**	September 2024	People Academy Chair notified. Item will be delivered as part of the quarterly workforce report starting in July 2024. Action closed.
21.5.24	A.5.24.11	**Limited assurance internal audit report** BH432024 – Nursing assessment & care plans deferred to September meeting	**Chief Nurse A24027**	September 2024	Item included on September agenda. Action closed
21.5.24	A.5.24.7	**Internal Audit progress report** BM referred to the payroll audit wording on page 24 relating to the payroll department opinion being provided on a payroll department which is not run by the Trust. KE confirmed that the wording should say 'the payroll department within the Foundation Trust' and agreed to update this.	**Internal Audit A24026**	September 2024	Report updated. 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.	**Director of Finance A24024**	September 2024	May 2024. Two documents require signature of AC Chair in relation to HFMA sustainability exercise. MH to arrange for this to take place. Action to remain open

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		MH agreed to circulate this to the AC for review once completed.			
22.4.24	A.4.24.6	**External audit annual plan 2023/24** Value 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	May 2024. As and when the CQC report becomes available it will be provided to Deloitte. Action to remain open An update will also be provided to the AC in September. Agenda item added to the September agenda.- action closed
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	13.8.24 – overseas presentation included on September agenda. Action closed 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.
23.5.23	A.5.23.22	**Partnership arrangements: implications for the Audit Committee** JH noted that an update to the public sector internal audit standards is due imminently which will be shared once it is received.	**Internal Audit A23025**	2024/25	19.6.24 – New standards due to be issued January 2025. Action to remain open. 12.9.23 Item on hold pending the update which is due in 2024/25. Action to remain open. 21.02.24 Awaiting the publication of the standards. Once issued they will be shared with the Committee. Action to remain open.