Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS OPEN

BOARD OF DIRECTORS OPEN

28 November 2024

09:00 GMT Europe/London

Conference room, Field House, BRI

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AGENDA -28.11.24

REFERENCES

Only PDFs are attached

Bo.11.24.0 - Open Board Agenda 28.11.24.pdf

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	Thursday, 28 November 2024	**Time:**	09:00 – 11:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair

- 09:00-09:20– Bo.11.24.5 – Getting to know the CSU - Transforming A&E Programme
- 10:05-10:15 - Sara Hollins, Bo.11.24.10 Maternity and Neonatal Services update

Observers: Helen Wilson, Raquel Licas and John Waterhouse, Governors

No.	Agenda Item	Lead	Outcome	Papers attached
09:00 Section 1: Opening matters				
Bo.11.24.1	Apologies for absence • Altaf Sadique, NED • Mohammed Hussain, NED • Sughra Nazir, NED	Chair	For information	Verbal
Bo.11.24.2	Declarations of interest	Chair	For information	Bo.11.24.2
Bo.11.24.3	Minutes of the meeting held on 25 September 2024	Chair	For approval	Bo.11.24.3
Bo.11.24.4 Bo.11.24.4a	Matters arising • Depth of Coding	Chair Chief Digital and Information Officer	For information For assurance	Verbal Bo.11.24.4a
Bo.11.24.5	Getting to know the CSUs – Transforming A&E Programme	Chief Operating Officer/Chief Medical Officer/Chief Nurse	For information	Presentation
09:20 Section 2: Business Reports				
Bo.11.24.6	Report from the Chair	Chair	For information	Bo.11.24.6
Bo.11.24.7	Report from the Chief Executive	Chief Executive	For information	Bo.11.24.7
09:35 Section 3: Patient Care				
Bo.11.24.8	Report from the Chair of the Quality Committee: a. October & November 2024 b. Digital Strategy bi-annual update c. Mental Health, Learning Disability and Neurodiversity Strategy 2024-28 d. Patient Experience 6 month update (including Inpatient survey)	Chair of the Quality Committee	For assurance	Bo.11.24.8
Bo.11.24.9	CQC published reports	Chief Nurse	For assurance	Bo.11.24.9
Bo.11.24.10	Maternity and neonatal services update	Chief Nurse	For assurance	Bo.11.24.10

10:15 Section 4: People				
Bo.11.24.11	Report from the Chair of the People Academy: a. October & November 2024 b. Freedom to Speak Up (FTSU) quarterly report c. Guardian of Safe Working Hours quarterly report	Chair of the People Academy	For assurance	Bo.11.24.11
Bo.11.24.12	Equality & Diversity Council update	Chief Executive	For assurance	Bo.11.24.12

BREAK 10:25 – 10:30

10:30 Section 5: Finance and Performance				
Bo.11.24.13	Report from the Chair of the Finance and Performance Committee: a. October & November 2024 b. Finance Report c. Closing the Gap d. Integrated Dashboard e. Performance Report f. Winter Plan g. Emergency Preparedness, Resilience & Response (EPRR) and NHSE Core Standards	Chair of the Finance and Performance Committee	For assurance	Bo.11.24.13
Bo.11.24.14	Budget setting process and timetable	Chief Finance Officer	For information	Bo.11.24.14

10:45 Section 6: Strategy				
Bo.11.24.15	Strategy – emerging issues a. Summary of Board Development Session - Health Inequalities	All Director of Strategy & Transformation	For information For assurance	Verbal Bo.11.24.15a
Bo.11.24.16	Corporate Strategy annual update	Director of Strategy & Transformation	For assurance	Bo.11.24.16
Bo.11.24.17	Partnerships – strategic view	Director of Strategy & Transformation	For assurance	Bo.11.24.17

11:00 Section 7: Audit & Assurance				
Bo.11.24.18	Report from Chair of the Audit Committee – 19 November 2024	Chair of Audit Committee	For assurance	Bo.11.24.18
Bo.11.24.19	Report from Chair of the Charitable Funds Committee – 6 November 2024	Chair of Charitable Funds Committee	For assurance	Bo.11.24.19
Bo.11.24.20	Charitable Funds Committee terms of reference	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.11.24.20

11:10 Section 8: Governance				
Bo.11.24.21	Board Assurance Framework, risk appetite review and high-level risks	Associate Director of Corporate Governance/Board Secretary	For assurance & approval	Bo.11.24.21
Bo.11.24.22	Constitution amendments	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.11.24.22
Bo.11.24.23	Standing Financial Instructions (SFIs) and Scheme of Delegation	Chief Finance Officer	For approval	Bo.11.24.23
Bo.11.24.24	Modern Slavery Statement	Chief People & Purpose Officer	For approval	Bo.11.24.24

Bo.11.24.25	Health & Safety annual report	Director of Estates & Facilities	For assurance	Bo.11.24.25

11:25 Section 9: Board Meeting Outcomes				
Bo.11.24.26	Any other business	Chair	For information	Verbal
Bo.11.24.27	Issues to refer to Committees or elsewhere	Chair	For approval	Verbal
Bo.11.24.28	Review of meeting	Chair	For information	Verbal
Bo.11.24.29	Date and time of next meeting: • 30 January 2025	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 28 November 2024

Annex 1: For Information				
Bo.11.24.30	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.11.24.30

Annex 2: For Information: Board Committee Governance				
Bo.11.24.31	Confirmed Committee/Academy minutes: a. Quality Committee –19 September & 17 October 2024 b. People Academy –19 September & 24 October 2024 c. Finance & Performance Committee – 19 September & 16 October 2024 d. Audit Committee – 10 September 2024 e. Charitable Funds Committee – 22 July 2024	Chairs of Committees	For information	Bo.11.24.31

BO.11.24.1 - APOLOGIES FOR ABSENCE

BO.11.24.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.11.24.2 - Declarations of Interest.pdf

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21,2021/	Outside Employment		industrial member	GS1	0
						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.		
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/	Outside Employment		Partners Telefonica, GS1, Zebra & Patient Source.	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08/12/2021	2021/22,2022/	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01/09/2022	2022/23,2023/	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	01/04/2024	2024/25	Loyalty Interests		Charity to help build better emergency healthcare in south east Asia region.	HALO Charity	0
Benjamin Roberts	Chief Finance Officer	01/09/2006	2015/16 & befo	Loyalty Interests		Fellow of Charted Institute of Management Accountants	Charted Institute of Management Accountants	0
Benjamin Roberts	Chief Finance Officer	01/09/2006	2015/16 & befo	Loyalty Interests		Member of the HfMA (Healthcare Financial Management Association) and sit on their Digital Council	HfMA (Healthcare Financial Management Association)	0
Bryan Machin	Non-Executive Director	04/02/2020	2019/20,2020/	Outside Employment		Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01/09/2023	2023/24,2024/	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	2022/23,2023/	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01/12/2022	2022/23,2023/	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	22/03/2021	2020/21	No Change to existing declarations				0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	Loyalty Interests		wife is employee of Rotherham Doncaster and South Humber NHS Trust	Rotherham Doncaster and South Humber NHS Trust	0
James Rice	Chief Digital & Information Officer	01/06/2019	2019/20,2020/	Loyalty Interests		member of the strategic advisory board	Strategic Advisory Board of the Yorkshire & Humber AHSN	0
James Rice	Chief Digital & Information Officer	01/07/2020	2020/21,2021/	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Netwwork national	0
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/	Loyalty Interests		Son is now an employee of Yorkshire Ambulance Services.	Bradford Teaching Hospitals NHS Foundation Trust	0
James Rice	Chief Digital & Information Officer	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
James Rice	Chief Digital & Information Officer	08/10/2024	2024/25	Hospitality		Meal at the Embassy of Ireland, London.	Enterprise Ireland	50
James Rice	Chief Digital & Information Officer	12/03/2024	2023/24	Hospitality		Meal at Rewired event.	Penpole Consulting	27.5
James Rice	Chief Digital & Information Officer	11/03/2024	2023/24	Hospitality		Meal at Rewired event.	Meditech	27.5
James Rice	Chief Digital & Information Officer	09/05/2024	2024/25	Hospitality		Invited to sit on the Apira table at the Leeds Digital Ball.	Apira	30
James Rice	Chief Digital & Information Officer	11/06/2024	2024/25	Hospitality		Meal at Australasia in Manchester.	IBM	30
Julie Lawreniuk	Non-Executive Director	11/03/2021	2020/21,2021/	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		board member	Incommunities housing association	0
Julie Lawreniuk	Non-Executive Director	31/03/2021	2020/21	No Change to existing declarations				0
Julie Lawreniuk	Non-Executive Director	01/07/2022	2022/23,2023/	Outside Employment		Board member and chair of system finance and performance committee	Bradford District and Craven Partnership	0
Karen Dawber	Chief Nurse	01/09/2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12/11/2022	2022/23	Loyalty Interests		Member of Professional Body	Member of the Royal College of Nursing	0
Karen Dawber	Chief Nurse	01/11/2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the PPE hub	Ellie Dawber	0
Karen Dawber	Chief Nurse	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	01/07/2024	2024/25	Nil Declaration				0
Laura Parsons	Associate Director of Corporate Governance/Bo	17/10/2024	2024/25	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/	Loyalty Interests		Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	02/02/2022	2021/22	No Change to existing declarations				0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/	Outside Employment		Trustee of a charity which is a nil remuneration post.	Pharmacist Support (Charity)	0
Mohammed Hussain	Non-Executive Director	26/07/2023	2023/24	Outside Employment		Digital therapeutics lead for Viatris	Viatris	0
Raymond Smith	Medical Director	10/10/2018	2018/19,2019/	Clinical Private Practice		Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/	Clinical Private Practice		Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	01/12/2019	2019/20,2020/	Clinical Private Practice		Anaesthetics within scope of normal clinical practice	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	28/02/2022	2021/22	No Change to existing declarations				0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests		Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests		Brother a GP and Primary Care Clinical Lead for Calderdale CCG	Calderdale CCG / Calderdale PCN	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment		Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment		MBA Industry Advisory Board Chair	Bradford University	0
Sajid Azeb	Chief Operating Officer	31/03/2021	2020/21	No Change to existing declarations				0
Sarah Jones	Chairman	01/10/2020	2020/21,2021/	Outside Employment		Chair of Realise Education & Training	Realise Education & Training	0
Sarah Jones	Chairman	04/03/2024	2023/24,2024/	Loyalty Interests		Brother MD of the Cheshire & Merseyside Cancer Alliance	Cheshire & Merseyside Cancer Alliance	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Outside Employment		Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Loyalty Interests		Parish councillor Sandy Lane Parish Council	Sandy Lane Parish Council	0
Sughra Nazir	Non-Executive Director	01/10/2023	2023/24	Outside Employment		associate with Social Care Institute of Excellence	Social Care Institute of Excellence	0

Sughra Nazir	Non-Executive Director	01/05/2024	2024/25	Outside Employment	Non Executive director with an NHS agency that provides consultancy support and training to the NHS.	Advancing Quality Alliance	0
Zafir Ali	Non-Executive Director	01/11/2016	2016/17,2017/	Outside Employment	Various roles including: Deputy Head of Internal Audit – Department of Health & Social Care Head of Internal audit for the NHS Counter Fraud Authority Head of Internal audit for the NHS Health Research Authority	Government Internal Audit Agency	0

BO.11.24.3 - MINUTES OF THE MEETING HELD ON 25 SEPTEMBER 2024

REFERENCES

Only PDFs are attached

Bo.11.24.3 - Unconfirmed Minutes of the meeting held on 25 September 2024.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS OPEN MEETING
MINUTES

Date:	Thursday 25 September 2024	**Time:**	09:30 – 12:20
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair
Present:	**Non-Executive Directors:** - Sarah Jones (SJ) - Bryan Machin (BM) - Julie Lawreniuk (JL) - 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) - Ben Roberts, Chief Finance Officer (BR) - Mark Hindmarsh, Director of Strategy and Transformation (MHi)		
In Attendance:	- Paul Rice, Chief Digital and Information Officer (PR) - David Moss, Director of Estates and Facilities (DM) - Renee Bullock, Chief People and Purpose Officer (RB) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Ruth Tolley, Quality Lead for Patient Experience (RT) *for item Bo.9.24.5 only* - Shaheen Kauser, Patient & Public Engagement Officer (SK) *for item Bo.9.24.5 only* - Sara Hollins, Director of Midwifery (SH) *for item Bo.9.24.7 only* - Sam Wallis, Consultant Neonatologist (SW) *for item Bo.9.24.7 only* - Katie Shepherd, Corporate Governance Manager - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- Farideh Javid, Governor - Molly Tate, Graduate Management Trainee - Zainab Rasheed, Graduate Management Trainee - Yaqub Ibrahim, Graduate Management Trainee		

No.	Agenda Item	Action
Section 1:	**Opening Matters**	
Bo.9.24.1	**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 - Karen Walker, Non-Executive Director - Professor Louise Bryant, Non-Executive Director	

No.	Agenda Item	Action
Bo.9.24.2	**Declarations of Interest** There were no declarations of interest in relation to the items on the agenda.	
Bo.9.24.3	**Minutes of the Meeting held on 11 July 2024** The minutes of the meeting held on 11 July 2024 were approved as a true and accurate record.	
Bo.9.24.4	**Matters Arising** The following actions were reviewed, and the outcomes confirmed. • Bo240015 Report from the Chair of the People Academy – March and April 2024: Discussions between Leeds University and the Trust around the sexual safety charter have taken place. Action completed. • Bo230017 Corporate Strategy – A key has been added to the logic model document. Action completed.	
Section 2: Patient Care		
Bo.9.24.5	**Patient story** SJ welcomed SK and RT to the meeting for this item. Board colleagues had viewed the patient story video prior to the meeting, and a section of the video was played in the meeting. It featured a patient's daughter describing her experience as a carer for her mother. JL recognised the importance of compassionate treatment as well as good clinical care and the need to consider how to influence this further so that all staff are compassionate and kind. KD confirmed work is ongoing to ensure more accessibility for carers of patients to allow them to be more present and able to assist whilst the patient is in hospital. RT recognised the importance of family involvement in care, and family-focused care. SK also commented on the increased opportunities to learn as a result of working closely with family members and developing relationships with them. The Board thanked RT and SK for joining the meeting.	
Bo.9.24.6	**Report from the Chair of the Quality and Patient Safety Academy – August and September 2024** JL gave an overview of the reports which provided an update from the Quality and Patient Safety Academy meetings held in August and September 2024.	

No.	Agenda Item	Action
	JL alerted the Board to a new risk on the high-level risk register relating to capacity issues in chemotherapy. Mitigations were in place and the Academy was assured that the risk was being managed appropriately. JL also alerted the Board to the ongoing challenge of addressing the Summary Hospital-level Mortality Indicator (SHMI) rating, which does not reflect the Trust's actual mortality rates which are the best in the region. A programme of work was being undertaken to address the associated coding issues. The Board would receive an update on the progress in relation to the actions being taken at the next Board meeting. There were two further issues to alert to the Board in relation to 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). There were plans to address this and training attendance will be closely monitored until deadline. The Academy was advised of an increase in cases of MSRA colonisation in babies as part of routine swabbing within Women and Newborn services. There have been no associated cases of bacteraemia and no instances of harm to babies, and the Academy was assured by the timely identification of the outbreak and robust plans to address. The Board was assured by the update.	**Chief Digital and Information Officer Bo240017**
Bo.9.24.7	**Maternity and Neonatal Services Update** KD welcomed SH and SW to the meeting to provide an update on maternity and neonatal services. In relation to maternity services, SH highlighted that as previously referenced, there is a 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, but less confidence that the anaesthetic position will be recoverable. The increase in cases of MRSA colonisation in the maternity and neonatal unit has now been declared as an official outbreak despite no cases of harm. There have been no new cases in August, but it has been agreed to implement decolonisation for staff to ensure that there is no further spread. SJ recognised the hand washing and infection control procedures of the unit are exemplary and very clearly signposted upon entry to the neonatal unit. The Board was asked to approve the Maternity and Newborn Safety Investigations (MNSI) escalation of concerns improvement plan, specifically the actions relating to consultant attendance at clinical scenarios which has been developed following the receipt of an escalation of concerns letter. This is a compliance requirement of Safety Action 4 of the Maternity Incentive Scheme.	

No.	Agenda Item	Action
	SW provided an update in relation to the neonatal service, highlighting the current workforce position including the improvements made to the sickness rate but a continued challenge around the number of speciality nurses (currently at 47% against a target of 80%). The Trust was a positive outlier in some areas of the National Neonatal Audit Project 2023. In relation to mortality, since March 2024 there have been 12 infant deaths including 8 preterm babies and 2 deaths on the labour ward. There were no areas of concern in terms of specific themes and no issues with the care provided. In terms of achievements, SW recognised high levels of family engagement and positive feedback received, and the recent CQC visit. The Board thanked SH and SW for the update. The Board was assured by the report and approved the MSNI escalation of concerns action plan.	
Bo.9.24.8	**Research activity in the Trust** RS gave a brief overview of the report which provided information on some of the key research activities in the Trust. He highlighted that at the end of 2023/24 the Trust's recruitment into research studies was 26,325 (the highest in Yorkshire and Humber region) with the Bradford Royal Infirmary site being the highest recruiting site in the country with 25,320 recruits. The Board was assured by the update.	
Section 3: People		
Bo.9.24.9	**Report from the Chair of the People Academy – August and September 2024** RB gave an overview of the reports which provided an update from the People Academy meetings held in August and September 2024: • Board members were asked to complete the three Freedom to Speak Up e-learning modules as a priority. October is Speak Up month and there will be a focus on the power of listening. • Year to date absence is 5.73%, down from 6.09% in July 2023, but this remains a key focus area. The report detailed a number of mitigating actions to address this. • The 2024 Staff Survey launches on 30 September. Last year's response rate was 43% and for 2024 there is a stretch target of 92%. RB felt this to be achievable if dedicated focus is given to encouraging staff completion. JL referred to the increased number of staff in post over the last year and the financial impact given the current focus on closing the gap. RB confirmed that these are predominantly clinical positions, and that all non-clinical vacancies require executive sign off to ensure they are appropriate and necessary. KD recognised that there has been a corresponding reduction in bank and agency usage. A report detailing the drivers behind the change in staffing numbers would be presented to the next People Academy meeting. The Board was assured by the update.	**Chief People and Purpose Officer Bo240018**

No.	Agenda Item	Action
	Workforce Report The report was noted by the Board. **Medical Appraisal & Revalidation Annual Statement of Compliance** The report was noted by the Board. **2024 Training and Education Self-Assessment Report** The report was noted by the Board.	
Bo.9.24.10	**Equality & Diversity Council (EDC) update** MP referred to the update report. RB had joined the EDC meeting to discuss the observations made during her first 90 days in post and complimented the EDI team on their exemplar EDI strategy and strong foundations for EDI in the Trust. There were a number of key actions to undertake to develop this further including the review of people policies and practices, building on the success of refreshed staff equality networks, and working on management development to realign leadership approaches and cultures. MP also updated that she had been invited to present at the Future Leaders Programme discussion with a focus on Multiculturalism in the NHS, reflecting that she was invited to this given the progress and commitment BTHFT has made to equality and diversity. The Board was assured by the update.	
Section 4:	**Finance and Performance**	
Bo.9.24.11	**Report from the Chair of the Finance and Performance Academy – August and September 2024** JL gave an overview of the reports which provided an update from the Finance and Performance Academy meetings held in August and September 2024: • The Trust will not reach the referral to treatment (RTT) target for over 65 week waits, with 71 expected at the end of September against a target of 0. The Trust is seeking mutual aid support to clear long waits where possible. • There is a significant risk that the Trust will not deliver its financial plan. It was suggested that discussions are planned with the Board in October and November to discuss and understand the implications should the financial plan not be delivered. • There is also 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.	

No.	Agenda Item	Action
	• There is a significant risk that the Trust will require cash support from NHS England in the latter months of the financial year. Even if cash is provided, this will likely impact on capital allocation. BR confirmed other organisations were already requesting cash and revisiting their capital plans as a result. BR referred to a financial framework for Trusts to follow should a change in financial forecast be declared. This included both ICB and NHS England oversight. ZA queried both the deadline for applying for cash support, and any impacts and repercussions of this, and BR confirmed that the deadline would be by the end of month 9. BM referred to opportunities available through digital innovation, recognising this would result in a reduced need for staff which makes this very complex. MHi recognised the balance between implementing short term gains to meet the target in year, and longer-term transformational measures that will help support finances in the next year and beyond. The Board was assured by the update. **Closing the Gap** MHi referred to the presentation which was noted by colleagues. He noted the change in focus to deliverability of schemes rather than the number of schemes on the tracker and highlighted that 50% of schemes are recurrent which is beneficial as this will impact on subsequent years. Closing the gap week was ongoing and it is hoped that this will further encourage progress on closing the gap schemes, with a number of sessions available for services to attend for support in specific areas. **Integrated Dashboard** The Board noted the report. **Finance Report** The Board noted the report. **Performance Report** The Board noted the report.	
Section 5: Audit & Assurance		
Bo.9.24.12	**Report from the Chair of the Audit Committee – 10 September 2024** BM introduced the report and alerted the Board to a report received from the Chief Nurse on progress in addressing the recommendations in the internal audit report, Nursing Assessment and Care Plans, which had received Limited Assurance. KD advised that whilst the report indicates that care plans are not fully completed, this relies on data from one particular section of EPR and the	

No.	Agenda Item	Action
	information is often recorded in a separate data entry. A solution was being considered that would ensure data entry into the correct fields. She also highlighted that the report is not reflective of the level of care received as care is managed via a number of other routes on a daily basis. Following consideration by the Quality Committee, an updated report would be shared with the Audit Committee. The Board was assured by the update.	
Bo.9.24.13	**Report from the Chair of the Charitable Funds Committee – 22 July 2024** SA introduced the report and alerted the Board to the delay in progress against plan for the move to Charity independence due to the departure of the Charity Director. There has since been an appointment to this role with the successful appointee due to start on 4 November 2024. The Board was assured by the update.	
Section 6: Business Reports		
Bo.9.24.14	**Report from the Chair** SJ introduced the report to the Board, highlighting her work to support recruitment across the patch including sitting on the Chair interview panel at Airedale NHS Foundation Trust. An appointment was not made, so at present an Interim Chair would remain in place. The Board noted the report.	
Bo.9.24.15	**Report from the Chief Executive** MP introduced the report, highlighting the following points: • Performance remains strong in comparison with other Trusts across a number of areas including urgent care and cancer metrics. • Whilst progression is being made on the St Luke's Day Case Unit, disappointingly, the contractor has failed to meet the handover date of 31 August and the Trust is now awaiting a revised completion date. • The planned go live of the theatres EPR enhancement has also been rescheduled to the end of November to allow for staff training and familiarisation with the function to reduce service disruption. • Asian Heritage Month was celebrated in August with a number of positive events across the Trust. MP acknowledged that sadly, in the same month, the country witnessed racism and rioting across the nation. In recognition of this, an extraordinary 'Pause for Peace' event was held which was well received by colleagues. • The Long Service and Brilliant Braford Awards would be held on 26 September, which the Board had been invited to attend. • On 17 September, the Trust hosted Stephen Kinnock MP, Minister of State for Care, who visited to hear about the work being	

No.	Agenda Item	Action
	undertaken around integrated care and some of our specialist services. • The factual accuracy checks in respect of the draft CQC reports has now been completed. The publication date of the final reports has not yet been received. MP also presented the West Yorkshire Association of Acute Trusts (WYAAT) Memorandum of Understanding (MoU) which had been updated. The Board approved the updated WYAAT MoU and noted the update.	
Section 7: Governance		
Bo.9.24.16	**Board Assurance Framework and High-Level Risks** LP introduced the new Board Assurance Framework (BAF) which now contained 13 risks which have been aligned to the Trust's strategic objectives. LP advised that that a review of risk appetite is still required, and 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. The Board approved the updated BAF. LP also presented 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 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.9.24.17	**Board, Committee and Academy Terms of Reference and work plans** LP presented the paper which provided the updated Terms of Reference and work plans for the Finance and Performance Committee, People Academy, and the Quality Committee for review. The paper also included the Terms of Reference for the Board Nominations and Remuneration Committee and the work plan for the Board of Directors. The Board of Directors approved the Committee/Academy Terms of Reference and work plans, and the Board work plan.	
Bo.9.24.18	**Premises Assurance Model (PAM) progress report** DM presented the PAM report, which 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. Whilst the overall rating remained as 'good', there were a number of areas detailed within the paper which had been reduced to 'requires minimal improvement'.	

No.	Agenda Item	Action
	The Board was assured by the update.	
Bo.9.24.19	**Annual security report (inc. Violence Prevention and Reduction Standard)** DM introduced the report which sets out the Trust's progress in relation to the management of security. He updated the Board on the increased security presence within the A&E department and the upcoming implementation of body worn cameras to help de-escalate situations and enhance the safety of staff. The PCSO presence across sites would also be maintained. The Board was assured by the update.	
Bo.9.24.20	**Annual Data Protection Officer report** PR presented the report which sought 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, and provided an overview of the arrangements in place to manage information risks and compliance in the year ahead. The Board was assured by the update.	
Bo.9.24.21	**Use of the Trust seal** LP presented the paper which provided a summary of the use of the Foundation Trust Seal during the period 15 September 2023 to 18 September 2024, noting that there were thirteen instances. The Board noted the report.	
Section 8: Board Meeting Outcomes		
Bo.9.24.22	**Any Other Business** PR referred to the LIMS deployment which is scheduled to take place on 1 October. Discussions were ongoing regarding the relative preparedness to inform a go / no go decision, but at the moment, there were not any anticipated delays.	
Bo.9.24.23	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no issues to refer elsewhere.	
Bo.9.24.24	**Review of Meeting** The Board agreed that it was most useful to receive the Chair and Chief Executive reports at the start of the meeting and so future agendas would be revised to reflect this. Comments were also made around the benefits of watching an extract from the patient story video live during the meeting.	

No.	Agenda Item	Action
Bo.9.24.25	**Date and Time of Next Meeting** 14 November 2024 – 9:30am	

ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 25 September 2024

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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. **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	Work is being undertaken with Education on incorporating this with training. This is a long-term initiative and over time more staff will be aware. **Action closed.**
Bo240017	Bo.9.24.6	**Report from the Chair of the Quality and Patient Safety Academy – August and September 2024:** The Board would receive an update on the progress in relation to coding at the next Board meeting.	Chief Digital and Information Officer	November 2024	Included on the November Board agenda. **Action closed.**
Bo240018	Bo.9.24.9	**Report from the Chair of the People Academy – August and September 2024:** A report detailing the drivers behind the change in staffing numbers would be brought back to the next People Academy.	Chief People and Purpose Officer	November 2024	Presented at the People Academy on 24 October 2024. **Action closed.**

BO.11.24.4 - MATTERS ARISING

DEPTH OF CODING

BO.11.24.5 - GETTING TO KNOW THE CSUS ? TRANSFORMING A&E PROGRAMME

REFERENCES

Only PDFs are attached

Bo.11.24.5 - Getting to know the CSUs presentation.pdf

Owing the population of Bradford an…
OUTSTANDING Health Service

OVERCROWDING *(RCEM)*:

Emergency Department (ED) crowding is a major threat to public health and represents a serious policy challenge that must be urgently tackled…it has worsened significantly in recent years in the UK due to the severe mismatch between demand and capacity in the NHS.

Increasing patient demand coupled with high hospital bed occupancy has resulted in exit block - the key reason for crowded EDs. This results in long waits to be seen, breakdown of departmental processes, patients waiting or being treated in non-designated clinical areas such as corridors, and delayed ambulance offloads.

BTHFT:

Despite our ECS performance ranking in the top decile of Acute Trusts in England, our current reality is far from ideal. Our risk assessments reveal critical areas of concern, and patient feedback underscores the urgent need for a transformative change.

To align with Trusts' vision of being an outstanding healthcare provider, we must reimagine our service delivery to better meet the needs of our staff and patients. This program will help shape a future-focused acute hospital service that meets these evolving needs.

Programme Objectives:

"To enhance patient and staff experiences by reducing wait times, preventing harm, and shortening all patient's length of stay within the ED footprint and beyond."

Our Outstanding Emergency Care Programme …

Why?

Bradford, a city of contrasts, faces significant challenges. Its vibrant and diverse culture exists alongside severe deprivation, creating complex healthcare needs. As our population evolves and community services struggle, our current model is becoming increasingly inadequate.

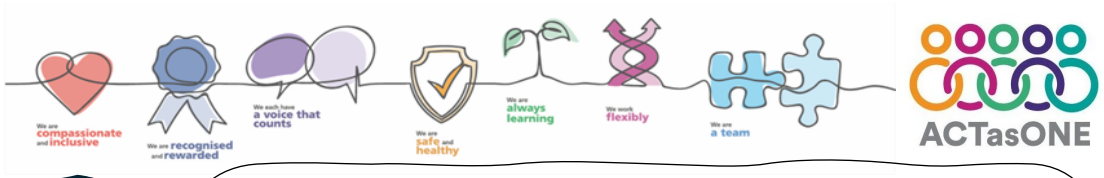
Our current model is struggling to keep pace with evolving healthcare needs. We're experiencing an impact on patient care quality and a growing strain on our workforce. While we've implemented temporary measures to address immediate concerns, these solutions are not sustainable in the long run…therefore:

- As our population evolves and grows, we have an opportunity to model a health service that goes beyond the ED but starts at the front door.
- An opportunity to work even closer with our specialties, our partners, our patients and our people to design a service that is fit for the future and needs of the community we serve an outstanding health service.

How?

Learn from the innovative work of our colleagues in Outstanding Maternity Services. Their transformative approach, now in its fourth year, continues to evolve and inspire us to strive for excellence…

Our Outstanding Emergency Care Programme…



Improving OUR Patient Experience

Listening and responding to our Patient Stories

Engaging and enabling OUR People

Listening and responding to our Staff Experiences

Standardising OUR Processes

Continually improving how we deliver our Complex Service Collaboratively

Getting It Right First Time

Right patient…in the…Right place

Enhancing OUR Performance

(Patient Experience & Outcomes, Staff Experience, Operational Excellence, Financial Improvement)

How?

To start we need to engage with our Patients, People and Partners to understand:

- Where are we now?
- What does **OUTSTANDING** look like?
- How does the journey look like to get there?

What do we need…?

- **Your commitment**
- **Your support and influence**
- **Your involvement**

(champions for engagement events)

- **Protected time**
- **Resources to deliver**

(dedicated roles and space towards to engage all stakeholders with the programme)

- **Capital to make a start**

(to brand the programme and deliver engagement events with our patients, people and partners)

Our Outstanding Emergency Care Workstreams & Programme Governance

Proposed Workstreams (prior to Patient, People and Partner engagement)

Getting from A to B	Waiting Room	Saving Beds	Sharing the Load	Making Beds	Space
Arrival to Bed Request - Length of Stay - Patient Experience - Environment	**Capacity for Assessment** - Right patient, right place - Trolleys - Cubicles	**Admissions** - Decision making - Right patient, right place	**Minimising ED Touch time** - Right patient, right place - Cross speciality engagement	**Inpatient Bed Capacity** - Right patient, right place - Decision making - GE Technology	**Expanding the UEC Footprint** - Right patient, right place - Environment

Trust Board

F&P & Quality Academy

Trust Board & Academies updated with progress every 2 months

Monthly Executive Steering Group
(Karen Dawber - Executive Sponsor)

Executive Team Meeting
(Monthly Update)

Programme Board (Monthly)

SRO: Saman Khan, **Programme Lead** :Vaqass Akhtar, **Clinical Lead:** Mayada Elsheikh, **Operations Lead:** Shaun Milburn, **Nursing Lead:** Sarah Freeman, **Matron Lead**: Tania Windle, **PMO Lead:** Alison Smith, **Estates Lead**: David Moss, **Public & Patient Engagement Lead:** Jill Clayton, **People Lead:** Renee Bullock, **Informatics Lead:** Adam Griffin, **Performance Lead:** Fabienne Peraudeau, **Quality Lead:** Byron Johnson

Transforming AED Delivery Group (Fortnightly - flexible)

SRO: Saman Khan, **Programme Lead:** Vaqass Akhtar, **Clinical Lead:** Mayada Elsheikh, **Matron Lead:** Tania Windle, **PMO Lead:** Alison Smith, **Public & Patient Engagement Lead:** Jill Clayton, **Informatics Lead:** Adam Griffin, **People Lead:** Cat Shutt, **Performance Lead:** Fabienne Peraudeau, **BI Lead:** Nick Dodds, **Quality Lead:** Byron Johnson

Workstream Leads: 1 – 3 to be nominated from ME, James Taylor & Farah Naz, Sarah Buckley, and David Moss to nominate.

What we are working on for Winter 2024/25

Initiative	Rationale	Timescales	Progress Update
Amber Zone sub wait extension	To release capacity in the Amber Zone by creating a larger chair-centric area for those "majors" patients who do not require a cubicle for their care.	January 2025	Paper written by JT; Capital costs identified. Signed off.
Increase Amber Zone nursing establishment (winter resilience funding)	Safe working and quality of patient care.	November 2024	Approval required to progress recruitment.
Improved efficiency for surgical fit to sit transfers from ED	To reduce the time, it takes for surgical ambulatory patients to be transferred to ASU.	January 2025	Requires Exec support (John Bolton/Ray Smith)
Direct pathways (in-hours) for ambulatory patients who currently attend AED who require speciality assessment.	Quality of patient care and relieving overcrowding in AECU.	December 2024	Requires Exec support (Karen Dawber). Specialty: *ENT, MaxFax, Plastics etc*
Increase self-handovers for Ambulance arrivals	Reduce AAA congestion and relieve pressure on the AAA nurse.	December 2024	Agreed for YAS recommunicate Self H/O SOP. Support agreed from ACP (Liam Hunt).
AED signage	Improved orientation for and communication with patients across AED, AECU and UTC footprints.	December 2024	Engaged with Estates, awaiting update.

BO.11.24.6 - REPORT FROM THE CHAIR

REFERENCES

Only PDFs are attached

Bo.11.24.6 - Report from the Chair.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.6

Report from the Chair

Presented by	Sarah Jones, Chair	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Sarah Jones, Chair	
Purpose of the paper	To provide an update on my engagement with partners, stakeholders and governors since my previous report provided to the Board in September 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

There have been several Place and System meetings over recent weeks which have allowed me to get to know my Chair colleagues better and develop our working relationships. Last week the Secretary of State and CEO of NHS England gathered all Chairs & CEO to a briefing on the new performance management changes that they are aiming to implement over coming months. On the 21 November NHSE Region have called a meeting to discuss the 10-year plan and, looking ahead to December, I have been asked to support the Leeds Teaching Hospitals Chair recruitment process.

2. Council of Governors

- **Feedback to the Council following Board of Director meetings**

I met with governors in September to provide an update on the items discussed at the September Board. My next session, to provide an update from our November meeting is scheduled for 3 December at 5pm.

- **Council of Governors meeting scheduled for 16 January 2025**

Our next Council of Governors meeting is scheduled to take place on Thursday 16 January from 3.30pm to 5.30pm. Following this the Council will hold a meeting in private to consider confidential matters. Please note that the venue is yet to be confirmed.

- **NHS Providers session for Governors and NEDs**

NHS Providers will be supporting the development of our Council by facilitating a bespoke development session earlier in the day on 16 January (our Council of Governors meeting day). So that NHS Providers can properly tailor the session to our needs they have requested that all Governors complete a pre-session questionnaire. This is currently in process. The Board is asked to note however that the overall aim of the session is to provide guidance to governors in their role and to help to build and strengthen relationships between governors and NEDs.

- **Council of Governors Task and Finish Groups**

As the Board will be aware, the task and finish group working on the Constitution has completed its work and the Constitution was approved by the Council at its meeting in October. The Constitution is now presented at today's Board meeting for approval.

I am also pleased to advise that our second task and finish group covering key policies and procedures primarily related to the Governors is now concluding its package of work which will be presented to the

Council of Governors in January for consideration. I would like to thank those Executives and NEDs for their contributions to date. It has been good to see Governors and Board members working together on these improvements.

- **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.

- **Governor Induction Programme: Site tours**

A well-received site tour took place on 14 October to key areas within our BRI Estate including A&E and Ward 5. This included several of our newer Governors and Non-Executive Directors.

Our second site tour covering the Bradford Institute of Health Research and, our Education Service (including the Simulation Centre) will be shared shortly. We are also scheduling a site tour of St Luke's Hospital to include the new SLH Day Case Unit. The invitations will be extended to our NEDs to join the tours if their calendars allow.

3. Annual Members meeting - 28 November 2024

As the Board is aware we will now be holding our Annual Members Meeting today, on 28 November. This is scheduled between 1.00pm and 2.00pm in the Sovereign Lecture Theatre at BRI.

The agenda will include presentations on the Annual Report and Annual Accounts from our Chief Executive, and Chief Finance Officer. Our public Governor, David Wilmshurst will provide an update on the Council's work and Membership during 2023/24. Shortly before the end of the event we will also be screening a short video featuring the work of our Neonatal team which has just been awarded an 'outstanding' rating from the Care Quality Commission.

Recommendation

The Board is asked to note this report.

BO.11.24.7 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

- Bo.11.24.7 - Report from the Chief Executive (cover).pdf
- Bo.11.24.7 - Appendix 1a - MP_Nov24.pdf
- Bo.11.24.7 - Appendix 1b - 2024_11_22 MPickup NeoCQC.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.7

Report from the Chief Executive

Presented by	Professor Mel Pickup, Chief Executive	
Authors	Katie Shepherd, Corporate Governance Manager	
Lead Director	Professor Mel Pickup, Chief Executive	
Purpose of the paper	The report provides the Board with a summary position with regard to our Patients, People, Place and Partners since the last report to the Board in September 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

Attendances to the Emergency Department (ED) and the number of patients in hospital beds is increasing as we enter the winter period. The Trust continues to benchmark positively against the Emergency Care Standard (ECS) at a West Yorkshire Association of Acute Trusts (WYAAT), Regional and National level, with our current position remaining in the upper decile of Acute Trusts in England. Despite this positive position we are not meeting the national constitutional standard of X% but we are achieving the 2024/25 operational target set by NHS England of X%. However, some of our patients do 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.

Part of the challenge for admitted pathways relates to overall bed occupancy and the ability to maintain adequate patient flow through the system. We have approved the launch of an improvement programme for Urgent and Emergency Care to further improve the overall patient journey. We continue to work collaboratively across place with system partners in particular local authority colleagues on trying to reduce the pressures associated with social care. With strong internal processes we have minimised the impact and since launching H-Fast in July the speed of priority discharges has improved. 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.

We have developed a fully costed operational plan for winter which has been approved at the Executive Team Meeting (ETM) and presented to the Finance and Performance (F&P) committee in October 2024. The plan has also been submitted to the Integrated Care Board (ICB) for inclusion in the system-wide winter plan. In addition, providers were asked to consider the impact of forecasted winter pressures and re-submit their planning assumption for the second half of the year. This was completed in October following approval at ETM.

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 have also been identified for targeted work under the Closing the Gap (CTG) programme with dedicated senior operational leadership and allocated improvement resource. Outpatient activity is tracking ahead of planned levels but the delay to the St Lukes Hospital Day Case Unit means inpatient activity is now behind plan. Work to increase activity at BRI in response to this position is progressing with some additional weekend operating in place.

Efforts to reduce elective waiting times continue and whilst almost all services now have no waits over 65 weeks, there will be some in T&O (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 West Yorkshire and from Sheffield. The Elective Care Recovery Group for West Yorkshire is exploring what more can be done with regards to mutual aid to further reduce waiting times.

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 to improve oversight of pathways and this is going well. The Trust is exploring other digital enhancements in this area of work for further strengthen the position.

The Trust benchmarks well for cancer performance and is focussed on further pathway improvements, working with system partners on earlier diagnosis and implementing optimal pathways when cancer is suspected. One stop Neck Lump 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. Treatment pathways are an area of focus for all tumour groups during the current period and will be the key topic for the cancer timeout in November.

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) was not met. A revised programme has been submitted by Darwin Group, it is likely that we will be first patient ready in January. The facility will provide much

needed ringfenced capacity for our day case patients. During the period of delay operational capacity at BRI is being increased using the staff from the DCU but theatre space is a limiting factor.

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. Robertsons have been awarded the contract and a ground breaking ceremony attended by myself and the Chair took place in October 2024.

Theatres, Anaesthesia and Critical Care Electronic Patient Record Build (TACC)

In partnership with Airedale NHS Foundation Trust we are deploying additional functionality in our enterprise Electronic Patient Record (EPR) – Oracle Health's (Cerner) Millennium product. Progress towards the go-live date in November has been made with training and testing continuing at pace. We expect to have gone live with TACC from the 23rd November 2024. The programme represents a further step forward in enabling digital transformation in the Trust and will further improve the quality of services for our patients whilst streamlining clinical processes for our staff.

On preparations for the Airedale EPR deployment, ourselves and Calderdale and Huddersfield Hospitals which share the same EPR provider have been systematically preparing our organisations for some additional changes in functionality of our system, which has been a huge undertaking but will bring with it significant clinical benefits.

2. People

Recruitment - Improved Candidate Engagement

New initiatives have been launched to improve our community engagement, tap into local talent and improve work opportunities for the communities that we serve. These include:

- Launch of **Recruitment Candidate Pack** - The purpose of the pack is to promote BTHFT as a brand, to showcase us as a preferred employer and to promote Bradford as a city of choice. The candidate pack is designed to complement the job description and person specification when we advertise new vacancies.
- **Community Outreach events** – we have developed a calendar of outreach events where we will be providing helpful advice on career opportunities, how to complete application forms and tips on improving interview skills. Events include:
  - school/college career fairs (closed events)
  - Bradford Business Unlocked (a Bradford council initiative that is aimed to inspire young people about the diverse career paths available within the Bradford District and provide them with practical insights into the job pathways across Business.
  - Community Hubs events including the Sutton Centre (BD4) and Girlington (BD8.
  - DWP/Jobcentre Plus collaboration to support people into work.

Open events will be displayed on our web page/ social media campaigns to encourage attendance.

Root out Racism – Development of a District wide Anti-Racist Strategy

The voluntary sector Race Equality Network (REN) have been tasked with developing an Anti-Racist Strategy for the Bradford district. System leaders were invited to take part in a stakeholder engagement session which took place on 15th October at Grange Interlink Community Centre. A range of leaders including myself and organisations were represented at the event, including BTHFT. Kez Hayat, Head of EDI along with other system colleagues facilitated a range of round table discussions to seek the expertise, insights, and experiences with focus on shaping and developing a city-wide approach to anti-racist activity that addresses the pressing issues of racial inequality.

This event was an opportunity for key stakeholders across the district to collaborate on the strategy, ensuring it is comprehensive, actionable, and reflective of the diverse voices within our district. A range of information and feedback has been captured from the event with further focus on sharing this across the district and ensuring system partners are involved in any future involvement and engagement. A timeline for the strategy is to be developed and implemented across the district and will be shared with all system partners. BTHFT will be involved in any future engagement activity and are one of the key partners supporting this important work.

Successful ESR Silver Award revalidation

We have successfully secured our Defence ERS Silver Award revalidation, which is a national recognition for our commitment to the Armed Forces, supporting veterans who seeking employment in the Trust and ongoing people support for veterans and reservists. The award is valid for another 5 years and we will be going for Gold when the Gold Award programme when it opens in the new year.

SEQOH Accreditation

The Workplace Health & Wellbeing Centre has achieved accreditation from the Faculty of Occupational Medicine based on the Safe Effective Quality Occupational Health Standards SEQOHS 2023. These standards are in the public domain and serve to ensure that providers, purchasers and workers understand the standards that they should expect from an Occupational Health Service. Eligibility for the award of SEQOHS Accreditation was assessed on the basis of the collection and presentation of suitable documentary evidence and on observation. Upon SEQOHS Accreditation being achieved, the WHWBC will be required to complete annual reaccreditation for five years until the next full SEQOHS Accreditation assessment in year five. The assessors outcome report stated:

The Workplace Health and Wellbeing Centre for Bradford Teaching Hospitals NHS Foundation Trust is congratulated on their reaccreditation to the SEQOHS standards. The provision of safe, effective and high-quality occupational health services is facilitated by a comprehensive array of policies and procedures, for which clinical audit helps to identify any areas for improvement.

A good team ethic, effective management and medical leadership, and a modern clinical environment, help to ensure that managers and staff accessing the service receive good quality advice, support and care.

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3. Place Updates

West Yorkshire Equity, Diversity and Social Justice Strategy

The strategy and priorities have been shaped with the input of key stakeholders throughout the partnership, and through various engagement activities at place and at ICB level. Phase One of engagement has included an event, focus groups and surveys. Phase Two will focus on reaching out to previously underrepresented voices through targeted engagement initiatives.

There was a clear request that the strategy should be more specific than general mission statements and values and that they serve to articulate our aspirations as a partnership during challenging times and assist in navigating complex decisions. As a result, these ambitions have been developed to ensure we support this request to establish clear expectations for behaviour and to ensure that they reflect the partnership, our values, mission, and behaviours. These will continue to evolve based on feedback from Phase Two. We anticipate that the final Equity, Diversity, and Social Justice Strategy, including its objectives and action plan, will be completed by the end of December 2024. You can see the work undertaken to date by visiting the West Yorkshire Health and Care Partnership website.

West Yorkshire Local Transport Plan and Mass Transit Plan

The West Yorkshire Combined Authority (WYCA) are working with the five West Yorkshire local authorities (Bradford, Calderdale, Kirklees, Leeds and Wakefield) to renew the Mayor's West Yorkshire Local Transport Plan. This is a plan that all Transport Authorities must develop and regularly renew for their area to assess their transport needs and challenges. The plan then sets out different ways in which to tackle those challenges. It matters because it guides decision making on transport policy and investment across all types of transport in the region.

The LTP will be submitted for adoption by the Mayor at the West Yorkshire Combined Authority meeting in March 2026. Between now and then the Combined Authority wishes to continue working and engaging with partners, stakeholders and members of the public to ensure we develop and establish an LTP that has consensus and consent. This will include a period of statutory consultation in 2025.

To achieve our vision of a region where communities, business and places all benefit from sustainable economic growth, the LTP must consider how our ways of travelling are impacting our health and the environment, and ensure LTP policies contribute to provide clean, safe, healthy and inclusive mobility.

Our ambition to strengthen our local economy

Integrated care systems have a defined mission to improve health outcomes, address inequalities, enhance service quality and importantly, support broader social and economic development. To review the progress against this big ambition, in West Yorkshire we use the framework set out in the publication "Unlocking the NHS's social and economic potential: a maturity framework", authored by Cathy Elliott, Chair of NHS West Yorkshire Integrated Care Board (NHS WY ICB) and published by NHS Confederation.

Our health and care system is making significant progress in strengthening the local economy through employment initiatives, innovation, and collaboration with local businesses. By leveraging our position as anchor institutions, and with the support of frameworks/networks like the West Yorkshire Fair Work Charter and the Health Innovation Network, we are well-positioned to continue driving local economic

growth and improving health outcomes. However, sustained efforts are required to address ongoing challenges and maximise the potential for inclusive economic development. Further updates will be provided in due course, organisations across our integrated care system are also being asked to assess their own activities against the maturity framework.

National director role

Theres Patten, Place Lead, has been asked by Amanda Pritchard, Chief Executive for NHS England, to take on a new role as National Director of Place Development. This role at NHS England will be alongside Therese's current roles as Place Lead for Bradford District and Craven and Chief Executive for Bradford District Care NHS Foundation Trust. Therese will also continue to serve as an executive member on the NHS West Yorkshire Integrated Care Board.

This position will involve working with national colleagues to identify and share best practice operating models, including strong cross-sector partnership working, and how NHS England can best support the development of place-based work, building on the good foundations that we already have. Members and our wider partnership will be kept updated on progress.

Airedale Hospital build to go ahead

It has been confirmed that the Airedale Hospital build will be going ahead. This was announced by the government as it shared the terms of reference for their New Hospital Programme review. As well as confirming the new for Airedale, it was confirmed that the other RAAC hospitals, as they have commonly been referred to, will also be going ahead. The New Hospital Programme review: terms of reference are available on the gov.uk website. This news follows soon after it has been confirmed that Bradford District Care NHS Foundation Trust has secured £50 Million funding to redevelop Lynfield Mount Hospital site.

Ministerial visit to Bradford District and Craven – Stephen Kinnock MP, Minister of State for Care

Our partnership hosted Stephen Kinnock MP, Minister of State for Care who visited us from Monday 16 September to Tuesday 17 September, to hear about the work we are doing around integrated care as well as some of our specialist services.

On the first day of his visit, the Minister of State for Care went to Horton Park Health Centre and spoke to colleagues from the Proactive Care Team (PACT) and specialist community dental service (run by Bradford District Care NHS Foundation Trust). Colleagues from the community dental service were able to share the positive outcomes for who are unable to access dental treatment by a 'high street' NHS dentist due to their additional needs. The service supports a range of people who have specific support needs such people with learning disabilities, challenging medical conditions and people who are housebound. The Minister learned more about the PACT model and the positive impact it has having on patients by providing responsive care within the community, contributing to people staying well at home.

On the Tuesday, the Minister visited Bradford Teaching Hospitals NHS Foundation Trust. Stephen met colleagues at the Command Centre, Europe's first hospital command centre powered by artificial intelligence (AI) to provide real-time overview across the Trusts 800 beds before hearing more about the work of our Multi-agency Integrated Discharge Team (MAIDT), where health and social care professionals work alongside voluntary, community and social enterprise colleagues to ensure patients with complex needs can be discharged from our hospitals on the correct pathway in a safe and timely

manner. Stephen was also able to hear first-hand about the Home First Assessment Support Team (H-FAST) project at Bradford Royal Infirmary which has been implemented following a successful pilot at Airedale NHS Foundation Trust. This is a partnership project between the NHS and Bradford Council, with the aim of discharging people within 24 hours once they are medically fit to leave hospital, with an assessment undertaken (over a period of up to three days) within the individual's own home to determine their immediate care and support needs.

Here's a short clip of the two-day ministerial visit.

Local leaders making an impact globally

Thanks to our local colleagues who are making a splash globally as highlighted below

- A Bradford hospital consultant's new role will see him training surgeons of the future across the UK and Europe, who will be using state-of-the-art robotics. Consultant Uro-oncologist and Urological Surgeon, Raj Singh, has become a proctor for Intuitive Surgical, the manufacturers of the revolutionary da Vinci robotic-assisted surgical systems or 'robots', which are used at Bradford Royal Infirmary, part of Bradford Teaching Hospitals NHS Foundation Trust.
- Professor Udy Archibong MBE, Pro-Vice-Chancellor of Equality, Diversity and Inclusion at the University of Bradford has been made a fellow of the prestigious American Academy of Nursing.

New speech and language service for young children starts

A new pilot service called Early Language Support for Every Child (ELSEC) is now available to children aged two-and-a-half to seven years old at nine participating nurseries and primary schools across Bradford District. The pilot is one of nine running nationally funded by the Department for Education and NHS England. Participating nurseries: Moorside Nursery, Thornbury Play and Learn Nursery, Short Circuits Care Club, Woodroyd Nursery, Cavendish Lodge Day Nursery. Participating primary schools: Barkerend Primary Leadership Academy, Brackenhill Primary School, Miriam Lord Primary School, Bowling Park Primary School.

Reducing inequalities: actions for NHS organisations

Our Bradford District and Craven Health and Care Partnership's Reducing Inequalities Alliance is excited to share our new resource, Reducing inequalities: Actions for NHS organisations and partners in Bradford District and Craven. We've developed this guide to be a helpful reference document, which summarises key policies and guidance and collates evidence of effective interventions. Whilst its primary audience is NHS organisations, it will be of interest of partners who work with the NHS.

Help with rising costs for families expecting a baby, and households with young children

As fuel costs rise pregnant women and families with young children in Bradford District and Craven can get free financial help. On 1 October 2024, gas and electricity prices have risen by 10%, causing financial pressure and worries for many local families with young children. To support these families, Bradford District and Craven Health and Care Partnership and Bradford Council have partnered with Hope4U – an organisation that aims to eradicate poverty and improve financial sustainability.

New charter for public to shape future of health and social care

Communities are set to benefit from a new charter that has been launched to help shape the future of services across North Yorkshire. The charter and its framework sets out the council's commitment to

put individuals and communities at the heart of the development and day-to-day delivery of services and support. To view the involvement charter and framework, visit www.northyorks.gov.uk/getinvolved

Creative writing exhibition on coercive control launches at Keighley Library

Staying Put and The Coercive Control: From Literature into Law project are excited to announce that their Creative Writing Group will be exhibiting poetry at Keighley Library. After attending workshops for women with lived experience of domestic abuse and sexual violence, the women went on to produce their own creative writing and share it with the group. Their works will now be displayed alongside those of the Brontës in Keighley Library from throughout October. It is free to attend and open to the public. Find out more about the project.

Winners of photo competition counter stereotypes around old age

Striking and fun images celebrating the diversity of older people's lives and the contributions they make to society are set to tour venues across North Yorkshire. Often people later in life are portrayed as being frail, relying on walking aids, being in a medical or care setting or losing their independence. While misconceptions about age still exist, older people in North Yorkshire are combatting the often narrow, negative, and stereotypical ways that ageing is often portrayed in society. Although the photo competition is now closed, people are being encouraged to continue to submit their images to include in the associated North Yorkshire Council Ageing Well communications and publications.

Bradford 2025 programme launch and WhatsApp channel

On 12 September, Bradford played host to local, regional and national guests and media as we saw the launch of the initial programme for Bradford 2025. There's lots to see, do and join in with.
Want the latest updates from Bradford 2025? Join the WhatsApp channel! Be the first to hear about new events, when tickets go on sale, and how you can get involved. Join the community today.

4. Partners

West Yorkshire Partnership Board Meeting, 22nd October

The Chair and I attended the WY Partnership Board meeting on 22nd October, where we received a report around the ambition to reduce stillbirths, neonatal deaths, brain injuries and maternal mortality, including an acknowledgement of the complexities of the unique landscape providers are operating within; and assurance on the actions taken by the Local Maternity and Neonatal System to progress both the national and Partnership's ambitions. We also discussed our ambition to strengthen our local economy and endorsed the recommendation for partner organisations to assess their own activities against the framework, to tailor their efforts and consider the recommended next steps. We reviewed the proposed West Yorkshire Local Transport Plan vision and discussed how we would like to engage in the process to establish this going forwards. We noted progress to date on the West Yorkshire Equity, Diversity and Social Justice Strategy and considered the best process of implementation.

WYAAT Programme Executive Meeting, 5th November

I attended the WYAAT Programme Executive meeting on 5th November where we received the usual collaborative report and HCP report, and had a discussion on renal dialysis across WYAAT. We also received a paper on Information Governance and discussed the WYAAT service review. The AACE response to NHSE temporary escalation space (TES) guidance was also discussed under AOB.

In addition to the above, Julian Hartley joined part of the session with the Programme Executive.

West Yorkshire System Leadership Executive Group Meeting, 12th Nov

The West Yorkshire System Leadership Executive Group meeting was held on the 12th November regrettably I was unable to attend due to a diary conflict with the NHS Providers Conference. Saj Azeb, Chief Operating Officer, attending on my behalf to ensure representation from BTHFT. The meeting focused on the current context including national and regional updates, and a review of Place partnership arrangements in West Yorkshire.

WYAAT Committee in Common, 20th November

The Chair and I are due to attend the Committee in Common (CIC) meeting on 20th November, which post dates this report. This is a single item agenda to cover the WYAAT service review.

5. National Reports

Professor Lord Darzi Review of the NHS

The Independent Investigation of the National Health Service in England was commissioned by the government to understand the performance of the NHS and provide an analytical diagnosis of issues that exist in the system. It has been led by surgeon, independent peer and former health minister Professor Lord Darzi and its insights will set a baseline for the upcoming ten-year health plan.

Overall, the report positions the performance of the NHS within the changing and challenging external environment it has operated in over the last few decades. It recognises that many of the factors that have contributed to the NHS's current challenges are outside of its direct control.

The focus of the report will contribute to government's 10 year plan for the NHS which will be published in spring 2025. Following the publication of the review, the government confirmed that the focus for the 10 year plan should be on:

- Shifting care from hospital to community;
- Moving from treatment to prevention; and
- Going from analogue to digital.

Across West Yorkshire, and in the five places that make up our integrated care system, we will be looking to collect evidence to demonstrate the work we are already doing that fits with this future direction.

Change NHS: help build a health service fit for the future
The Government has this week launched a national engagement with the public and staff to inform the development of the new 10-year plan which is due out next spring.

In West Yorkshire, we will be contributing to the engagement by feeding in the vast amount of insight and feedback we have already. We will also be arranging activities across West Yorkshire to make sure that as many people as possible take part so that their voices are heard.

The Government recognises that NHS staff are working harder than ever to get services back on track, to get waiting lists down and consistently deliver the best care, and that many of the solutions we need are already here, working somewhere in the NHS today. Whether you have a little to say or a lot, your

views, experiences and ideas will shape the immediate steps and long-term changes through the 10-Year Health Plan for the NHS.

Myself and the Chair attended an event held in York on 21st November for Chairs, CEOs and ICB leads across the North East and Yorkshire region.

Colleagues are encouraged to get involved in the place-based and West Yorkshire wide engagement sessions once confirmed. Alternatively, people can get involved on the national website www.change.nhs.uk

NHS Confederation report: The case for neighbourhood health and care

NHS Confederation has published its case for change and the working better together in neighbourhoods report. NHS Confederation has developed a bank of case studies demonstrating neighbourhood working in action. This report has a clear synergy with the government's direction of travel for the NHS and health and care services, with a focus on shifting care from hospitals into community.

Therese Patten has thanked local VCSE partners who hosted a visit from the NHS Confederation early in summer to share the work being done locally as well as some of their ideas that could overcome some of the limitations posed by national policy and guidance that impacts on the stability of VCSE organisations.

Penny Dash review of CQC

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.

The final report makes seven recommendations:

1. Rapidly improve operational performance, fix the provider portal and regulatory platform, improve use of performance data within CQC, and improve the quality and timeliness of reports.
2. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.
3. Review the SAF and how it is implemented to ensure it is fit for purpose, with clear descriptors, and a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.
4. Clarify how ratings are calculated and make the results more transparent.
5. Continue to evolve and improve local authority assessments.
6. Formally pause ICS assessments.
7. Strengthen sponsorship arrangements to facilitate CQC's provision of accountable, efficient and effective services to the public.

The CQC has responded outlining how it will work to implement the recommendations. Therese Patten will keep colleagues updated on progress and what this means for us locally.

Sir Julian Hartley to take on chief executive role at Care Quality Commission

Sir Julian Hartley will be appointed as CQC's new Chief Executive. Sir Julian has been the Chief Executive of NHS Providers since February 2023, prior to which he had a distinguished career as Chief Executive of several organisations, most recently 10 years as Chief Executive of Leeds Teaching Hospitals NHS Trust. Sir Julian's start date is yet to be confirmed.

Tom Riordan appointed as Second Permanent Secretary in the DHSC

The Department of Health and Social Care (DHSC) has announced the appointment of Tom Riordan to the role of Second Permanent Secretary. The appointment has been made with the approval of the Prime Minister. Tom brings his 14-year experience as Chief Executive of Leeds City Council to the role, where he oversaw reforms to integrate health and social care.

Sir Julian Hartley and Tom Riordan are congratulated and welcomed to these national roles.

Sexual misconduct in the NHS: Launch of new framework, training and communications campaign

BTHFT is committed to keeping patients and colleagues safe. This includes a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual harassment and abuse. We have signed the NHS Sexual Safety at work charter. The charter commits to ten principles and actions to safeguard staff. The charter includes prevention, support for people who have experienced or witnessed sexual misconduct and robust action against individuals who commit this behaviour. We must all ensure the NHS is a safe space for colleagues and patients, and a place in which sexual misconduct, violence, harassment or abuse will not be tolerated. A working group has been established to ensure effective implementation of the policy and training framework, this group includes colleagues from Human Resources, Occupational Health, Freedom to Speak Up, Safeguarding, Equality and Diversity, trade unions and organisational development.

The letter can be found here: https://www.england.nhs.uk/long-read/sexual-misconduct-in-the-nhs-launch-of-new-framework-training-and-communications-campaign/

Evolution of NHS England's operating model

NHS England have been working closely over the past year, with colleagues across the NHS and more widely on the development of its operating model. The actions that will guide the refresh of the current operating framework are to simplify and reduce duplication, shift resources, devolve decision-making to those best placed to make changes, and to enable leaders to manage complexity at a local level. To achieve the desired outcome, NHS England have asked the wider NHS family to work together, along with partners in the wider system to full leverage the potential of the Integrated Care Systems. Further engagement events will take place with Trusts to allow them to fully support the evolution of the operating model.

The full letter can be found here: https://www.england.nhs.uk/long-read/evolution-of-our-operating-model/

CQC rates Bradford Neonatal Services Outstanding

Bradford Royal Infirmary's Neonatal Unit – which provides specialist care to newborn babies who need additional support – has achieved an 'Outstanding' rating from the Care Quality Commission (CQC).

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The CQC found the service was 'performing exceptionally well', was 'exceptionally caring' and families felt valued and part of the team caring for their baby.

The outstanding rating was testament to the hard work and dedication of all the staff who worked on the Neonatal Unit. The Neonatal Unit provides a unique and specialist service to babies, mothers and families at what is often an extremely worrying and emotional time. I'm very proud that the CQC found the team to be committed to treating patients and those close to them with compassion and kindness. I would like to thank every colleague on the unit for helping us continue to develop a culture of quality that is embedded in our work every day and reflects the Trust's aim of delivering outstanding care for patients. The service includes a Neonatal Intensive Care Unit (NICU), one of only four NICUs in the Yorkshire and Humber region which cares for some of the sickest and most premature babies.

In response to the report, I have received two letters of congratulations from Professor Shirley Congdon, Vice-Chancellor of the University of Bradford (See appendix 1a) and Deputy Speak of the House of Commons, Judith Cummins MP (see appendix 1b).

The CQC has also published reports in relation to Maternity Services and Medical Care, including older people's care, at Bradford Royal Infirmary (BRI).

While the CQC's overall 'requires improvement' rating for Maternity could not change since the last inspection, as the latest inspection only looked at two areas of the service, there were improvements to the well-led and safe domains – resulting in 'good' ratings. The Maternity services improvements are a credit to colleagues working in this area. These, together with the outstanding rating for our Neonatal services are a clear indication of our trajectory of improvement.

Medical care at BRI maintained its 'good' rating. Inspectors found medical care was safe and well-led and regularly receives positive feedback from patients. I'm pleased that the CQC has recognised our medical care as 'good' and well-led with patients receiving compassionate care and treatment from our dedicated and committed colleagues. These are strong foundations for further improvement to deliver even better quality care.

The CQC reports are included as a separate item on today's agenda (see item Bo.11.24.9).

Recommendation

The Board is asked to note this report.

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

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

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

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

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

UNIVERSITY of
BRADFORD
Office of the
Vice-Chancellor

Date: 24 November 2024

University of Bradford
BD7 1DP

Professor Mel Pickup
Bradford Royal Infirmary
Duckworth Lane
Bradford
BD9 6RJ

Dear Mel

Thank you for sharing the letter regarding the outcome of the Neonatal Unit 'Outstanding' ranking from the Care Quality Commission (CQC).

I am delighted that you have achieved this well-deserved rating.

Yours sincerely

Professor Shirley Congdon
Vice-Chancellor

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HOUSE OF COMMONS

LONDON SW1A 0AA

Deputy Speaker of the House of Commons
Judith Cummins MP

Mel Pickup
Chief Executive
Bradford Teaching Hospitals NHS Foundation Trust
Bradford Royal Infirmary, Duckworth Lane
Bradford
BD9 6RJ

Our Ref: JC18203

22 November 2024

Dear Mel

Re: Care Quality Commission 'Outstanding' Report

I am very pleased to see that the Trust's Neonatal Unit has been awarded an overall 'outstanding' rating from the Care Quality Commission at its latest inspection, and I write to congratulate you and your team on such a wonderful achievement.

I was particularly pleased to read that the inspectors stated that the service was 'performing exceptionally well' with staff 'providing exceptional care and treatment to people'

Please pass on my best wishes and congratulations to the hard-working and committed team.

I look forward to continue to supporting you and everyone at Bradford Teaching Hospital NHS Foundation Trust to provide the best possible care to everyone in Bradford.

Yours sincerely

Judith Cummins MP
Labour Member of Parliament for Bradford South
Deputy Speaker of the House of Commons

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PRIVATE AND CONFIDENTIAL

BO.11.24.8 - REPORT FROM THE CHAIR OF THE QUALITY COMMITTEE

A. OCTOBER & NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.11.24.8a - Report from the Chair of the Quality Committee October 2024.pdf

Bo.11.24.8a - Report from the Chair of the Quality Committee - November 2024.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Academy

Date of meeting: 17 October 2024

Key escalation and discussion points from the meeting

Alert:

No matters to escalate to the Board of Directors were identified

Advise:

Follow up from Alerts in September 2024 AAA report:

- **Moderate risk to achieving compliance with safety action 8 of the Maternity Incentive Scheme.** Due to the timing of the paper, the September training compliance is not available and will be included next month. The position is being closely monitored.

- **Increase in cases of MSRA colonisation in babies as part of routine swabbing within Women and Newborn service**s. Additional measures remain in place (hand hygiene and environmental mitigations). MRSA decolonisation of Maternity and Neonatal Unit staff commenced in October with a positive response and uptake from staff. A positive MRSA swab came from one of the computers on wheels used in the Unit. This has been thoroughly cleaned and staff reminded of hand hygiene protocols prior to using communal items of equipment. Work in conjunction with the IPC team is ongoing to determine if there is alternative equipment which can be used in the clinical environment. Further cases were identified in September, with a current total of 20 cases. No babies have developed a bacteraemia or become unwell as a direct result of MRSA.

Assure:

Board Assurance Review (BAF)

The BAF Review reduced the number of risks from 17 to 13. The review was approved by the Board in September 2024. Following discussion around an additional risk relating to patient safety/experience aligned to the Quality Committee, it was agreed that this be submitted to an Executive Team Meeting (ETM) and brought back to the Quality Committee, before being presented to the Board for approval. It was agreed that the Risk Appetite Statement will give further consideration at the next Quality Committee.

High level risks relating to the Academy

The HLRR report was received: 3 new risks were added, one risk has reduced in score.

Risk 2629: A new risk re: violence and aggression in the Emergency Department (ED) has been added. A security presence will be in the ED at all times. A two-year project is

proposed to focus on areas where emergency patients come into the hospital to improve the experience for staff and patients.

Risk 56: one of two Gamma cameras is no longer in operation and the other is approaching the end of its serviceable life. Mitigations have been put in place to address reduced capacity, but the risk will increase for BTHFT, and some surrounding hospitals should camera 2 fail. Plans, including financial, for replacing camera 2 will commence once the new one is installed.

Risk 2162: relates to the way pathology/radiology results come back into the Trust following Airedale NHSFT's (ANHSFT) go live of their Electronic Patient Records (EPR) system. Results will not go to the same places as they used to, and this is a potential issue for clinical services. An issue in the Emergency Department (ED) is for patients who have left the department and moved on to other areas of the hospital. Responsibility for reviewing the results passes to the receiving team but due to the new pathways and EPR changes, results could be sent to ED who no longer have clinical responsibility for the patient. This is being worked through.

Risk 187: the risk score has reduced to 12. Thanks were expressed to all involved in the recruitment of nursing staff over the last two years.

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

Quality Committee Dashboard

The Quality Committee dashboard provides a single view of quality aligned to the Trust's strategic objectives. The Summary Hospital Mortality-Level Index (SHMI) for BTHFT has been an outlier for some while and frequently discussed at QC. Work to improve clinical coding following investigation will bring SHMI more in line with expectations and reflect a more accurate picture. Some Artificial Intelligence (AI) processes are being worked on whereby patient records will be reviewed and the codes which should be attached will be actively located. This will result in an improved depth of coding and an increased number of co-morbidities being noted. As SHMI is done on 12 month rolling period changes are not always seen immediately.

Insights Report (Qs 1 & 2)

The INSIGHT report is intended to bring data together related to incidents, complaints, PALS and litigation. Compared to the same period last year there has been a 20% increase in the number of reported patient safety incidents. The five highest frequencies reported are pressure ulcers, blood transfusion issues, care and treatment issues, falls, and those classed as 'other'. Contributing factors are the transition to the Innovation, Research and Improvement System (IRIS) and the improved communications and reporting culture. There has also been a significant increase in complaints and concerns received by the Patient Advice and Liaison Service (PALS) over the previous year. Data held within the Patient Safety Incident Response Framework (PSIRF) can be thematically analysed to understand patient safety incidents and emerging risks. A discussion around resource needed to manage these increases to place. A business case for extra resource in Freedom to Speak Up (FTSU) team is to be submitted.

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Resource challenges within the Legal team were also noted. There is a significant increase in the number of inquests being heard by the coroner, which impacts on workload of staff required to give evidence. All deaths must now be reviewed by an independent Medical Examiner, and the deceased's family must be contacted to ask if they have any concerns, which may mean potentially more coronial referrals are made.

Quality Account Improvement priorities update Qs 1 & 2

BTHFT is one of 142 organisations within NHSE England's pilot implementation of Martha's rule - to ensure staff and patients have an opportunity to raise concerns and have access to a 24/7 rapid review Critical Care Outreach Team (CCORT). Of the four patients admitted to ICU following review by CCORT none had triggers of deterioration in their physiological markers, and signs were identified faster. BTHFT has received £40,000 from NHSE for involvement in the pilot, some of which has been used for two clinical staff secondments (1.0 FTE) to support staff and patients on the wards.

Patient Safety Incident Investigation Framework (PSIRF): Q 1 & 2

It was queried if the medication safety and blood transfusion workstreams are behind plan. It was confirmed those workstreams are behind partly due to there being no Medication Safety Officer in the Trust previously, but one is now in post. Transition to the Scan4Safety blood transfusion system has also impacted. Observational work by the Quality Improvement team will commence.

Maternity and neonatal services

The following position for September 2024 was shared with the QC.

- 2 stillbirths (21 in total in 2024) 1 MNSI
- 2 cases of Hypoxic-ischemic Encephalopathy (HEI)
- 1 neonatal death (anticipated) (16 this year of which 12 expected)
- 0 maternal deaths
- 3 occasions where the unit was assessed as needing to divert women to other trusts (4 women, one returned to give birth) and two attempted diverts
- 7 ongoing maternity SIs/Level 1 investigations: 3 MNSI and 4 Trust level, plus 1 MNSI investigation referred by Leeds regarding a Bradford woman
- 2 MNSI reportable cases, 1 accepted (stillbirth above), 1 rejected (HEI) and 0 reportable Serious Incidents (SI) declared in September
- 0 new or ongoing neonatal PSIIs

BTHFT has not yet met one of the 4 standards of the Perinatal Mortality Review Tool but there are no concerns it will not be met before submission date. The attendance of the Maternity and Neonatal Voices Partnership (MNVP) Service User Lead at the PMRT meetings was noted as positive. The Leads bring additional scrutiny particularly around social deprivation and inequalities, and act as the voice of the service users.

The Respiratory Syncytial Virus (RSV) vaccine programme (given to pregnant women from 28 weeks onwards to prevent bronchiolitis and respiratory infections in babies) had a required roll out date of 1/9/24. BTHFT was initially an outlier as most antenatal vaccinations take place in primary care. Our antenatal clinic and maternity assessment centre staff have now been trained to administer the vaccine. Since the second week in October, the vaccine has been offered to all women who attend for routine and ad-hoc

antenatal appointments. No other organisation met the deadline to our knowledge. Extra funding from PHE has been received to train community-based staff to vaccinate lower risk women who do not routinely attend hospital.

The Committee provided its approval of the PMRT quarterly report, and the learning included therein.

National Standards for Healthcare Food & Drink Annual Compliance Report/Food and Drink Strategy 2024-2028

It was reported that the only area of non-compliance with the food standards is in relation to the requirement to implement digital meal ordering for patients. There are financial implications, and projected costs are being considered. Difficulties with compliance in other Trusts was discussed. Two other points (suitable food and drink for staff) are partially compliant. There are plans to form a sub-group looking at food provision to staff and visitors to improve the offerings currently available.

Compliance has improved significantly over recent years, including the funding of a Dietician. Staff rest areas have been improved to include microwave facilities. The potential for improvement was raised regarding patients who need help with eating (indicated by in-patient survey results). When ward accreditation is undertaken good, compassionate preparation of patients for mealtimes and meal service is observed; this is not always replicated in the in-patient surveys, but improvement is always sought.

The Committee provided its approval of the Food and Drink Strategy 2024-2029 for its next stage recognising it is a Trust rather than a patient document.

Mental Health, LD & Neurodiversity Strategy 2024-2028
The refreshed Mental Health, Learning Disability and Neurodiversity Strategy 2024/2028 was shared. Past improvements have contributed to increased life expectancies for people with poor mental health, but further work is still required on a national level for people with learning disabilities.

The Committee provided its approval of the strategy.

Patient Experience 6 monthly update/National Inpatient survey

The Patient Experience Bi-annual Report was shared, providing detail of initiatives and learning undertaken by the Patient Experience Team (PET) along with the CQC adult in-patient survey findings. There has been an improvement on the previous year's results with fewer items on the action plan, some of which relate to issues with the Trust's estate buildings. A query was raised whether completers of the in-patient surveys represent the Trust patient population and ways to improve this. The CQC is a national survey, and steps are needed for them to improve their target audience. BTHFT does better in the Family and Friends Test (FFT) survey. Improvements to address resource shortages will hopefully correspond with improved survey results next time.

Digital Bi-Annual report

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The refreshed Digital Transformation Strategy and Business Plan is due to be completed by the end of 2024. As part of the refresh the Data and Business Intelligence team have been the subject of an external review by a trusted third party and areas for improvement highlighted. An improvement programme to address these has been developed which includes the new dashboards now being produced and which can be adapted to support all areas of the Trust.

A new Head of Applications and Development and four Associate Chief Clinical Information Officers have been appointed. Regarding EPR optimisation, the Theatres, Anaesthesia and Critical Care module is due to go live in a staged manner in Nov 2024

The Committee confirmed it is satisfied the informatics function continues to strive to ensure the Trust is well led regarding digital matters.

Report completed by:

Louise Bryant/Julie Lawreniuk

Committee Chair and Non-Executive Director/ Committee Member Non-Executive Director

6th November 2024

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Academy

Date of meeting: 21 November 2024

Key escalation and discussion points from the meeting

Alert:

There has been an increase in pressure ulcers, including those acquired in the Emergency Department (ED) setting. High levels of attendance, overcrowding and increased acuity of cases and wait for beds are contributory factors. A significant programme of work to address overcrowding in ED and other issues is ongoing. Learning from wards with high performance in relation to pressure ulcers will be shared with ED.

Advise:

Follow up from Alerts in October 2024 AAA report:

- **Risk to achieving compliance with safety action 8 of the Maternity Incentive Scheme.** The risk still remains, and the committee was appraised of the financial risk of non-compliance. The committee was assured that all efforts were being made to ensure colleagues were able to attend the training required.
- **Increase in cases of MRSA skin colonisation in babies as part of routine swabbing within Women and Newborn service**s. Additional measures remain in place (hand hygiene and environmental mitigations). Decontamination of equipment remains a focus and wipeable keyboards are being sourced. Cases remain very low (one in October), and no babies or mothers have developed bacteraemia.

Update on depth of coding of clinical events and patient morbidity

A paper submitted to the Executive Team in September 2024 highlighted a series of recommended improvements and areas of focus that would improve the depth of coding, income and subsequent SHMI and general Trust performance data. A Coding Recovery Programme was formalised, and the committee was given a positive progress update. Improved coding will bring ~ £1M in cost recoveries. As SHMI is done on a 12-month rolling period, changes may not be fully visible for approximately 18 months, though our crude mortality rate continues to fall.

Assure:

Quality Committee Dashboard

The Quality Committee dashboard provides a single view of quality aligned to the Trust's strategic objectives. The slight rise in pressure ulcers per 10,000 bed days was discussed (including in ED as above). Mitigating activities presented including staff training and sharing learning from wards with very low incidence with those where incidence has increased.

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Ongoing work to bring measurable metrics for Medicines Management to the Dashboard, was presented including missed doses of critical medicines and time data for discharge prescriptions.

The committee noted the report and was assured that the dashboard provides oversight of the current situation in relation to the objective of providing outstanding care. The sections on learning and improvement in the dashboard were identified as an important addition and supportive of our goal of being a continually learning organisation.

Maternity and neonatal services

The following position for October 2024 was shared with the committee.

- 3 stillbirths (24 in total in 2024) 0 MNSI investigations
- 0 cases of Hypoxic-ischemic Encephalopathy (HEI)
- 1 neonatal death (anticipated) (17 this year of which 13 expected)
- 1 maternal death
- 0 occasions where the unit was assessed as needing to divert women to other trusts
- 7 ongoing maternity SIs/Level 1 investigations: 3 MNSI and 4 Trust level, plus 1 MNSI investigation referred by Leeds regarding a Bradford woman (no change from September)
- 0 new or ongoing neonatal PSIIs

The Respiratory Syncytial Virus (RSV) vaccine programme (given to pregnant women from 28 weeks onwards to prevent bronchiolitis and respiratory infections in babies) has been rolled out. The service is vaccinating 10 - 20 women per. Additional evening clinics are available for low-risk women receiving community led care to book on, but as yet, no women have accepted the offer. There is a 2nd phase plan to offer vaccinations at more community locations from April 2025. Staff suggest there is vaccine hesitancy, and the service is working with BDCT to deliver communication on the importance of the vaccine, in addition to developing strategies to communicate with our diverse communities more effectively.

The Committee approved the PMRT quarterly report, and was assured they had oversight of any emerging trends concerns and issues.

Quality Oversight & Assurance Profile and PSII report

The position statement in respect of PSIIs and MNSIs as at 31/10/24 was shared: 29 safety incidents were escalated from the CSUs and discussed at Safety Escalation Group (SEG) between 1/09 and 31/10/24. 6 safety incidents discussed at SEG were escalated to Quality of Care Panel (QuOC). 1 PSII has been declared between 1/09 and 31/10/24 and 2 MNSIs have been declared during this period. Emerging Themes currently being monitored within the CSU/relevant team were provided as were appendices relating to learning and improvement as a result of safety investigations.

The committee noted the report and agreed it was assured that it had oversight of patient safety incidents and actions taken. It was assured that the quality of patient care is being managed and escalated appropriately.

Infection Prevention and Control Q1 and Q2 report

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An update on the MRSA outbreak in maternity and neonatal was given (as above). The position on Mandatory Organism infections at BTHFT was noted. There is normal variation, but we have lower than average levels for all 6. Updates on bacteraemia and CDiff prevention approaches were provided and improvement work to reduce hospital acquired EColi shared.

The committee noted the report and was assured by the oversight of infection, prevention and control activity, progress against annual infection prevention programmes and high compliance with the IPC Board Assurance Framework

Audit reports relevant to Quality Committee

1. Nursing assessment and care plan audit: action plan update

Audit Yorkshire provided a limited assurance report for Nursing Assessments and Care Plans on 14/05/24. It found that not all non-mandatory sections were completed, and care plans were not always initiated when they should be and those that were, were not always evaluated. An improvement plan has been devised from the 9 recommendations and the committee received an update on the plan. All actions identified have been assigned and monitored through the working group and chief nurse senior team meeting. Escalation and support may be required where delays are experienced in relation to changes to the EPR system or where resource is required. There is a risk that as the digital team are supporting roll out of EPR this may impact the delivery of the improvement plan. The committee asked for an update in 3 months.

2. National Dementia Audit

Reflections and data from round 6 of the audit were shared and future plans including identifying a new Lead for oversight of the National Audit of Dementia, improving assessment of patients for delirium on admission and maintaining documentation standards especially regarding pain assessment and management. It was noted that we need to improve the accuracy of data that is being shared and improve training rates regarding knowledge of delirium and dementia. The results should be published in December 2024 at the earliest so there no current National data to measure against.

3. Care of the deteriorating patient audit: November 2024

The review aimed to provide assurance around BTHFTs' systems and processes in relation to deteriorating patients and included the application of Martha's Rule. The audit provided a rating of a high levels of assurance. One minor recommendation was identified, which was that Recognition and Response to Acutely Unwell Patients Group may wish to consider presenting the work of the Critical Care Outreach Team to the wider clinical team as part of its evidence that Martha's Rule is being embedded, and to further highlight the work of the team generally.

Board Assurance Review (BAF)

A discussion around an additional risk relating to patient safety/experience aligned to the Quality committee had been raised in the October committee. It was decided that an additional risk was not necessary, but patient safety/experience risk would be explicitly

integrated into existing risks. Consideration of changing the risk appetite score for the Quality committee related risks took place but it was agreed to keep the Risk Appetite Statement as it is.

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

The HLRR report was received. There are no risks that are beyond the target mitigation date. 2 new risks were added but only one relevant to the Quality committee.

2653 (score 16) Lack of consistent archiving of Trust clinical research records including patient information has caused legal and regulatory risk across the organisation. The target mitigation date is 30/06/2025.

No risks have been closed since the last report but one risk relevant to the committee has reduced in score (605: 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). This has been reduced in score from 16 to 12 since agreement has been reached that the Consultant from Sheffield will continue to provide 3 PAs of in reach service. However, there still remains a lack of local service specification so 605 will remain on the HLRR.

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

Report completed by:

Louise Bryant

Committee Chair and Non-Executive Director/

26th November 2024

B. DIGITAL STRATEGY BI-ANNUAL UPDATE

REFERENCES

Only PDFs are attached

Bo.11.24.8b -Digital strategy bi-annual update.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.8b

Digital Strategy Bi-Annual Update

Presented by	Paul Rice, Chief Digital and Information Officer	
Author	Adam Griffin, Deputy Chief Digital and Information Officer	
Lead Director	Paul Rice, Chief Digital and Information Officer	
Purpose of the paper	To offer oversight and assurance of the Informatics function	
Key control	Assurance	
Action required	For assurance	
Previously discussed at/informed by	Informatics Performance Group (IPG) Quality Committee - October 2024	
Previously approved at:		**Date**

Key Options, Issues and Risks

The Informatics function provides a wide range of utilities, services, and expertise to the Trust. We pay careful attention to the performance and progress of these activities and continue to explore new ways of working, to ensure we remain safe, effective, and efficient. This paper has been written by the Chair of the Digital and Data Transformation Committee (DDTC), to provide the Board of Directors with an overview of the activities undertaken in the previous period.

Changing Our Mindset - Digital and Data Transformation Strategy Refresh

'Individual transformation fuels organisational success…'

Informatics are undergoing a period of strategy and business planning which sees us building on our previous plans and strategies to ensure they remain accurate for the challenges of today and the ambitions and opportunities for the future.

This process, which has involved a variety of stakeholders, has produced a revised draft Digital Transformation Strategy and Plan which is now subject to internal review and approval. The fundamental components of the draft strategy, and all underpinning plans are built on a series of strategic objectives which have the ambition to ensure Bradford Teaching Hospitals NHS Foundation Trust becomes a clinically driven, digitally optimised Trust.

In anticipation of this strategy and plan, 2024 has seen a significant focus on changing the mindset of the Informatics function. The mindset change is to predominantly see ourselves as a strategic, rather than purely operational partner to the Trust. This means we must re-think everything we do from the ground up to ensure we are providing the correct digital leadership and direction for the Trust, for the next generation.

To begin transitioning to this future state we identified five key priority areas to address in 2024/25:

1. Increasing the diversity, experience and composition of the senior leadership team. This journey has started by bringing in leaders from other sectors, and other Trusts. In doing so, we have seen a step change in the dynamics and discussions within the senior team.
2. Leadership first, management second. 'Leading people, and managing things' is a long-standing mantra within most sectors, and given the accepted statement that we must lead our people; greater emphasis and focus is now placed on the leadership qualities for everyone within the department – and especially those with line management responsibilities.
3. Bringing people together. Despite the suboptimal working environments, the team has worked hard to discourage remote meetings in favour of in person, and engaging interactions.

4. Reward and Recognition. Historically, Informatics has poor R&R rates, and whilst there were pockets of celebrating and rewarding success – it was too infrequent. To correct this, we have ensured a consistent agenda item for the sole purpose of ensuring we devote sufficient time and attention to those who go above and beyond.
5. Encouraging psychologically safe, challenging interactions. Following on from the third area of focus, we placed great emphasis on the need to challenge and discuss the *status-quo and* feel comfortable to challenge decisions and conversations.

So far, we have seen marked changes to the way our colleagues interact and engage with each other and whilst we still have a way to go on this journey, we are already seeing positive improvements in our engagement and performance rates. Further detail of this journey will be published in the Digital and Data Transformation Strategy and Plan.

EPR Optimisation and new Laboratory Information Management System (LIMS)

Informatics have been heavily focused on the EPR enhancements for BTHFT which will become available during November 2024. A major component of this enhancement is the introduction of the Theatres, Anaesthesia and Critical Care (TACC) module which is a unique, and specific set of optimised clinical and operational workflows tailored to this clinical domain.

On completion of these two major milestones, resources can be focused on the optimisation of EPR usage here at BTHFT. This effort will be led by one of the newly appointed associate CCIOs and will consist of a refreshed approach towards the governance, visibility, and prioritisation of EPR developments within BTHFT.

Also, BTHFT successfully moved Biochemistry, Haematology and Microbiology to the new West Yorkshire and Harrogate Pathology Network (WYHPN), Laboratory Information Management System (LIMS) – WinPath Enterprise (WinPath) on 1 Oct 24, as part of a wider West Yorkshire and Harrogate programme, to move to a single LIMS which is the forerunner to further optimisation of Pathology Services across the region. BTHFT and ANHSFT are the first Trusts to use this system throughout the Pathology service and are therefore paving the way for the rest of the Programme, having moved Histopathology and Blood Transfusion over in 2023.

Cyber Security

The appointment of the Trust's first dedicated cyber resource has enabled rapid progression and improvements towards the Trust's cyber arrangements, which include:

- The provision and completion of first- responder training (cyber incident) for all technical and managerial teams within Informatics.
- The introduction and testing of a new and comprehensive cyber response framework which has been tried and tested and is aligned to industry best practice.
- A revised suite of IT & Security operational procedures which have been drafted and will be adopted over time to further increase our 'defence-in-depth' arrangements.

In addition to these activities, the Cyber Manager is now working on a clear set of objectives which includes the provision of a robust vulnerability management capability, which will provide early warning and detection of technical vulnerabilities within BTHFT's digital estate which might be open to exploitation. Notably, BTHFT has been successful in the first round of shortlisting to secure external funding to further enhance its security controls, and we therefore have a high degree of confidence of success.

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Information Governance

The Chief Digital and Informatics Officer and Senior Information Risk Owner (SIRO) ensures effective Information Governance is in place to support all workstreams and services across the Trust providing advice and guidance on good practice with standards and legislative compliance. The Caldicott Guardian is the Chief Medical Officer and works closely with the SIRO, particularly where information risks relating to patient data are identified.

Effective Information Governance has been embedded and evidenced through multiple mechanisms policies and procedures (supported by IT/security controls and vulnerability testing - the Trust has also been awarded the international governance standard for IT and Data Security ISO27001) including by demonstrating compliance with the annual Data Security Standards of the Data Security and Protection Toolkit (DSPT).

The DSPT Assessment 2023/24 evidenced a compliant position of 'Standards Met'. A review of the evidence by Audit Yorkshire took place and confirmed High assurance. The DSPT was a key assurance control evidencing that Information Governance is embedded and effective. Information Governance mandated training for all staff was high, evidencing the necessary compliance. The % national NHS target changed in 2023/24 and the Training Plan and needs analysis was reviewed and updated to reflect this.

The Annual IG and Data Protection Officer report to SIRO was presented to the Trust in September 2024 with detail of information governance activities for 2023/24.

The DSPT Assessment for 2024/25 is underway with a deadline of 30 June 2025. It takes the form of a new CAF (Cyber Assurance Framework) based Toolkit. The Cyber Assessment Framework DSPT provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed.

Expectations about the standard a Trust should achieve for 2024/25 are set out. The new CAF model is aligned to the National Data Guardian Security Standards but places further emphasis on cyber security. It is outcome based and presents significant change in the assessment process this coming year. It still includes general Information Governance. However Cyber/information security is its focus. Completing this self-assessment will demonstrate that the Trust is working towards or meeting the required standard by 30 June 2025. Note this yearly assessment is from 1 July 2024 to 30 June 2025 not 1 April to 31 March, as for most other Information Governance reporting.

For the Information Governance team, the coming year will see a focus on progressing business as usual practices in accordance with business requirements and its IG Improvement Plan, alongside the CAF DSPT Assessment, and with mind to the evolving digital and general IG landscape and legislation. Activities such as review of Data Protection Impact Assessments and similar agreements and controls continue at pace with additional demand this last period, as a result of the EPR programme.
A refresh and review of work to engage and promote awareness with Information Asset Owners is planned. A focus also on exploring efficient ways of enhancing Trust engagement, consideration of tools needed to ensure data protection by design and default principles are inherent in the Trust's processing activities.

Information Governance is enshrouded in UK GDPR and Data Protection law, and the necessary controls and assurances surrounding it need to be embedded in the Trust processing activities that the Trust embarks upon at the outset. The Service will encourage continued raised profile and awareness of the key role it plays across the organisation.

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Information Technology

Whilst a critical component of our set of capabilities, the IT component of the CDIO portfolio is migrating towards an identity as a strategic partner, rather than one solely focused on operational matters. A significant example of this new way of thinking is evident in a trial which was conducted using world-class, cutting-edge technologies, 'Starlink' to solve clinical challenges.

'Starlink' is a system of low earth orbit satellites which can provide high-speed internet access for isolated areas in terms of signal availability or bandwidth. With this in mind, we identified an ideal opportunity whereby colleagues were reporting issues pertaining to on two Mobile Breast Screening Vans which are used at remote locations in West and North Yorkshire. Before the adoption of the new technology, Connectivity from the mobile vans back to the BTHFT network was previously reliant on weak 3G and 4G signals which proved frustratingly slow for the staff.

So, in response and in conjunction with our partner DEOS UK, a trial of Starlink satellite internet is being used to provide much enhanced bandwidth to the screening vans. Initial results are extremely positive, with speeds increasing from approximately 5Mbps to over 150Mbps in Skipton and Holmfirth, improving the user experience and the transmission speed of the images back to BTHFT.

Delivering Change at Pace

Given the volume, and inherent complexities associated with digital transformation and change at BTHFT, careful management of these types of change activities is paramount to ensure that we harness its benefits while mitigating potential risks.

In response to these risks and opportunities, Informatics have developed a comprehensive and strategic approach to change management.

This new approach manifests in the form of a business change gating model and methodology which has been designed to be simple, effective, and efficient. Most notably, the new model places greater emphasis on sound analysis to better determine the scope, cost, and impact of change. An overview of this new model is as follows:

- Step 1 – Feasibility: This stage focuses on understanding the request, defining the problem and is the fundamental step required to understanding the scope and size of the requirement. Requests are validated against a variety of criteria (strategic alignment, compatibility, architectural alignment etc.). If the request is considered 'feasible,' the two newly appointed Business Analysts will meet with stakeholders to define requirements in focused, timebound engagements using standard methodologies.

- Step 2 – Approval, Design and Planning: Using the output from the feasibility stage, funding can be sought, and solution design and project planning can begin. Given the preliminary analysis and feasibility conducted before, the planning stage is easier and quicker to complete.

- Steps 3 & 4 – Delivery, Handover and Closure: This sees the completion of planned works and more importantly the handover of the output of the project into operational use.

As the model matures over time, new capabilities such as capacity/resource planning will be introduced to effectively ensure the Trust has the sufficient ability to manage the volume of change needed from Informatics.

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Talent Management & Organisational Development

We have embraced a strategic approach to talent management focusing on improving how we attract, develop, retain, and optimise our workforce. One of our ambitions for 2025 is to have the best digital-employee value proposition which will see BTHFT as the best digital place to work in WYATT.

Evidence of progress towards this ambition can be illustrated by our activities in 2024:

- Learning & Development - We have enabled colleagues to access degree-level apprenticeships and training courses, including cyber incident responder training, Microsoft developer training and digital clinical safety training for our Informatics clinicians. This commitment ensures we are continually enhancing the skills and capabilities of our workforce to better meet the digital needs of our organisation. At least £27,000 spent on learning and development since September 2023.

- Apprenticeships - Within Informatics, we have expanded our apprenticeship programmes, with several team members now pursuing degree-level apprenticeships. Additionally, we celebrated success at the Skills for Health National Awards, where our Data Quality Analyst, Ben Martin, was honoured as the runner-up in the Apprentice of the Year category.

- University of Bradford and the Digital Health Zone (DHEZ) - We are committed to collaborating with higher and further education providers to enhance our placement opportunities and accommodate work experience students. Our partnership with the Digital Health Enterprise Zone at the University of Bradford has grown, and we proudly supported their Fastrack Healthcare Management Programme. This initiative helps graduates in West Yorkshire realise their potential and transition into roles within the NHS. These sessions have covered topics such as digital career paths, application and interview techniques, and change management.

Application Strategy (Phase 1 – Data Gathering and Trajectory Planning)

The ability for the Trust to fully exploit, optimise its use (and cost), and provide a clear and costed clinical and cost improvement strategy was hampered due to the absence of a comprehensive inventory and centralised understanding of its clinical, operational, and corporate applications. Key issues included unidentified application owners, unknown hosting locations, unclear criticalities, ambiguities regarding vendor support, and poorly tracked licensing agreements.

In response, Informatics engaged with a significant assessment programme to define its current application/system landscape for which an improvement plan could be based upon.

To achieve this, the assessment involved several key steps. Firstly, the senior IT team identified application owners who then provided detailed information about their applications, including vendor details, technology versions, support arrangements and usage. Secondly, a criticality assessment was conducted to understand the importance of each application. Finally, vendors were contacted to confirm support arrangements, licensing agreements, and current version statuses, ensuring a comprehensive understanding of the application landscape and support structures within the Trust.

The assessment highlighted several critical areas that require immediate attention to mitigate risks and enhance the operational efficiency of BTHFT's application landscape.

In anticipation of the outcome of this assessment, it had already been identified that there were significant gaps and shortfalls towards the skills, disciplines and resources deemed essential for adequate application lifecycle management and therefore a series of proactive steps were set in motion to ensure immediate progress upon the release of the application state assessment:

1. A Head of Applications, Development & Integration has been in post since September 2024 who is responsible for ensuring a consistent and complete approach towards application management.
2. A Technical and Integration Architect is to be appointed who will play a key role in optimising and simplifying the application landscape at BTHFT.
3. The strategic aim for the optimisation of clinical information systems is geared to consult and engage in a manner to clinically assess and provide direction to the rich tapestry of clinical applications within the Trust.

The second phase of the application strategy is to incrementally assess each application (by clinical specialty) and provide an objective assessment whether to Grow (Invest), Maintain, Migrate or Converge (to EPR, or other clinical system), or retire. This work has already begun under the stewardship of our new Head of Applications and Development, and Associate CCIO.

Clinical Coding

Overseen by the Executive, the Trust has embarked on a coding recovery and optimisation programme of work which is intended to mitigate the risk of lost income and improve the completeness of patient and clinical documentation. This programme is focused in 5 key areas:

1. Improving Depth of Coding and removing the backlog of coding activities

Two organisations have been engaged to tackle the backlog whilst the internal team is working to code within month. This area of focus also includes an exploration into increasing the current scope of coders to add additional procedure/diagnosis codes which will improve the depth of coding rates and thus income.

2. Correctly recording non-elective to planned activities

This element will see a retrospective 'fix' towards the incorrect recording of non-elective patients, who then returned to hospital later for a planned procedure but retained an Acute admission status. This element of recovery will also provide a training and education package to mitigate a repeat occurrence.

3. Addressing unrecorded planned activity

There is a high-volume of instances whereby a planned procedure has not been recorded within EPR. This lack of visibility presents a blind spot in terms of the accuracy and availability of the procedure a patient has undergone, as well as the lost revenue this incurs. To correct this, a retrospective coding activity is taking place, as well as a proactive training and education package to mitigate repeat occurrence.

4. Addressing unrecorded outpatient procedures

It has been identified that there is a significant volume of outpatient procedures related to outpatient activities (e.g. clinics), that is not recorded. This presents the same issues as not recording planned activity in terms of visibility of applied treatments, and lost income. Here, we have successfully deployed automation to clear a backlog of procedures.

5. Culture, Education, and the correct use, and optimisation of EPR

Most of the issues highlighted above are predominantly rooted in the sub-optimal use of EPR, and the correct workflows inherent within. Therefore, a significant element of the coding recovery work will be to focus on the correct use of EPR and the importance of accurate patient procedure recording.

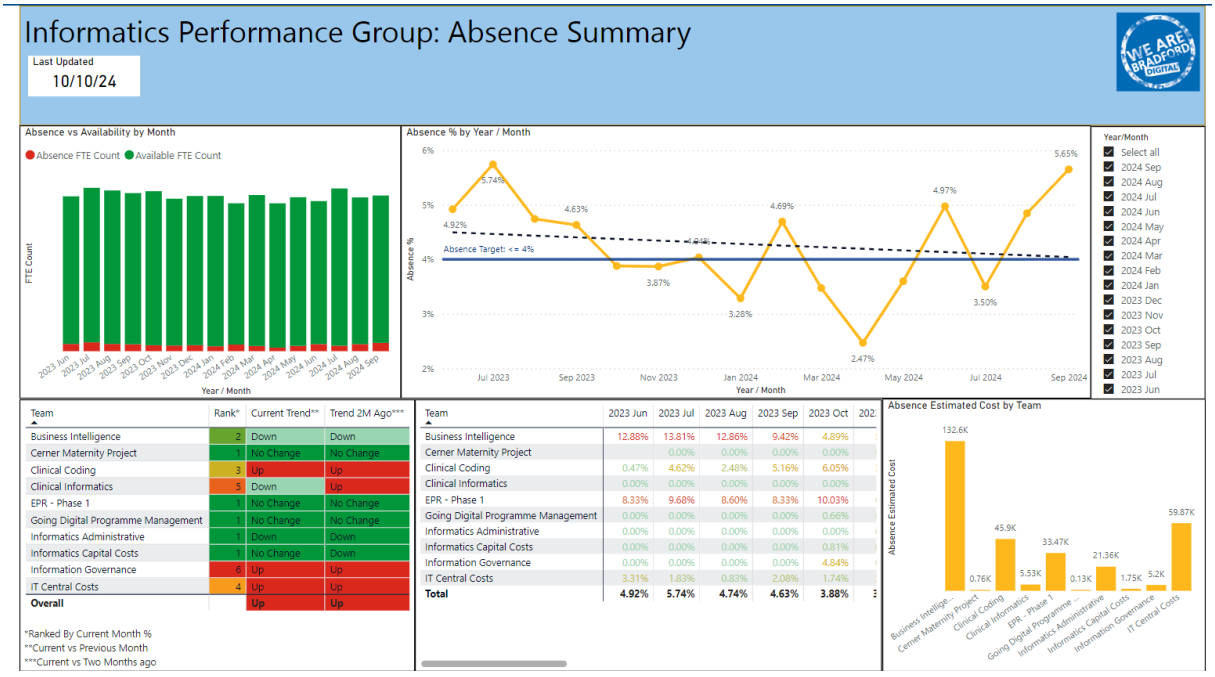
Data and Business Intelligence

The team are moving to a new operating model which will see greater alignment to data disciplines and methodologies, which will allow for greater analytics capabilities for the Trust. This new model includes

the clear articulation and availability of a series of refreshed data/analytics products via a catalogue, which will promote the availability and self-service nature of information and analysis we continue to promote.

A significant achievement of the function has been the production of a suite of new dashboards which provides detailed analysis of absence, training, and appraisal rates, which are all indicators of a well-led team/service. These dashboards are now going to be adopted across the Trust and used at a corporate level to helpfully intervene and support CSUs and corporate areas. The notable benefit is that this data is considered 'self-service,' meaning there is little-to-no requirement to extract, nor manipulate data which takes time. An additional benefit is that with the data in this solution (and not Excel), predictive analytics can be applied to help inform workforce planning activities.

A sample of the new dashboard is included below:



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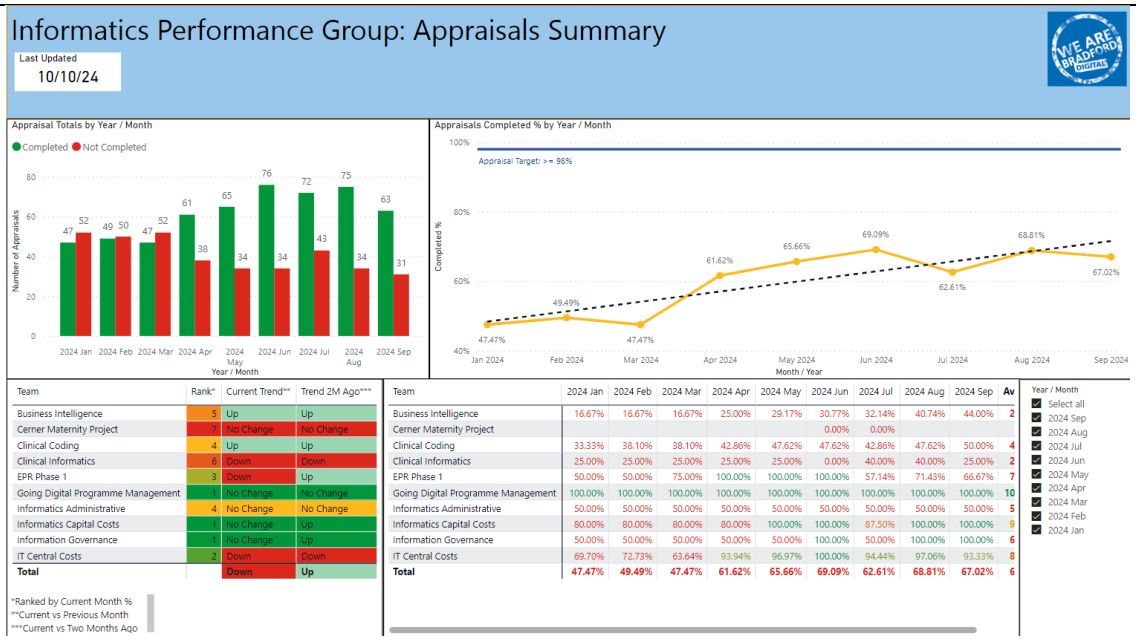

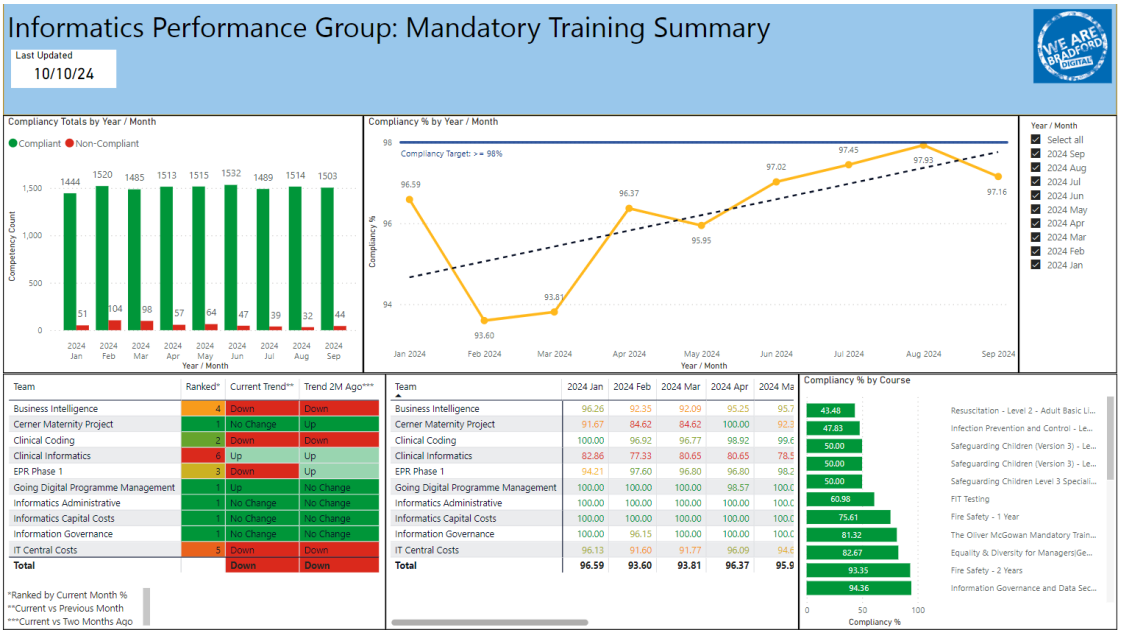

Additional key developments and initiatives delivered throughout the year are as follows:

- Elective Recovery Fund - As part of the ongoing Elective Recovery Fund (ERF) initiatives, the Business Intelligence (BI) and Data Warehousing team has been instrumental in supporting the organisation's efforts to attract appropriate funding for both inpatient and outpatient services. Through targeted improvements in data accuracy, procedure documentation, robotic process automation and reporting capabilities, the team has driven progress in capturing additional funding, enhancing the efficiency of care pathways, and improving data quality.

- Academy/Board Reporting - Developed a new suite of Academy and Board reports to streamline high-level organisational performance tracking. These reports provide critical insights into performance and operational metrics, allowing the Board and Executive teams to make data-informed decisions in an 'Making Data Count' format.

- Diagnostic and RTT Dashboards - Delivered multiple diagnostic Power BI dashboards, including Referral to Treatment (RTT) dashboards. These visualisations empower teams to monitor and manage patient pathways more effectively, ensuring timely interventions and compliance with regulatory standards.

- Access Team – Waiting List Management & App Development - Introduced a waiting list management solution for the Access Team via an integrated application and associated dashboards. This tool enhances team efficiency by enabling real-time tracking and prioritisation of patients on the waiting list.

- Virtual Ward Dashboard - Developed a Virtual Ward dashboard to support real-time patient management, contributing to analysis that optimises resource allocation and supports patient flow.

- RTT/Non-RTT Text Validation Automation - Achieved full automation of RTT and Non-RTT text validation processes, minimising manual data entry and validation tasks. This improvement reduces human error, saves time, and ensures accurate and timely reporting.

- Medication Reconciliation Data - 100% reliable and validated medicine reconciliation data across the organisation, supporting physicians and teams with better data visibility to optimise patient care processes and fully meet CQC recommendations.

- Performance Team Enablement for Power BI - Supported the Performance Team in developing their own Power BI dashboards. By building their internal capability, we have empowered teams to self-serve and gain deeper insights from their data, fostering a more data-driven culture within the organisation.

- Pathway Tracking Application - Rolled out the Pathway Tracking App for RTT and Non-RTT pathways. This application allows managers to proactively monitor patient progress through pathways and identify potential bottlenecks.

- Therapies Data Automation - Collaborated with Therapy teams to automate reporting for inpatient and outpatient data, extracting from Clinical Manager to data warehouses. The transition to app-based tracking enables Therapies to engage in Trust access conversations more effectively.

- Clinic Utilisation Tool Updates - Worked with relevant teams to update and refine the Clinic Utilisation tool, providing more accurate and timely insights into clinic capacity and usage, which supports optimal scheduling and resource allocation.

- Community SitRep Reporting - Provided ongoing support for Community SitRep reporting, a critical component of the organization's real-time situational awareness. This effort, led by team members Abi and Safia with support from Richard, has proven essential for managing community health operations.

In summary, the past year has seen a significant focusing on advancing our data capabilities, automation, and user empowerment within the organisation. By improving our data infrastructure and developing intuitive reporting solutions, the BI and Data Warehousing team has made considerable progress in driving data-driven decision-making. The upcoming year will focus on further refining our tools, expanding automation efforts, and continuing team development to support the organisation's evolving data needs in terms of its strategic ambitions.

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Conclusion

In conclusion, the Chair of the DTTC is satisfied that the Informatics function continues to work hard to ensure that the Trust is well led in digital matters and that its leadership is focused on continually striving to improve its services to ensure it delivers digital and change services in a safe, effective, and efficient manner.

The Chair also recognises the shift in the way in which Informatics is being recognised and used more as a tactical and strategic function, rather than one solely as a utility for the Trust.

The next few months will be a very exciting time for the team, and broader Trust in terms of digital, change and data.

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

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

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

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Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: 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	Finance & Performance	Other (please state)
☐	☒	☒	☐

C. MENTAL HEALTH, LEARNING DISABILITY AND NEURODIVERSITY STRATEGY 2024-28

REFERENCES

Only PDFs are attached

Bo.11.24.8c - Mental Health Learning Disability and Neurodiversity Strategy.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
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MENTAL HEALTH, LEARNING DISABILITY AND NEURODIVERSITY STRATEGY 2024-2028

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Sarah Turner, Assistant Chief Nurse Vulnerable Adults	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	Mental Health Strategy	
Key control		
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**
	Quality Committee	17.10.24

Key Options, Issues and Risks

One in four people across Bradford District and Craven will suffer from poor mental health at some point during their lives and those with a severe illness can die up to 21 years earlier than the rest of the population. The life expectancy gap for people with a learning disability is 33 years with the average age of death being 52 years, 48% of people die in hospital and only 21% where they usually live. Forty-eight per cent of people have five or more chronic health conditions.

Having a learning disability increases the likelihood of experiencing deprivation and poverty, and evidence shows being autistic limits the chances of people being able to work and look after their own health. The life expectancy gap for autistic people is approximately 16 years on average compared to the general population and almost 80% of autistic adults experience mental health problems during their lifetime.

The current financial challenges may prevent some of the solutions happening quickly, however workplans that sit behind the strategy will ensure focus is kept on the key areas and movement is monitored.

Analysis

The existing Mental Health strategy is widened to incorporate Learning Disabilities and Neurodiversity in line with the Bradford and Craven District strategy. This recognises that the challenges faced by people accessing care with a Mental health condition are often similar challenges to people with a learning disability or who are neurodiverse. These include, stigma, inaccessible services, feeling unsafe and therefore avoidance of seeking support.

This strategy aims to reduce inequalities and promote active engagement in service design and delivery. The people who are best placed to help us identify barriers to accessing support are the people who are affected by them and although as professionals we would be able to identify some of those barriers there would be a significant number we wouldn't identify. By following the "no decision about me without me" thought process we are evidencing we are committed to partnership working to improve services and therefore outcomes for people.

Recommendation

The strategy is adopted and work continues in embedding the changes.

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

Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments		
Quality implications	x	
Resource implications	x	
Legal/regulatory implications	x	
Diversity and Inclusion implications	x	

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	28 November 2024	Agenda item	Bo.11.24.8c

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	Finance & Performance	Other (please state)
☐	☒	☐	☐

Meeting Title	Board of Directors		
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1 PURPOSE/ AIM

The purpose of this paper is to present the Trust Mental Health, Learning Disability and Neurodiversity Strategy 2024/2028. The aim of the strategy is to reduce potential inequalities and promote active engagement of partners in service design and delivery.

2 BACKGROUND/CONTEXT

One in four people across Bradford District and Craven will suffer from poor mental health at some point during their lives and those with a severe illness can die up to 21 years earlier than the rest of the population. The life expectancy gap for people with a learning disability is 33 years with the average age of death being 52 years, 48% of people die in hospital and only 21% where they usually live. Forty-eight per cent of people have five or more chronic health conditions.

Having a learning disability increases the likelihood of experiencing deprivation and poverty, and evidence shows being autistic limits the chances of people being able to work and look after their own health. The life expectancy gap for autistic people is approximately 16 years on average compared to the general population and almost 80% of autistic adults experience mental health problems during their lifetime.

For many people, mental health problems begin in childhood but stay with them and their families for life. Poorer mental health is often associated with higher rates of smoking and substance use, decreased social relationships and resilience.

Bradford District and Craven Mental Wellbeing strategy 2016-21 was written and released in response to the above. It was replaced in 2024 with the Healthy Minds strategy “A strategic plan for Mental Health, Learning Disability, Neurodiversity and substance misuse”.

It’s three strategic aims are –

- **Promote Better lives**
- **Respect Rights**
- **Improve Support**

BTHFT launched its Mental Health Strategy in 2021, this new strategy recognises the work already undertaken and identifies the need for further work in relation to Learning Disabilities and Neurodiversity.

3 PROPOSAL

The existing Mental Health strategy is widened to incorporate Learning Disabilities and Neurodiversity in line with the Bradford and Craven District strategy. This recognises that the challenges faced by people accessing care with a Mental health condition are often similar challenges to people with a learning disability or who are neurodiverse. These include, stigma, inaccessible services, feeling unsafe and therefore avoidance of seeking support.

This strategy aims to continue to work already undertaken and develop on what we have learned so far.

The strategic objectives are:-

To deliver outstanding care

To be a continuously learning organisation

To collaborate effectively with partners

This proposed strategy continues with the same 4 strategies to help deliver the objectives, acknowledges the progress already made and outlines how we will continue to develop and grow services to ensure we are meeting the needs of the population we serve in line with the district's strategic objectives.

Training: All staff should receive training appropriate to their role to ensure they are aware of how best to support persons accessing care at the Trust who may have a learning disability, mental health condition or are neurodiverse.

What we do:-

- The Trust made mandatory the Oliver McGowan training, in recognition of the importance of ensuring the workforce is understanding of the needs and adjustments/ considerations required to ensure appropriate care for persons with a learning disability and/ or autism who may access care at BTHFT. This was instigated in January 2024 and current compliance rate is 83%.

- Simulation sessions relating to patients in Mental health crisis.

- Offer placements to students who are undertaking Mental Health or Learning disability nursing courses.

- Access external training courses for delivery to small groups of staff in specialist subjects such as Mental Health First Aider training, Makaton and autism awareness.

What we will do:-

- We will work towards being a trauma informed organisation by 2030 in line with NHS England.

- We will identify staff to lead on the delivery of a wider range of training related to Mental Health, Learning disabilities and neurodiversity.

- Recruitment of persons with lived experience to co deliver training.

- We will continue to work on developing services for young people transitions to adult services with the help of partner agencies and specialist services.

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Workforce: The Trust has a suitably skilled workforce that is able to meet the needs of people in their care and that the workforce feels supported and valued.

What we do:-

- We currently have specialist nurses in Learning Disabilities, Mental Health and an Additional Needs Navigator in post.
- We have employed a dual qualified nurse in Adult and Mental Health Nursing.
- We work with the universities to understand what roles can be offered to dual registered nurses to ensure recruitment and retention.
- We have Project Search.
- We support staff with their own Mental health needs and have developed pathways for accessing support and guidance for managers.
- THRIVE.

What we will do:-

- We will continue to look at opportunities to develop roles that meet the areas of development we have identified ie transitions etc.
- We will continue to explore options with partner agencies in ensuring there is co design of services where possible and reduce barriers to accessing support.
- We will continue to develop the offer of services/support to staff to ensure their well-being at work, specifically with a trauma informed lens.
- We will feedback to staff learning from feedback from people with lived experience.

Information sharing : We have safe, effective and reliable information sharing processes in place.

What we do:-

- Have and continue to develop templates in Electronic Patient Record (EPR) to assist staff in recognising Learning disabilities, Mental Health and ensuring reasonable adjustments are identified and communicated.
- Where electronic systems do not communicate with each other, there are procedures in place for ensuring relevant and necessary information can be sought guided by Information governance procedures and respecting the rights of the individual.

- Ensure appropriate mechanisms are used to highlight a person with a learning disability ie flag on EPR, and that these are monitored and amendments made as necessary.

What we will do:-

- Further development of templates such as transitions care plan.
- We will work with partner agencies to ensure information is able to be shared in an appropriate and timely way, specifically in relation to Right Care Right Person.
- We will explore how data can be sought to provide areas of development and share with partners to enable development of services specifically relating to the transforming care workstreams to reduce hospital admissions for people with a Learning disability.
- Further exploration of the use of flags for highlighting other neurodiverse conditions to ensure staff are aware of any reasonable adjustments that may need to be made.
- Further development of work to ensure communications with people who use our services are appropriate and flexible.

Partnership working: We will develop services in collaboration.

What we do:-

- We work with partner agencies for a shared understanding and agreement on priorities, through a number of Boards and subgroups.
- We work with people with lived experience through attendance at external groups ie Healthy lives, Treat me well etc.
- We work with carers to understand when things could have been better.

What we will do:-

- We will work with a wider network of people with lived experience.
- We will co-opt where appropriate people with lived experience into some of our existing meetings.
- We will explore opportunities to be members of external groups that we currently are not present at.
- We will actively seek the help of lived experience groups to come into the Trust and help us assess our environments.

This strategy aims to reduce inequalities and promote active engagement in service design and delivery. The people who are best placed to help us identify barriers to accessing

support are the people who are affected by them and although as professionals we would be able to identify some of those barriers there would be a significant number we wouldn't identify. By following the "no decision about me without me" thought process we are evidencing we are committed to partnership working to improve services and therefore outcomes for people.

4 RISK ASSESSMENT

There is an increasing demand on provision of services for people with mental health conditions, learning disabilities or who are neurodiverse, with the latter experiencing significant challenges and delays in diagnosis and therefore accessing support. It should be recognised that BTHFT has a role to play in this, however it is a system and national issue and therefore solutions are often not quick or easy to find.

Our strength is in our partnerships, and by working with our partner agencies as well as people with lived experience and advocacy groups it I hoped that we can start to address some of the current gaps in provision.

The current financial challenges may prevent some of the solutions happening quickly, however workplans that sit behind the strategy will ensure focus is kept on the key areas and movement is monitored.

5 Appendices

The document can be viewed at:-

https://bdcpartnership.co.uk/wp-content/uploads/2024/01/Healthy_Minds_Strategy_01_2024.pdf

D. PATIENT EXPERIENCE 6 MONTH UPDATE (INCLUDING INPATIENT SURVEY)

REFERENCES

Only PDFs are attached

Bo.11.24.8d - Patient Experience 6 month update (inc Inpatient Survey).pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.8d

Patient Experience: Six Monthly Update

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Joanne Hilton, Deputy Chief Nurse Ruth Tolley, Quality Lead for Patient Experience	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	Patient Experience Bi -Annual Report update	
Key control	This paper is a key control for the strategic objective to provide outstanding care for patients.	
Action required	For assurance	
Previously discussed at/ informed by	Patients Experience Group (in part) Monthly PEG summary sent to QPSA Community Engagement meetings.	
Previously approved at:	**Academy/Group**	**Date**
	Quality Committee	17.10.24

Key Options, Issues and Risks

This report provides a 6 monthly update on the work that has taken place in relation to Patient Experience and Engagement (PEE) and the work streams that feed into the Patient Experience Group (PEG) and Community Engagement Group (CEG) in line with the Patient Experience and Engagement Strategy 2023-28.

Recommendation

- Support is required from all areas to promote and endorse the Patient Experience and Engagement Strategy 2023-2028.
- Continue promoting the use of real time feedback via FFT to react and make timely improvements.
- Use of QI methodology for tests of change.
- National Survey (CQC) action plans to be monitored via the PE Group for improvement, led by the designated area lead once complete.
- Continue collaboration work with Bradford District and Craven Health Care Partnership to improve collective and consistent improvements.
- Benchmark against other Trusts that are doing well or significantly better in key Patient Experience (PE) areas.

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

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

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☐Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Caring
Care Quality Commission Fundamental Standard: Person Centred Care
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

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

Meeting Title	Board of Directors		
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Patient Experience and Engagement 6 month update October 2024.

The 6 monthly report focuses on activity that has taken place under the headings of the Patient Experience and Engagement Strategy. The report details more examples of work that has taken place to widen the engagement element of the strategy. The specific details for patient feedback from complaints can be found in the Insight report that is presented to Quality Committee. Image 1 sets out the areas of the strategy.

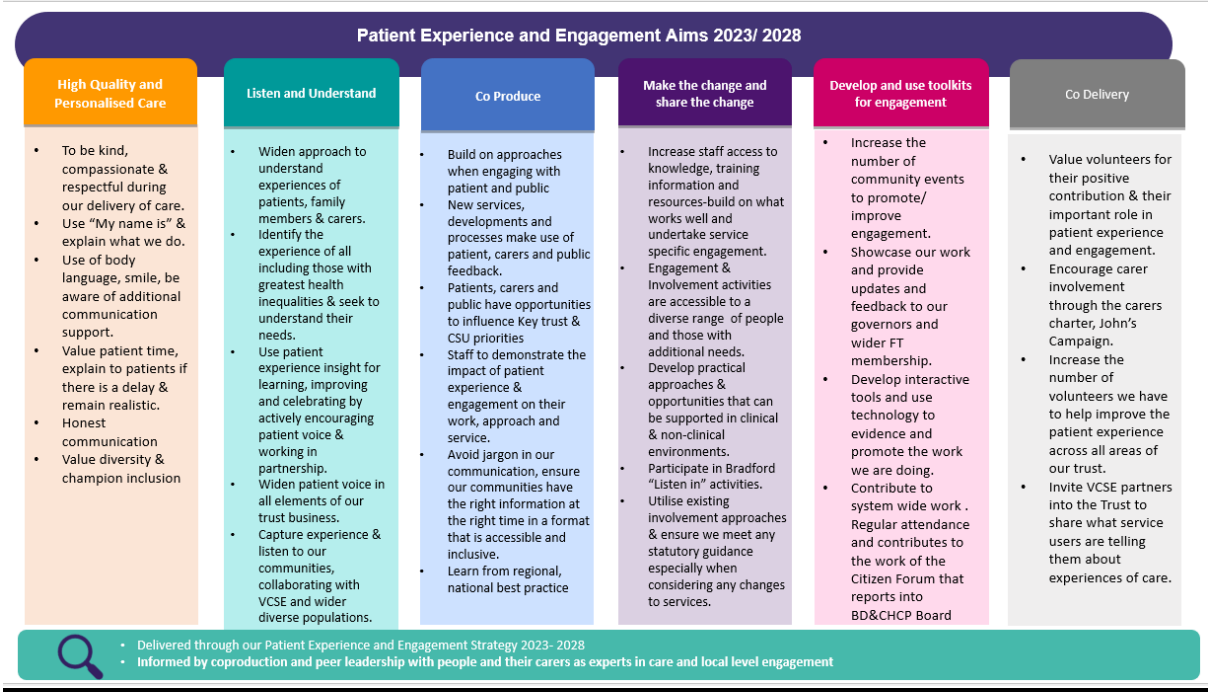

Image 1. Areas of the Patient Experience and Engagement Strategy 2023-2028 Kindness at every step no decision about you without you.

The patient experience team have been focusing on the culture of improving experience with the Clinical Service Units (CSUs):

Ask and capture

Listen and understand

Act to improve

Measure and share

Aim 1 High Quality and personalised care

The work under aim 1 has continued with positive examples shared from the additional needs team, work with the Equality and Diversity team and CSU focused activity. Whilst the 'kindness approach' is well recognised for patient experience across the organisation the next 6 months will focus on the development of family centred care and listening to those with lived experience. There

are good examples of this approach in paediatrics, palliative care and supporting patients with additional needs. There will be further work in this area under aim 2 and learning for improvement from patient feedback, thematic reviews and the voices of carers.

One element of personalised care is the use of the interpreting service. Our interpreting services team supported people on **27,964** occasions in over 60 different languages. It meets the needs of non-English speakers and British Sign Language users, primarily through face-to-face interpreting. The service also provides support using telephone and video, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through the team. The top 10 languages requested are shown below in table 1.

Top 10 languages requested through interpreting services from 1st April to 31 September 2024

Urdu/Punjabi	14522
Czech/Slovak	3215
Bengali	1874
Polish	1605
Arabic	1495
Hungarian	633
Pushto	503
Kurdish	398
Farsi	384
BSL	355

Table 1

Interpreters are used to communicate with patients about their medical history, to obtain information from them about their current problem, to discuss diagnosis and treatment options, to obtain consent for any treatment or procedure and delivering bad news. The service is also supported by the use of Card Medic to aid translation, there has been a continued focus on the uptake of this application in practice. Healthwatch are supporting the Trust to undertake a review with patients and carers where English is not their first language around the use of the services available at the Trust.

Aim 2 Listen and Understand

The next 6 months will focus on widening our approach to understanding through some of the workstreams development. There are key initiatives taking place in the Trust that will inform this work such as the worry and concerns work (Martha's rule), community engagement group

feedback and learning from patient safety partners. The terms of reference and attendance at the Community Engagement Group and Patient Experience Group has been reviewed and widened to provide oversight to the work of the strategy to feed into the Quality Committee.
Patient stories continue to be shared at the Board of Directors and work has taken place to widen participation in this form of feedback. Stories have been used to support educational activities in departments and learning from lived experience.
As part of the work to improve communication with patients there are 2 key workstreams for Accessible Information and patient information / education.

Accessible Information Standard

A successful trial has been undertaken by the staff, in the reception team who work within the CPBS, to provide information and training regarding the Accessible Information Standard to enable the Trust to meet the steps outlined in the Accessible Information Standard to identify and record a patient's information and communication needs. The Trust's training package comprises of the YouTube video and awareness training produced by NHS England which provides staff with an overview of the standard along with a training script produced by the Education Team regarding the identification and recording of needs in the patient electronic medical record. This training is also included as part of the Trust's Induction programme for new starters.
Following the trial, by the staff working in the CPBS, the training script produced by the Education Team has been updated. The trial highlighted changes required to the drop-down box of the preferred communication format in the patient electronic record.
The challenge for the next 6 months is to ensure that this training is undertaken by all the other reception teams within the Trust in order for them to identify and record patient's information and communication needs. Work will be undertaken with the CSU's for them ensure staff within these teams are trained and that they are asking and recording patient's information or communication needs or recording if there are no accessible needs.
Undertaking this work will ensure that information about individuals' information and/or communication support needs is included as part of existing data-sharing processes and as a routine part of referral, discharge and handover.

Patient Information

BTHFT recognises that patient information is a crucial part of the patient journey. It is a key element in the overall quality of the patient's experience and is important for achieving informed consent and informed decision making. It also enables patients to choose whether or not to be treated at BTHFT.

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Since January 2024 the Communicating with Patients Approval Group (CPAG) has approved 63 new items, reviewed 173 items, approved 42 video scripts linked with the work being undertaken by the virtual hub patient education and logged 62 external resources.

The patient and public involvement team have been involved in some key activities in the last period.

‘Listen in’

As part of the ‘Listen In’ project the team worked with Bradford Talking Media (BTM) who organised a group of people with varying vulnerabilities and disabilities to discuss the critical issues they face in accessing essential services. The issue which caused most discussion was transport around the city, the inconvenience caused by not having the Bradford Interchange. Some of the group who are/have been our patients have a set and organised routine in their head and it takes time to adapt to any changes. When translating this information to the hospital we found if some of our patients are regular attenders, and we make any changes i.e. different entrance and exit ways, changing furniture around, moving wards/Outpatient areas it can cause them issues. Another point learnt is some have bus passes which are free from a specific time so a very early appointment would disadvantage them.

Infant feeding

The objective was to be able to obtain feedback on the support / advice given regarding infant feeding.
It was discussed how FFT feedback can be obtained from patients. As these patients do not have an appointment booked through EPR, they won’t get a text message asking for FFT feedback.
Infant feeding advice and support is delivered by the team / midwifes as part of the patient stay.
The infant feeding team are to ask patients using the service to provide feedback by completing a FFT card. Infant feeding team is now set up on ENVOY so feedback from these patients can be recorded and analysed.
The aim of this project is to gain evidence to be a UNICEF accredited facility when it comes to infant feeding / maternity care.

Interventional Radiology

The objective of this project is to be able to understand when and where is the best time to obtain patient consent from a patient undergoing an Interventional Radiology procedure.
There are concerns that consent is being taken in waiting areas which may prevent patients from feeling able to discuss or ask questions prior to providing consent due to the proximity of other

patients, or equally, if this is avoided by taking patients into the procedure room to obtain consent they may not feel able to decline a procedure. The team want to hear the patient view of this to inform practice and any changes that would be beneficial. Ward 20 are supporting a pilot survey with Interventional Radiology patients booked to have an Interventional Radiology procedure with them. The results will be collated and feedback given to the Service area.

Inpatient Therapies

The Objective was to look at ways to obtain Patient FFT feedback for Inpatient Therapies as part of their inpatient stay.

We surveyed patients on Ward 9, 26,27 asking about Physios, SALT, Dietitians, Occupational Therapists involvement in their care whilst on the ward. Inpatients only receive a text message asking for feedback on their stay on the ward not any other involvement by other staff from the multi disciplinary team.

FFT

Between the months of May and August 24 Healthcare Communications have supported 39 clinical services that are not on EPR to receive Friends and Family Test data via the cards methods. Services include Physiotherapy, Interventional Radiology, infant feeding and other clinics that are keen to utilise/analyse what their patients are telling them in order to make a difference and improve their visit to their areas. These teams are now getting monthly feedback from their patients.

FFT results

FFT Result for Jan 2024 to June 2024 in table 2.

	1- Very Good	2- Good	3- Neither good nor poor	4 - Poor	5 - Very poor	6 - Don't Know	Grand Total
A&E Feedback	3298	1353	497	442	1141	47	6,778
Inpatient Feedback	7879	1240	257	154	254	40	9,824
Outpatient Feedback	4783	701	135	68	117	15	5,819
Maternity Feedback	779	65	18	20	27	1	910
Totals	**16,739**	**3,359**	**907**	**684**	**1,539**	**103**	**23,331**
Percentage	**71.75%**	**14.40%**	**3.89%**	**2.93%**	**6.60%**	**0.44%**	**100.00%**

Table 2

There is a piece of work on-going to separate out the Maternity Function and Virtual Services into its own area on the Envoy reporting system for FFT, the same as A&E.

FFT continues to provide us with positive data that we can share with the teams to help support staff morale and understanding how patients feel about their care provision. Ward leaders are

engaging positively with it and this is being evidenced across the wards and clinical areas with FFT boards and you said we did boards. A number of specialist areas are approaching us to be included in FFT although this does provide some challenge from an IT and EPR perspective.

Aim 3 Co Produce

The development of a toolkit has commenced to support clinical staff with the approach. There is more work to be done in this area with a programme of work across the year being developed to enable appropriate support for these activities from the patient experience team.

Last year HiVis completed a walkaround the hospital to highlight any issues or potential issues for patients who are partially sighted. Some invaluable changes have been made especially the signage around the hospital. There is current work with RNIB representatives to concentrate on Eyes/ENT area and a workshop with all the staff in the area. This will be a simulation session using varying spectacles representing different eye conditions, how vision is affected, with the aim of making any small changes or improvements in this part of the hospital to create a better patient experience.

Training Package and Engagement Plan for Co-Production has commenced. The development and delivery of a training package focused on co-production principles with the first lunch and learn session held in October.

Aim 4 Make the change and share the change

As the work develops on the programmes and projects detailed in the report this will be shared with the Community Engagement Group, patient experience representative and the citizens forum to support wider communications on the activity taking place withing BTHFT to improve patient experience. An example of this is the Day Case Unit work and how this stakeholder panel can support the ongoing review and improvements within this service.

Day Case Unit:

A stakeholder panel for the St Lukes Day Case Unit has been arranged, ensuring that patient experience considerations were integrated into the unit's operations and that our local partners were able to ask questions and gain an in depth understanding of the unit.

Aim 5 toolkits for engagement

There have been specific pieces of work around engagement. Whilst feedback is received through CQC patient surveys, complaints, compliments and FFT these are purposeful activities as a result of specific feedback, service redesign or service objectives (there is a snapshot of these below). As part of the schedule for engagement more of this work will be planned in the next period.

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Breast Screening Survey April 24

At the start of 2024, from a national screening report, it was noted that Bradford district take-up rate was 2nd to bottom in the country at 58%, national average at the time was 68%. Inner-city rates were lower. The objective was to obtain a better understanding of why patients are not taking up the offer of a breast screening appointment and explore any potential barriers. A snapshot was chosen due to the high numbers of patients, with a telephone survey being the most patient friendly option.

The survey took place during the second half of April 2024; a sample was obtained from a list of 256 patients from a large inner-city practice, who had previously been sent a letter and/or a text inviting them to book their appointment, but had not yet booked. Every 5th patient from the list was included in the survey – 52 patients.

The response rate was 35/52 – 67%.

The main themes for not booking their appointment were too busy/ not got around to it; difficulties arranging around work commitments; apprehension/ concern about the procedure/ fear of pain; privacy / dignity around undressing; patient unwell; financial reasons/ no phone credit / travel costs;

Recommendations summary: Raising awareness across the district using a short video/ animation, ideally with community involvement to ensure a co-ordinated approach; review of letter and text message to ensure it is patient friendly and easy to assimilate. This has been feedback to the service for implementation and the team will follow up the outcome of this work.

Visiting Hours Repeat Survey - ongoing

NHS England have issued updated guidance on visiting. A repeat survey of patients, visitors and staff is underway for a sample of wards across the Trust. This includes various options for visiting. The outcomes of this will inform a revised policy.

Discharge Process Survey - ongoing

The MAIDT Team have introduced a new Discharge Co-Ordinator role to help facilitate discharge. The team have been obtaining feedback from both patients and staff on the trial of the new role. This will include contacting patients by telephone, with consent, to obtain their feedback, collating and analysing the information from patients and staff and providing a report with recommendations for the team. This forms part of the work to improve patients experience of discharge from hospital as part of the in patient survey improvement plan.

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Eccleshill Community Diagnostic Centre Patient Survey – planned for October

A redesign of the reception and waiting areas has taken place, an in-person survey is planned to obtain patient feedback on the renovation.

Engagement through the SPaRC team.

The SPaRC Team supported staff, patients and carers by providing Spiritual, Pastoral and religious care. In the last 6 months, approximately 11,860 visit/ contacts were made, and 297 specific referrals were made by staff, patients, carers/family and the community (clergy, Imams etc) with each referral being logged via the SPaRC logging system. These visits/contacts were made by the core team, bank staff and a handful of volunteers.

Cultural Competency and SPaRC training

The Sparc Team have been delivering tailor made cultural competency training to various departments across the Trust upon request. Examples of these are delivering a session on culture and Religion to all the matrons. Feedback has been very positive and matrons have requested specific training for their staff in their areas. One session has been carried out and feedback has been extremely positive. Ongoing training in other areas continues such as ICU and newly appointed HCA's on a monthly basis. Some thought is being given as to how to role out this training across the Trust.

Aim 6 co delivery

One of the elements of co delivery is the work with voluntary services and volunteers. After a heavy focus on implementing the Volunteer service, along with rolling out new and improved recruitment and induction processes, volunteering has gone from strength to strength over the last 6 months.

A new Volunteer Coordinator was welcomed to the team in May, which resulted in a fully staffed team. This has broadened the ability to develop a wider variety of volunteer roles across the whole trust. There are many new volunteer roles from Paediatrics, Oncology, Emergency Department, Neonatal and many others. One such development is the recruitment of volunteers into the new Day Case Unit at St Luke's ready for when it opens.

A further two recruitments have taken place in June and October, and now have a total of 123 active volunteers with 102 currently in recruitment stage. All new volunteers are following the new recruitment and induction, and all existing volunteers have completed the refreshed induction training after being brought back after Covid.

Five volunteers have been presented with their completed National Volunteer Certificate, which showed their commitment in giving BTHFT 60 hours of their time to volunteer.

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Examples of volunteer roles for enhanced patient experience:

Current

Activity Support Volunteer (Ward 26)

Feedback Volunteer (Alcohol Care Team)

Oncology Daycase Unit Volunteer

SPaRC Volunteer

Volunteer Guide – across main entrance, Women's and Newborn Unit and UCC

Volunteer PLACE Assessor

ICU Support Volunteer

Patient Safety Volunteer

Maternity Ward Support Volunteer (M3)

Skin Cancer Team Support Volunteer

Ward Support (Falls Prevention W17) Volunteer

Children's Therapy OPD Volunteer (St Luke's)

Neonatal Volunteer

Patient and Public Engagement Volunteer

PAT Dog Volunteer

New for September 2024

Day case Unit Volunteer (St Luke's)

Emergency Dept Volunteer

Renal Support Volunteer

Tobacco Dependency Volunteer

The next period will evaluate the impact of the roles in the areas introduced.

Regular Patient Experience Activity.

The PLACE assessment is currently taking place and results will be shared when available. This has been exceptionally well supported this year with a new cohort of volunteers having been recruited adding diversity of age, gender and cultural background. More of our colleagues have also asked to be inviolved this year.

Headline results show that 1250 invitations to take part were sent. 336 completed the survey which is an average of 29% response rate. The average response rate for all trusts was 42% with our last average being 28% last year.

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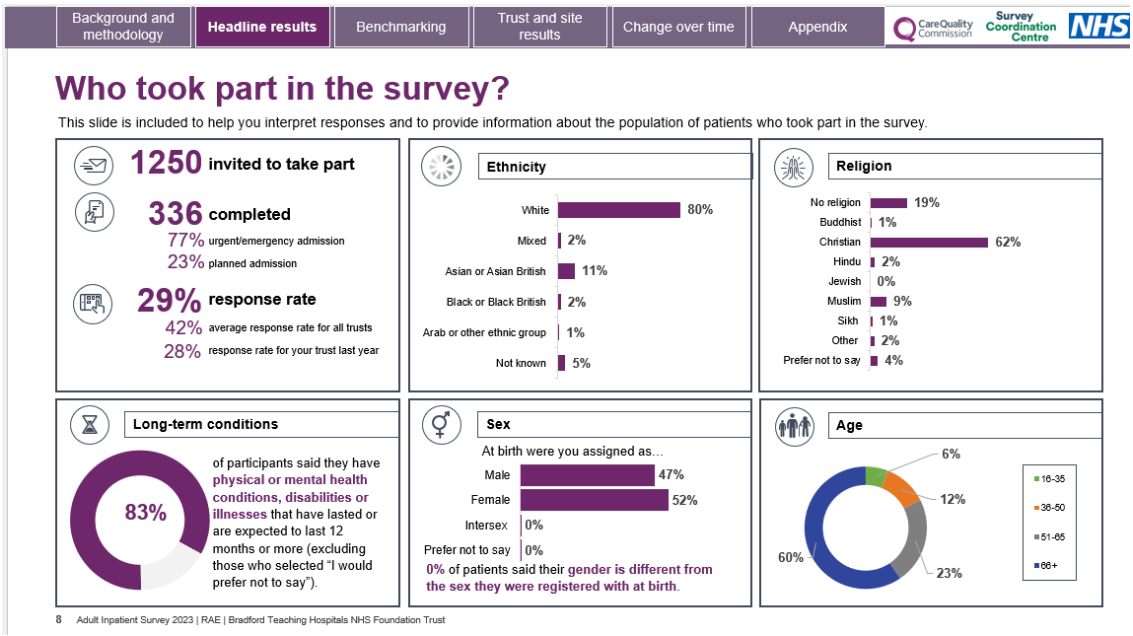
We had 40 questions scored about the same, 3 somewhat worse than expected, 5 worse than expected and 1 much worse than expected.

Key areas for improvement were
Sleeping (noise)
Leaving hospital (ensuring additional equipment at home as part of the discharge discussion)
Help from staff to wash
Help from staff to eat
Bed waits

Areas of good practice included Patient information on discharge
Contact details provided on discharge to report concerns
Privacy
Food
Confidence in doctors



Meeting Title	Board of Directors		
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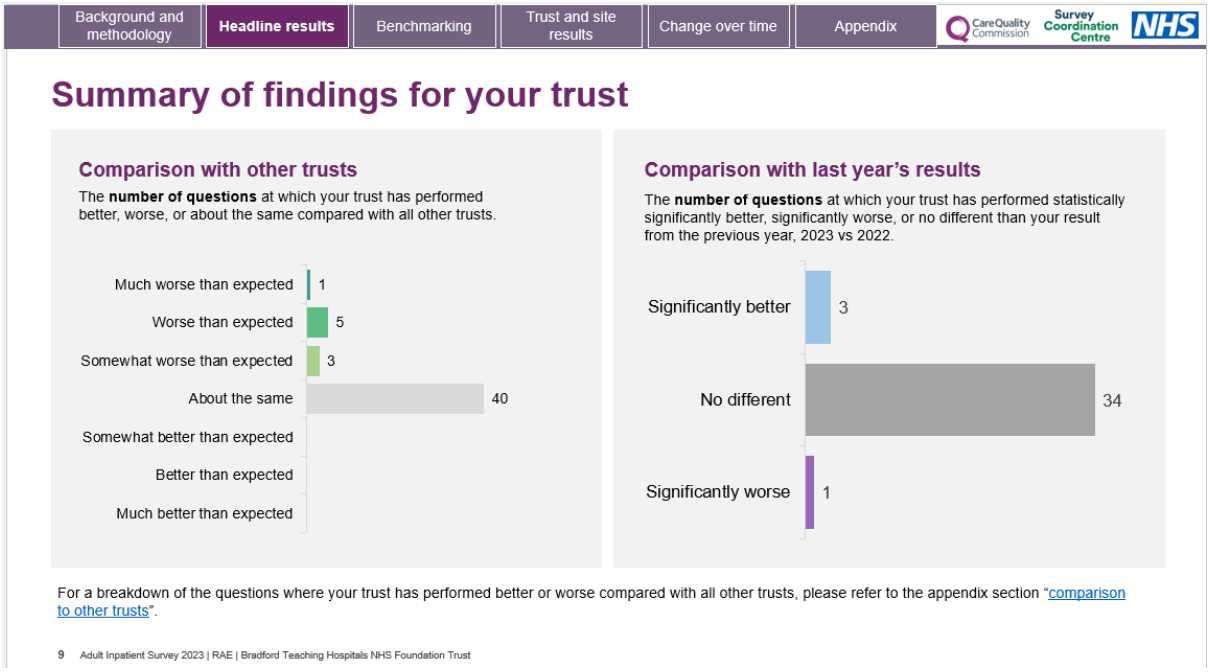

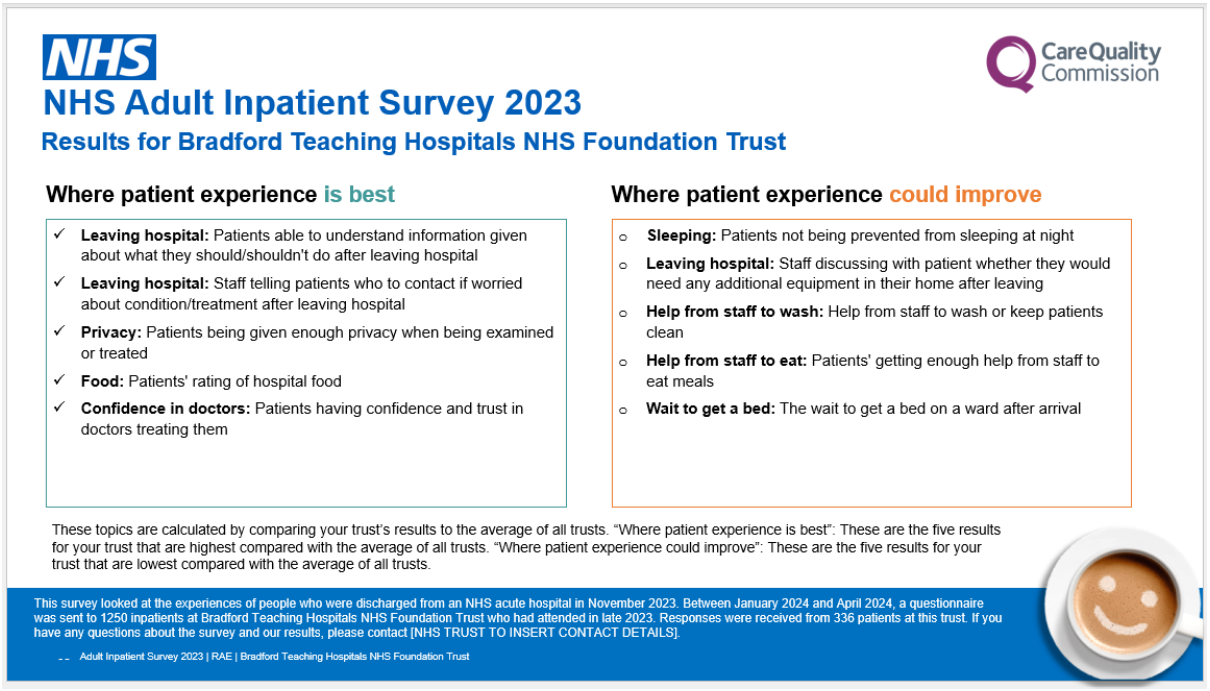

The Trust has just received the maternity patient survey results. These are in review by the CSU and an updated improvement plan will be shared with the Patient Experience Group.

The Accident and Emergency CQC survey is expected in the next month. There has been an increased focus on patient experience work in the department as a result of patient experience and this will be a key focus in the outstanding programme to support the improvement for patients and carers accessing this service.

The National Cancer Patient Experience Survey (NCPES) 2023 results show positive year on year improvement. For the 2023 survey the Trust had 6 areas scoring better than other Trusts and 0

scoring lower than. The NCPES questions have been categorised into 14 sections. Each section reflects an element of the cancer journey. There are a number of ongoing quality and service improvement projects that support many aspects of the patient pathway as part of business as usual. Each cancer specialist team will also identify a focus for further improvement based on their individual NCPES scores. These will be collated and shared once the free text reports have been analysed.

Within the report there are sub-group breakdowns that present patient experience data by age group, gender, ethnicity and IMD quintiles. This will provide the lead cancer team an opportunity to further focus improvements to those groups where patient experience is lower than the general population.

The whole document can be accessed: **Latest results - National Cancer Patient Experience Survey (ncpes.co.uk)**

BO.11.24.9- CQC PUBLISHED REPORTS

REFERENCES

Only PDFs are attached

Bo.11.24.9 - CQC reports.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.9

CQC PUBLISHED REPORTS

Presented by	Karen Dawber, Chief Nurse	
Author	Karen Dawber, Chief Nurse	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	To formally receive the published CQC reports at Board	
Key control	N/A	
Action required	For assurance	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Meeting**	**Date**
	N/A	

Key Options, Issues and Risks

Below are the links to the core service CQC reports published on 20 November 2024 following inspections in March / April 2024.

Maternity

Medical Care

Neonatal services

No PDF / Word versions are available and the reports can only be viewed via the CQC website.

Analysis

The reports are positive and reflect the good and outstanding practice that our teams provide on a daily basis.

Neonatal services have been rated as Outstanding.

Medical Care remains Good overall with one element (Effective) remaining Requires Improvement – Note on querying as part of factual accuracy the rating could not move as the CQC had not reviewed enough elements in order to re-rate this domain.

Maternity remains Requires Improvement, however only the Well Led and Safe domains were assessed. Well Led remains Good and Safe has improved from Requires Improvement to Good. We have asked the CQC to re-visit maternity to review Effectiveness and Responsive (previous Requires Improvement) as these have not been reviewed since 2019. If either of these elements are related as Good the service would move to Good overall.

Recommendation

The Board is asked to formally receive the CQC reports and the high assurance these provide.

Following on from the CQC engagement visit planned for December 2024 the Chief Nurse will update Board in January on the next steps.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.9

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

Benchmarking implications	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	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: All
Care Quality Commission Fundamental Standard: All
NHS England Effective Use of Resources: Clinical Services
Other (please state):

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

BO.11.24.10 - MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

Only PDFs are attached

Bo.11.24.10 - MatandNeoServicesBoardAssurancePaperAug-Oct (cover).pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.10

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – AUGUST, SEPTEMBER, AND OCTOBER 2024

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Board with assurance that the Quality Committee has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers.	
Key control	N/A	
Action required	For assurance	
Previously discussed at/informed by	Quality Committee	
Previously approved at:	**Meeting**	**Date**
	Quality Committee (QC)	September, October, November 2024

Key Options, Issues and Risks

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

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

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

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

The format of the monthly reports supports 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		
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The monthly paper also serves as the main mechanism for QC, as a Committee of the 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 QC, 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 QC provide the Board with assurance that a monthly review of maternity and neonatal quality and safety activity relating to August, September, and October 2024, was presented and key elements discussed including:

- The number of harms occurring in August, September, and October, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of MNSI and SI cases were discussed.
- There were 2 completed MNSI and internal investigations/SI reports in August, 0 in September and 1 in October. Learning and recommendations from the investigations was also shared with QC.

This paper also includes:

- Moderate risk associated with achieving overall compliance with year 6 of the Maternity Incentive Scheme, reported to October Board.
- Progress update on actions following an increase in babies with MRSA positive results between July and October.
- Information regarding the roll out of the Respiratory Syncytial Virus (RSV) in the acute maternity service.
- Celebration of the opening of the new Maternity Assessment Centre.

Recommendations

- The Board is asked to note that that the QC has reviewed and was assured by the contents of the August, September, and October 2024 Maternity and Neonatal (Perinatal) Services Update papers, as a committee of the Board.
- The Board is asked to note 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.
- The Board is asked to note and be assured by the progress on actions to manage the increase in babies with MRSA positive results between July and October.
- The Board is asked to note the roll out of the RSV programme in the acute maternity service, and the plan to expand this to low risk women.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.10

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

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

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

Regulation, Legislation and Compliance relevance			
NHS England: (please tick those that are relevant)			
☒Risk Assessment Framework	☒Quality Governance Framework		
☐Code of Governance	☐Annual Reporting Manual		
Care Quality Commission Domain: Choose an item.			
Care Quality Commission Fundamental Standard: Choose an item.			
NHS England Effective Use of Resources: Clinical Services			
Other (please state):			
Relevance to other Board of Director's meetings: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☐	☒	☐	☐

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.10

1 PURPOSE/ AIM

The purpose of this paper is to provide Board with assurance that Quality Committee, as a committee of the Board, 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 August, September and October updates and associated appendices were respectively discussed at the September, October and November Quality Committee meetings. The full papers are available on Team Engine.

The key elements of the papers discussed included:

- The number of harms occurring in August, September and October, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and SI cases were discussed.
- There were 2 completed Internal/MNSI reports and learning/recommendations to share for August, none in September and 1 in October.
- In November, the QC was asked to note that the Perinatal Leadership Quad joined the September bi-monthly perinatal safety Champion meeting, which took place on 1 October, and that there were no safety escalations requiring support from Board.
- In September, October, and November, the QC 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 QC, the service would like to update the Board on the following specific items:

- In September, the Board was informed that there is a moderate risk to achieving compliance with Safety Action 8 of the Maternity Incentive Scheme, based on the current trajectory of obstetric and anaesthetic compliance attending emergency drills training (PROMPT) and fetal monitoring (obstetricians only). All outstanding individuals have been booked on the remaining training days, but this remains high risk with minimal threshold for non-attendance due to sickness or clinical activity. Failure to achieve safety action 8, jeopardises achievement of the entire scheme and carries a significant financial penalty for the Trust. The position is being closely monitored throughout November.

- In September, the Board was informed of an increased number of babies testing positive for MRSA across the Women's and Newborn unit during July. Further positive cases occurred during September, despite colleagues from maternity and neonatal working 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. In late September, the decision was made to proceed with decolonisation of all staff working in the acute maternity and neonatal clinical areas.

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Decolonisation commenced on 7 October, and this was met positively with the majority of staff (265) accepting decolonisation, and a small number of staff choosing to be swabbed to determine status. All environmental controls, screening and review processes remain in place until further advice from infection prevention colleagues.

- The maternity service rolled out the offer of RSV vaccination on 10 October, within antenatal clinic and Maternity Assessment Centre (MAC). Evening clinics have now commenced for low-risk women to book into, currently offered at the Women's and Newborn site only, with a plan in place to rollout in community venues from April 2025.

- Phase 1b of the maternity building works completed in October with the opening of the new MAC. Both staff working in the area and service users, are delighted with the new environment which has immediately improved privacy and dignity, facilitates safe transfer to the intrapartum area, and enables enhanced surveillance of women waiting to be seen acutely.

3 RECOMMENDATIONS

- The Board is asked to note that that the QC has reviewed and was assured by the contents of the August, September, and October 2024 Maternity and Neonatal (Perinatal) Services Update papers, as a committee of the Board.
- The Board is asked to note 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.
- The Board is asked to note and be assured by the progress on actions to manage the increase in babies with MRSA positive results between July and October.
- The Board is asked to note the roll out of the RSV programme in the acute maternity service, and the plan to expand this to low risk women.

BO.11.24.11 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY

A. OCTOBER & NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.11.24.11a - Report from Chair of the People Academy October 2024.pdf

Bo.11.24.11a - Report from the Chair of the People Academy November 2024.pdf

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Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 24 October 2024

Key escalation and discussion points from the meeting
Alert:
Sickness – the Assistant Director of HR shared a comprehensive analysis of sickness absence between Sept 22 and Sept 24, as requested at September's Academy. Monthly sickness fluctuates but overall has reduced over the two years from a high of 7.24% in Sept 22 to 5.77% in Sept 24. Long-term sickness accounts for most sickness absence across most areas but has decreased over time to 3.35% in Sept 24. Short-term absence fluctuates month on month but has remained steady, at 2.54% in Sept 24. A quarter of all absence relates to anxiety, stress and depression. Estates and Facilities top absence reason relates to musculoskeletal issues. Estates and Facilities and Additional Clinical Services contribute the highest sickness rates at just under 10% each. There is a lot of work underway with changes to policy, support for managers, skills development and we had a robust discussion about Occupational Health support, the introduction of sickness clinics for managers and tracking Trust wide initiatives that may impact absence. We also discussed the need to analyse the stress factors and the positive impact of a realistic workload, clarity of roles and responsibilities, feeling valued, living the values, comprehensible communications and capable leadership. Sickness absence and mitigating activity will continue to be tracked closely through the People Academy. **Risks** – the Associate Director of Corporate Governance introduced the High Level Risk Register. There are two new risks relevant to the People Academy: one relating to violence and aggression in the Emergency Dept and the other relating to the Emergency Department Consultant review of pathology and radiology results. Both risks score 15. The risk of harm to patients, staff and visitors within planned and unplanned care due to the Trust's ability to maintain safe staffing levels as a result of the pandemic has reduced from 16 to 12 following the recruitment of newly qualified nurses and midwives who started this month. This lower score removes the risk from the High Level Risk Register.
Advise:
WRES/WDES – the Head of EDI highlighted the Trust's EDI performance and the 2024-25 action plans which have been aligned to the NHS People Plan and the People Promise. The Trust continues to improve equality, with a representative workforce of 41% against a 35% target, and in the top ten Trusts nationally for its diverse leadership at 19%. However there is still work to be done on career development, reducing the likelihood of bullying and harassment and improving support for ethnic and disabled staff. The action plans focus on recruitment and selection, learning and career development and creating a civil and respectful culture. The Academy praised the simplicity and focus of the action plans and approved them both. Regular updates will be provided to the Academy. **GMC feedback** – the Director of Education shared the 2024 GMC Survey results. The

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survey was completed by 77% of BTHFT post-graduate trainees between March and May this year. The Trust scored mid-quartile for all 18 indicators with excellent feedback for Gastroenterology, Neonatal Medicine, Oral and Maxillo-Facial Surgery, Paediatrics F2, Trauma and Orthopaedics. Emergency Medicine FY2, Medicine FY2 and Plastic Surgery have seen significant improvements to their scores. The workload in Emergency Medicine FY2, and rota design and support in Surgery FY1 continue to cause issues. The Trust is ranked 216th of all 230 UK Acute and mental Health Trusts for workload however, when benchmarked locally with Leeds, Calderdale and Huddersfield, Mid Yorkshire and Airedale, the Trust scores 1st on 9 indicators, 2nd on 7 indicators, 3rd for facilities and 4th for workload. The Trust ranks 55th of 230 for educational supervision. The results have been shared with the relevant stakeholders and progress against actions will be monitored Through the Foundation Sterring Group and the Postgraduate Medical Education Steering Group with a regular update to the People Academy.

Assure:

Education Strategy – the Head of Education highlighted the revised Education Strategy for 2025-30 which responds to the shift in education since the pandemic. The new strategy outlines an approach which fosters a future-proofed, strong and empowering learning environment. It focuses on collaborating well with our local community and ensures our workforce is specifically equipped to deal with Bradford's health needs with the primary objective to develop a well-educated, skilled and diverse workforce capable of dealing with the complex health needs of the local population. There is a new objective focused on innovation, research and building strong partnerships. The Academy celebrated the strength and quality of the new strategy and welcomed the January 25 launch event.

Freedom To Speak Up – the Chief Nurse shared a successful outcome to an issue raised through Freedom To Speak Up that resulted in a change to the Dress Appearance Policy. A student was concerned about not being able to wear their niqab during their medical training. The policy has been changed to approve the wearing of a niqab in public areas and with patients, and a face mask in clinical areas. If patients find it difficult communicating with someone wearing a niqab then the wearer can find an alternative practitioner.

Karen Walker
People Academy Chair and Non-Executive Director

24 October 24

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Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 13 November 2024

Key escalation and discussion points from the meeting

Alert:

Flu vaccine – the Workplace Health and Wellbeing manager shared the latest vaccine data following the proposal for Healthcare Worker Influenza and Covid vaccination programme 24-25 presented at September's People Academy. The number of people taking the flu vaccine is significantly down year on year at 19%. The Academy discussed vaccine fatigue and whether the % uptake included only those who took the offer through BTHFT as people often took the vaccine elsewhere. The Workplace Health and Wellbeing manager will review the data and return to January's academy.

Sickness absence relating to stress, anxiety and depression – another follow up to an action from September's academy, the Workplace Health and Wellbeing manager shared the sickness data relating to work related stress, anxiety and depression. 428 staff were assessed by Occupational Health following referral by their manager between 1st August and 31st October 24. 32% of the referrals were deemed by OH to be work related, either caused by work (acute incident or chronic) or made worse by work. A third of all cases were assessed for mental health reasons, the majority relating to common mental health problems (low mood, anxiety, depression) followed by stress. 52% of the mental health cases were assessed as caused by work due to either acute or cumulative events at work or the condition was made worse by work. The academy discussed and were content with the support and wellbeing offer available, plans to increase the profile of the EAP programme, and the level of resilience created through training and onboarding programmes. Progress will be monitored through the monthly People Academy dashboard updates.

Advise:

Risks – The Director of HR took the academy through the high level risks. The academy noted a reduction in the Haematology risk score from 16 to 12, and the combining of Estates and Facilities risks 2652 and 2573 agreed at ETM. The lack of a People risk for the Closing The Gap programme was identified and the Associate Director of Corporate Governance will review this and revert back to the Academy in January.

FTSU – the Freedom to Speak Up Guardian shared the Q2 report. There were 36 concerns raised, (4 anonymous) which is the highest ever volume quarterly. Most concerns related to inappropriate attitudes and behaviours and the highest number of concerns were raised by the Nursing and Midwifery, Estates and Ancillary and Admin and Clerical teams. The Guardian updated the academy on the recruitment of more ambassadors across the Trust. 21 applications were received and training began on 18 November. All Trust staff now have FTSU e-learning within their training curriculum and FTSU e-learning has been mandated for band 7 and above.

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Audit Yorkshire audited the BTHFT FTSU service in July/August and received significant assurance that the Trust can evidence meeting all 8 NGO principles where people feel safe to speak up with confidence. They commented that the FTSU Guardian and Board and cross organisation support, together with robust processes, demonstrate a strong foundation for speaking up, which when reviewed with staff survey results, indicate a slightly better speaking up culture than the national average for NHS Trusts.

Maternity Incentive Scheme Safety Action 4 – the Maternity Incentive scheme supports the delivery of safer maternity and perinatal care and applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts. The scheme measures performance against 10 safety actions. Safety Action 4 relates to clinical workforce planning. The Consultant Neonatologist updated the academy on the neonatal medical and nursing workforce and the progress made on successful recruitment, training and development. There are still challenges such as a continued fall in the number of trainee doctors, immediate availability of some specialist resources and resilience in the some specialist services but these are mitigated through robust action plans which the academy approved.

Assure:

Recruitment, Policies and Progression – the Head of OD and Head of EDI have led a review of recruitment, people policies and progression, working closely with other stakeholders. This has identified lengthy, complex and difficult to find people policies with a reactive approach to policy review dates. The approach to progression is inconsistent, progression can be inaccessible for some people and there is a desire to create more opportunities and nurture home grown talent. Recruitment wise, attracting local talent to the Trust can be difficult, the standard of managers' decision making is inconsistent and the recruitment process needs simplifying and a greater EDI lens applied.
The plans to address these issues cover simplified people policies, a clear progression roadmap for all job families coupled with an improved approach to development and a short, smart, EDI focused recruitment process. The academy welcomed the review, the progress and the action plans which will be tracked through the academy.

Dynamic Conversations – the Head of OD shared her work on building the confidence of managers to help them operate efficiently, empower them to make good decisions and provide appropriate support, leadership and development for their people. She introduced the concept of dynamic conversations covering health and wellbeing, performance enablement, prioritisation and aspiration and motivation. These conversations are an opportunity for managers and their people to engage in fluid, organic conversations and are intended to replace all management conversation under the four pillars. The plan includes increased support for managers such as leadership development, toolkits, career conversation tools, a talent management platform and improved recruitment and onboarding processes. The academy was delighted with the concept and progress made and is excited to see the results of the initiative.

Karen Walker
People Academy Chair and Non-Executive Director
20 November 24

B. FREEDOM TO SPEAK UP (FTSU) QUARTERLY REPORT

REFERENCES

Only PDFs are attached

Bo.11.24.11b - Freedom To Speak Up Q2 2024-25.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

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FREEDOM TO SPEAK UP (FTSU) QUARTER (Q) 2 REPORT 2024-25

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Sue Franklin, Associate Chief Nurse, Freedom to Speak Up Guardian	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide assurance in relation to the conduct and outcome management of the FTSU arrangements in the Trust	
Key control	A key control for the strategic objectives to provide outstanding care for patients and to being in the 20% of NHS employers.	
Action required	For assurance	
Previously discussed at/ informed by	None	
Previously approved at:		**Date**
	Quality Committee	17.10.24
	People Academy PA.11.24.10	13.11.24

Key Options, Issues and Risks

This paper provides the 2024-25 Quarter (Q) 2 update for the People Academy and the Quality Committee on FTSU at Bradford Teaching Hospitals (BTHFT).

Analysis

This paper describes the number of concerns that have been raised during Q2 2024-25 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern (Appendix 1).

It shows a trend line of the number of concerns raised here at BTHFT (Appendix 2).

The number of open and closed cases each quarter is shown in Appendix 3.

This paper also provides an update on feedback received from staff in Q2 (Appendix 4).

Included in the paper is the Internal audit report for FTSU completed in July 2024 with the management action plan. (Appendix 5)

This paper describes the plans for October speak up month at BHTFT.

This paper gives an update on the FTSU Ambassador recruitment and training.

Recommendation

For the Board/Academy/Committee to note the contents of the report and the FTSU concerns that have been raised at BTHFT during Q2 2024-25.

For the Board/Academy/Committee to note the feedback from staff who have spoken up in Q2.
For the Board/Academy/Committee to note the Internal audit report and the significant assurance rating.

For the Board/Academy/Committee to note the plans for FTSU speak up month in October.

For the Board/Academy/Committee to note the work of the FTSU Guardian and FTSU Ambassadors at BTHFT.

For the Board/Academy/Committee to encourage all staff to complete the eLearning FTSU training.

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

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

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

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

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

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1 PURPOSE/ AIM

1.1 This paper provides assurance to the Board/Academy/Committee in relation to the conduct and outcome management of the FTSU arrangements in the Trust by:

- Providing an update, using the National Guardian's Office (NGO) template, on FTSU and the progress in Q2 2024-25 (Appendix 1).
- Representing the number of concerns raised per Quarter and year as a line graph of data plotted over time (Appendix 2).
- Noting the number of open and closed FTSU cases (Appendix 3).
- Providing feedback received in Q2 from staff who have raised concerns (Appendix 4).
- Sharing the Internal audit report of the FTSU whose purpose was to determine compliance with national and local policy and provide assurance that the concerns raised by stakeholders are addressed and effectively managed in line with NHSE requirements. (Appendix 5).
- Informing to Academy of the FTSU month plans for October, speak up month.

2 BACKGROUND/CONTEXT

2.1 Freedom to Speak Up is vital in healthcare. When workers feel psychologically safe, they will speak up to avoid harm, bring great ideas and be able to express their concerns. Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust.

2.2 The FTSU Guardian has a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patients' safety and/or the way that the concern has been handled.

2.3 The Guardian's role is to listen to and empower staff to speak up and support the organisation to a healthy speaking up culture. Besides raising awareness and working to remove barriers to speaking up, we must input data quarterly; keep up to date by attending the Guardian network meetings and completing annual refresher courses.

2.4 The FTSU Guardian is Sue Franklin, Associate Chief Nurse for Quality Improvement. The deputy FTSU Guardian is Dr LeeAnne Elliott, Consultant Radiologist.

2.5 Karen Dawber, Chief Nurse, is the Executive Lead for FTSU and the Non-Executive Director lead is Julie Lawreniuk.

2.6 There are 11 FTSU Ambassadors who have completed the training provided by the NGO.

2.7 We have recently been recruiting for new FTSU Ambassadors from across the Trust. We have had 21 applications for staff to join the FTSU team. These have come from several areas across the Trust. The training for these new Ambassadors is on Monday 18th November 2024.

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2.8 The FTSU group meets every four to six weeks. This meeting is to update the FTSU group on any new updates from the National Guardian's Office (NGO) and to discuss and monitor any ongoing FTSU concerns and issues. The NGO directs how we listen to concerns and document those concerns. Following any case review published by the NGO, the FTSU group discuss the review and check each recommendation to ascertain which ones are relevant to BTHFT. These recommendations are actioned to ensure we meet the expected standards.

2.9 The FTSU group have a Human Resources (HR) link who they liaise with as/when necessary to discuss any concerns that need HR support or guidance.

2.10 The FTSU Guardian attends the FTSU regional network where there is attendance from the NGO. She also has close working links with the Equality, Diversity and inclusion team and the Organisational development team and is a member of the Civility programme Board. She is a mentor for new FTSU Guardians led by the national team.

2.11 The NGO requests regular updates and currently requests quarterly reports (in a standard template) on the concerns raised from each NHS Trust. We have complied with this submission.

2.12 The NGO, in collaboration with Health Education England, have three modules for FTSU on the eLearning platform.

- **Speak Up** – is for all workers and covers what speaking up is and why it matters.
- **Listen Up** – for managers, focuses on listening and understanding the barriers to speaking up.
- **Follow up** – is for senior leaders throughout health care, including Executive and non-executive directors, lay members and governor – its aim is to provide an opportunity for them to pause and reflect on the influence they and their fellow leaders have in shaping the speak up culture in our organisation.

2.13 Whilst discussing the Q1 FTSU report it was decided at the People Academy for staff to have the FTSU eLearning modules in their learning profile on ESR and we have now mandated the FTSU modules for Band 7 and above.

2.14 The Equality monitoring form is ongoing and is sent out to any member of staff who raises a concern through FTSU. This data is shared in the Annual report, alongside the staff survey data.

2.15 Audit Yorkshire carried out an audit in July/August 2024 of the FTSU service at BTHFT. Overall significant assurance was provided - the Trust can evidence meeting all 8 NGO principles for an environment where people feel safe to speak up with confidence. These principles formed the control objectives for this review.

The experience of the FTSU Guardian and the support network at Board level and the wider organisation, along with robust processes provide a strong foundation for speaking up. This is triangulated with staff survey results which indicate a slightly better speaking up culture than the national average for NHS Trusts.

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3 PROPOSAL

3.1 The FTSU team at BTHFT are working hard to truly make speaking up business as usual but the National Guardian states that the system needs to firmly commit to living up to the values of supporting and listening to workers. FTSU is an additional route for workers to speak up to, but they cannot improve the speaking up culture on their own.

3.2 The NGO have a Speak up month in October every year. The theme for October 2024 will be focusing on the power of listening, and the important part which listening plays in encouraging people to speak up. The FTSU team will be out and about across the Trust throughout October and there are FTSU stands in the Concourse. The FTSU screen saver and Let's Talk articles are planned for the month.

4 BENCHMARKING IMPLICATIONS

4.1 Alongside the data headlines for each quarter, the NGO publish on their webpages the data submitted by all the Trusts in England. This enables each organisation to benchmark against similar types and sizes of organisations. This data is varied, but on average at BTHFT (classified as a medium sized Trust in the NGO data set) the data is consistent with other medium sized Trusts. There are however some examples of 'medium sized Trusts' reporting a lot more concerns than BTHFT.

4.2 In addition the annual NHS staff survey on safety culture about raising concerns provides an opportunity to monitor how BTHFT is performing in relation to other organisations classified as the best, average and worst performing. This was shared in the Annual report 2023/24.

4.3 The FTSU team are working hard to ensure staff feel safe to speak up but need the support of leaders throughout the organisation to make speaking up just what we do here at BTFHT, The National Guardian states that FTSU Guardians do not work in isolation. All leaders are responsible for setting the tone when it comes to fostering a healthy speak up, listen up, follow up culture.

4.4 There is a positive correlation between the line-management and Freedom to Speak Up sub-scores suggesting that where workers have good relationships with their line managers, this may have an impact on perceptions of speaking up in organisations.

4.5 Audit Yorkshire have completed their review of the FTSU arrangements in the trust, this is included in Appendix 5.

5 RISK ASSESSMENT

5.1 The FTSU Guardian has 12 hours protected time within their substantive role to perform their FTSU duties. The deputy and FTSU Ambassadors currently have no protected time within their substantive roles.

5.2 The FTSU team is being developed by recruiting and training more FTSU Ambassadors and will further the Guardian network later in the year. The Chief Nurse, Executive lead for FTSU

has asked for a business case for more hours for the FTSU Guardian role due to the increase in concerns year on year.

5.3 It is highlighted in the internal audit report that as there has been an increase in the number of concerns, then we need to address the resource requirements, otherwise this could be a potential weakness in the system. As the number of FTSU concerns are rising every year (55% rise last year) we are reviewing the staffing requirement for the FTSU team.

6 RECOMMENDATIONS

6.1 To note the number of FTSU concerns that have been raised during Q2 2024-25 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern.

6.2 To support the work of the FTSU group to continue with raising awareness of FTSU for staff and education for Guardians.

6.3 To continue with quarterly reports to the Board/Academy to update on progress with FTSU at BTHFT.

6.4 To support the staff across the organisation to complete FTSU training on the eLearning platform, including the Executive and Non-Executive team.

6.5 To continue supporting the FTSU team to deliver the two elements of their role. One part is the reactive – listening to workers, thanking them and supporting them so that their voices can be heard and actions taken. The other part is the proactive element – supporting the organisation to learn from the opportunities which speaking up brings.

6.6 To acknowledge the Internal audit report and its findings of significant assurance of the FTSU processes in the Trust.

7 Appendices

Appendix 1 – BTHFT Q2 data.

Appendix 2 – Run charts of number of concerns.

Appendix 3 – Open cases for FTSU.

Appendix 4 – Feedback received in Q2.

Appendix 5 – Internal Audit report July 2024 - *this report received 'significant assurance' and has been previously circulated to all Board members. It remains available in the Board reading room on the 'Team Engine document management system.*

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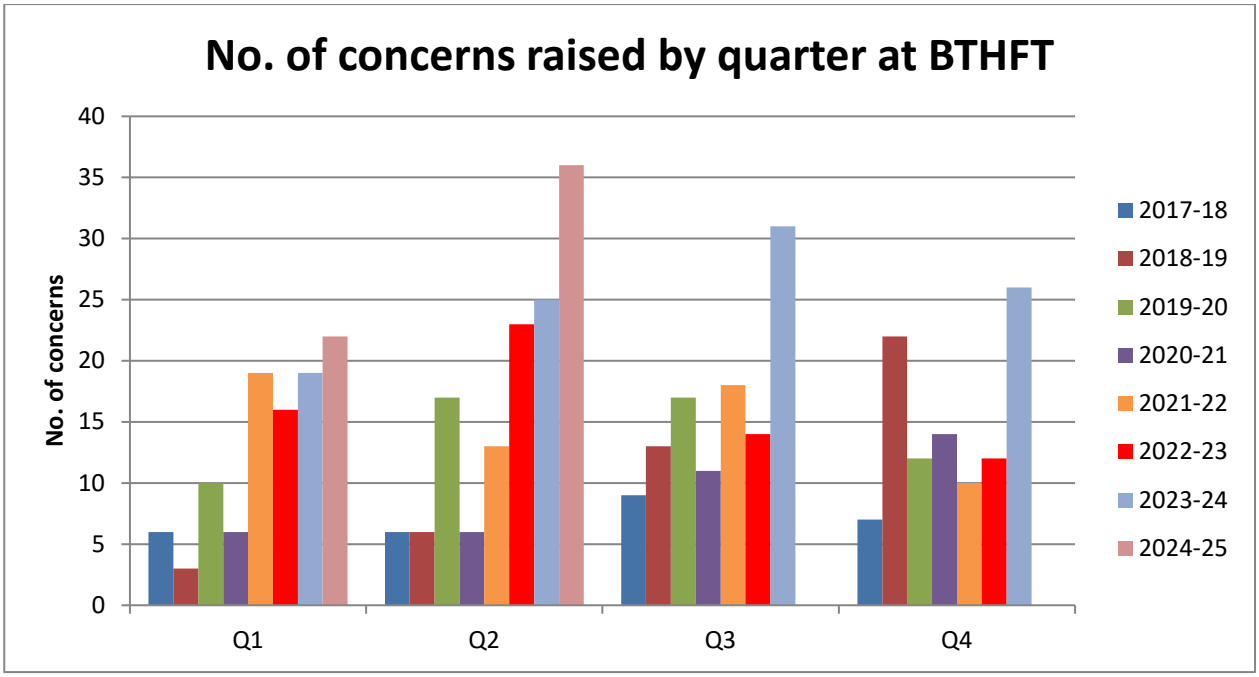
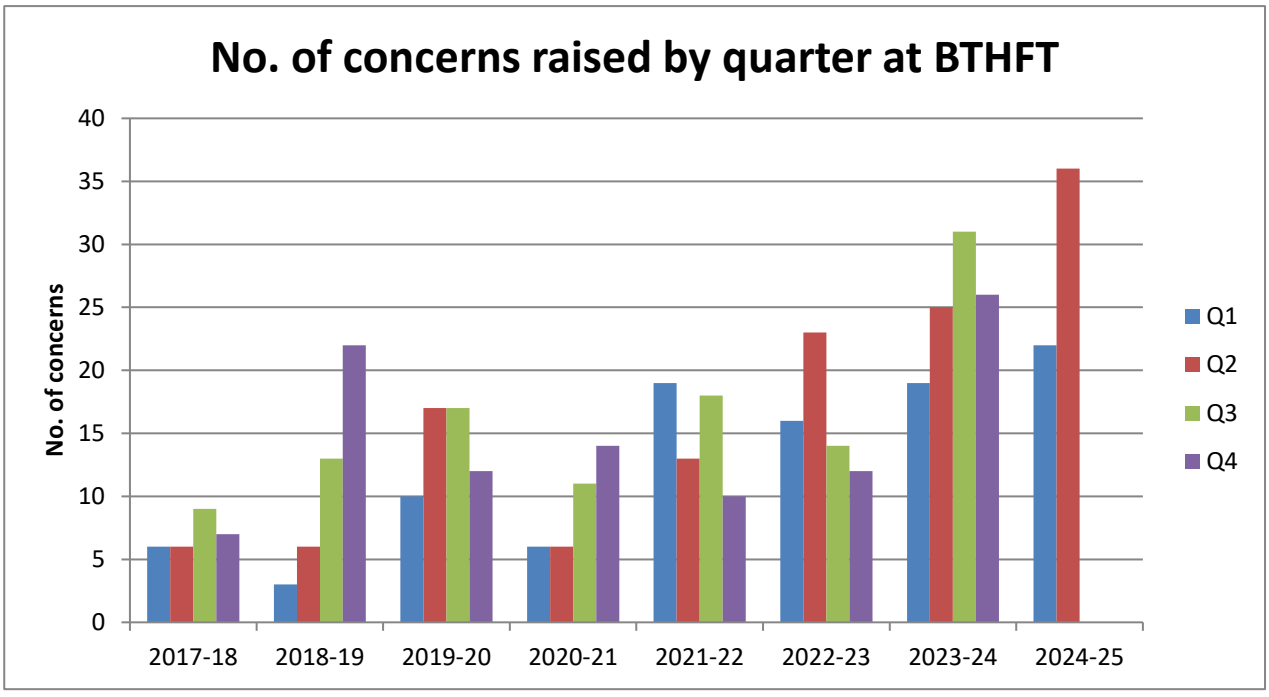
7 Appendices

Appendix 1 – FTSU Concerns raised at BTHFT by Quarter and by Year.





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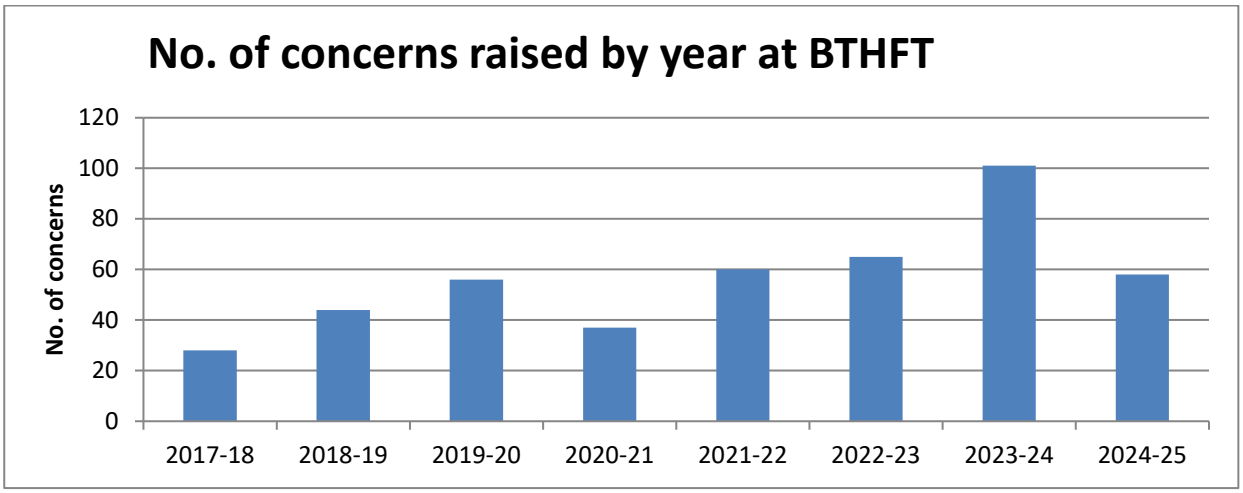


7.1 These graphs show the number of concerns raised in Q2 at BTHFT by quarter and by full year. It is displayed alongside the previous year's data to facilitate comparison.

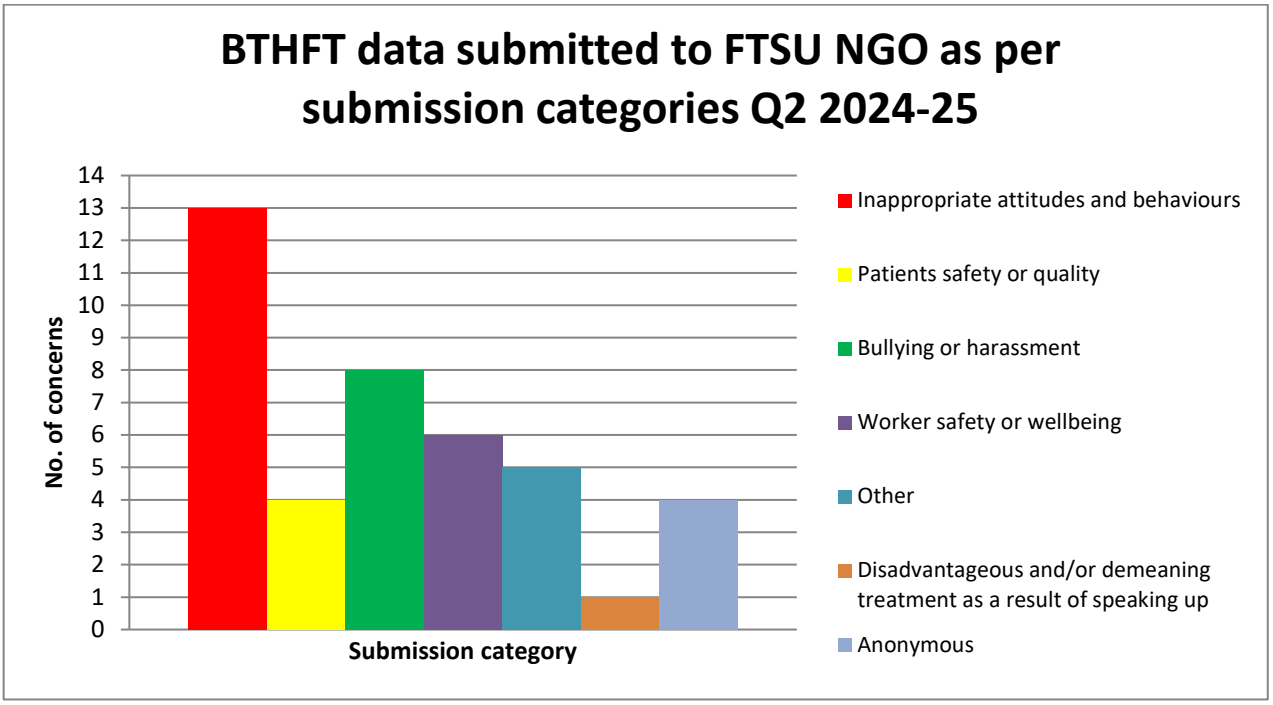
7.2 In Q2 there were 36 concerns raised to the FTSU team. This is the highest number of concerns raised in any quarter since the start of FTSU.

7.3 There were 4 concerns this quarter raised anonymously via the FTSU App. The NGO advocate that staff should be able to raise concerns anonymously if necessary.

Concerns raised by category (Using the NGO's submission categories)

The graph below shows the concern categories for Q2 2024-25*

*** A FTSU concern may have more than one category.**



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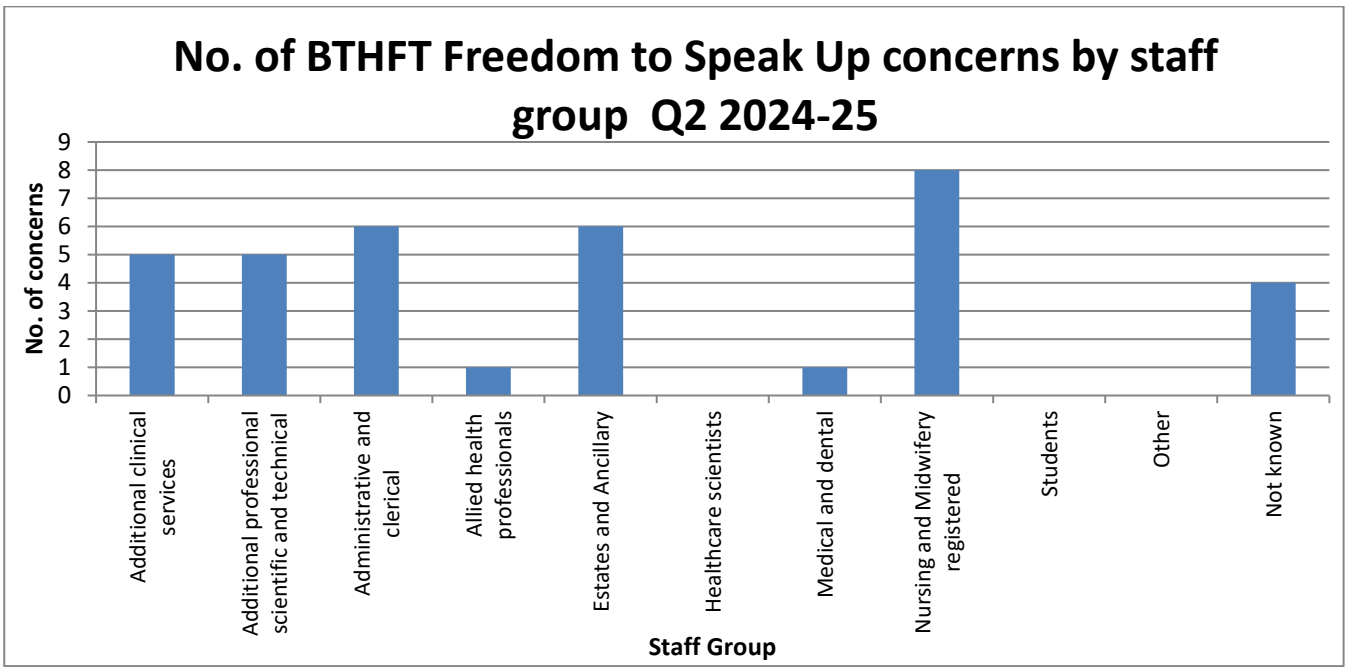
7.4 In Q2, of the 36 concerns raised,

- **4 had an element of patient safety/quality** - (Any case that may indicate a risk or adverse impact on patient safety or the quality of care)
- **8 had an element of bullying and/or harassment** - (This can be a current or past matter and may identify risks or be about actual events)
- **13 had an element of inappropriate attitudes and/or behaviours** - (Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute Bullying or harassment). 36% involved an element of inappropriate behaviours and attitudes. This matters because we know that working environments affect quality and safety, impacting on staffing, retention, and ways of working.
- **6 had an element of worker safety or wellbeing –** (Any case that may indicate a risk of adverse impact on worker safety or wellbeing)
- **5 were categorised as 'other' –**
  - 1 concern reporting racism
  - 1 was concerning hate crime,
  - 1 was concerning alleged theft,
  - 1 is being looked into by the Counter fraud team
  - 1 was Maternity rights.
- **1** person has reported that they are suffering disadvantageous and/or demeaning treatment as a result of speaking up (Detriment). This is being reviewed by the Chief Nurse.
- **4** people reported their FTSU concerns anonymously to us. At BTHFT we have a FTSU App that staff can report concerns through to us anonymously if they wish to do so.

Number of Concerns by staff group for Q2 (Using the NGO's grouping)



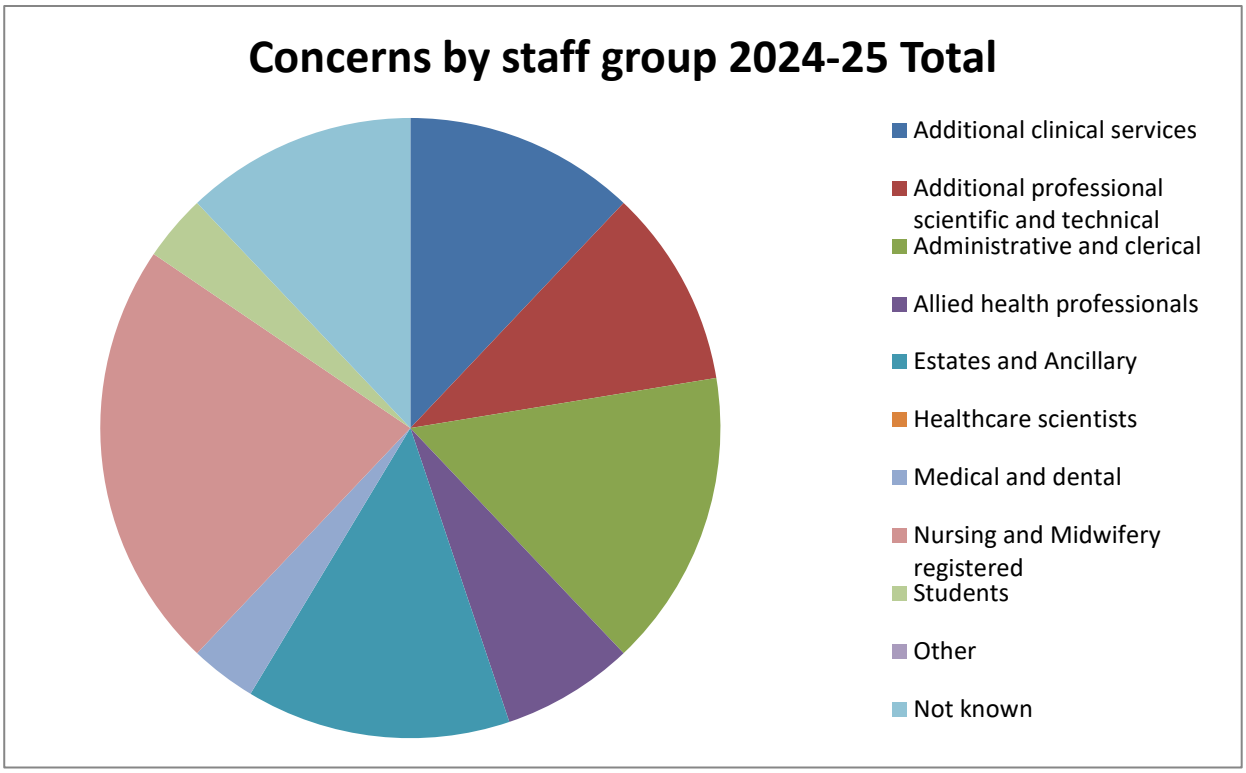
7.5 The above table shows the staff groups who have raised concerns in Q2.

- 8 concerns were raised by either a registered nurse or midwife.
- 1 concern was raised by medical staff.
- 1 concern was raised by an AHP.

- 5 concerns were raised by additional clinical service staff.
- 6 concerns were raised from Admin and Clerical staff.
- 6 concerns were raised by staff working in Estates and Facilities.
- 0 concerns were raised by students.
- 5 concern was raised by additional and professional scientific and technical staff.
- 0 concerns were raised by healthcare scientists.
- 4 of the concerns raised were unknown as they didn't stipulate or were anonymous.

The pie chart below shows the FTSU concerns by staff group for 2024-25

7.6 This data is utilised to identify areas where promotion/education around FTSU may be required.



7.7 Workers from a range of professional groups spoke up to the FTSU team. Nurses and midwives accounted for the bigger portion (22%) of cases raised. This is mirrored in the national data too where the highest number of workers who spoke up were registered nurses or midwives.

Meeting Title	Board of Directors		
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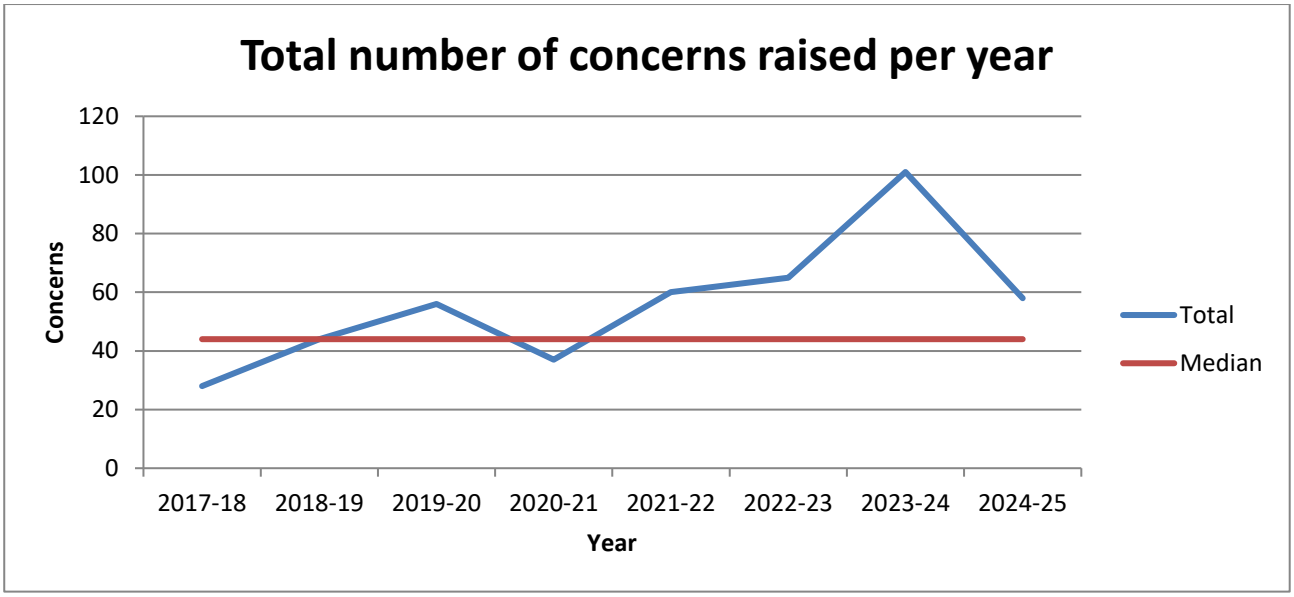
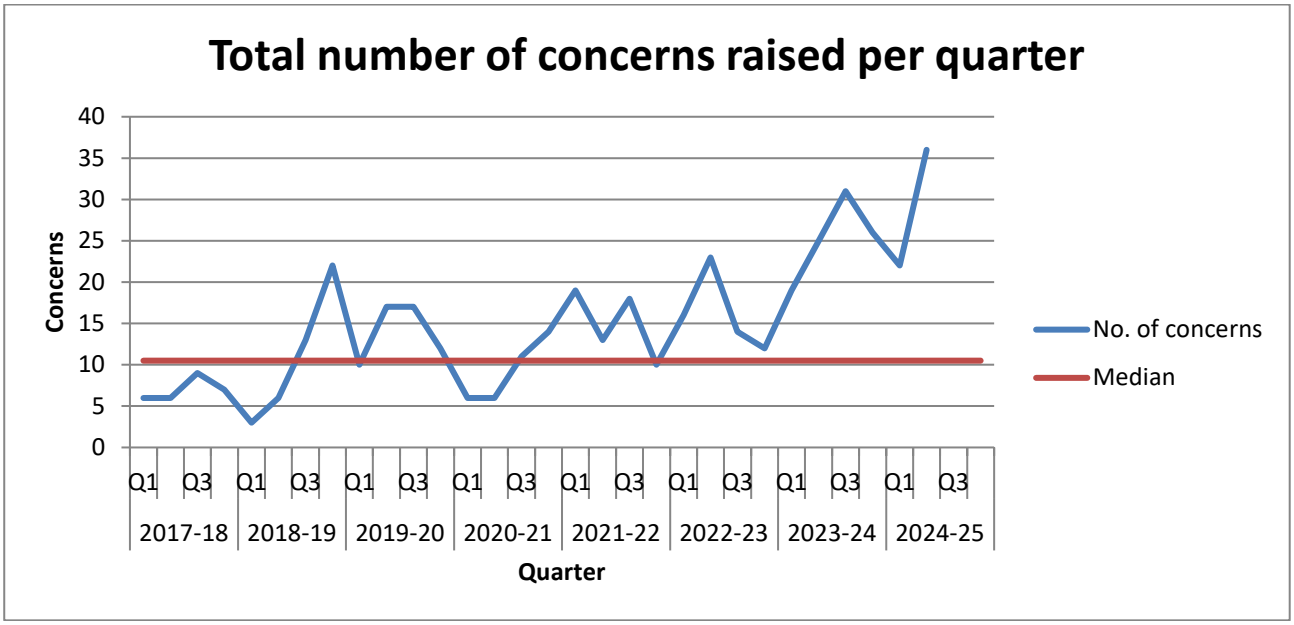
Appendix 2 – Run charts of the Total number of FTSU concerns raised by quarter and year

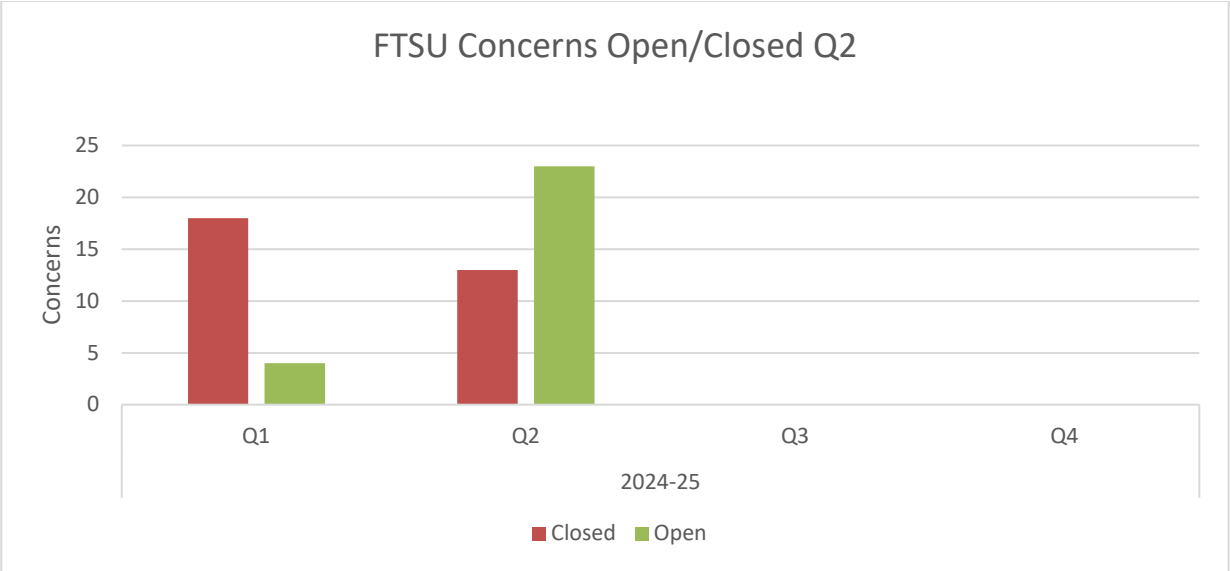




These two charts show the number of FTSU concerns raised over time at BTHFT. In Q2 there were 36 concerns raised to the FTSU team.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo11.24.11b

Appendix 3 – Open concerns in Q1 and Q2



Appendix 4 – Feedback from staff in Q2 (The numbers represent the person who raised the concern to maintain confidentiality)

Person who raised the concern	Given your experience would you speak up again?	Feedback from the person raising the concern
1	Yes	The service was a lifeline to me when management were not listening. I do not think I would have got through the time without their support. I would highly recommend the team to others.
2	Yes	FTSU Guardian helped and corrected the unfair and undervalue I got from my line manager. The FTSU Guardian spoke to appropriate senior manager of the team to handle. I got fair judgement from my senior manager regarding the incident that happened during the course of my work and her quick intervention on my case made the outcome of the meeting a good one. She helped me to understood that I am part of the team and I deserved to be valued at my job role. FTSU was indeed very helpful to my case and I felt proud of being NHS staff and carried on with my active job role till date. Thank you very much the FTSU team .

Appendix 5 – Audit Yorkshire report of FTSU (Attached separately).

Internal Audit - FTSU Final Report A

C. GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT

REFERENCES

Only PDFs are attached

Bo.11.24.11c - Guardian of Safe Working Hours.pdf

Meeting Title	Board of Directors		
Date	28th November 2024	Agenda item	Bo.11.24.11c

GUARDIAN OF SAFE WORKING HOURS DOCTORS AND DENTISTS IN TRAINING QUARTER 2 2024-25

Presented by	Dr Ray Smith, Chief Medical Officer	
Author	Dr Joanna Glascodine, Guardian of Safe Working Hours	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	Provide assurance that doctors and dentists in training are working safe hours	
Key control	High Level Control for Objective 1 & 3	
Action required	For assurance	
Previously discussed at/informed by		
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

The 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the board to provide assurance that doctors and dentists in training are working safe hours. Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1 July – 30 September 2024.

Analysis

Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. The Guardian monitors hours-related reports, while the Director of Education monitors training-related reports.

In Quarter 2 there were 73 exception reports. 69 of these were related to hours/working patterns, 1 was related to education and 3 due to the service support available to the trainee. In addition, 3 reports were flagged as an immediate safety concern.

In total, 90.25 additional hours were reported.

Recommendation

Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainees in post are happy with their current pattern. This will be discussed every time a new trainee rotates and approved at JDF.

The highest number of reports came from Foundation trainees in General Medicine and the highest number of hours from higher trainees in Oral Maxilofacial Surgery.

3 of the 73 reports were flagged as an immediate safety concern.

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

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

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

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

Meeting Title	Board of Directors		
Date	28th November 2024	Agenda item	Bo.11.24.11c

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

QUARTER 2

1 PURPOSE/ AIM

To provide a quarterly update report to give assurance that doctors and dentists in training are working safe hours.

2 BACKGROUND/CONTEXT

The 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the board to provide assurance that doctors and dentists in training are working safe hours.

3 PROPOSAL

Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1 July – 30 September 2024. No fines were levied within this period.

4 RISK ASSESSMENT

Risks have been identified but actions have been taken and continue to be taken to mitigate against the risk.

5 RECOMMENDATIONS

Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainee in post is happy with their current pattern. This will be discussed every time a new trainee rotates and approved at JDF.

There were 90.25 additional hours claimed this quarter. The highest number of reports came from Foundation Doctors in General Medicine. The highest number of hours came from trainees in Oral Maxillofacial Surgery. This was due to staying late with busy on-calls / being in theatre.

There were 3 immediate safety concerns this quarter. The first was from a Foundation trainee in General Medicine who was unable to take a break on their first set of nights. The next came from an Oncology trainee who did not get enough rest on their non-resident on-call and finally a trainee in Emergency Medicine who did not get a break on their night shift.

Meeting Title	Board of Directors		
Date	28th November 2024	Agenda item	Bo.11.24.11c

6 Appendices

Introduction

The 2016 junior doctor contract requires the Guardian of Safe Working Hours to submit a quarterly report to the board to provide assurance that doctors and dentists in training are working safe hours. Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1 July – 30 September 2024.

Exception reports

Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. The Guardian monitors hours-related reports, while the Director of Education monitors training-related reports. In Quarter 2 there were 73 exception reports. This is a 35% increase in reports compared with Quarter 1. The majority of these are related to hours / pattern but there was 1 linked to a missed educational opportunity and 3 were linked to service support. In addition, 3 reports were flagged as an immediate safety concern. This is selected as an option on an exception report if the trainee feels that they saw something that could have led to an issue for patient safety. This is most commonly due to understaffing for that shift. The first was from a Foundation trainee in General Medicine who was unable to take a break on their first set of nights. The next came from an Oncology trainee who did not get enough rest on their non-resident on-call and finally a trainee in Emergency Medicine who did not get a break on their night shift. All 3 cases have been discussed with the individual's educational supervisor.

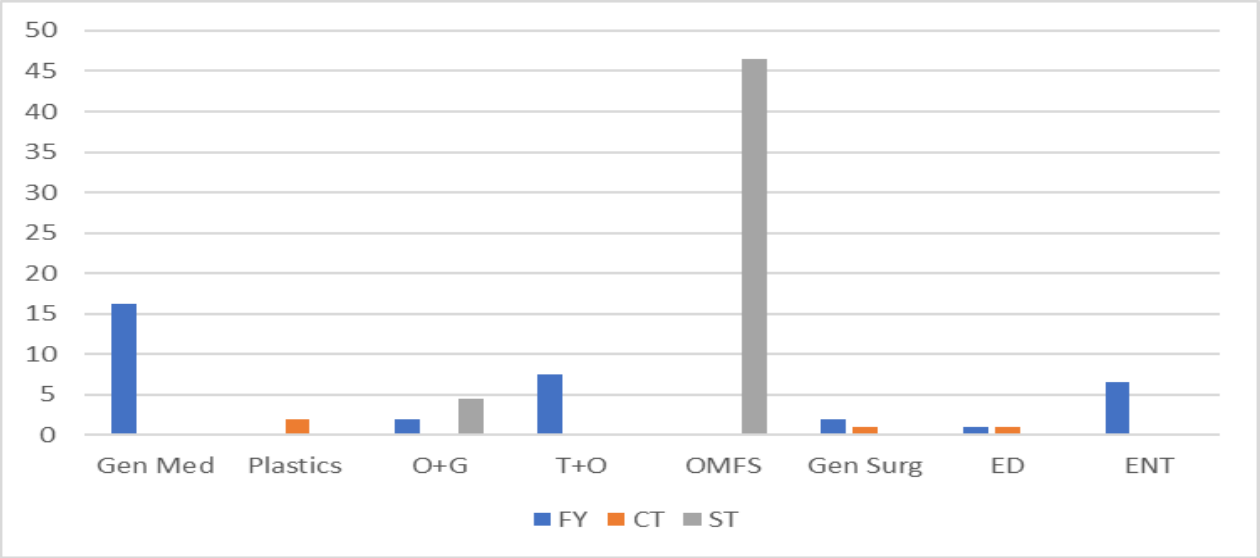
The highest number of reports were from Foundation trainees in General Medicine. These were mostly hours related due to staying late during busy day shifts. Most of these reports came from Foundation Year 1 doctors. The highest number of additional hours came from higher trainees in Oral Maxillofacial Surgery. This was mostly due to staying late for cases in theatre.

The 5 specialities with the most reports are shown below in table 1 and additional hours claimed by speciality and grade in Figure 1.

Table 1: Number of exception reports by top 5 specialties July - September 2024.

Exceptions by Speciality	Hours/work pattern	Educational	Service support	Patient safety
General Medicine	24	0	0	1
OMFS	14	0	0	0
Orthopaedics	12	0	0	0
ENT	6	1	1	0
O+G	5	0	0	0

Fig 1: Exception reports (hours) by specialty and training grade July – September 2024



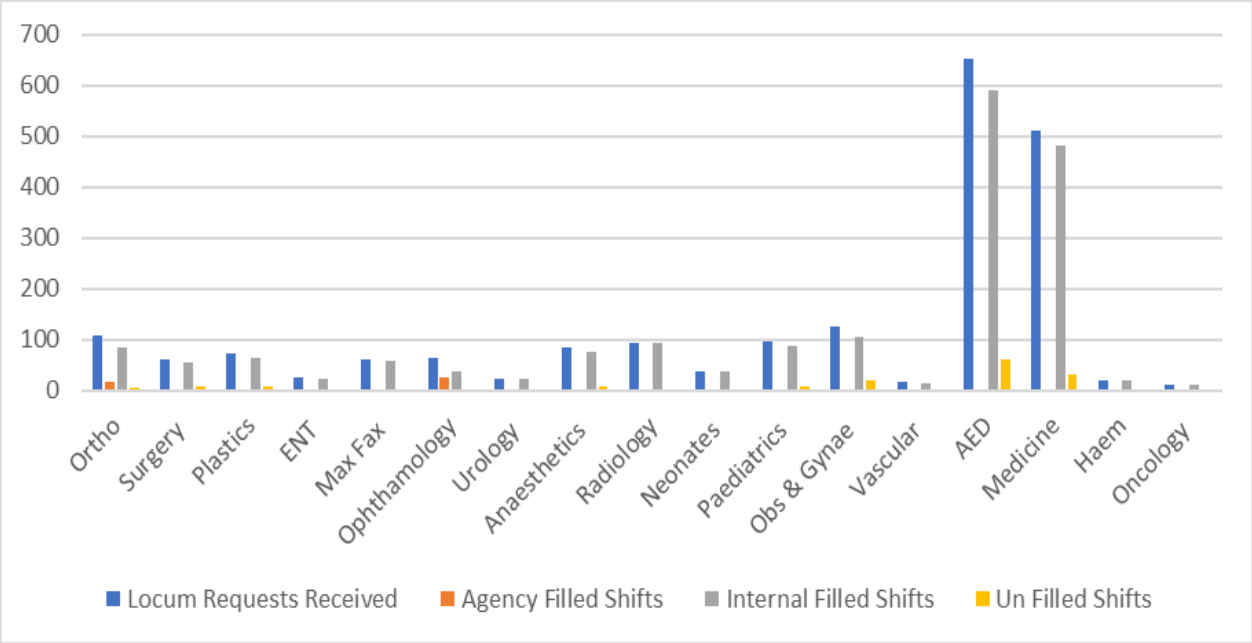
Work schedule reviews
Every trainee agrees a work schedule with their educational supervisor. A work schedule review takes place when changes are needed to ensure safe working hours or to provide better training opportunities. There were no work schedule reviews this quarter.

Rota gaps
A rota gap results from a post not being filled or from long term sickness. Gaps may be filled by doctors who are not in training. There are currently 67 unfilled training posts out of a total of 497.
The trust employs 14 post-foundation fellows, 7 post-core fellows and 52 locally employed doctors to help cover the rota gaps and enhance the junior medical workforce.

Locum bookings
Rota gaps may be filled by bank or agency locums via the flexible workforce team. This quarter there were 2059 requests which is a decrease of 12% on the previous quarter. 8% of the shifts remained unfilled compared with 10% in quarter 1. The two departments requesting the highest numbers of trainee doctor locums were as always; the Emergency Department and Medicine (see figure 2).

Meeting Title	Board of Directors		
Date	28th November 2024	Agenda item	Bo.11.24.11c

Figure 2: Locum shifts by department July – September 2024



Fines

The Guardian levies a fine against a department if contract rules on hours or breaks are broken. Some is paid to affected doctors with the remainder being disbursed via the Junior Doctor Forum to improve the working lives of junior doctors during their time in Bradford. No fines have been levied in this quarter.

Issues arising and actions taken

The highest number of exception reports came from Foundation doctors in General Medicine. These have almost entirely come from new Foundation Year 1 doctors who have stayed late after their shift to finish jobs / documentation or missed breaks. This could be due to being new so may decrease as they are more settled in their roles.
The next highest number of reports came from specialist trainees in OMFS (mostly from the same trainee). This led the highest number of hours claimed due to staying late on busy shifts / being in theatre. This is known to be a very busy shared rota between Plastics / ENT / OMFS which the teams are aware of and are doing their best to support the trainees.

The February 2020 TCS requirement for maximum weekend frequency working of 1:3 has been achieved across all rotas with the exception of palliative medicine (Marie Curie Hospice) although there is agreement from the hospice, the trust, the guardian and the current trainee on the rota that this will continue and will remain under review. There are no new updates.

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Summary

- There were 73 exception reports in Quarter 1 which is a 35% increase compared with the previous quarter.
- The highest reporting group of doctors were Foundation trainees from General Medicine. They submitted 24 reports relating to hours / work pattern and 1 addition patient safety concern.
- Specialist trainees in OMFS submitted the highest number of additional hours.
- There was a 12% decrease in locum requests this quarter with around 8% going unfilled. ED and Medicine remain the departments in need of most locums.
- Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainees in post are happy with their current pattern whilst we work to find a long-term solution.

BO.11.24.12 - EQUALITY & DIVERSITY COUNCIL UPDATE

REFERENCES

Only PDFs are attached

Bo.11.24.12 - Equality & Diversity Council update.pdf

Meeting Title	Board of Directors		
Date	28th November 2024	Agenda item	Bo.11.24.12

Strategic Equality and Diversity Council November 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 September 2024.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For assurance	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Academy/Group**	**Date**
	N/A	

Key Options, Issues and Risks

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

This report provides an update on the key highlights from the last EDC meeting which was held on 16th October 2024.

Analysis

The following key items were discussed at October EDC meeting:

- Update on Recruitment Workshops
- Update on Inclusive Colleague Recreational Areas
- EDI Strategy Implementation Plan
- Policy, progression and recruitment review update
- Staff Equality Network Updates on progress and future plans
- Health Inequalities 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		
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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				G		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					G	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

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

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

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

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

Meeting Title	Board of Directors		
Date	28th November 2024	Agenda item	Bo.11.24.12

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 September 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 16th October 2024

3.1 EDC continues to be well attended and generates lots of useful discussion, with 22 people attending the October meeting. This section provides a summary of agenda items and actions arising from EDC since the last Trust Board update provided in September 2024.

The table below captures some of the key discussions from the meeting which took place on 16th October 2024.

Matters Arising
Update on Recruitment Workshops Trust colleagues are working in collaboration with other local employers to attend a small number of community events supporting people in high deprivation areas into employment. As well as working with local schools they are developing a a monthly roadshow event focusing on "how to succeed in applying for jobs". Sughra has provided some useful contacts to facilitate this programme. Karen Dawber has obtained a grant for £130k from Shipley College and is liaising with Education with a view to using the money to provide entry level work experience placements focussed on upskilling people in the community and getting them into employment.

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Kez Hayat is working with Project Search and Bradford College to develop a pre-internship programme, preparing eligible students for entry into the Project Search Programme.

Inclusive Colleague Recreational Areas

Sonia Sarah shared draft designs from Estates for the development of Field House colleague recreational area. OD have managed to obtain charities funding to incorporate some covered work pods into the design, along with a number of inclusive design idea's which have been provided by our staff network members. This has been a long time coming and the plans provide a real positive wellbeing opportunity for the wider workforce and a celebration of how much we value our diverse colleagues.

EDI Strategy Implementation Plan

Our EDI Strategy was launched in April 2023 featuring 5 key strategic EDI objectives developed through targeted engagement with our diverse colleagues and communities. With a growing and complex EDI agenda, our strategy is helping us to align some of the national, local and regional priorities in terms of EDI.

Kez Hayat shared the newly developed EDI Strategy Implementation plan which showcases the excellent progress that is being made across the Trust in delivering some of the key work area's that are allowing us to embed and advance EDI across the organisation and identifies "what next".

The EDI team have been working with a range of departments, including our operational management team to develop local EDI action plans tailored to address EDI related challenges specific to each area of the Trust.

In addition to this, focus on four building blocks of EDI have helped in developing some of this work and Kez provided EDC members with examples of how we are progressing around each of these 4 key areas:

- Leadership & Governance
- Organisational Culture
- Engagement, Consultation & Involvement
- Collaboration & Partnerships

We are also having an influence at place level, including involvement in the development of the ICB 3-year EDI strategy and development of an anti-racist strategy, with connections also providing opportunity for learning and sharing best practice.

EDC colleagues congratulated the EDI team on this progress and discussed area's of focus going forward, including:

- Provision of safe spaces to influence those who are not currently emplowered around EDI (e.g. Introduction of Schwartz Rounds with an EDI focus)
- Developing allyship programmes
- Developing an EDI toolkit to educated and prevent "clumsy behaviour/ language"

- Potential to review some of our targets around Senior Leadership representation, to ensure they are achievable and showcase the progress being made.
- Relaunching and widening the scope of the Reciprocal Mentoring Scheme (to include General managers, not just Execs)

Policy, progression and recruitment review update

Kez Hayat and Cat Shutt had been asked by Renee Bullock to review our People policies (including recruitment) and progression with an OD and EDI lens, to build on the fantastic work that is taking place in these areas and consider how we could do things differently and more collaboratively. Full recommendations from the review will go to People Academy in November, but Cat provided a brief overview to EDC of some of the issues and solutions already identified as part of the review:

- Length of policy documents: Develop a policy on a page for each document and incorporate key reference information from each policy into a colleague People Policies handbook, along with a Managers Toolkit (to harmonise and bring together all the guidance they need around our People Policies in one place)

- Lack of clarity around progression routes: Create a digital talent management platform, featuring a series of progression maps (in a digital format) built around job families.

- Lack of consistency in career development conversations: developing a dynamic career conversation tool to ensure good career and personal development conversations.

- Duplication and lack of consistency in Job Descriptions/ Person Specifications: Reviewing and standardising.

- How we attract talent from our local communities: Recruitment workshops for our diverse communities/ work with schools/ social media activity. Co-produced a candidate pack (that showcases EDI at the Trust)

- How we support progression through the Trust in our recruitment processes: Developing an Inclusive Recruitment Toolkit. Considering recruiting internally before externally for some roles to provide development routes for existing colleagues.

Staff Network Updates

LGBT Staff Network Update:

Karla provided an update for the LGBT+ network.

Pride was a busy and successful month for the network with an event on the main concourse and the launch of a new screensave raising the profile of the network and sharing some key messages. The network are looking forward to next years Bradford Pride event following the successful City of Culture bid and are already planning their engagement about his on social media.

Connections have been made with other Trusts and Bradford Council to explore how they might take a collaborative approach to re-launching the Rainbow Badge training in a digital format, which it is hoped will be more accessible and easier to maintain.

Karla has also been meeting with other organisations to share experiences in how they are addressing a lack of engagement, with digital communication options proving to be more successful. Work is ongoing to trial this and to understand what members most want or need from the network going forward.

Allyship was a key theme of some of the discussions and an approach to this will be developed through the new colleague network Chair of Chairs forum.

RESIN Staff Network Update

Raquel provided EDC with an update on two workshops that have taken place with international colleagues (led by Renee Bullock with support from OD colleagues). The focus has been on developing an action plan in response to the recent listening events which have identified a number of issues and challenges experienced by our international recruits. Improvements, which align to the NHS EDI Improvement Plan, will be made in the following areas: recruitment, onboarding and integration, improving cultural and religious competency among teams and focus on personal and professional development. Initiatives such as a "buddy system", a "relocation officer" and a "soft induction" (prior to Trust Induction) should help provide a more supportive introduction to Bradford and working at BTHFT.

Since the last EDC, RESIN colleagues have actively celebrated a number of key events in the diversity calendar, sharing culture, lived stories, music and traditional food:

- South Asian History Month
- Black History Month
- Diwali and Bandi Chor (with a special light up event)

Members enjoyed the Brilliant Bradford awards event, and 5 Filipino colleagues were invited to join 40 other Filipino nurses at Florence Nightingales childhood home for a special tribute event hosted by Kind Charles. Black History month was a great success (and with the Lifestyle restaurant again serving a special menu every Thursday). D

Enable Staff Network Update

Sonia Sarah announced the appointment of Mark Hindmarsh as Exec sponsor for the Enable network and updated EDC with plans for Disabilty History month (14 November to 20 December), including their collaborative work with place level partners to deliver this years "Connected on Ability" festival which takes place during the first week of December. Colleagues are working with BDCT to provide a virtual session on disability declaration (4th Dec 10.30am – 11.30am). There will also be focus on hidden disabilities and neurodiversity (improving awareness by sharing lived experiences).

The network are currently in a period of growth having overcome some recent challenges with filling core network roles. A hybrid meeting approach is helping to resolve some of the difficulties colleagues had been experiencing in connecting up. At a recent meeting the group discussed key areas of focus for their work plans, including addressing on-site parking

challenges, colleague/ visitor access (particularly where corridors are blocked or there are works taking place), compassionate and inclusive management approaches and flexible working. The network would also like to be involved in raising awareness of the disability equality policy.

Health Inequalities Update

Naveed Saddique provided an update to EDC on the progress for the Health Inequalities agenda. There are currently 3 key areas of focus:

1. Progress made in relation to the outcomes of the NHS Providers health inequalities self-assessment in April 2024.

Having achieved a rating of maturing across all four domains last year (Leadership, Capability, Partnerships and Data), an action plan has been developed using NHS provider guidance for "what good looks like" to improve our ratings for next year. The action plan covers 3 key areas:

- To increase the uptake of health inequalities training, and raising awareness at induction
- To setup an oversight group focusing on aligning the health inequalities work across the Trust to align all the work that is taking place across the Trust
- To shift the focus to cover outcomes and experiences as well as access (working with the performance team).

3. Delivery of a Health Inequalities focused Board Development Session in October 2024.

The team have worked collaboratively with Performance, Research and the Reducing Inequalities Alliance to develop a model which showcases our role and approach to Health Inequalities at BTHFT. The model was developed to facilitate discussion at board level and to develop awareness, action and advocacy around our role as:

- An Anchor Institution
- A System Partner
- A Research Institute
- A Service Provider
- A Teaching Hospital

Any actions/ ambitions from the Board Development session will be used to further develop the HI action plan.

4. Our Work with Partners

We are strengthening our relationship with the Reducing Inequalities Alliance (RIA) and working with 'Living Well' to raise awareness of what they can offer across the Trust (e.g. working with our Facilities team to support the provision of health food options).

We are raising the profile of the Improving Population Health Fellowship to encourage participation. The programme is particularly beneficial to the Trust, in that it requires participants to complete an improvement project in health inequalities over the 12 months duration. We have had a number of colleagues complete the programme so far and one that is currently enrolled.

3.2 Next EDC is due to take place on Wednesday 22nd January 2025.

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.11.24.13 - REPORT FROM THE CHAIR OF THE FINANCE AND PERFORMANCE COMMITTEE

A. OCTOBER & NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.11.24.13a - Report from Chair of F&P Committee Oct 2024.pdf

Bo.11.24.13a - Report from the Chair of the Finance and Performance Committee - November 24.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13a

Committee Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Committee

Date of meeting: 16th October 2024

Key escalation and discussion points from the meeting

Alert:

Monthly Finance Report – There remains a significant risk that the Trust will not deliver its financial plan. The Trust is still reporting it will deliver its £14m financial deficit plan but this is the best-case scenario, the likely case is that the Trust will deliver a £23.5m deficit (£9.5m worse than plan). This is in the main due to the shortfall in forecast savings through the closing the gap programme.

Closing the Gap – There has been significant progress on engagement across the Trust with the programme, However the mid case risk is that the Trust will not deliver the £38.9m of schemes required to deliver the financial plan. As at month 6, £29m of schemes are forecasted to be delivered. The best-case scenario is that £33.9m of savings will be delivered.
The Committee discussed the recurrent/non recurrent delivery of schemes and the impact on next year's financial plan. The Committee asked to focus on the workforce aspect of closing the gap in next month's meeting.

Treasury Management Update (cash position) – there is a low to medium risk that the Trust will require cash support from NHS England in the last quarter of the financial year.

Consequences and Control Measures of Moving off Forecast (Financial protocol) – the Committee discussed the consequences of the Trust, the system or the WYICS reporting off plan. Should any of these scenarios happen, additional controls will be imposed on the Trust.

Advise:

Core Standards and EPRR Update –The Committee approved two further documents to ensure compliance with the Core Standards prior to their formal submission.
Winter Response Plan – The Committee approved the Trust's Winter Response Plan noting how we will open, close and flex capacity as required.

Operational Improvement Plan Referral to Treatment – Within the RTT workplan there has been a focus on those actions that are part of the closing the gap programme. Workstreams include, clinic productivity, reducing DNAs, outpatient transformation, day case effectiveness and theatre productivity.

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Length of Meeting – Over the last few months the Committee has added new items onto the work plan and the last few meetings have started to feel "rushed." In order, to make sure we have appropriate time to discuss relevant items the meeting length will be extended to 2.5 hours from November.

Assure:

Performance Highlight Report – the Academy received and reviewed the monthly comprehensive report. Performance remains strong with pressures on day case unit activity (delay to opening of new day case unit) and Trauma and Orthopaedics, where work is ongoing within the service to improve performance. ECS performance in September was 82.49% and although attendances have increased, performance remains in the top decile of Trusts.

Board Assurance Framework – The Committee were satisfied that the Board assurance Framework captured the relevant strategic risks aligned to the Finance and Performance Committee.

High Level Risks Relevant to the Academy -. A new risk re Nuclear Medicine Capability has been included on the risk register. The Committee were assured that all relevant key risks had been identified, reported to the Academy, and were being managed appropriately.

Report completed by:

Julie Lawreniuk
Committee Chair and Non-Executive Director

5th November 2024

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13a

Committee Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Committee

Date of meeting: 20th November 2024

Key escalation and discussion points from the meeting

Alert:

Monthly Finance Report – There remains a significant risk that the Trust will not deliver its financial plan. The Trust is still reporting it will deliver its £14m financial deficit plan but this is the best-case scenario and confidence in delivery of the plan is low. The likely case is that the Trust will deliver a £23.3m deficit (£9.5m worse than plan). This is in the main due to the shortfall in forecast savings through the closing the gap programme.
The Trust has developed a 5-year revenue plan that demonstrates that it will take 3 to 4 years to recover to a breakeven position based on current assumptions.

Closing the Gap – Although there has been significant progress on engagement across the Trust with the programme, this has not translated into the run rate improvement on the scale needed to deliver the financial plan. The mid case forecast is that the Trust will deliver £27.2m of the £38.9m target savings, the best-case scenario is that £33.4m of savings will be delivered.
The Committee reviewed the workforce workstream that is part of the programme and the two phases of work that are underway as part of that.

Advise:

Finance and Performance Committee Dashboard – The Committee agreed that there should be a review of the Dashboard to ensure it captures the appropriate Estate metrics now that Estates forms part of the Committee workplan.

Core Standards and EPRR Update – The Committee approved two further documents to ensure compliance with the Core Standards. The final submission was returned to the WYICB on the 31st of October. The Trust reported 50 core standards as compliant and 12 as partially compliant, a significant improvement on last year's return. An action plan has been produced for the standards that were reported as partially compliant.

Operational Improvement Plan Cancer and Diagnostics – The Committee were assured by the improvement plans that are underway to improve Cancer and Diagnostics Performance and patient experience.

Treasury Management Update (cash position) – There is a low to medium risk that the Trust will require cash support from NHS England in the last quarter of the financial year.

Budget Setting Process and Timetable – A paper was shared with the Committee setting out the budget setting process and timetable for 2025/26. Communications with

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the CSUs re savings targets for 2025/26 have already commenced as part of this process.

Corporate Strategy Update – This report analysed how the work of Board Academies and Committees provided a "real time" view of progress towards our strategic objectives. The Committee requested further consideration to how this progress could be consolidated into a report for Board to show overall progress against delivery. A further discussion is planned with Board members.

Estates Water and Ventilation Compliance and Health and Safety Update – The Committee received these two reports for assurance noting they were still in development. Further updates will be provided as this work continues.

Annual Estates Compliance Report – This report assured the Committee on management of operational maintenance compliance within the Estates Division for the financial year 2024/25. Evidence that the Trust is adhering to the appropriate standards has been provided from independent advisors who oversee and guide actions in relation to their area of expertise. It was pleasing to see the improvement in compliance year on year.

Length of Meeting – This meeting and future meetings have been extended to two and a half hours. This felt better and gave us more time to discuss the papers. We will continue to monitor.

Assure:

Performance Highlight Report – The Academy received and reviewed the monthly comprehensive report. Performance remains strong with A and E Performance remaining in the upper decile of Acute Trusts despite increases in daily attendances.

Internal Audit Reports relevant to the Committee – The Committee received three internal audit reports for information, all had received significant assurance.

Board Assurance Framework – The Committee were satisfied that the Board assurance Framework captured the relevant strategic risks aligned to the Finance and Performance Committee.

High Level Risks Relevant to the Academy – Two new risks re Estates (will be incorporated into one) had been added onto the risk register, these were reviewed as part of the Estates papers that the Committee received. No risks had changed in score, and none had been closed. The Committee were assured that all relevant key risks had been identified, reported to the Academy, and were being managed appropriately.

Report completed by:

Julie Lawreniuk
Committee Chair and Non-Executive Director

25th November 2024

B. FINANCE REPORT

REFERENCES

Only PDFs are attached

Bo.11.24.13b - Finance Report - month 7.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13b

Month 7 Finance Board Report

Presented by	Ben Roberts, Chief Finance Officer	
Author	Chris Smith, Deputy Director of Finance & Michael Quinlan, Deputy Director of Finance	
Lead Director	Ben Roberts, Chief Finance Officer	
Purpose of the paper	To provide the Board with an update of the financial position.	
Key control	Key control – Deliver of our financial plan	
Action required	For assurance	
Previously discussed at/ informed by	*Discussion at Finance & Performance committee for assurance.*	
Previously approved at:	e.g. Academy / ETM / CSU group	**Date**
	Finance & Performance Committee	20th November 2024

Key Options, Issues and Risks

The Trust continues to report on plan year to date and still forecasting to achieve it's plan at the year end.

Analysis

The Trust continues to report on plan in month and year to date. Reporting a £13m deficit year to date, delivering efficiencies of £12.2m through the Closing the Gap programme.

The capital programme remains on track spending £15.7m year to date against a planned spend of £22.9m. The slippage on the capital programme predominately realtes to new Endoscopy Unit due to unforeseen delays. Mitigating actions are being put to ensure the capital programem delivers to plan. The cash balance at month 7 is £40.2m, which is £14m better than planned.

The Trust is formally reporting its best-case financial forecasts to West Yrokshire Integrated Card System (WY ICS) and NHS England (NHS E). The Trust is forecasting having a £9m cash balance under this forecast scenarios at the year end. Therefore, we are not currently expecting to need cash support in 2024/25. The likely, mid-case, forecast has improved this month to a £23.3m deficit, under this scenario the forecast cash position is £0.5m.

If the most likely I&E forecasts for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and the WY ICS remain unchanged following the month 8 results, the organisation will need to consider the necessity of submitting a revised off-plan forecast to NHSE. Board approval would be required for this revised forecast which would need to be done in coordination with the WY ICS and in compliance with NHSE's protocols for providers and systems falling behind their financial plans.

Recommendation

The Board is asked to note the contents of this report.

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

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

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

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

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

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13b

1 INTRODUCTION

The Trust is reporting a year-to-date Income and Expenditure (I&E) deficit of a £13m against a planned deficit of £13m, this has been supported by non-recurrent measures, with an underlying deficit of £17.6m to month 7. The Trust is continuing to make progress with our Closing the Gap (CTG) efficiency with £12.2m of improvement being delivered year-to-date against a plan of £16.5m.

The capital programme has spent £15.7m against a planned spend of £22.9m year to date, with slippage in spend predominately around the new Endoscopy Unit which is being externally funded. The cash balance at month 7 is £40.2m, which is £14m better than planned, this mainly driven early payments from Health Education England in the month and other higher receipts from other NHS organisations.

The Trust is formally reporting its best-case financial forecasts to achieve our financial plans at the year end across I&E, capital and cash. The Trust produces a range of forecasts from best to worse, the likely I&E forecast is currently a £23.3m deficit which is £9.3m worse than the planned £14m deficit. The key differences between the best case and the likely case are underachievement of the Elective Recovery Fund (ERF), underdelivery of our CTG programme and operational pressures being higher than expected. Mitigating actions are being taken across three workstreams looking at pay controls, technical flexibilities and ERF. There is a risk the Trust will need to report off-forecast at month 8.

The capital programme is current forecasting to underdeliver by £5.5m, mainly due to slippage on the externally funded Endoscopy scheme. Mitigating actions are being taken to manage the slippage to ensure we met our capital plan. The two mitigating actions include engaging with NHS E and system partners to support the management of the underspend and developing plans to bring forward spend from future years.

The year cash position on the best-case forecast is £9m, under likely forecast it is £0.5m. Therefore, we are not currently expecting to need cash support in 2024/25.

The West Yorkshire Integrated Care System (WY ICS) is currently reporting a year-to-date deficit of £48.0m against a planned deficit of £24.9m. The WY ICS is still formally reporting to achieve plan at the year end, the likely forecast is currently a £77m deficit against a break-even plan.

2 IN MONTH & YEAR TO DATE POSITION

I&E

Meeting Title	Board of Directors		
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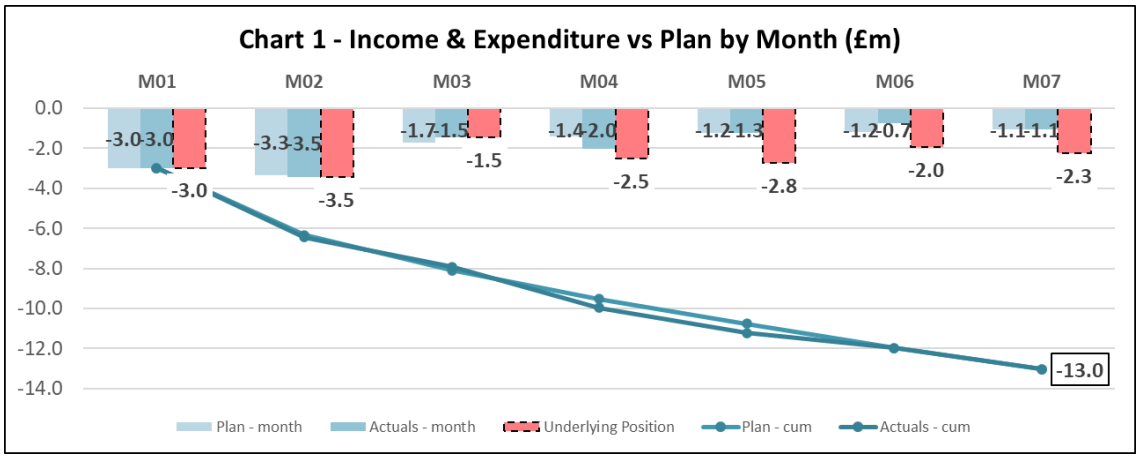


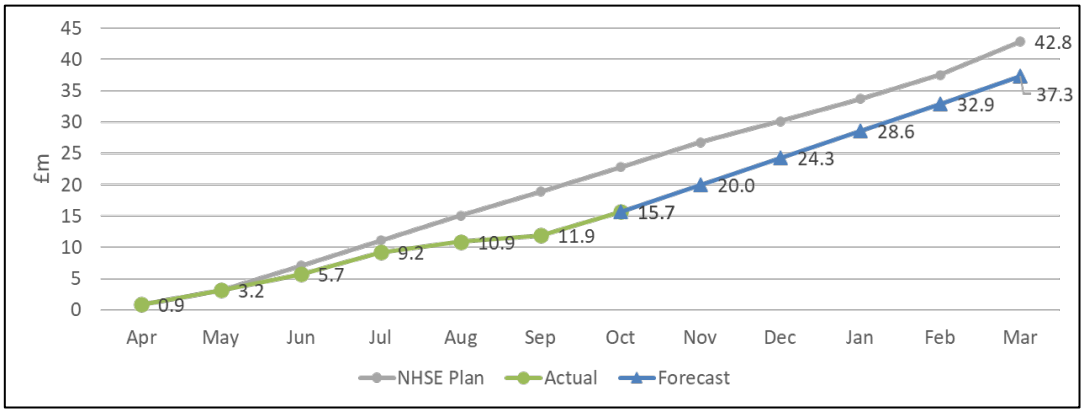
The reported Month 7 I&E position assumes recovery of 100% of the ERF funding included in NHS contract plans for 2024/25, however up to date coded ERF activity data is not yet available and NHSE is yet to issue a comprehensive position against which to monitor. In October, NHSE has informally communicated the risk that the ERF mechanism may be curtailed in Half 2, with the potential consequence that ERF performance improvements in Quarters 3 & 4 may not result in increased funding.

The latest internal analysis suggests the Trust is cumulatively £0.6m ahead of its combined ERF targets at Month 7, however this is uncertain and is not reflected in the reported YTD position. Plans are being put in place to significantly increase ERF income as part of the Closing the Gap plans which target ERF increases of over £8m in Quarters 3 & 4. NHSE's informal stance on ERF casts this level of improved income recovery into significant doubt.

The in-month October underlying deficit of £2.3m represents a £0.3m deterioration on Month 6 but an improvement on Months 4 & 5. The overall level of improvement is not sufficiently material to suggest that the best-case scenario forecast (£14m deficit plan) will be achieved in 2024/25.

Bank and Agency pay expenditure reduced by £0.04m compared to Month 6 (this item is adjusted for pay award), following a more substantial reduction last month. 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 Trust plans to address this by the introduction of new pay controls via an Executive sponsored Workforce Steering Group.

Capital



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The Trusts 24/25 Operational Capital Budget is £25.6m, which is allocated annually by WY ICS. The Trust has spent £11.7m up to Month 07 which is £2.9m lower than YTD Operational Capital allocation. Forecast outturn is expected to be under operational budget by £2.0m, with mitigating actions in place to ensure delivery of the plan.

Externally funded PDC capital during 24/25, at the end of Month 07 the Trust spent £3.1m on PDC schemes which is £4.8m less than budget. Forecast outturn is expected to be £4.0m less than the funding available.

The Trust has been awarded £0.4m of Targeted Investment Funding (TIF) for the St Luke's Hospital Day Case Unit. At Month 07 the Trust spent £0.4m against its TIF allocation. This project has been delayed and the Trust has top sliced £4.6m of its operational budget to fund this scheme in 2024/25.

Cash

As a the end of month 07 the Trust held £40.2m in the bank which is £14.5m more than planned (£25.7m).

Income and Expenditure cash is £11.6m more than plan mainly during to movements in working capital (deferred income £5.9m, payables £5.3m and provisions £3.1m).

Capital cash is £3.8m more than plan as the programme is currently behind plan (£7.3m).

ICS Financial Position

Organisation	I&E reported Month 07 24/25			I&E forecast		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Bradford ICB	(4.5)	(11.0)	(6.4)	(7.8)	(17.8)	(10.0)
Calderdale ICB	(0.0)	1.0	1.0	0.0	0.0	0.0
Kirklees ICB	(0.0)	0.5	0.5	(0.0)	(0.6)	(0.6)
Leeds ICB	(7.2)	(7.7)	(0.5)	(12.3)	(13.1)	(0.8)
Wakefield ICB	(0.0)	0.0	0.0	0.0	(1.1)	(1.1)
WY ICB	23.8	26.2	2.4	41.5	54.0	12.6
West Yorkshire ICB Total	**12.1**	**9.1**	**(3.0)**	**21.4**	**21.4**	**0.0**
Airedale NHS Foundation Trust	(1.5)	(6.8)	(5.3)	(6.9)	(6.9)	0.0
Bradford District Care NHS Foundation Trust	(1.2)	(1.3)	(0.1)	0.0	0.0	0.0
Bradford Teaching Hospitals NHS Foundation Trust	(13.0)	(13.0)	0.0	(14.0)	(14.0)	0.0
Calderdale And Huddersfield NHS Foundation Trust	(3.3)	(3.1)	0.3	(1.3)	(1.3)	0.0
Leeds and York Partnership NHS Foundation Trust	(1.2)	(0.9)	0.3	1.0	1.0	0.0
Leeds Community Healthcare NHS Trust	0.6	0.6	0.0	1.0	1.0	(0.0)
Leeds Teaching Hospitals NHS Trust	(16.1)	(22.3)	(6.2)	2.1	2.1	0.0
Mid Yorkshire Hospitals NHS Trust	(2.0)	(10.2)	(8.2)	(3.4)	(3.4)	0.0
South West Yorkshire Partnership NHS Foundation Trust	0.3	(0.6)	(0.9)	0.0	0.0	0.0
Yorkshire Ambulance Service NHS Trust	0.5	0.6	0.1	0.0	0.0	0.0
West Yorkshire Provider Total	**(37.0)**	**(57.1)**	**(20.1)**	**(21.4)**	**(21.4)**	**(0.0)**
West Yorkshire ICS Total	**(24.9)**	**(48.0)**	**(23.1)**	**(0.0)**	**(0.0)**	**(0.0)**

The month 7 year-to-date position for the ICS was an actual £48.0m deficit against a planned £24.9m deficit; a shortfall/adverse variance against plan of £23.1m. The month 7 adverse variance of £23.1m has worsened from the adverse variance at month 6 of £17.2m, a deterioration of £5.9m.

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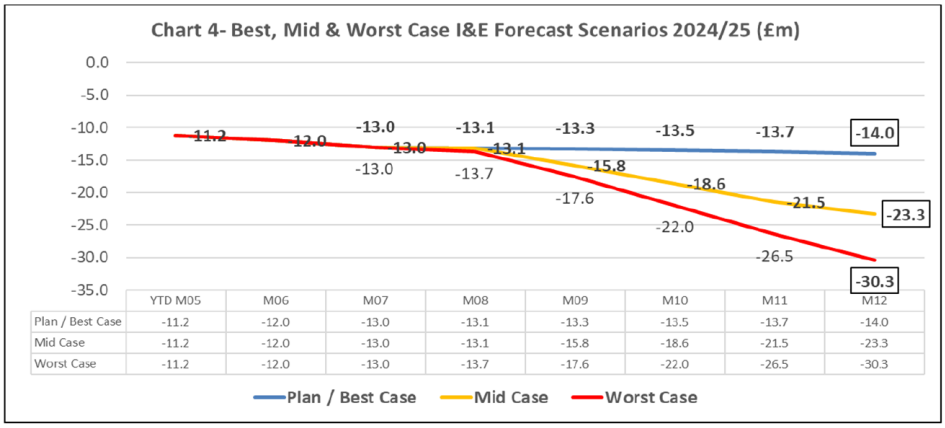
The main reasons for the month 7 adverse variance are slippage on delivery of waste reduction/efficiencies, additional costs of drugs/devices, and pay overspends in part due to shortage of pay award funding, offset in part by an improvement in the ICB prescribing position.

Following reporting the Month 6 position, the ICS has now been escalated to level 3+ as part of the I&I process and as a result is subject to weekly reporting to NHSE.

3 YEAR END FORECAST

I&E Forecast



The Trust continues to formally report a forecast delivery of the financial plan in full of the planned £14m deficit. There remains a challenging but plausible route to achieving the plan, although this remains at risk. Three scenarios for the I&E forecast for the remainder of the financial year have been modelled.

Best Case scenario is based on the dleviery of the planned £14m deficit position. Based on current run rates and CSU projections for CTG savings delivery, together with the expected impact of a number of additional cost pressures, including winter, mean this scenario must be considered as challenging. Delivering the plan in the remaining months of the year would require the Pay Award cost pressure to be funded in full by NHSE (£0.8m), the recovery of at least £8m additional ERF funding via the productivity, counting and coding projects, the full deployment of £7.5m non-recurrent measures and an increase in forecast delivery against all departmental CTG targets. The Best Case scenario also assumes the improved base run rate in Month 6/7 is maintained in full throught the remainder of the year.

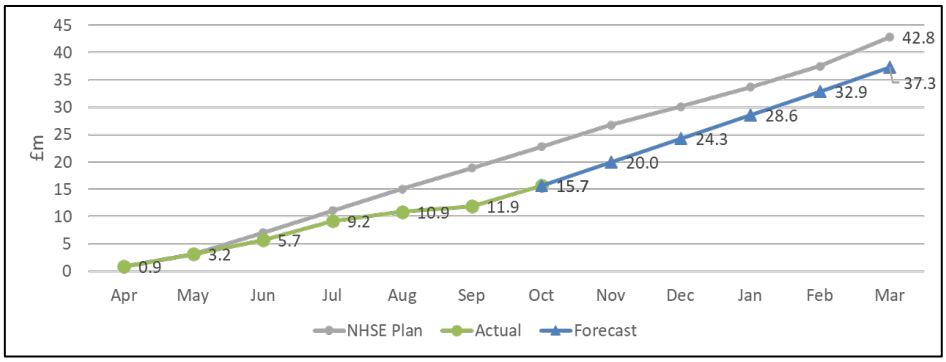
The Mid Case scenario is showing a likely forecast position of a £23.3m deficit, falling behind plan at Month 9. Based on current run rates and known future cost pressures, this is currently considered to be the most likely scenario, with a forecast year end deficit in the range of £23m - £24m. The exact timing at which the Trust will fall behind the planned cumulative deficit is uncertain, although it is not anticipated the organisation will be able to deliver the Month 9 position without major improvements to the underlying run rate.

The Mid Case Scenario assumes the full £7.5m of non-recurrent measures are used but that only 33% of the ERF benefits are realised (£2.7m) and that 50% of the new pay controls result in cost

reductions (£0.8m). This scenario also assumes that no additional funding is provided to offset the estimated £0.8m pay award pressure.

Worst Case is showing a £30.3m deficit, falling behind plan at Month 9. As per the Mid Case, but with a number of known risks occurring concurrently, including zero recovery of additional ERF, the actual ERF run rate deteriorating resulting in de-funding, the projected CTG run rate improvements for medium and high-risk plans not being delivered. No additional pay control benefits and greater cost pressures arising over winter. This is considered to be an unlikely scenario.

Capital Forecast



To deliver the capital programme the Trust will need to invest £27.1m (63.3%) during the next five months (average £5.4m per month, current average is £2.2m). Mitigating actions are being put in place to deliver the plan.

If the Trust does not deliver its I&E position total CDEL may reduce over the next five years by 10%. Trust is also investing approx. £6.1m per annum more in capital than the cash generated from its operations.

Current forecast underspend for 24/25 is £5.5m. Under the current use it or lose it regime the Trust is not able to move CDEL from 24/25 to 25/26. The Trust is currently engaging with both NHS and WY ICB to explore options of moving CDEL from 24/25 to 25/26.

Cash Forecast

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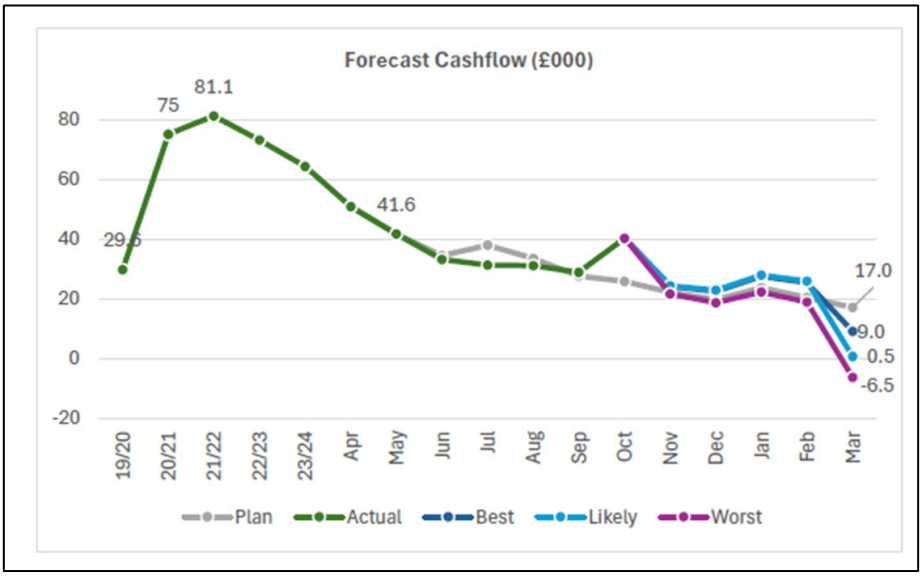


Forecast cash is expected to be £0.5m which means that there is a significant risk that the Trust will require revenue cash support. The timing of revenue cash support largely depends on deliverability of the closing the gap programme (£38.8m) but it is expected that cash support will be required during quarter 4.

At the moment the Trust is forecasting to spend £42.7m this financial year on capital. At month 7 the Trust has spent £15.6m which means that the Trust is forecasting to spend £27.1m over the next five months. Any further slippages to the capital programme will reduce the risks of the Trust requiring revenue cash support during 2024/25.

ICS Financial Position Forecast

Organisation	Scenarios - Org assessment				Explanation			
	Best Case Variance £m	Likely Case Variance (System Support Req.d) £m	Likely Case Variance (Risks and Limited Mitigations) £m	Worse Case Variance £m	Worse Case Variance- CIP £m	Worse Case Variance- ERF Income (-) £m	Worse Case Variance- ERF Expenditure (+) £m	Worse Case Variance- Other £m
Bradford ICB	(2.6)	0.0	(10.0)	(20.3)	(2.3)	0.0		(18.0)
Calderdale ICB	2.0	0.0	0.0	(1.3)	0.0	0.0		(1.3)
Kirklees ICB	2.5	0.0	(0.6)	(6.1)	(2.3)	0.0		(3.8)
Leeds ICB	3.3	0.0	(0.8)	(15.3)	(0.5)	0.0		(14.8)
Wakefield ICB	3.6	0.0	(1.1)	(7.6)	0.0	0.0		(7.6)
WY ICB	2.1	0.0	0.0	(15.8)	(17.0)	0.0		1.2
NHS West Yorkshire ICB Total	**10.7**	**0.0**	**(12.6)**	**(66.5)**	**(22.1)**	**0.0**	**0.0**	**(44.4)**
Airedale NHS Foundation Trust	0.0	0.0	(8.9)	(15.4)	(2.5)	(2.8)	0.0	(10.1)
Bradford District Care NHS Foundation Trust	0.0	0.0	(0.9)	(1.7)	0.0	0.0	0.0	(1.7)
Bradford Teaching Hospitals NHS Foundation Trust	0.0	0.0	(9.5)	(20.3)	(13.5)	(2.0)	0.0	(4.8)
Calderdale And Huddersfield NHS Foundation Trust	0.0	0.0	(4.0)	(10.6)	(0.8)	(2.1)	(0.7)	(7.0)
Leeds and York Partnership NHS Foundation Trust	0.0	0.0	0.0	(4.9)	(1.7)	0.0	0.0	(2.1)
Leeds Community Healthcare NHS Trust	0.0	0.0	0.0	(2.5)	0.0	0.0	0.0	(2.5)
Leeds Teaching Hospitals NHS Trust	0.0	0.0	(25.4)	(54.4)	(23.3)	(2.3)	0.0	(28.8)
Mid Yorkshire Hospitals NHS Trust	0.0	0.0	(15.7)	(37.0)	(17.2)	(9.0)	0.0	(10.8)
South West Yorkshire Partnership NHS Foundation Trust	0.0	0.0	0.0	(8.2)	0.0	0.0	0.0	(8.2)
Yorkshire Ambulance Service NHS Trust	0.0	0.0	0.0	(3.9)	(2.6)	0.0	0.0	(1.3)
West Yorkshire Provider Total	**0.0**	**0.0**	**(64.5)**	**(158.9)**	**(61.6)**	**(18.2)**	**(0.7)**	**(77.3)**
West Yorkshire ICS Total	**10.7**	**0.0**	**(77.0)**	**(225.4)**	**(83.7)**	**(18.2)**	**(0.7)**	**(121.7)**

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13b

Scenario analysis suggests potential risk of up to £77m. Four organisations have submitted Financial Recovery Plans in advance of reporting the Month 7 position, highlighting the risk of delivering their plan and outlining actions to address.

The full-year plan for the ICS is a planned £433.9m efficiency delivery (the plan is phased in a way that means the ambition in each month increases significantly over remaining months).

The forecast for all ten NHS provider organisations and ICB is to deliver efficiencies of £418.0m against a plan of £433.9m, a full-year shortfall/adverse variance of £15.9m.

There is an increasing unplanned full-year reliance on non-recurrent schemes (£17.5m more than plan) which does not offset the full-year shortfall against recurrent schemes (£33.4m less than plan).

4 POLICY CHANGES AND IMPACT ASSESSMENT

There haven't been any formal policy changes in the month, the Trust is still awaiting an update on the impact of the budget on NHS Organisations.

5 RISK ASSESSMENT

There is no change to BAF risk relating to the delivery of our financial plan.

If the most likely I&E forecasts for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and the WY ICS remain unchanged following the month 8 results, the organisation will need to consider the necessity of submitting a revised off-plan forecast to NHS England (NHSE). Board approval would be required for this revised forecast which would need to be done in coordination with the WY ICS and in compliance with NHSE's protocols for providers and systems falling behind their financial plans.

6 RECOMMENDATIONS

The Board is asked to note the contents of this report.

7 Appendices

None.

C. CLOSING THE GAP

REFERENCES

Only PDFs are attached

Bo.11.24.13c - Closing the Gap Update November 2024.pdf

CLOSING THE GAP UPDATE

BOARD OF DIRECTORS

NOVEMBER 2024

CONTENTS

CTG POSITION Vs TARGET

SCHEMES

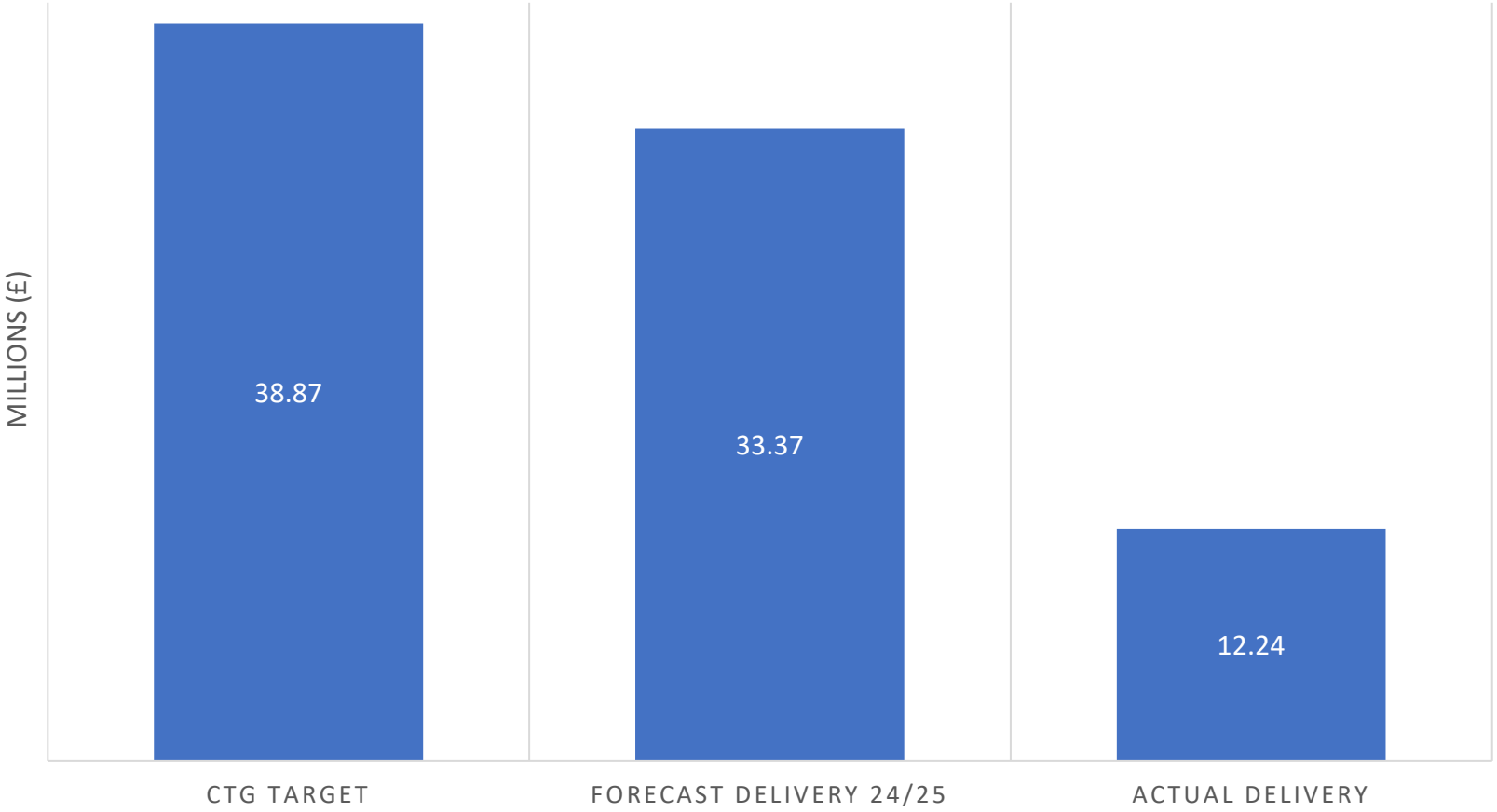
PROGRAMME GOVERNANCE

WORKFORCE EFFICIENCY GROUP

AUDIT

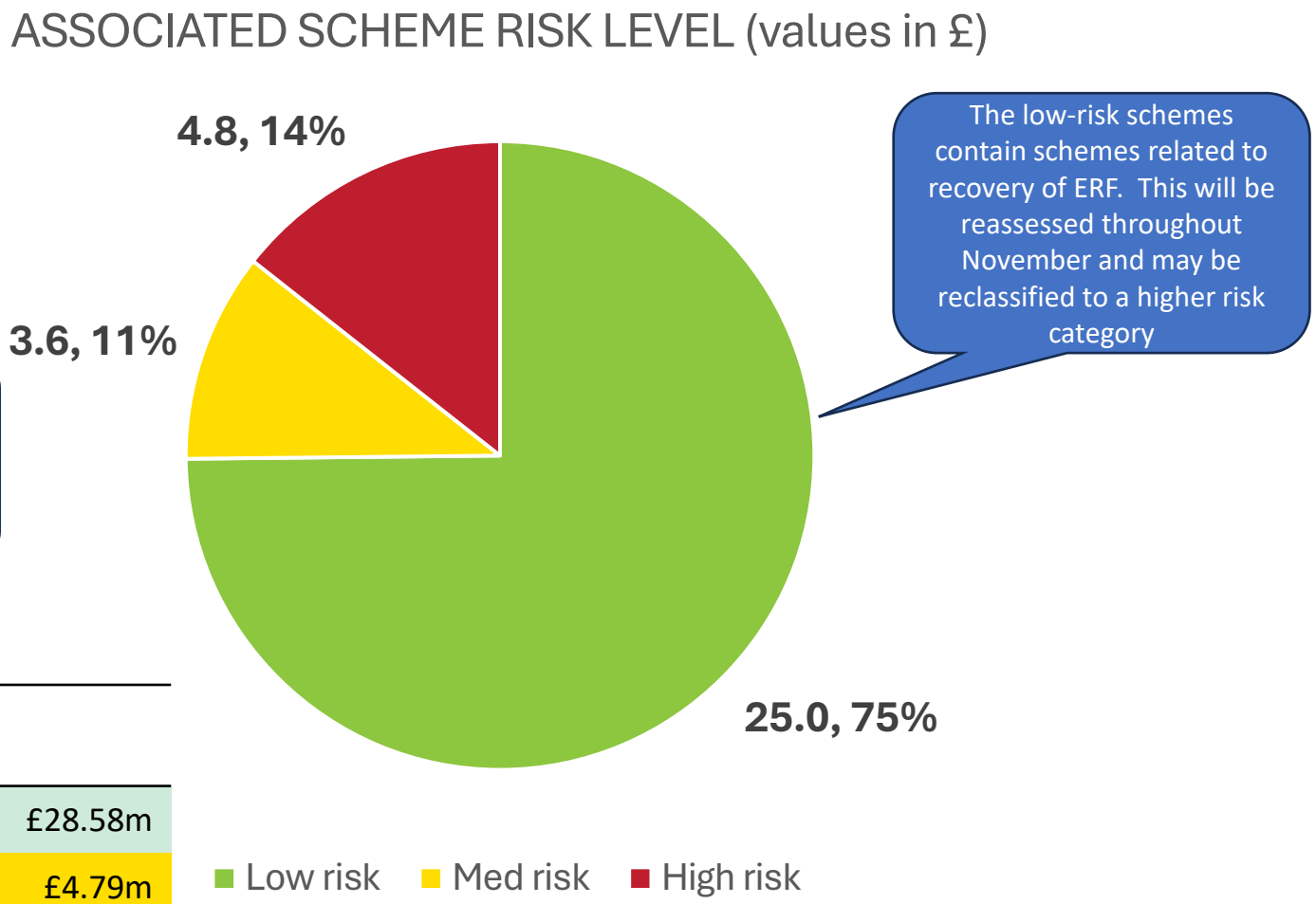
NEXT STEPS

POSITION Vs TARGET



Data correct as of 8th November 2024

SCHEMES



The low-risk schemes contain schemes related to recovery of ERF. This will be reassessed throughout November and may be reclassified to a higher risk category

£8m of ERF plans included in the recurrent figure may be non-recurrent dependent on NHSE 25/26 guidance

Oct update

Recurrent	£28.58m
Non-Recurrent	£4.79m

Data correct as of 8th November 2024

GOVERNANCE

Board of Directors	Next update 28th November
Finance & Performance Committee	Update 20th November
Executive Team Meeting	Weekly updates taking place
Closing the Gap Board	Took place 14th November

Workstreams

- Elective productivity
- Medicines Mgt
- Workforce
- Financial controls

Quality Oversight Panel

Workforce Control Panel → Workforce Control Panel

WORKFORCE EFFICIENCY GROUP

- The most significant Closing the Gap opportunities for the Trust relate to Workforce – we have strengthened our work in this area and created the Workforce Efficiency Group
- The Chief People and Purpose Officer is Executive Lead
- Members are
  - Deputy Chief Operating Officer
  - Deputy Chief Medical Officer
  - Deputy Chief Nurse
  - Deputy Chief Financial Officer
  - Director of HR
- Supported by CTG Team and Head of Workforce Information and Flexible Workforce
- Identified key areas of work – split into phases

WORKFORCE EFFICIENCY GROUP

Phase 1 – implementation underway

- Bank rates – to remove 15% premiums from 1 January 2025

  Applies to nurses, AHPs, ODPs, unions consulted, comms to be issued, no other WYAAT Trust pays uplifts

- Consultants moved to electronic rostering system for additional activity/PRA from 1 November

  Facilitates control of activity and standardisation of rates paid, ensures improved management information, improves grip on PRA worked, old paper system open to error.

- Consultants moved to electronic rostering system for annual leave and study leave from 1 December

  Brings consultants in line with all other staff groups, informs capacity and demand calculations, supports tracking of job plan quantum delivery

- Application of Consultant job planning guidance in full

  Includes recovery of DCC sessions cancelled for Clinical Governance, calculation of quantum sessions and recovery of mutually agreed shortfalls, review of DCC/SPA split (with default to core 1.125 SPA per week), uptake of an additional PA for all consultants with private practice

- Creation of Workforce Control Panel from 21 October

  Replaces Variable Pay Panel and role of ETM in approving use of variable pay and requests to unlock the non-clinical vacancy freeze - remit to provide greater rigour and analysis of risk

WORKFORCE EFFICIENCY GROUP

Phase 2 – to begin implementation Nov/Dec

- Review of rosters for Junior Doctors, Nurses and HCAs

  Will allow greater control over staffing – currently significant overspends compared to staffing establishments, high "unavailability" in some ward rosters

- Collation of Junior Doctor rotas from 2019 to compare to current rotas

  To ensure staffing can be rationalised and service expectations are realistic

- Use of electronic rostering system to plan junior doctor rotas

  Current practice of unauthorised software (e.g. google docs) in many instances creates poor data quality and little opportunity for oversight and reporting. Will improve decision making when additional resource is requested

- Review of rostering in theatres

  Part of a longer-term review to identify theatre efficiencies

- Review of training programme director roles so that the equivalent PA allocation matches the funding received

  Trust is funded by HEE at £10k per PA, this figure has remained static for many years. Consultants will be job planned to match funding e.g. if a PA costs £15k, then 0.67PA will be allocated

AUDIT

PWC

Second full West Yorkshire wide review commissioned from PWC

Included all other non-acute providers and ICB.

We submitted our progress to date against previous PWC recommendations and updated forecast positions.

Separate paper provides details

Internal audit

Internal audit began mid-October

Completed testing phase.

Expecting report imminently

NEXT STEPS

1.
   - Understanding implications of changes to Elective Recovery Fund and develop appropriate actions
2.
   - Implementation and management of workforce workstream and associated changes
3.
   - Focus on delivery of identified 2024/25 schemes and planning for 2025/26

D. INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.11.24.13d - Integrated Dashboard Nov 2024 (cover).pdf

Bo.11.24.13d - Integrated Dashboard - October 2024.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13d

Integrated Dashboard – November 2024

Presented by	Mel Pickup, Chief Executive	
Author	Paul Rice, Chief Digital and Information Officer	
Lead Director	Paul Rice, Chief Digital and Information Officer	
Purpose of the paper	Integrated Board Report	
Key control		
Action required	For information	
Previously discussed at/informed by		
Previously approved at:		**Date**

Key Options, Issues and Risks

The Integrated Board report is developed by combining the individual performance reports that are received and scrutinised by the Committees:
(1) Finance and Performance
(2) People
(3) Quality

Historically the individual metrics have been agreed with the Executive Leads for these Committees, updated on a rolling basis as policy, planning and performance imperatives require.

The organisation has confirmed its intentions to adopt the principles of the NHS England Making Data Count programme and is in a period of transition to confirm:
(a) which metrics should be included in a refreshed dashboard
(b) what statistical tool is best suited to capture and illustrate absolute changes and trends in that data
(c) the rationale for any material changes in the data
(d) how the position (deteriorating) will be recovered or (improving) amplified.

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	28 November 2024	Agenda item	Bo.11.24.13d

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

October 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

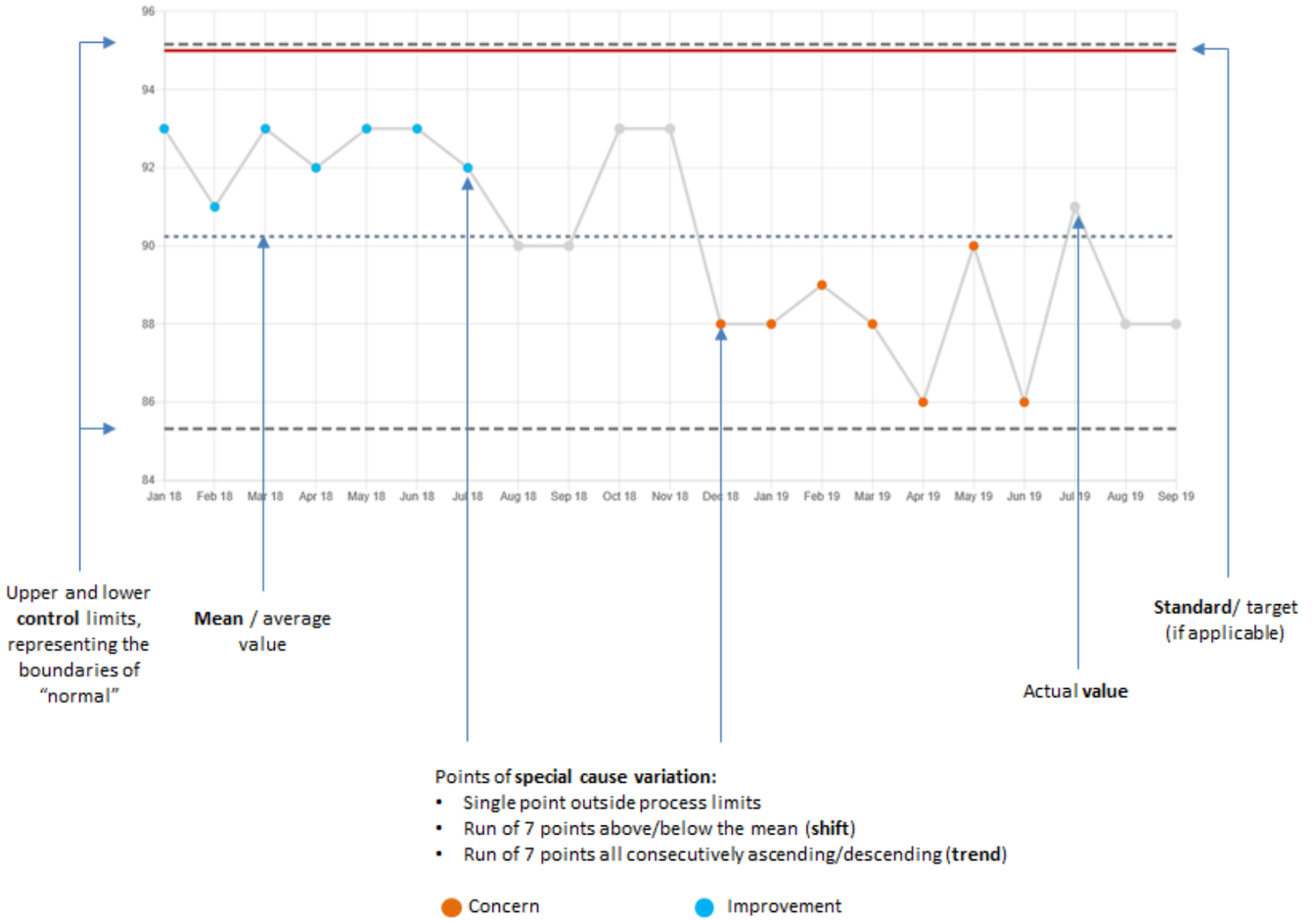
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

Interpreting Statistical Process Control Charts

Guidance notes

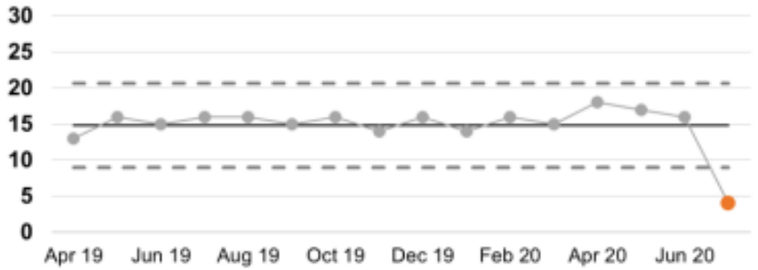
Reporting within this document uses a combination of chart types. Where appropriate, Statistical Process Control (SPC) charts have been used to aid analysis.

SPC charts

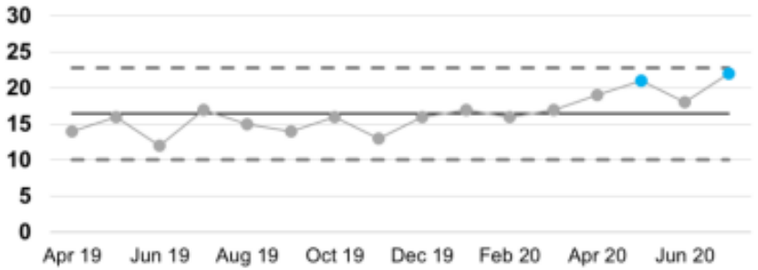


SPC rules : special cause variation

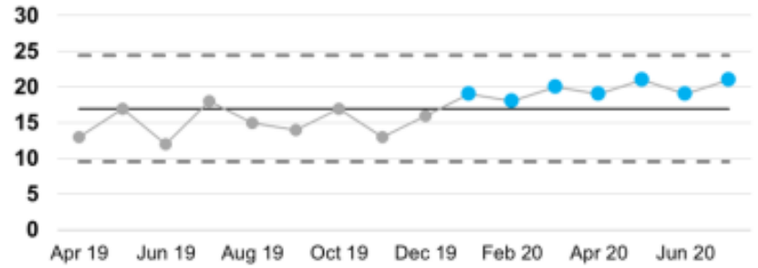
A single point outside the process limits



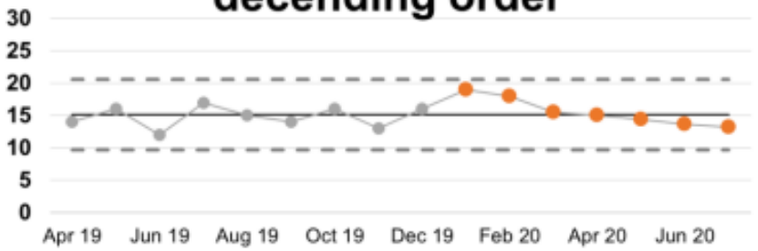
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or decending order



Operational Performance – Executive Director: Sajid Azeb

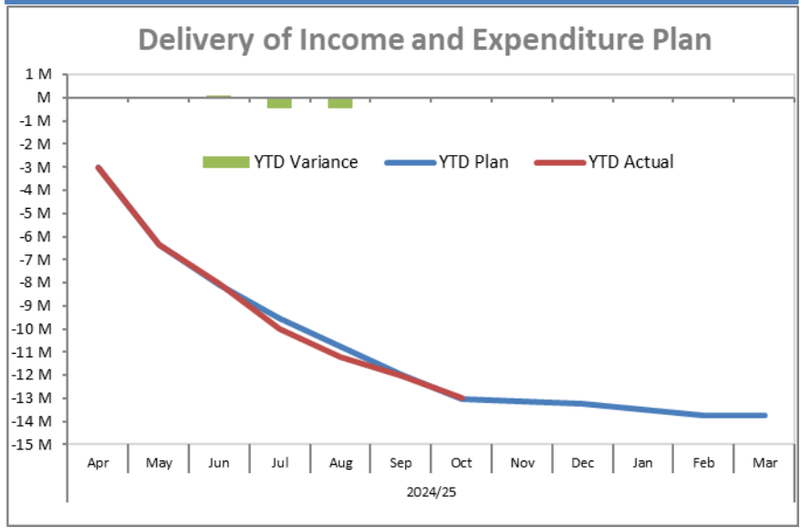
Bradford Teaching Hospitals NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	Oct-24	45.1%				56.40%
% Ambulance Handover <30 Mins - * All	Oct-24	76.3%				85.80%
% Ambulance Handover <60 Mins - * All	Oct-24	93.7%				96.50%
Ambulance Arrivals - * All	Oct-24	3,446				3,200
Bed Occupancy - * All	Oct-24	91.30%	93%			90.70%
Cancer 2 Week Wait - * All	Sep-24	93.90%				93.80%
Cancer 28 Day Faster Diagnosis	Sep-24	79.02%				81.6%
Cancer 31 Day 1st Treatment	Sep-24	91.00%				92.6%
Cancer 62 Day Wait - * All	Sep-24	70.00%	75%			74%
Day Case Rate - * All	Oct-24	88.40%				88.90%
Diagnostic Waiting List - * All	Oct-24	7,606				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	Oct-24	84.50%	95%			72.50%
DTA to Admission > 12 Hours	Oct-24	2.3%				2.01%
DNA Rate - All	Oct-24	7.90%				8.85%
ED - Time to Initial Assessment - * All	Oct-24	23.60				24.4
ED Attendances (% < 4hr) - * All	Oct-24	79.84%	77.30%			75.60%
Elective Ordinary and Daycase Admissions	Oct-24	4,889				4,190
Elective Theatre Sessions Volume Completed	Oct-24	616				520
Length of Stay 21+ Days - * All	Oct-24	103				103.5
Not Meeting Criteria to Reside - * All	Oct-24	13.50%	14.79%			13.06%
Outpatient Attendances	Oct-24	47,499				41,567
Outpatient Attendances % New or with Procedure	Oct-24	56.00%				56%
Outpatients Discharged to PIFU	Oct-24	3.12%				2.14%
Patients Discharged on/before DRD	Oct-24	83.3%				81.90%
Pts in ED >12 Hrs - * All	Oct-24	813				680.1
RTT 18 Weeks (%) - * All	Oct-24	61.80%				68.90%
RTT 18 Weeks (Total Pathways) - * All	Oct-24	34,887	30571			35,619
RTT 52 Week Breaches - * All	Oct-24	426				613.3
RTT 65 Week Breaches - * All	Oct-24	61				81.6
Theatre Capped Utilisation	Oct-24	85.30%				82%

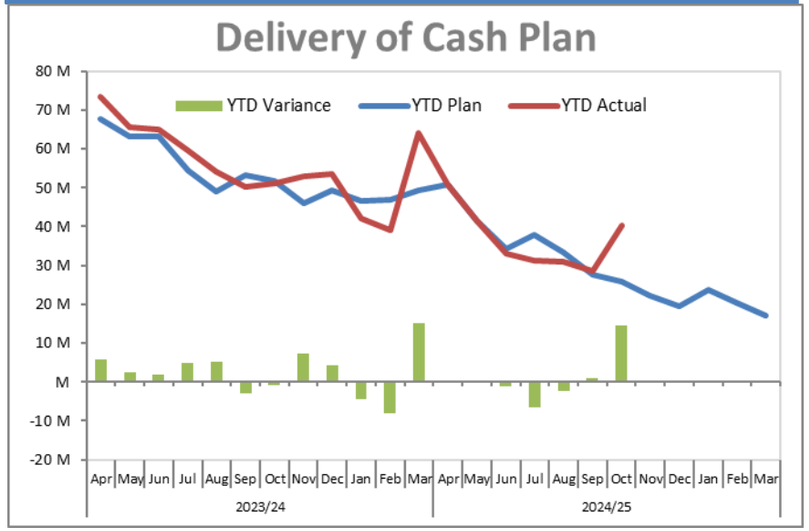
Finance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

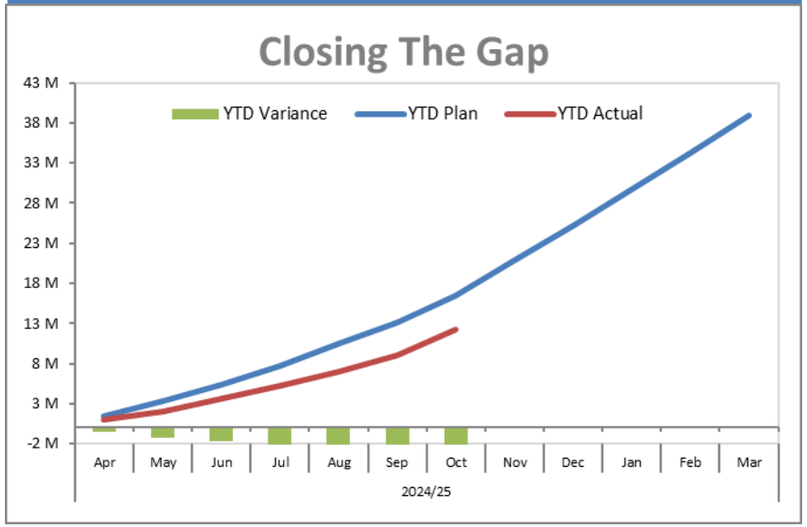
October 2024 – -£13.0m



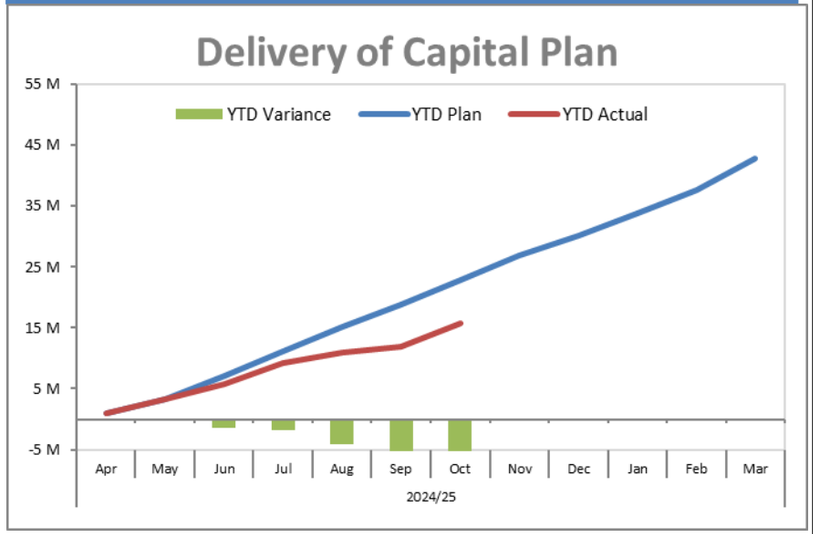
October 2024 – £40.2m



October 2024 - £12.2m



October 2024 – £15.7m



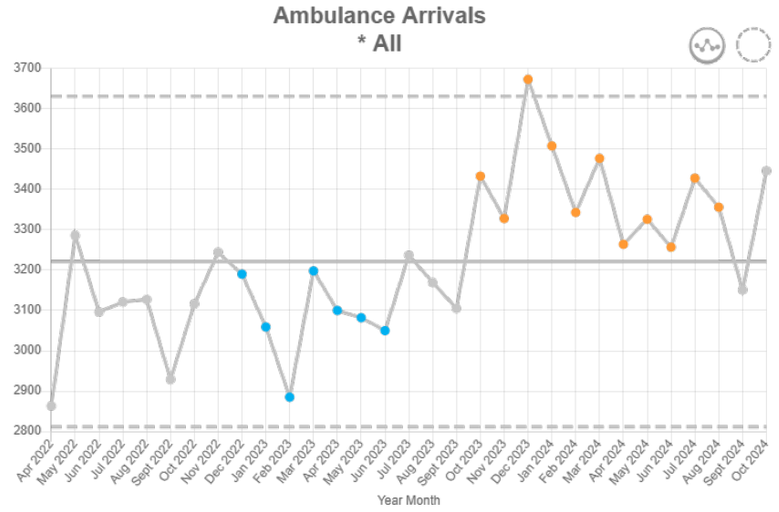
Analysis

Income & Expenditure The Trust had reported a YTD deficit of £13m which is in line with the planned £13m deficit.
The in-month position is a deficit of £1.1m in line with plan.
The *underlying* in month deficit of £2.3m does not show the required improvement to provide confidence that the £14m deficit plan will be delivered by year end. The formal and best case scenario forecast is delivery of the planned £14m deficit at year end, although there remain significant unmitigated risks to achieving this. The mid-case and most likely forecast is a deficit of £23.3m which is £9.3m behind plan. It is anticipated that the Trust will need to submit an off-plan forecast to NHS England prior to Month 9 reporting.
Cash The Trust had reported a YTD cash balance of £40.2m which is £15.4m higher than plan. I&E cash balance is £11.6m higher than planned (mainly due to pay awards). It is expected that this will reduce over the next two months so that cash is in line with plan. Capital Cash balance is £3.4m more than planned as the capital programme is behind plan. Forecast cash at the end of March 2025 is expected to be £9.0m which is £8.0m less than plan (£17.0m). The main reason for the reduction in cash is I&E cash performance.
Capital The Trust reported YTD capital programme to be £15.4m behind plan. This is mainly due to the Endoscopy Transformation Programme being behind plan (£4.8m). Forecast capital spend is expected to be in line with plan. The Trust is forecasting to spend £27.1m for the remainder of the year (c.63% of the capital budget). Capital could be behind plan by up to £5.5m but the Capital Strategy Group are reviewing options to mitigate this risk.
Closing the Gap The Closing the Gap programme has delivered £12.2m of cost reductions against a target of £16.5m, resulting in a £4.3m shortfall, which has been offset by non-recurrent measures and expenditure controls. The current best case year end forecast is delivery of £33.4m of savings against the £38.9m target leaving a shortfall of £5.5m. The mid-case forecast is delivery of £29m and a £9.9m shortfall. Both CTG forecasts are reliant on significant growth in H2 ERF income which is a significant risk.

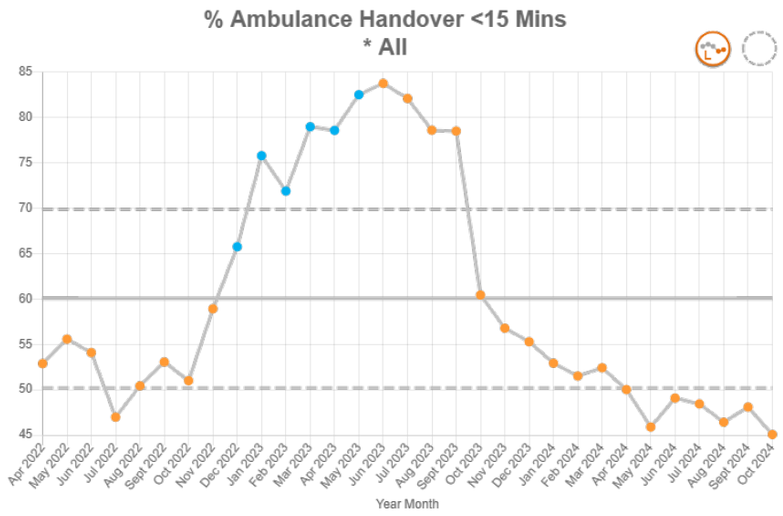
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

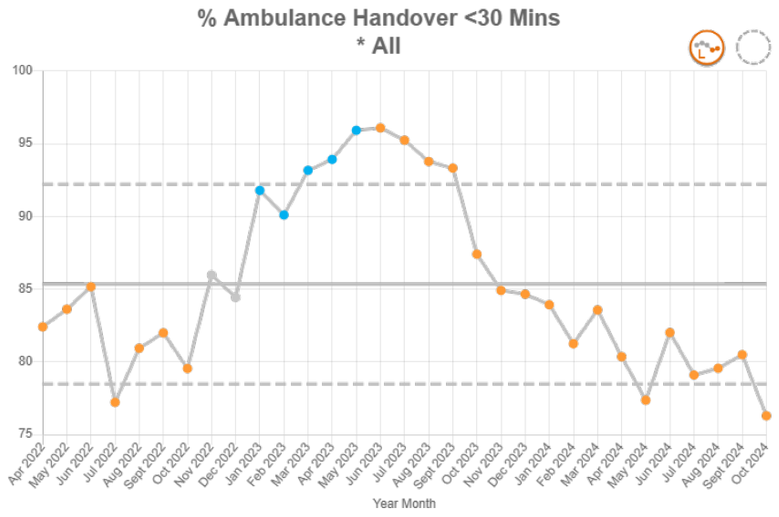
October 2024 – 3,446 ambulance arrivals
Common cause variation



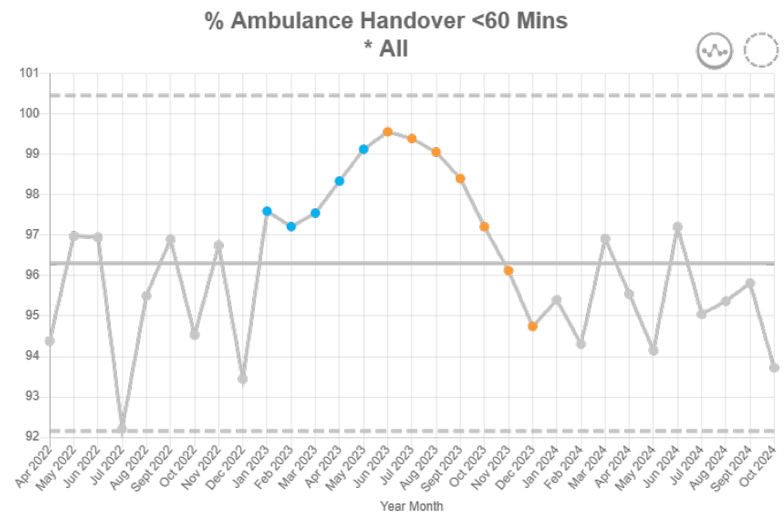
October 2024 – 45.1% ambulance arrivals
Special cause variation of a **concerning** nature



October 2024 –76.3% ambulance arrivals
Special cause variation of a **concerning** nature



October 2024 – 93.7% ambulance arrivals
Common cause variation



Analysis

Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 45.73% in October compared 48.47% in September. Ambulance arrivals has increased in October and into early November compared to previous months with acuity remaining comparably high.
Overall handover times for the Trust continue to track below the regional average (~23 mins compared to a regional average of ~32 mins).

Risks, Mitigations and Assurance

The jointly approved handover process used to accurately record handover times is fully operational in the ED but has not resulted in any substantial changes to performance.
A Quality Improvement lead has now been nominated to support with further improvements in handover reporting and to help streamline ambulance self-handovers processes to reduce AAA congestion (currently BTHFT record zero self-handovers vs 4% across the region).
YAS is currently recruiting to provide additional support to Hospital Trusts' during the winter period, the role will involve a Senior Paramedic being present on-site to assist crews with clearing times.
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.

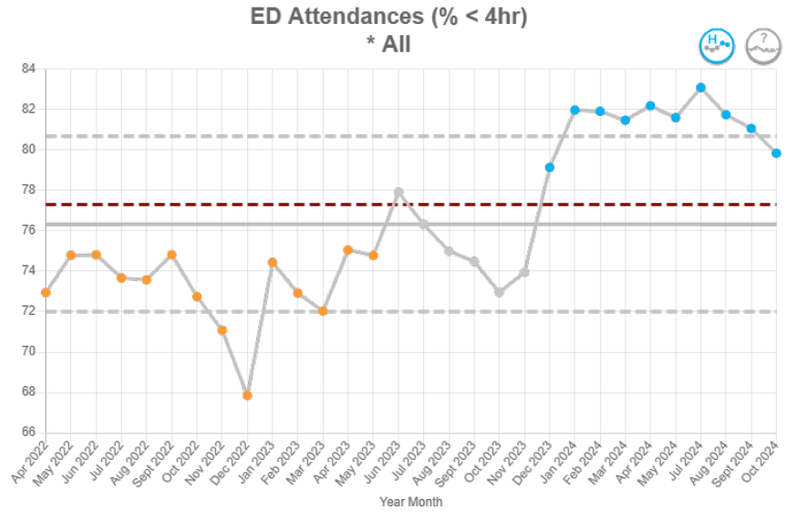
Benchmarking

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.

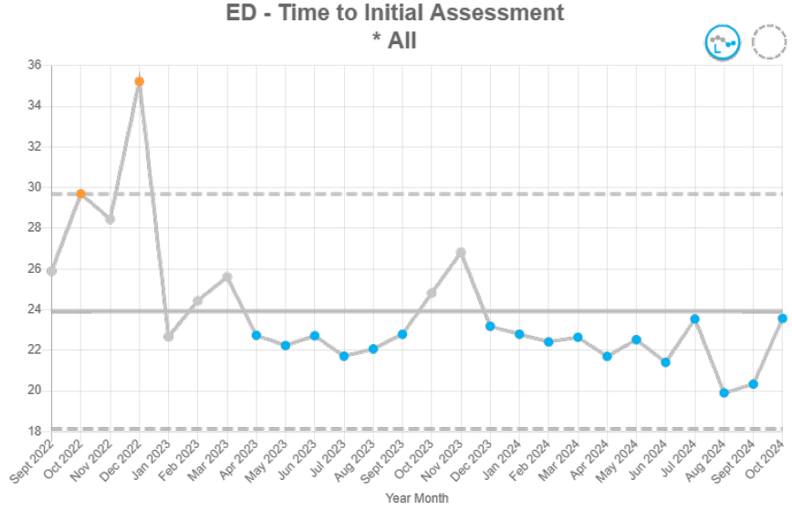
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

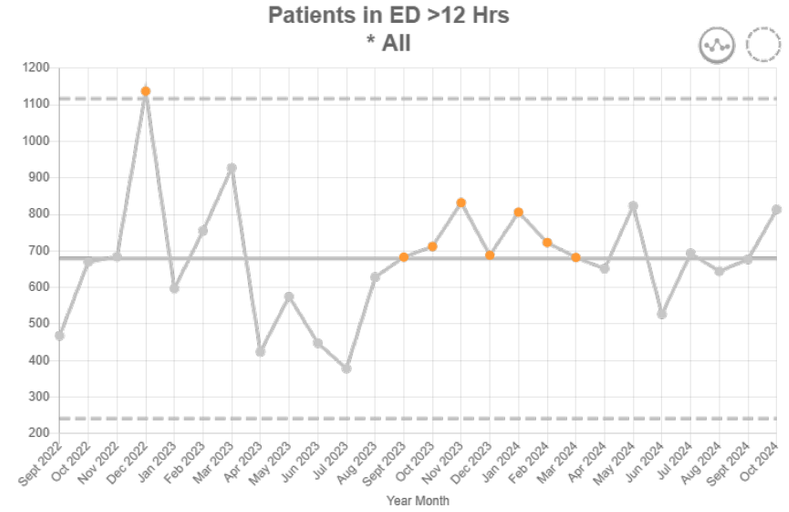
October 2024 – 79.84% - Year end target 77.3%
Special cause variation of an **improving** nature



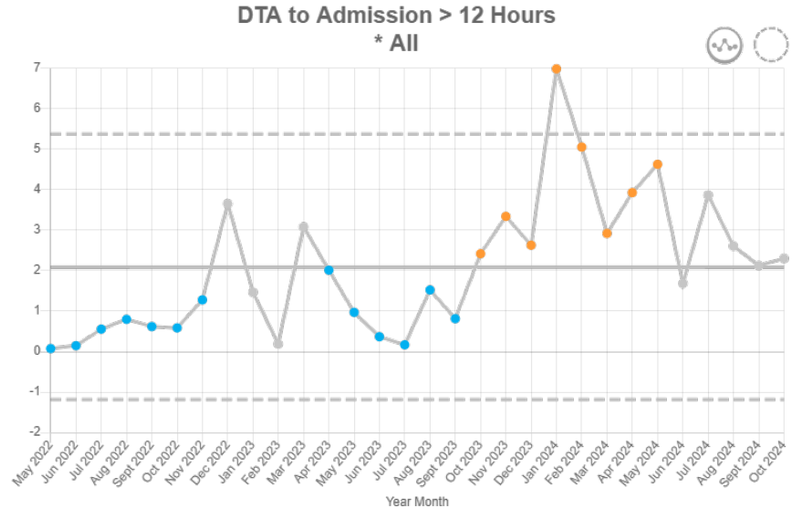
October 2024 – 23.6 minutes
Special cause variation of an **improving** nature



October 2024 –813 patients
Common cause variation



October 2024 – 2.3%
Common cause variation



Analysis

ECS performance for Type 1, 2 & 3 attendances was 81.41% for a October 2024 and is currently forecast at 81.54% for November 2024. This remains in the upper decile of Acute Trusts in England. Daily attendances in October increased to 414 ED arrivals per day compared to 400 in September with demand increasing earlier than forecasted.

Risks, Mitigations and Assurance

Streaming to the AECU service continues to remain effective, positively impacting a range of UEC metrics.
G&A adult bed occupancy remained stable at 91.29% in October. High acuity patients and issues within the social care sector continue to impact the timely discharge of patients as reflected in an increase in the number of patients not meeting the criteria to reside during October (13.5% compared to 12.7% in September).
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.
The Outstanding ED project presented in October will focus additional effort on reducing overcrowding and improving the experience of patients waiting in ED, subject to board sign off in November.

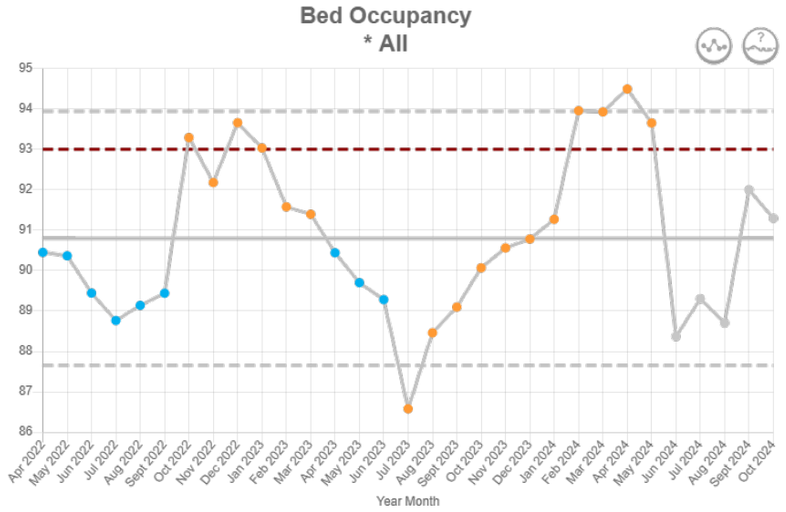
Benchmarking

Performance is above national, peer and WY averages. For ECS the Trust performs in the upper decile of Acute Trusts in England.

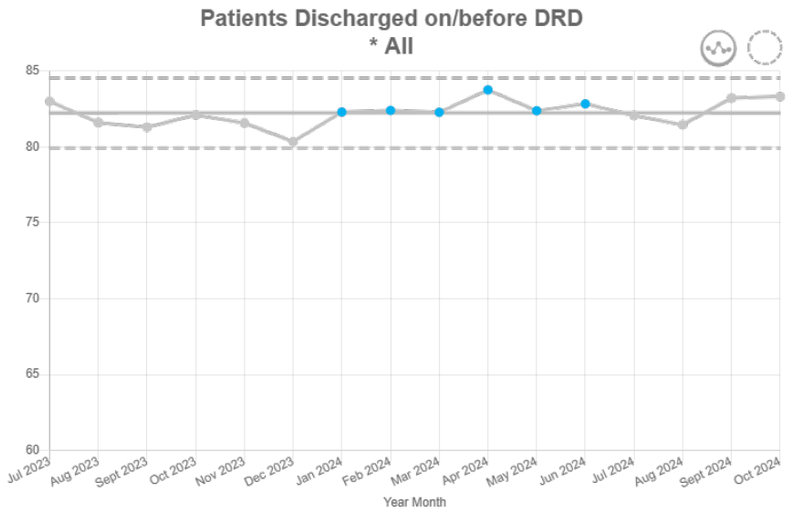
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

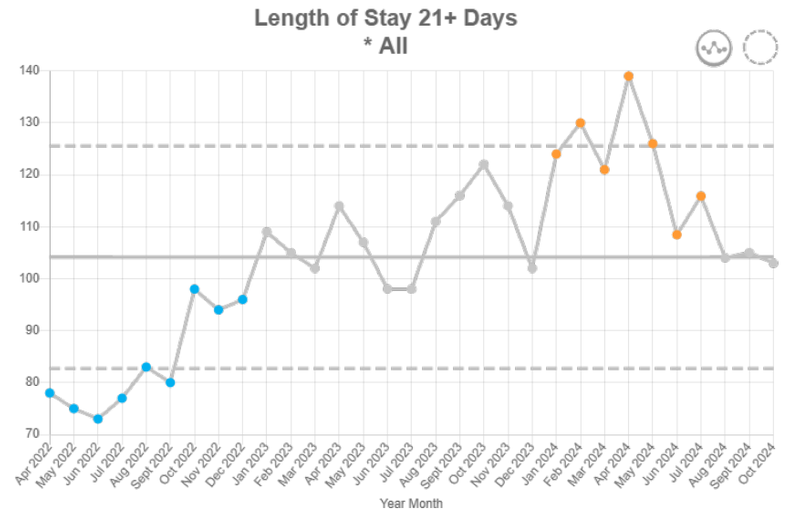
October 2024 –91.3% occupancy – Year end target 93%
Common cause variation



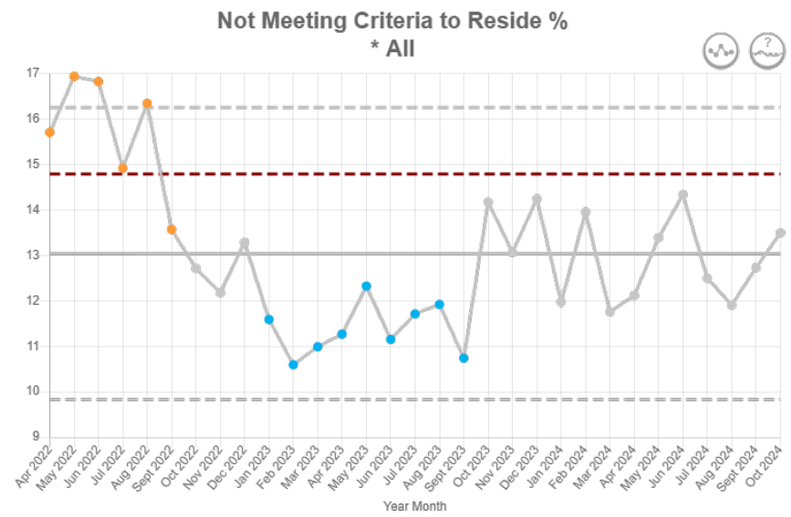
October 2024 – 83.3%
Common cause variation



October 2024 – 103 patients
Common cause variation



October 2024 –13.5% – Year end target 14.79%
Common cause variation



Analysis

The daily average number of patients with a length of stay (LOS) > 21 days has remained stable at 103 in October 2024. BTHFT's strong partnerships with community, social care, and voluntary sectors are helping to alleviate occupancy and discharge pressures.

Risks, Mitigations and Assurance

Increasing 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, although H-Fast is now discharging up to 4 discharges per day and is expected to increase incrementally to 6 discharges per day.
A discharge coordinator position is being piloted 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 '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.
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.

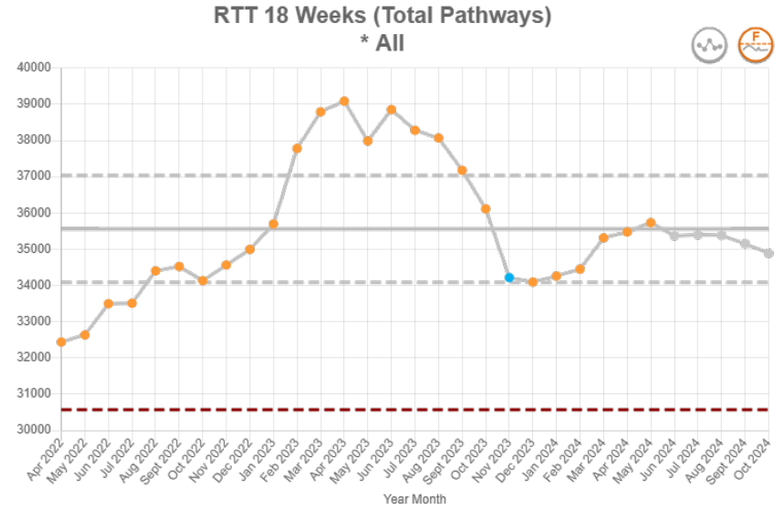
Benchmarking

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.

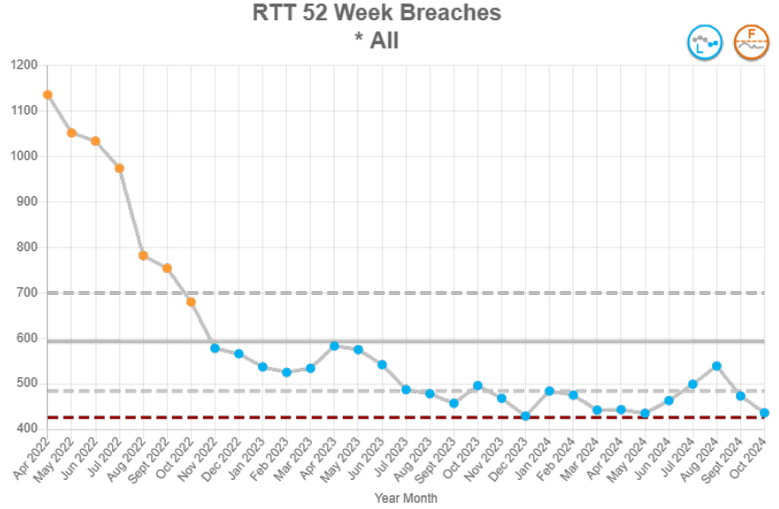
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

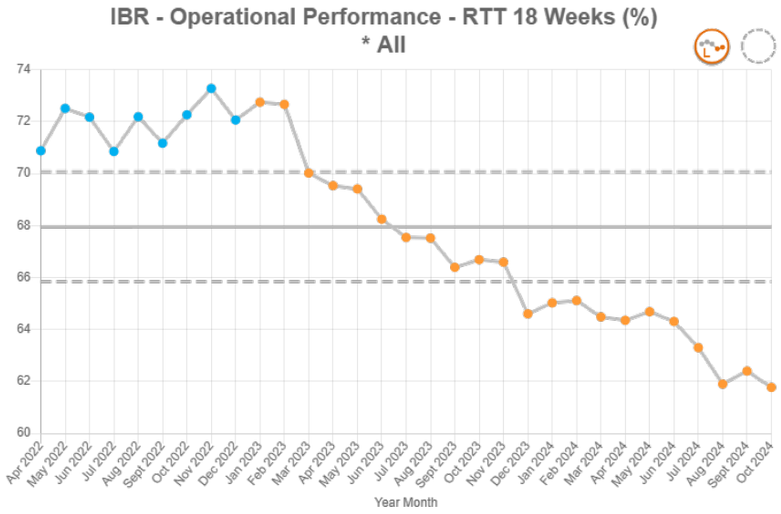
October 2024 – 34,887 pathways – Year end target 30,571
Common cause variation



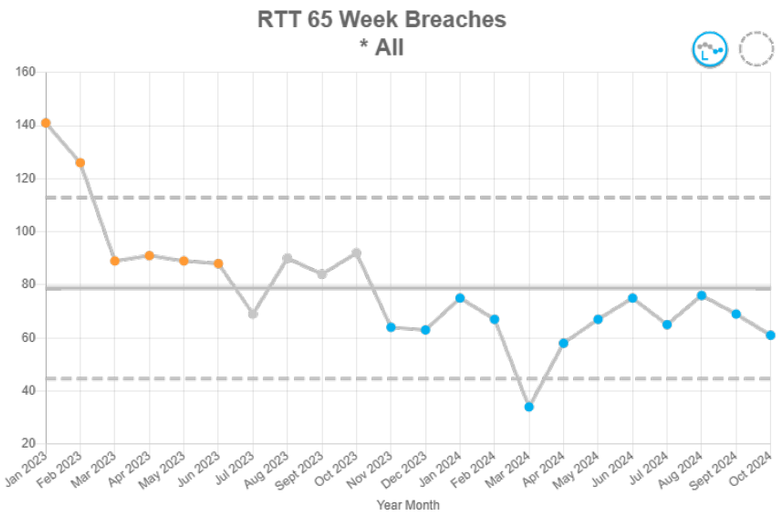
October 2024 – 436 pathways – Year end target 426
Special cause variation of an **improving** nature



October 2024 –61.8%
Special cause variation of a **concerning** nature



October 2024 –61 patients
Special cause variation of an **improving** nature



Analysis

Referral to Treatment (RTT) performance reduced slightly in October 2024 at 61.77% and 52-week performance is improving and is now in line with plan.
There were 4 patients reported >78 weeks at the end of October with 2 patients projected >78 weeks at the end of November.
61 patients breached 65 weeks, predominately in T&O for whom action plans are progressing and forecasts into November and December show improvement. This position is monitored weekly by NHSE.

Risks, Mitigations and Assurance

T&O, ENT, and OMFS continue to have weekly meetings to support recovery action plans.
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.
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.

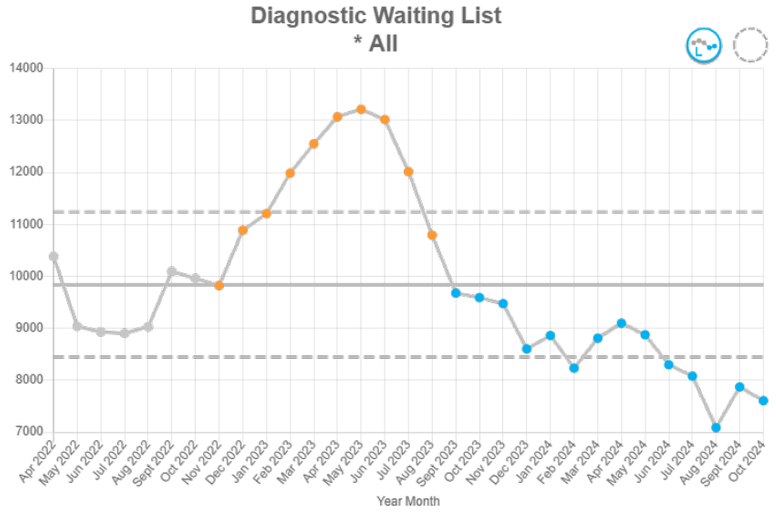
Benchmarking

Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.27% in October 2024.
52-week performance benchmarks in the best quartile nationally whilst we are just below the best quartile for 18 weeks.

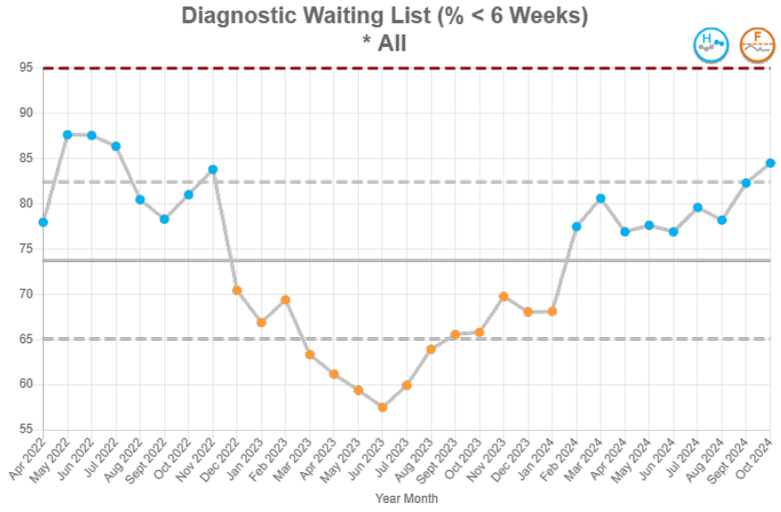
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

October 2024 – 7,606 pathways
Special cause variation of an **improving** nature



October 2024 – 84.5% <6 Wks – Year end target 95%
Special cause variation of an **improving** nature



Analysis

DM01 performance for October improved on September performance to a position of 84.46%. This uplift is forecast to continue into November.

Risks, Mitigations and Assurance

CDC continues to provide additional capacity for all the modalities we had planned to include. Process and efficiency improvements are being explored to further capitalise on this resource.
MRI performance has recovered in October, and this is expected to continue with equipment issues resolved and staff returning to work. There is a shortfall in staffing to support the ideal capacity model and further work is needed to maximise potential and realise improvements.
Endoscopy services are expected to experience an extended period of high demand linked to national cancer awareness campaigns including Gastric cancers and preparations are underway. FIT testing alongside STT (Straight to Test) and the streamlining of waiting list management are improving waiting times despite this growth.
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.

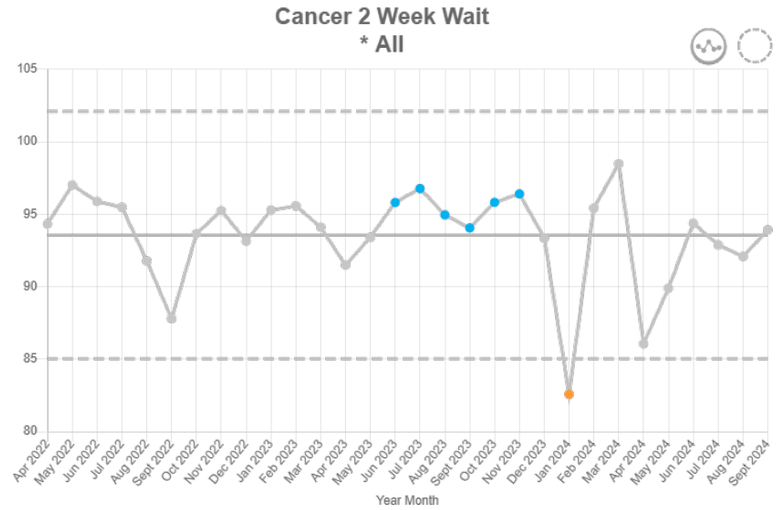
Benchmarking

It is expected that this additional capacity will mean the current improvement trend will continue during 2024/25 and bring performance back into the upper quartile nationally.

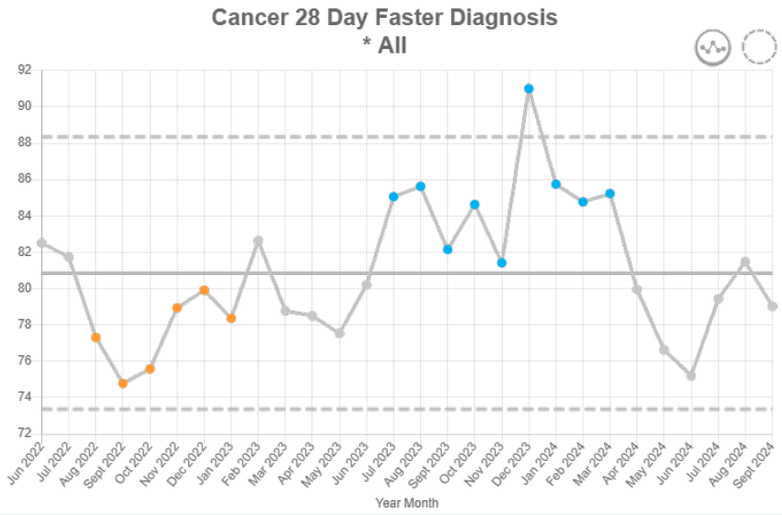
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

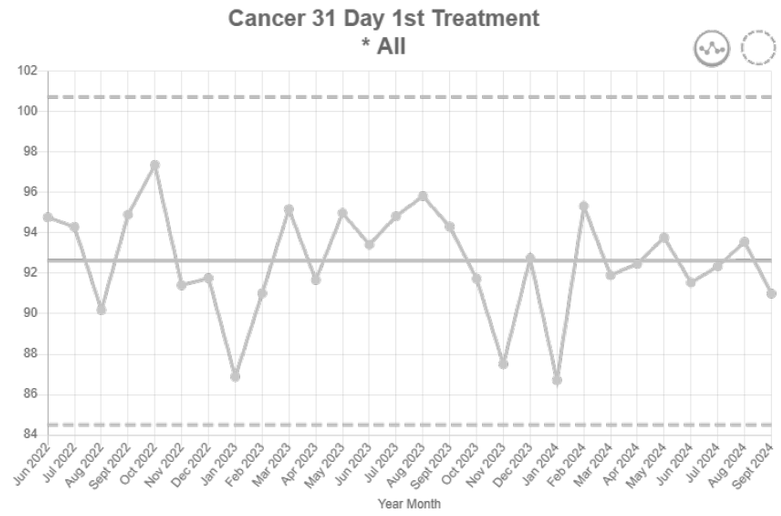
September 2024 – 93.9%
Common cause variation



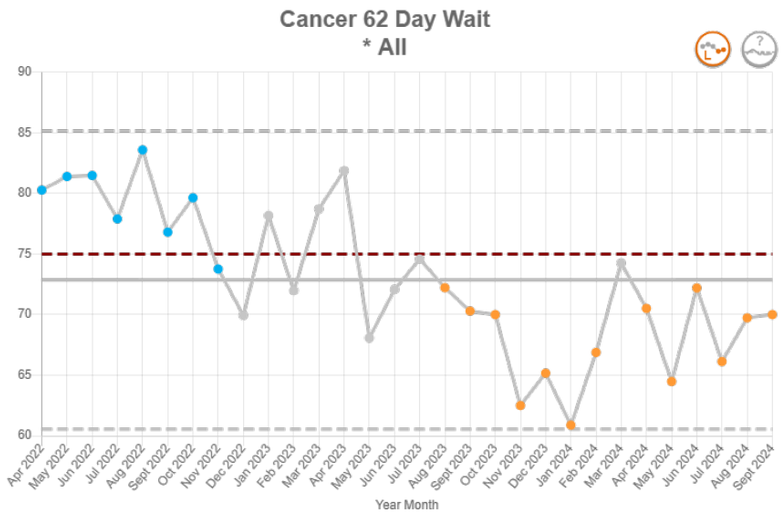
September 2024 – 79.0%
Common cause variation



September 2024 – 91.0%
Common cause variation



September 2024 – 70.0%
Special cause variation of a **concerning** nature



Analysis

The 28-day faster diagnosis standard (FDS) performance remained above target at 79.02% in September. 31-day general treatment is forecast to remain below target for September being impacted by extended consultant leave. 62-day performance achieved the 70% performance threshold for September, with the back log of patients waiting over 62 days starting to drop to an on-plan position in October. There is no single cause for delays, with tumour groups experiencing increased complexity, reduced treatment capacity, diagnostic delays, and patient-initiated delays.

Risks, Mitigations and Assurance

A second cancer time out session took place in November and was well attended. These sessions are part of the Cancer Board program of work to develop a shared clinical vision for the Trust's Cancer Strategy. Improvement plans, a focus on 31-day performance, health inequalities, and patient experience all featured on the agenda.
2WW demand is high due to national cancer campaigns taking place throughout Autumn. Performance is being impacted as a result. 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.

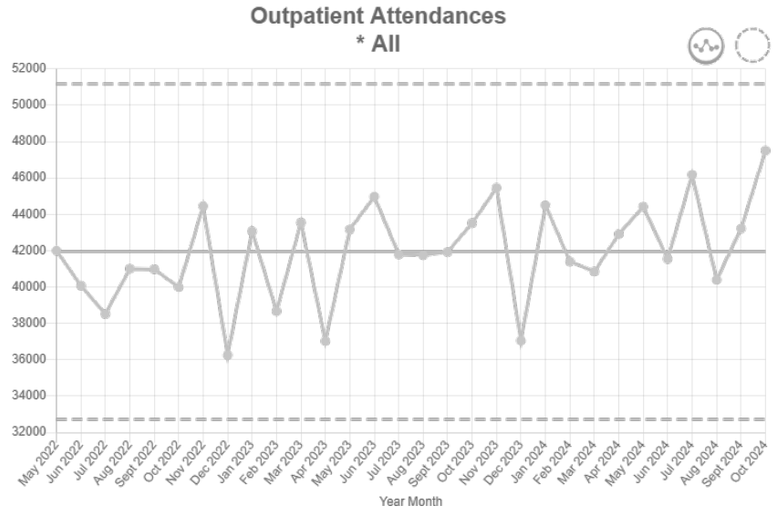
Benchmarking

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.

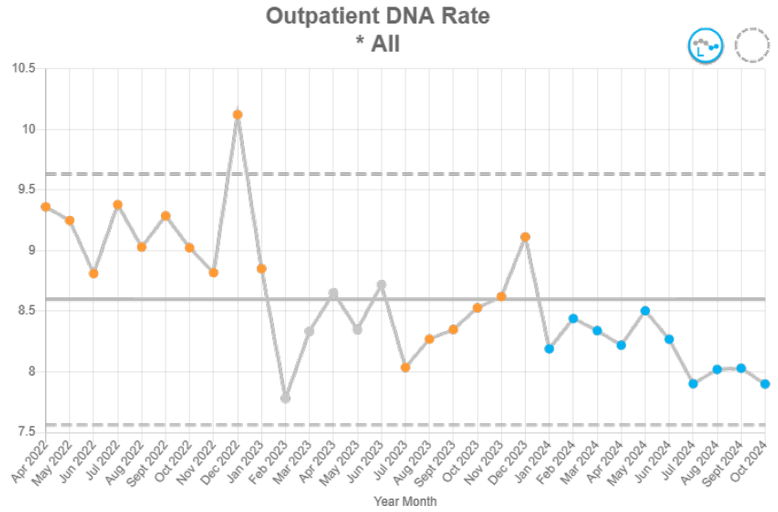
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

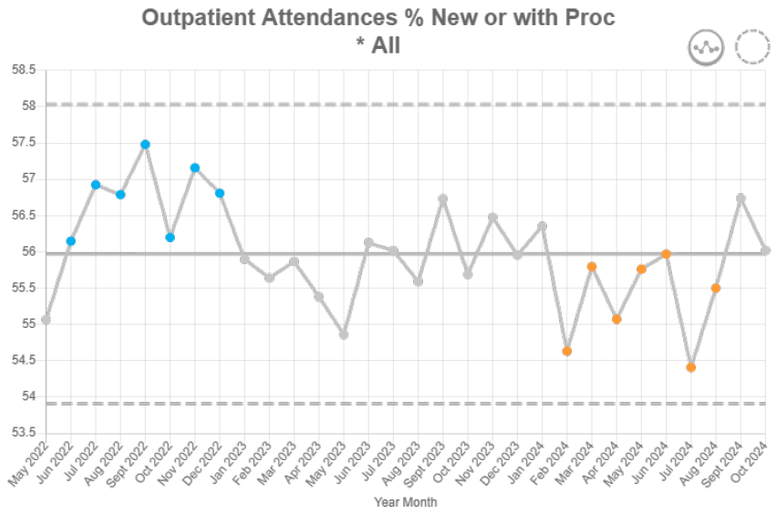
October 2024 – 47,499
Common cause variation



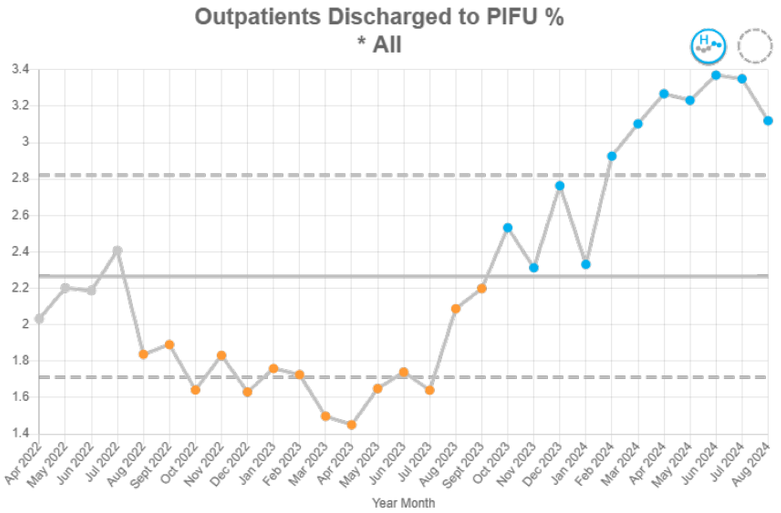
October 2024 – 7.9%
Special cause variation of an **improving** nature



October 2024 – 56.0%
Common cause variation



October 2024 – 3.12%
Special cause variation of an **improving** nature



Analysis

Outpatient activity delivered above plan in October 2024 and is projected to deliver in line with plan in November 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 and improved for the last 3 months. DNA rates for patients from CORE20 postcodes have improved more significantly closing the gap previously described to this committee.

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. Counting and coding improvements are also being identified by this work.
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.

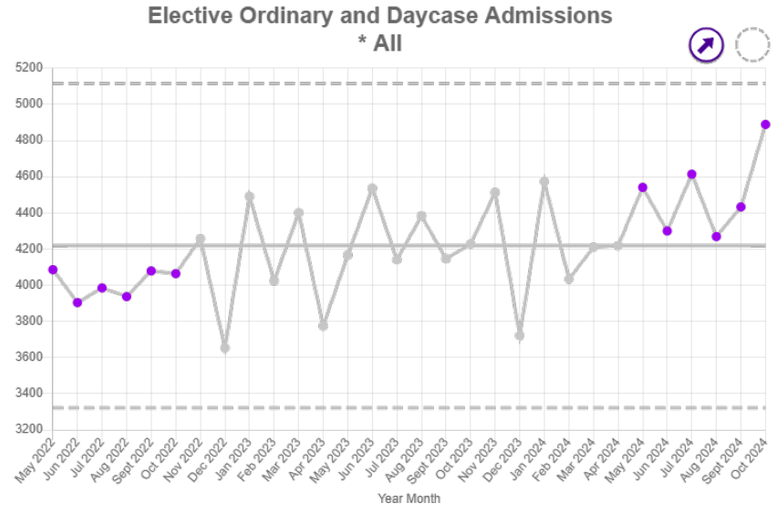
Benchmarking

Outpatient recovery and plans compared favourably to neighbouring Trusts.

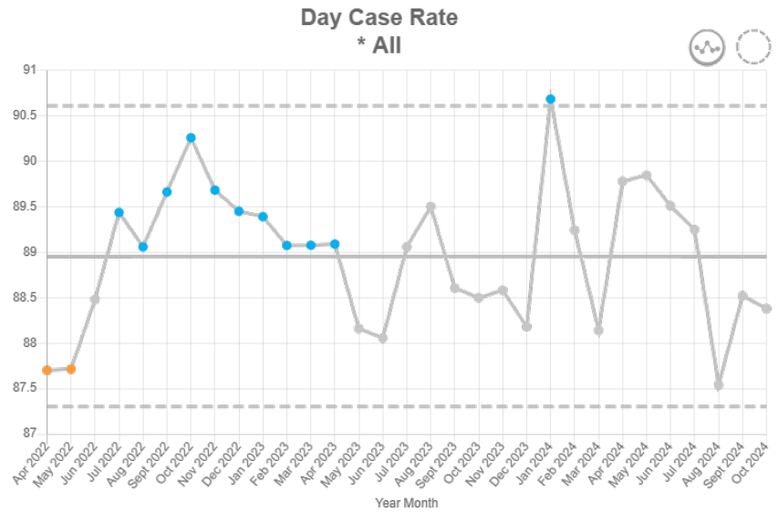
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals
NHS Foundation Trust

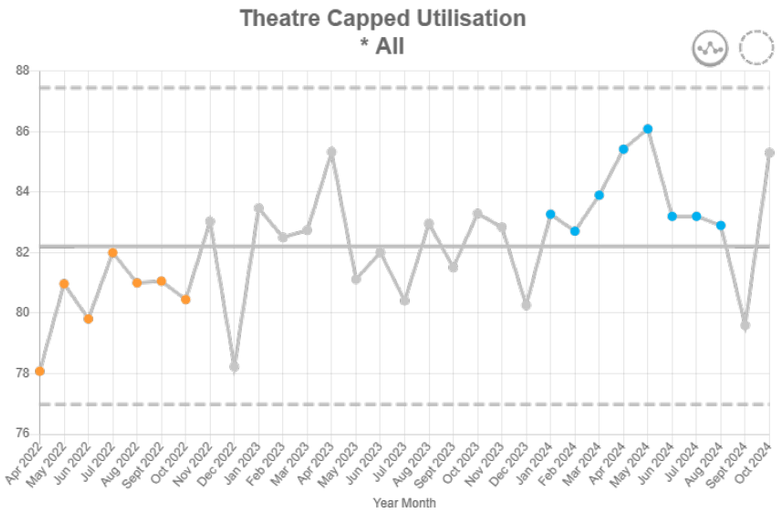
October 2024 – 4,889
Common cause variation



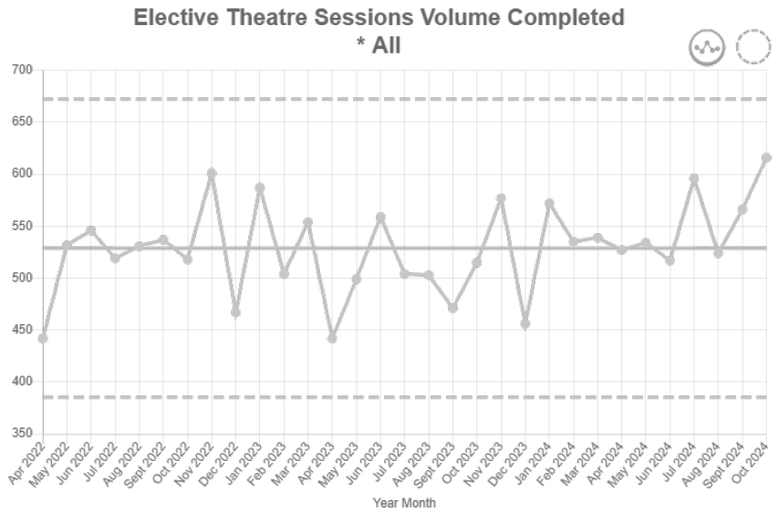
October 2024 –88.4%
Common cause variation



October 2024 – 85.3%
Common cause variation



October 2024 – 616
Common cause variation



Analysis

Inpatient activity delivered below plan in October 2024. Lists are running at increased levels whilst patients per list and capped utilisation remain relatively stable, although improvement in both is needed to support ERF targets. The delay to the SLH DCU is having a negative impact on delivery against plan.

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

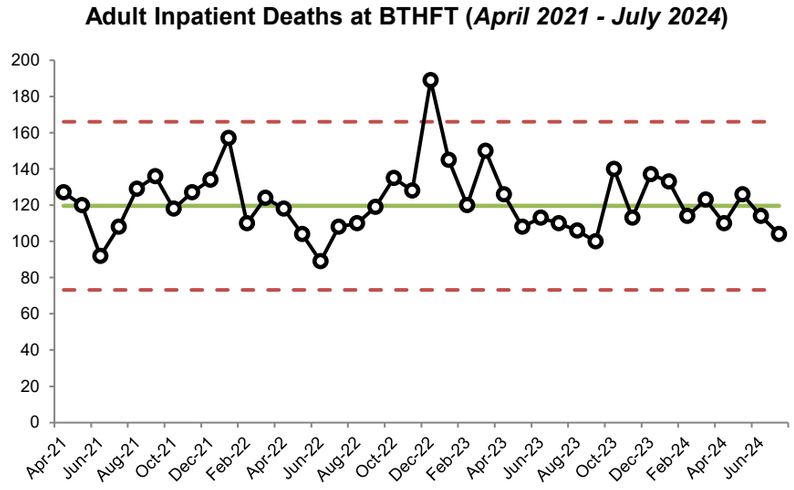
The Trust is above the national average for day case rates, and capped utilisation. Elective activity compares below other Trusts in our region as a percentage of 2019/20 baselines.

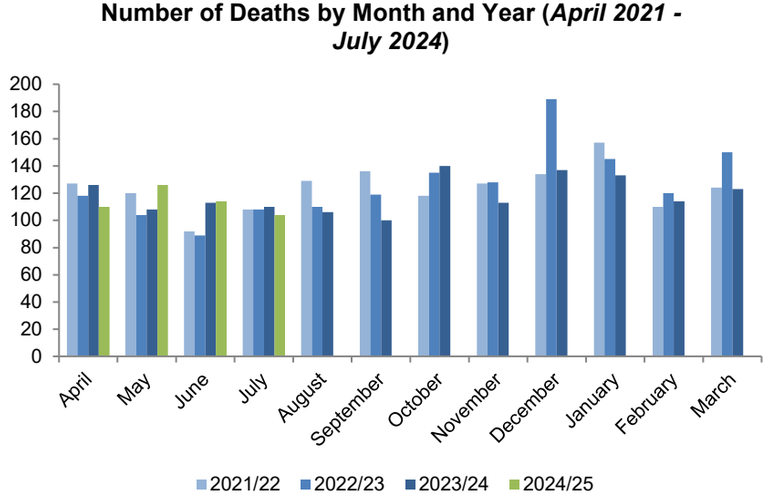
Quality – Executive Director: Dr Ray Smith and Karen Dawber

Clinical Effectiveness - To provide outstanding care for patients

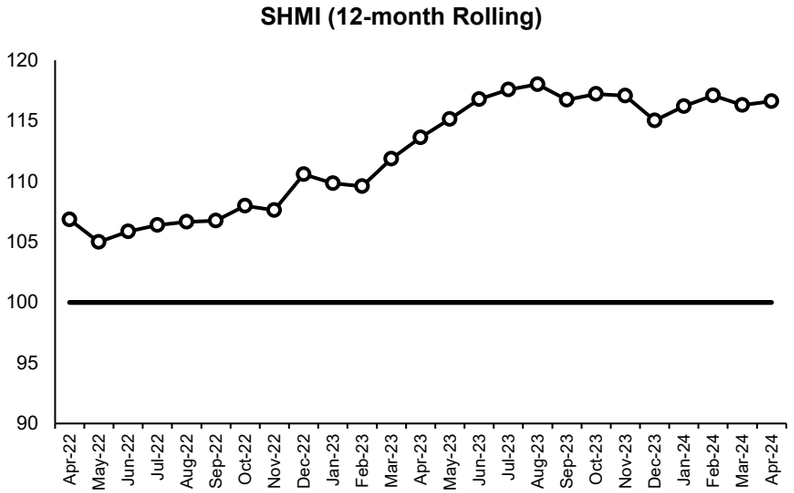
Bradford Teaching Hospitals NHS Foundation Trust

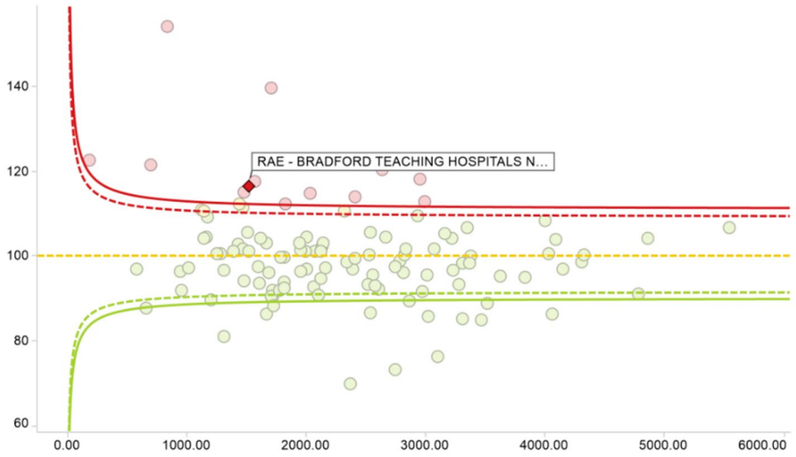
July 2024 – 114 Adult Inpatient Deaths





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

People – Renee Bullock

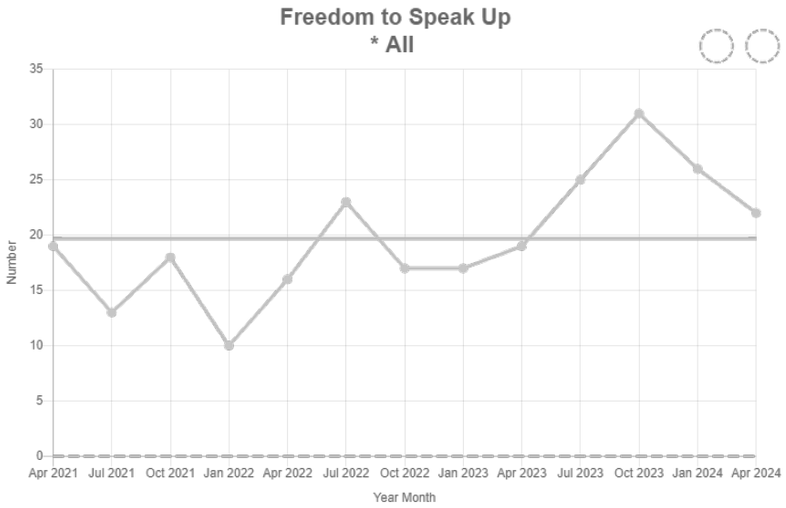
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	Aug-24	0.96%				2.33%
Appraisal Rate - Non-Medical	Aug-24	75.79				75.30%
BAME Split - Band 8+	Sep-24	19.6%				17.45
BAME Split - Bands 1-5	Sep-24	48.9%				43.91
BAME Split - Bands 6-7	Sep-24	28.9%				25.57
BME - * All	Sep-24	43%				38.47
Core Manadatory Training - * All	Apr 24 - Sep 24	93.8%				90.20%
Disability Declaration - * All	Sep-24	5.0%				3.9%
Freedom to Speak Up - * All	Jan 24 - Mar 24	26.00				13.81%
Harrassment and Bullying - Disciplinary Action	Apr 24 - Sep 24	1				0.67
Harrassment and Bullying - Informal Action	Apr 24 - Sep 24	1				3.00
Harrassment and Bullying - In-progress	Apr 24 - Sep 24	6				7.00
Harrassment and Bullying - No Case To Answer	Apr 24 - Sep 24	2				3.00
Harrassment and Bullying - Resigned	Apr 24 - Sep 24	0				0.67
Harrassment and Bullying - Total Investigations	Apr 24 - Sep 24	10				14.33
Job Planning - Allied Health Professionals	Sep-24	3.8%				49%
Job Planning - Medics	Sep-24	43.1%				25%
Job Planning - Nurses	Sep-24	0%				60%
Nursing Agency Fill Rate - %	Sep-24	7.5%				12.9%
Nursing Bank Fill Rate - %	Sep-24	68.9%				46.3%
Staff Advocacy - Contacts	Apr 24 - Sep 24	17				14.00
Staff Advocacy - Contacts Not Resolved	Apr 24 - Sep 24	0				0.00
Staff Advocacy - Formal Complaints/Investigations	Apr 24 - Sep 24	1				0.67
Staff Advocacy - In-progress	Apr 24 - Sep 24	4				0.67
Staff Advocacy - Outcome Unknown	Apr 24 - Sep 24	6				0.33
Staff Advocacy - Resolved Informally	Apr 24 - Sep 24	6				9.00
Staff Sickness - * All	Aug-24	5.72%				6.5%
Staff Stability - * All	Aug-24	96.46%				98.8%
Staff Turnover - * All	Aug-24	10.17%				11.4%

People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

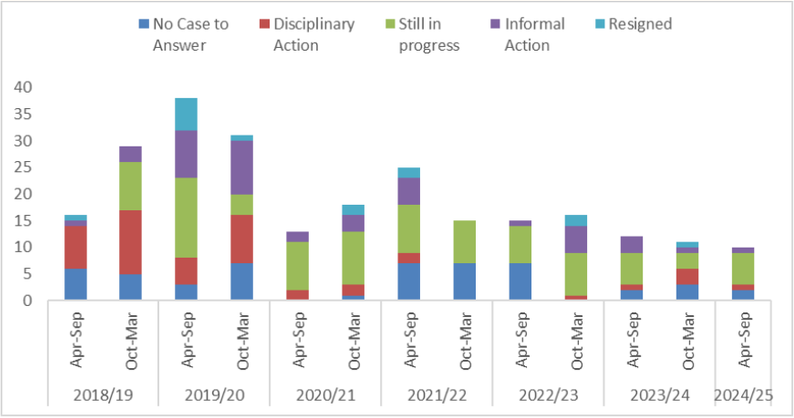
2023/24 Quarter 4 – 26



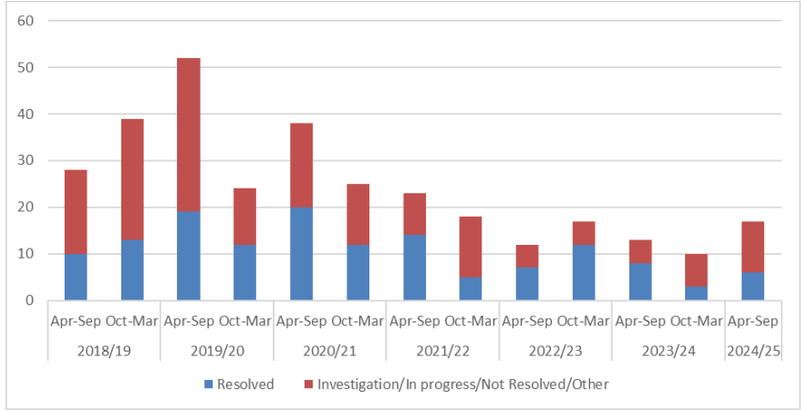
2024/25 October to March– Staff Advocacy

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
Apr 24 - Sep 24	17	1	6	4		6

2024/25 Quarter 2 Harassment and Bullying



2024/25 April to September –Staff Advocacy



Analysis

Harassment & Bullying Outcomes: A very slight reduction in the number of formal cases since the last 6-monthly update (reduction of 1 formal case to 10) and with all cases concluded within a 6-month period. Just 1 case resulted in a recommendation for informal action (same as last reporting period), 1 case resulted in disciplinary action (66% reduction from the last reporting period) and 2 cases resulted in 'no case to answer' (a 33% reduction from the last reporting period). Those cases that are still ongoing have either had a final outcome in October 24 (to be reported in the next 6 monthly reference period) or did not commence until September 24 (therefore a new case), which is an improvement in terms of case duration.

Contacts with staff Advocacy Service: The number of contacts with the Staff Advocacy Service has risen slightly in the last 6 months (from 10 to 17 contacts). The number of cases being supported that were resolved informally increased from 30% to 35%.

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

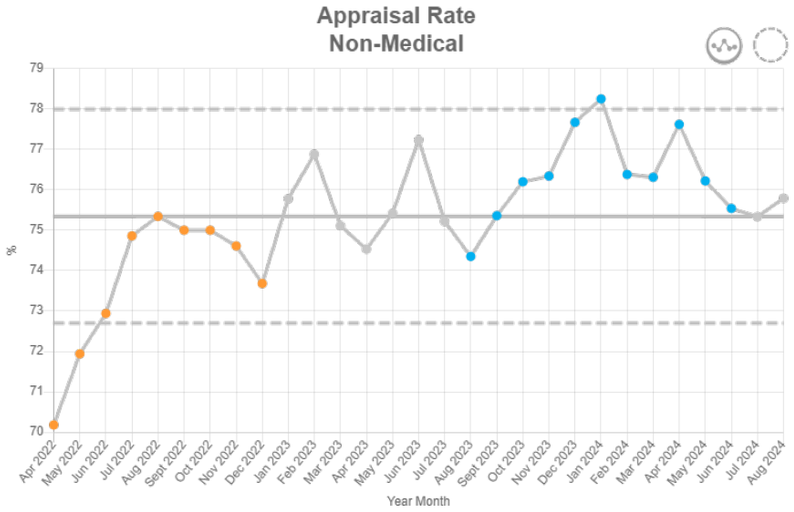
Harassment & Bullying Outcomes: Whilst there is still work to do to reduce the number of formal cases, and particularly those resulting in "no case to answer" the outcomes in this 6-month reporting period are more positive and reflective of the considerable work that has taken place , to speed up formal processes, and to ensure staff are supported to "nip issues in the bud" at an early stage (including the wider work around workplace civility focussed on developing a culture of dignity & respect). The launch of the new Respect, Civility & Resolution Policy, as part of a suite of refreshed People Policies (accompanied by both a staff and manager handbook) will all play a crucial role in developing this work further.

Contacts with staff Advocacy Service: The four newly trained staff advocates have joined established advocates in actively taking on cases. The Trust Intranet page has been updated with refreshed photo's/ contact details for all Staff Advocates, and the service is planned to be promoted more widely, along with other resources to support informal resolution as part of the implementation of the new Respect, Civility & Resolution policy.

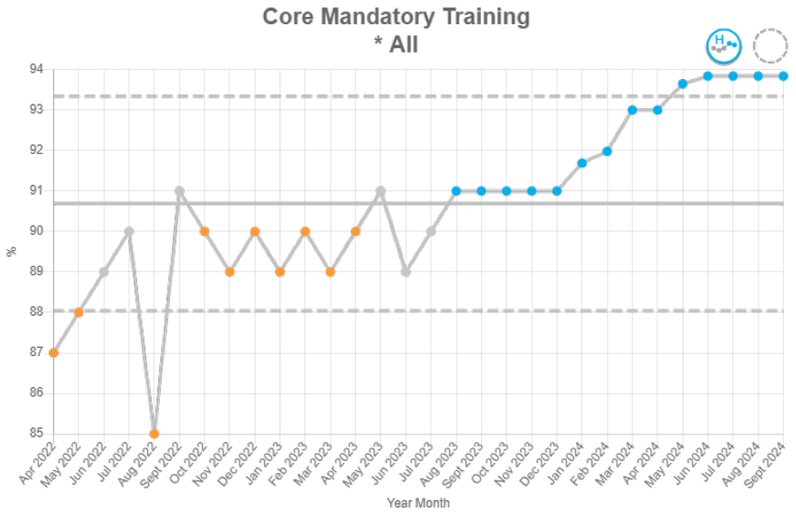
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

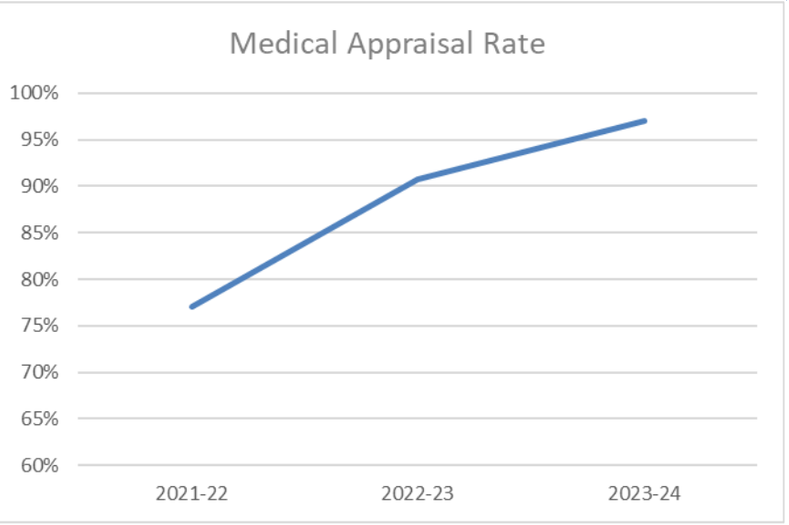
August 2024 -75.79%
Common cause variation



September 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, with current compliance standing at 81%.
- 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.
- Basic Life Support achieved 85% compliance in September, which is attributed to the increased insitu activity carried out by the Resus team.
- 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

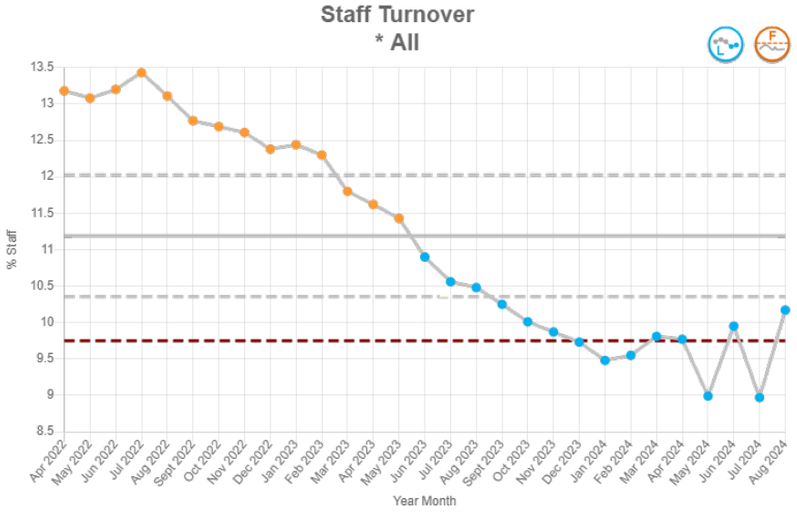
Appraisal

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.

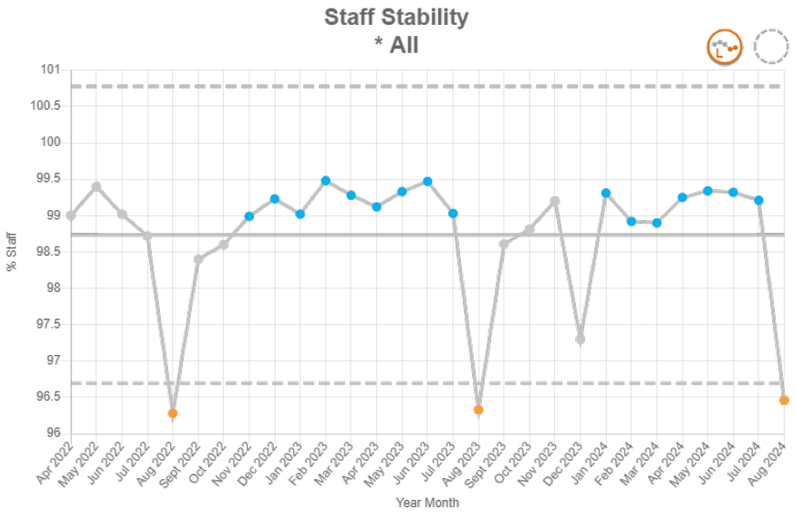
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

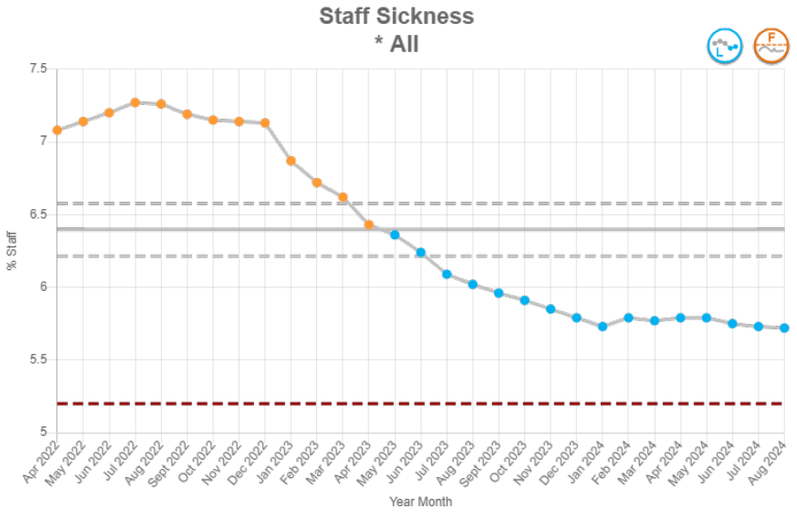
August 2024 – 10.17%
Special cause variation of an **improving** nature



August 2024 – 96.46%
Special cause variation of a **concerning** nature



August 2024 (rolling 12 months) -5.72%
Special cause variation of an **improving** nature



Analysis

Sickness for the month of August is 5.71% and the YTD is 5.72%, in comparison with July where the monthly sickness rate was 5.69% and YTD 5.73%.
The staff groups with the highest sickness rates are Additional Clinical Services at 8.67%, Estates & Ancillary at 7.65%, Admin & Clerical at 5.93%, Add Prof Scientific & Technic at 5.92% and Nursing & Midwifery at 5.61%. 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 August is 10.17%, an increase of more than 1% in one month with July turnover rate at 8.97%. This is not as a result of a decreasing workforce that has remained stable this month.

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 August 2024 has dropped from 99% to 96.5% . The dip in August 2024 is attributed to the August rotations for junior doctors.

Risks, Mitigations and Assurance

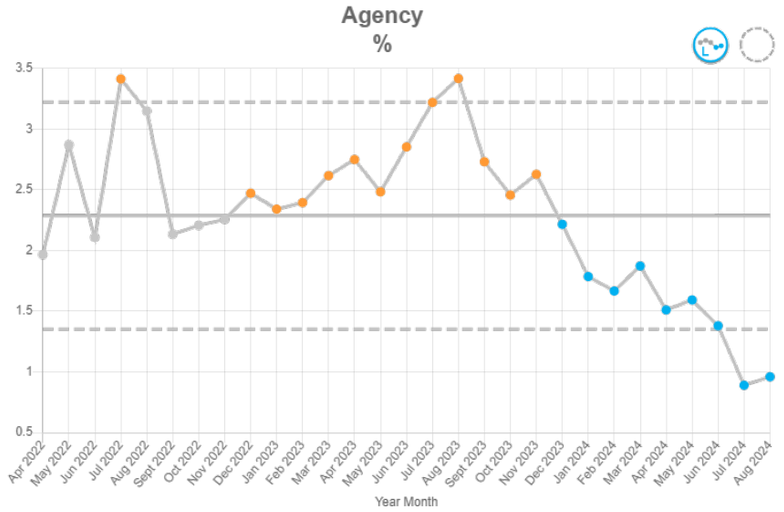
Since July 2022 sickness rates have been on a downward trajectory towards the Trust target of 5.5%. Although, over the last 6 months rates have levelled off remaining between 5.5% and 6% each month.
The following supportive measures have been put in place to improve rates;

- 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.
- Initial meeting with Associate Chief Nurse has taken place recently, where it was highlighted that there is a need to review nursing and midwifery managers understanding of their basic responsibilities to manage sickness absence.
- The HRBPs continue to attend monthly CSU Triumvirate and Performance meetings where sickness rates are discussed alongside ward/department turnover rates .
- 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 had been on a downward trajectory over the last 2 years. However, for August, turnover increased from 8.97% in July to 10.17%. The biggest turnover rates are in Research (2%), clinical support staff Band2-Band4 (0.7%) and Registered Nurses (0.72%). In Nursing this is attributed to a higher proportion of retirements and a slight increase in sickness.

People – Engagement – To be in the top 20% Employers

August 2024 – 0.96%
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.

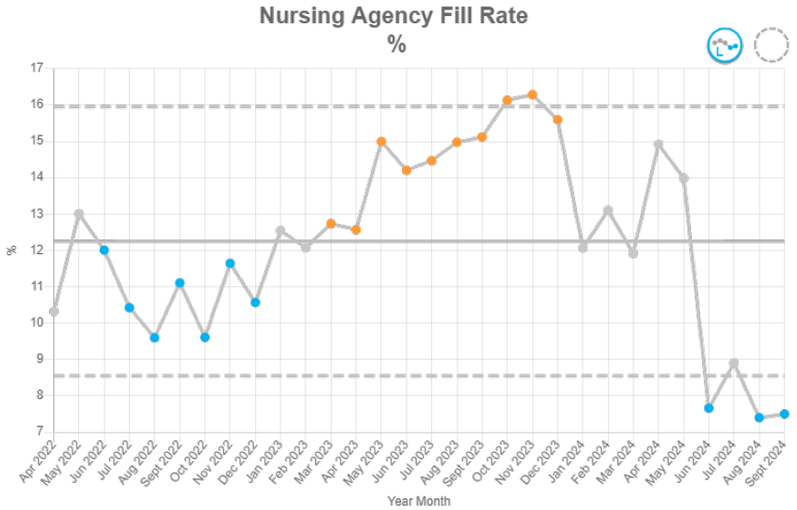
Risks, Mitigations and Assurance

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.

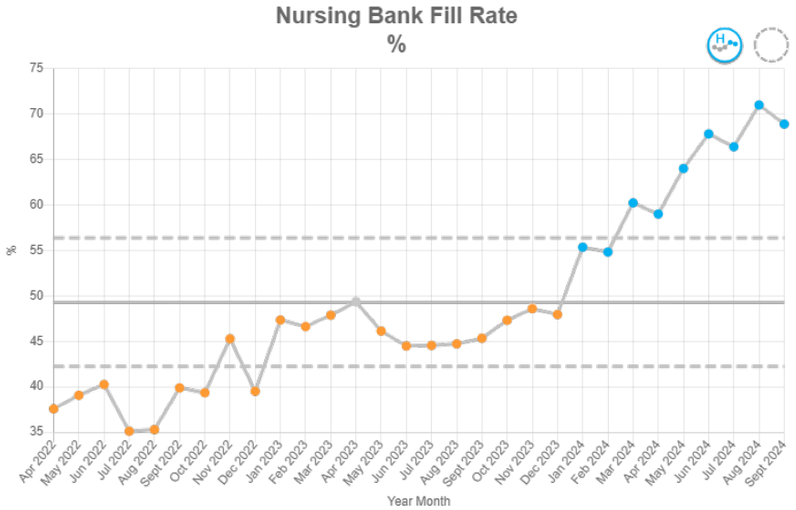
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

September 2024 -7.5%
Special cause variation of an **improving** nature



September 2024 – 68.9%
Special cause variation of an **improving** nature



Analysis

Nursing Agency
Agency staff filled 283 shifts in the month of September. This is split 283 registered and 0 unregistered staff. Out of the 283 filled registered shifts, 237 were filled with registered theatre staff. In September Agency fill rates increased for theatre staff by 1.11% for registered staff. Agency fill rates for HCA's are 0 as these have not been in use since September 2023.
Nursing Bank
Registered bank fill rates have decreased in September by 2.81%. Unregistered bank fill rates have increased by 1.7% in September compared to August. Requests have also reduced from 3860 in August to 3780 in September for registered staff and from 5244 in August to 5087 in September for unregistered staff.

Risks, Mitigations and Assurance

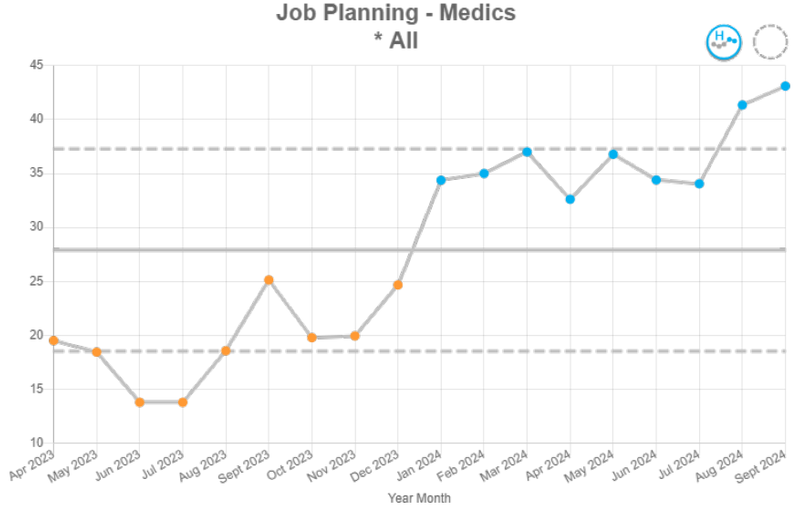
From the 20th November 2023 a new nursing agency approval process was put in place to give assurance around agency use for nursing. Confirm and challenge meeting were added from January 2024 for all areas with an overspend. Reports are being shared on a monthly basis with Nursing workforce lead.

People – Engagement – To be in the top 20% Employers

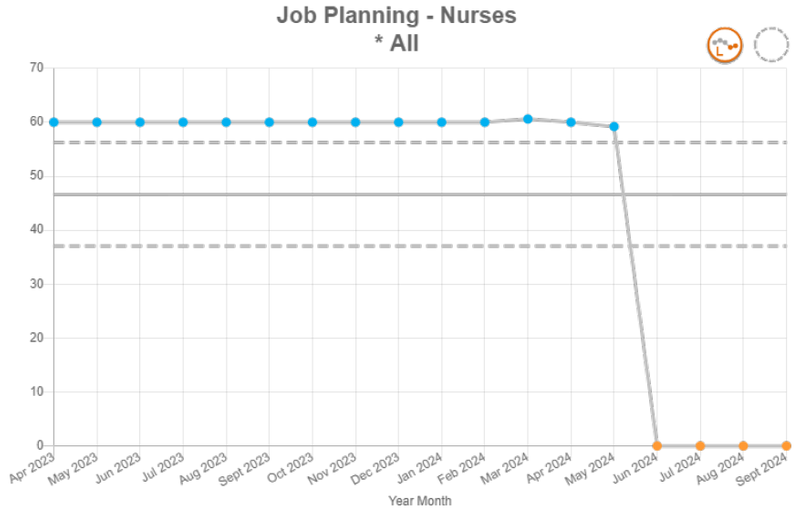
Bradford Teaching Hospitals
NHS Foundation Trust

September 2024 – 3.8%
Special cause variation of a **deteriorating** nature

September 2024 – 43.1%
Special cause variation of an **improving** nature



September 2024 – 0.0%
Special cause variation of a **deteriorating** nature



Analysis

There are currently 960 clinicians registered within this system. This figure is now made up of 418 Medics, 346 AHPs and 196 nurses.
Medics now have 180 signed off . AHPs have 13 and nurses have none signed off.

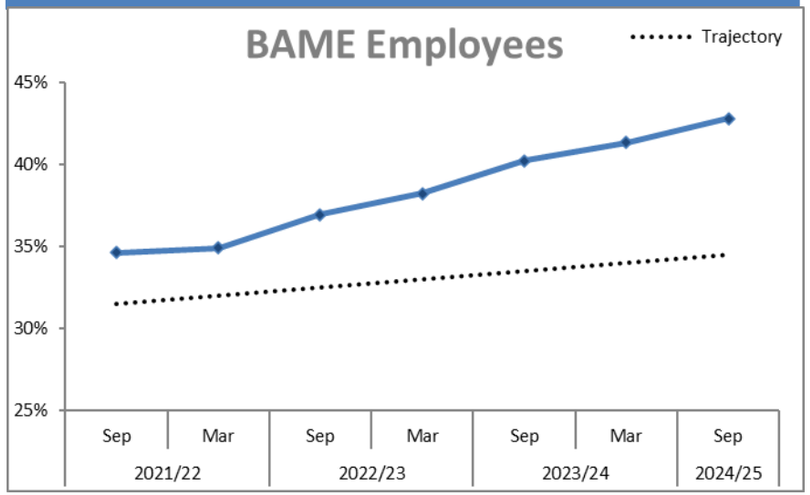
Risks, Mitigations and Assurance

We are in the process of moving across to a new provider from November, and then the focus will be on to improve in all areas on the amount of signed off job plans. Training will take place on a continual basis.

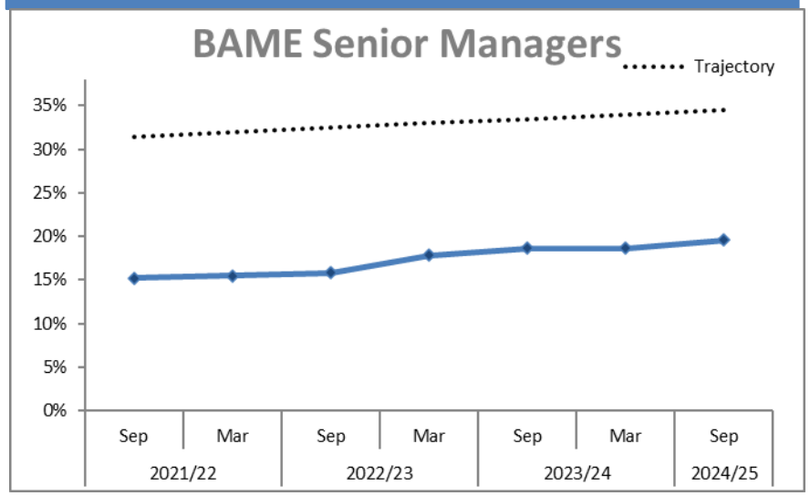
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

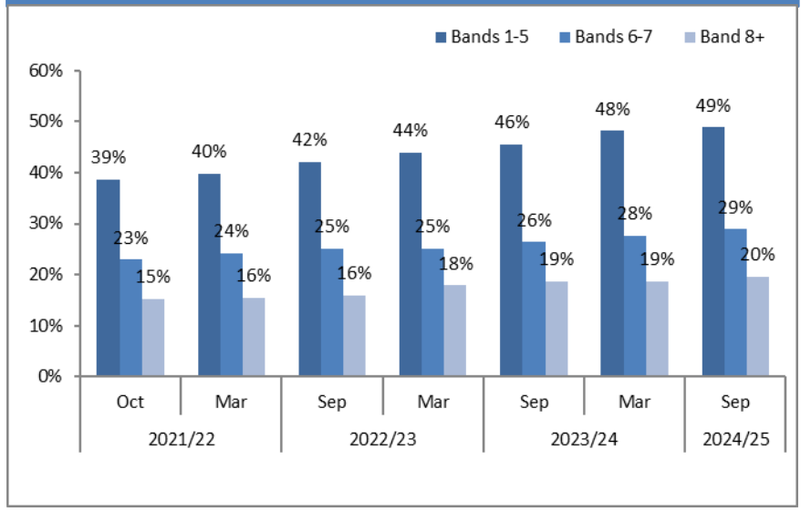
2024/25 Quarter 2 - 42.8%



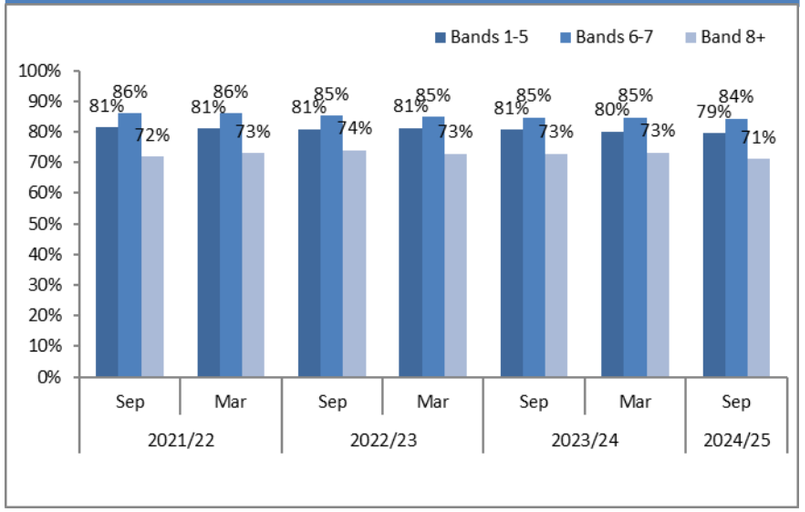
2024/25 Quarter 2 – 19.59%



2024/25 Quarter 2 – BAME employee % by band



2024/25 Quarter 2– Female workforce by band group



Analysis

The proportion of **Ethnic Minority employees** in the workforce continues to increase rising from 41% to 43% in the last 6 months 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+) has increased in the last 6 months from 19% to 20%, which is positive. We have also seen a 1% increase at Bands 6&7 (to 29%), which is encouraging. However Ethnic minority staff continue to be over-represented at lower levels in the organisation (a 1% increase to 49% for Bands 1-5). With 76% women in the workforce as a whole; **women continue to be over-represented in the lower to middle bands** (80% at Bands 1-5 with no change & 84% at Bands 6&7, with a 1% reduction in the last 6 months). There has been a 2% reduction in the percentage of women at senior management levels (Band 8+/ VSM) where women continue to be proportionately under-represented at 71%.

Risks, Mitigations and Assurance

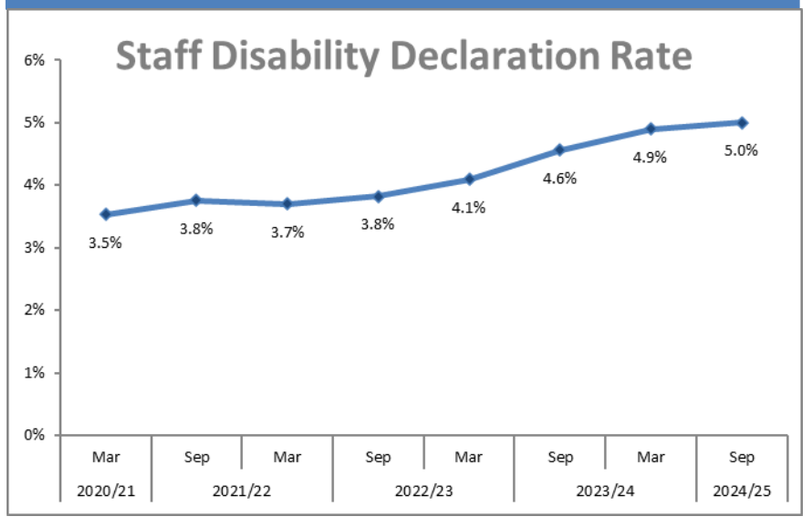
At our current rate of trajectory, achieving our ambition to have a senior workforce reflective of the local population (35% by 2025) continues to be challenging. This will continue to be a key focus of our refreshed WRES action plan for 2024/2025, as we continue to focus our efforts on providing development 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 Chief People & Purpose Officer has become Champion for Gender Equality in the Trust and the refreshed Gender Equality Reference Group met in September to review the latest data and discuss our agreed areas of focus (women in leadership, 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). The GERG will meet again in December, with a face-to-face workshop planned for early 2025 to ensure we are taking positive steps to address gender inequalities in the Trust, including working collaboratively with the wider ICS .

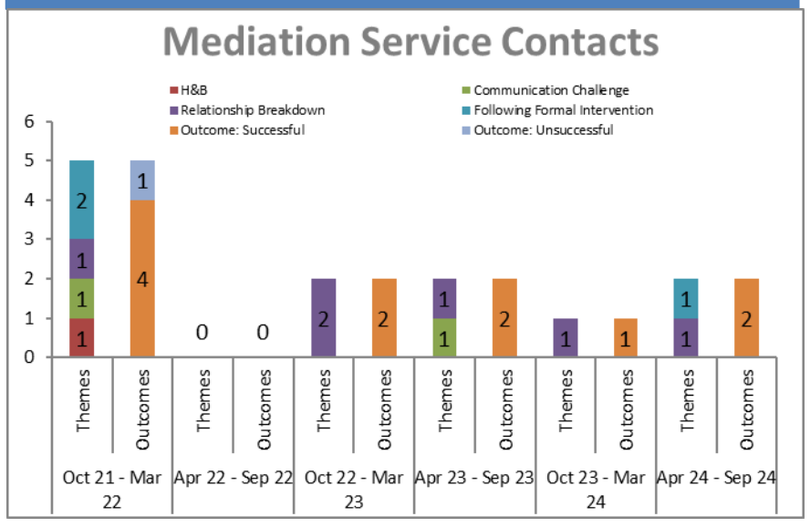
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

2024/25 Quarter 2- 5%



2024/25 Quarter 2



Analysis

Our **disability declaration rate** (as recorded in the Electronic Staff Record/ ESR) continues to remain fairly static with a small, but positive increase of 0.1% in the last 6 months to 5%.

2 **mediations** have successfully taken place since the last update, both resulting in positive outcomes for the parties with a further 3 cases are pending. Co-ordination of the service is undergoing a gradual transfer to HR to minimise potential delays and the number of people involved in the process.

Risks, Mitigations and Assurance

Disability Declaration: Whilst the 2023 staff survey results only represent 43% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 25% in 2023) 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 continues to generate 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. Our WDES action plan (which was approved at October People Academy) will continue to provide focus to improving the experience of colleagues with a disability or long-term health condition, which we hope will drive up declaration rates.

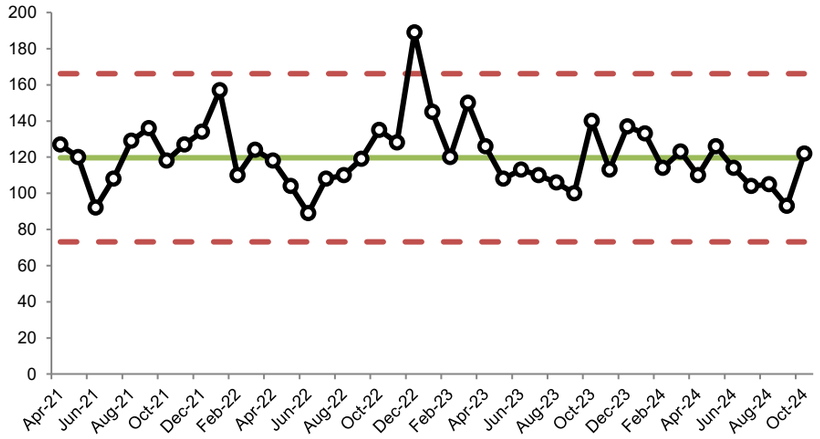
Mediation provides a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud'. The mediation service will become a key component of the newly developed Respect, Civility and Resolution policy and process when it is finalised 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.

Clinical Effectiveness - To provide outstanding care for patients

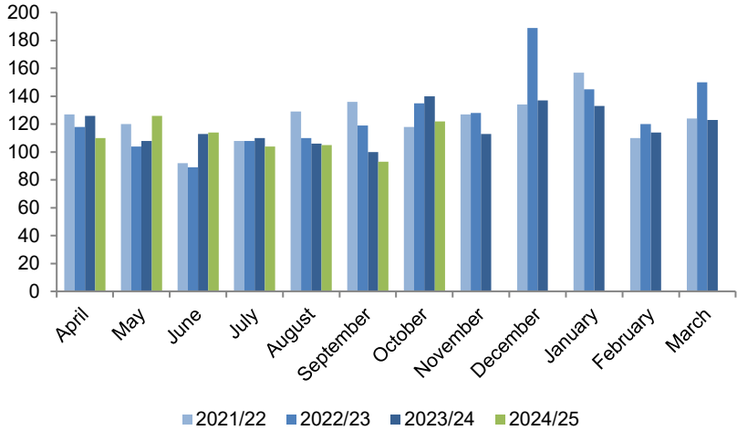
Bradford Teaching Hospitals NHS Foundation Trust

October 2024 – 122 Adult Inpatient Deaths

Adult Inpatient Deaths at BTHFT (*April 2021 - October 2024*)

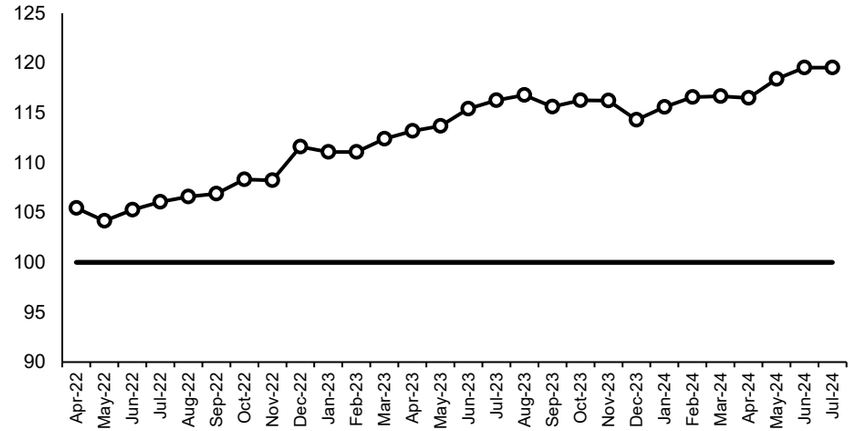


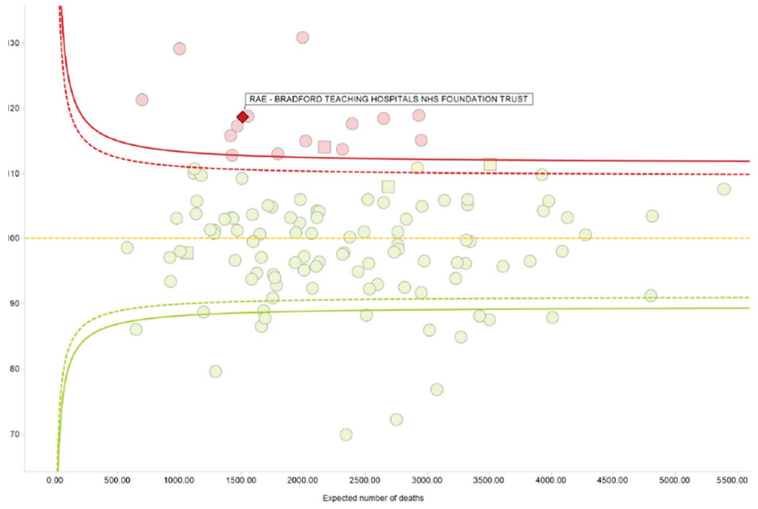
Number of Deaths by Month and Year (*April 2021 - October 2024*)



SHMI 12-month Rolling – 119.53 (*figure covering August 2023 – July 2024: Reported October 2024*)

SHMI (12-month Rolling)





Analysis

The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered.

Learning, Improvement, Assurance

In October 2024, the Trust saw 122 adult inpatient deaths. This is an increase on September however, this is still lower than the previous two Octobers and is in line with past trends when entering the winter period. The Learning from Deaths Team will continue to monitor monthly mortality numbers and act if significant increases are observed.

SHMI is still high at 119.53 and continues to increase.
Papers from Business Intelligence are expected to detail how this is to be tackled and improved as part of their work for the Closing the Gap initiative, in particular, with regards to coding.

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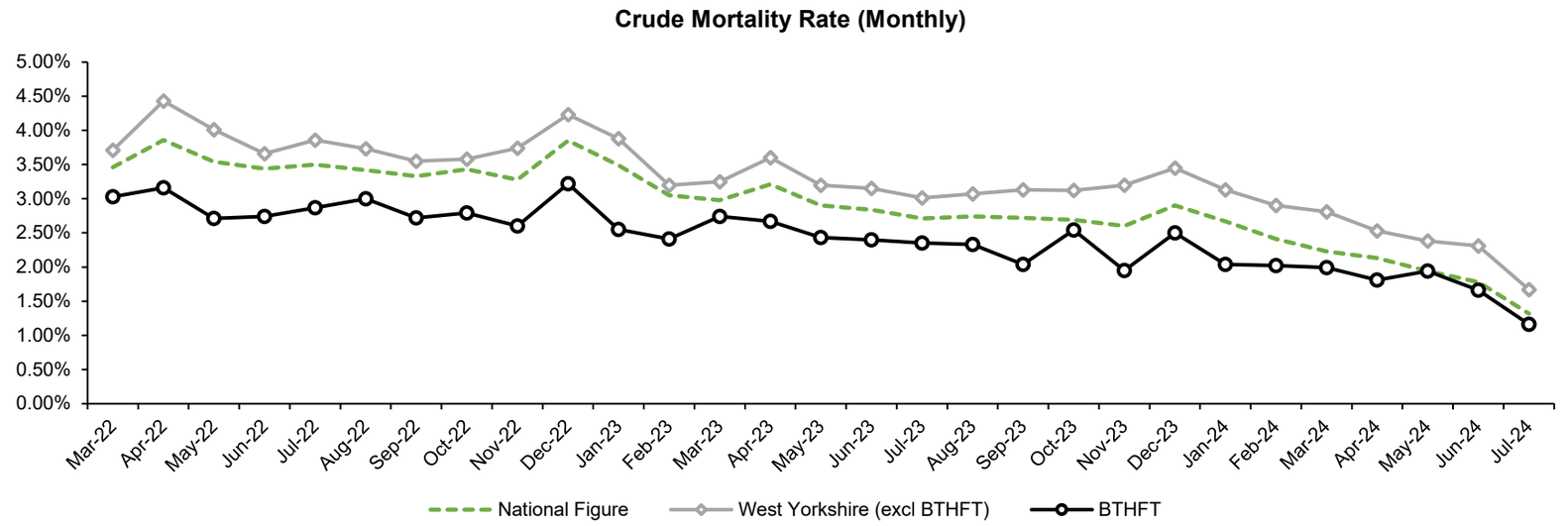
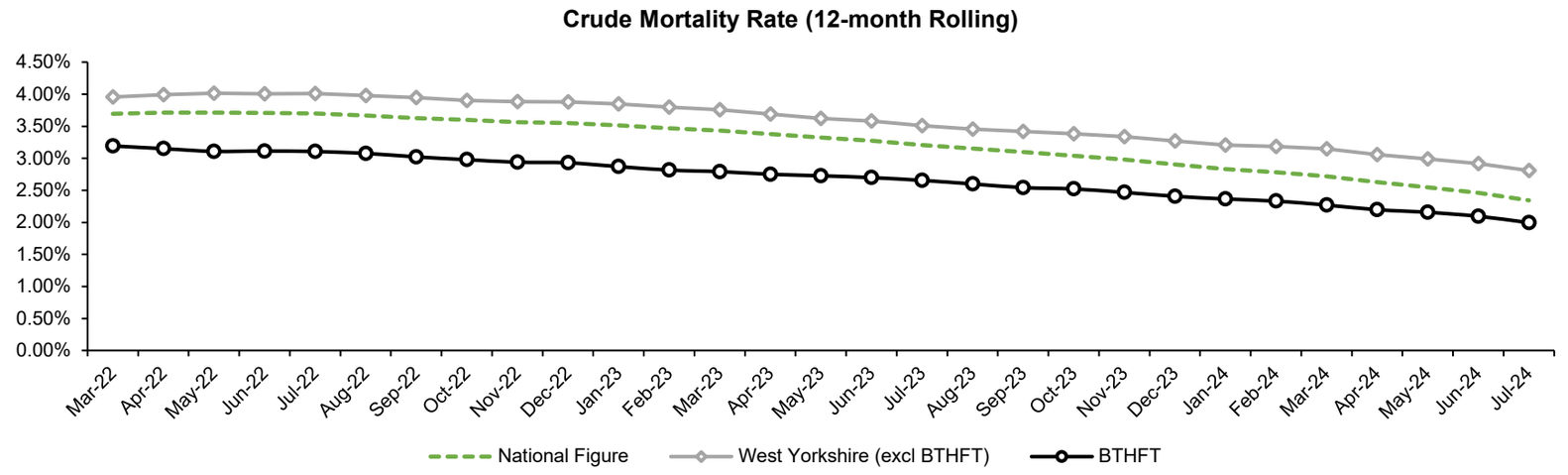
Crude Mortality Rate (monthly) – 1.16% (*figure for July 2024: Reported October 2024*)



Crude Mortality Rate (12-month Rolling) – 2.00% (*figure covering August 2023 - July 2024: Reported October 2024*)



Analysis

Our crude mortality rate continues an overall pattern of reduction at 1.16% for the month of July, the latest reported figure *(reported in October 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 2.00%, lower than the national average of 2.34% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.81%.

Learning, Improvement, Assurance

Crude mortality rate is a measure of the number of patient deaths as a proportion of overall patient activity. Crude Mortality Rate is an excellent way of looking at the rate of patient deaths as it takes into account the activity of the hospital by using the number of patient discharges as the denominator.

Since the discontinuation of HSMR by NHS England, the Learning from Deaths Team at BTHFT have chosen to focus on our crude mortality rates to balance against SHMI.

Our Crude Mortality Rate provides assurance that we continue to see very low rates of mortality at BTHFT despite a high SHMI value.

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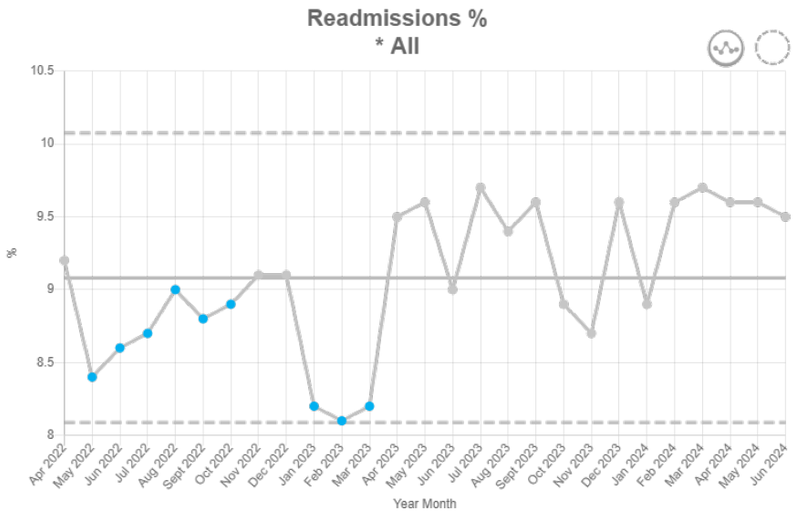
June 2024– 9.5%
Common cause variation



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.

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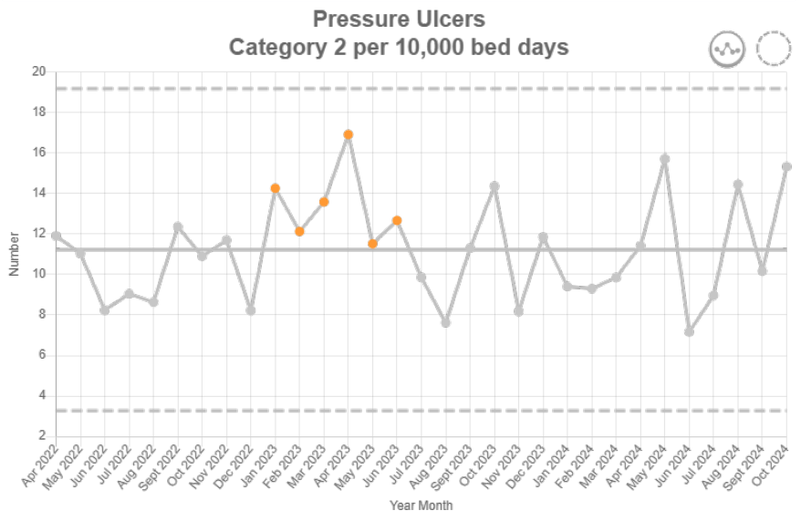
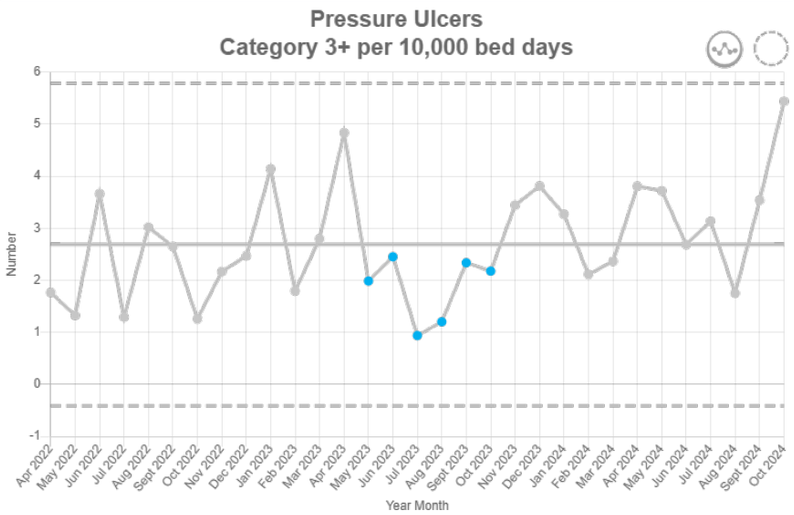
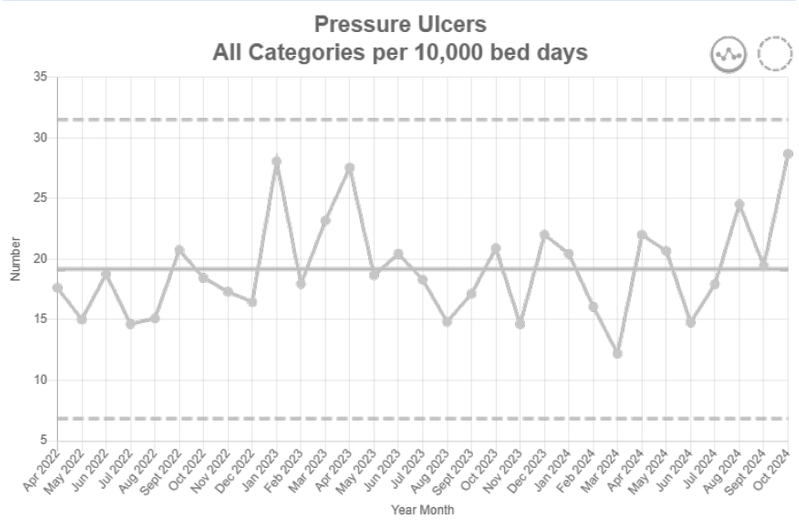
October 2024 – 15.3
Common cause variation



October 2024 – 5.4
Common cause variation



October 2024 – 28.7
Common cause variation



Analysis

In October the number of pressure ulcers per 10,000 bed days increased but is below the upper control limit and this pattern is common cause variation. This pattern is also noted for category 2 and 3+ incidents.
During October there were 6 wards/ depts with 4 or more pressure ulcer incidents (wards 3, 6, 17, 26, 28 & ED). Wards 17, 23 & 26 are continuing work on quality improvement projects using the Model for Improvement although progress is at different stages. QI support has been offered to ED.

It should be noted that Westwood Park have achieved 14 months without a hospital acquired pressure ulcer and GATU has achieved 12 months. The Lead TVN has met with WWP to explore their approach to pressure ulcer prevention in order to identify learning.

Learning, Improvement, Assurance

Risks:
1. Upward trend of pressure ulcer incidents.

Mitigations:
1. Update to pressure ulcer SSKIN bundle on EPR has been completed and is now live on EPR.
2. Quality improvement support has been provided to wards 23, 26 & 17.
3. Reviewed 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 has been updated and approved.

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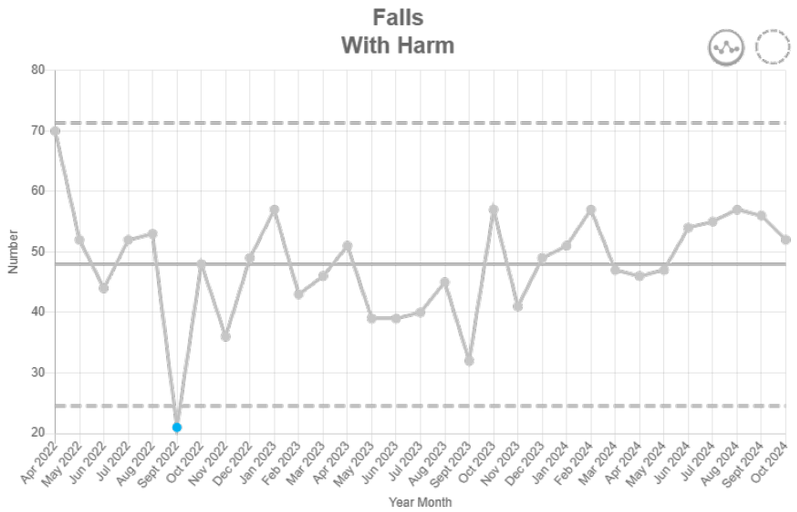
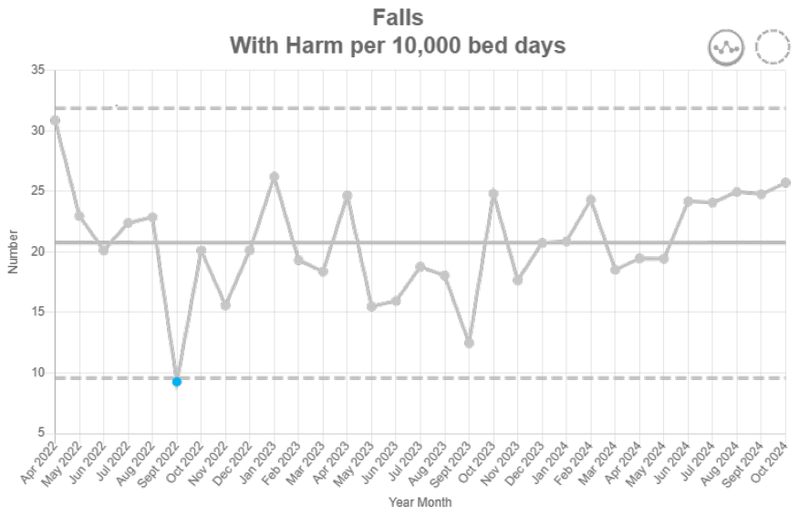
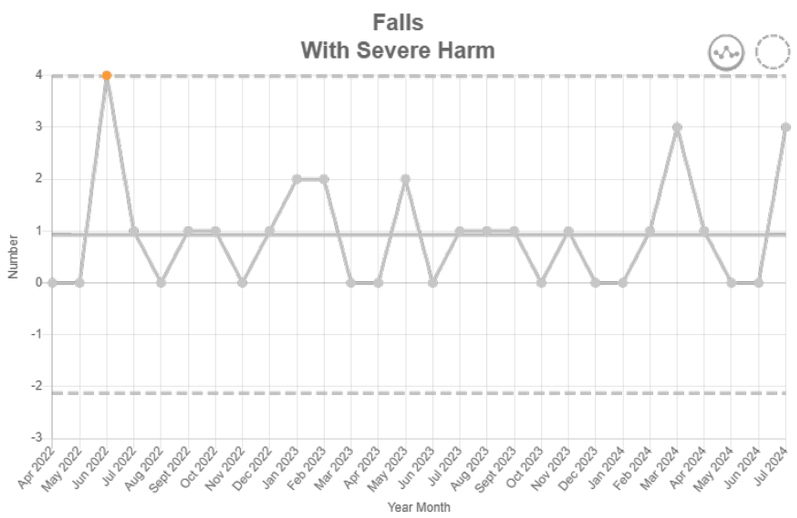
October 2024 - 52
Common cause variation



October 2024 –25.7
Common cause variation



October 2024 - 3
Common cause variation



Analysis

Learning, Improvement, Assurance

- 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.
- CSU's are requested to attend the falls improvement group to discuss ward data and themes from learning.
- 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 is due to be completed in January 2025 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.
- The National Audit for In Patient falls will soon start to monitor all fractures and head injuries within the Trust.

Proposed Medicines Management Metrics

Analysis

Following discussions held between the Quality Team, Medicines Management Team and Business Intelligence, there is ongoing work to bring new, measurable metrics for Medicines Management. These new metrics will include:

- Missed doses of Critical Medicines
    - The purpose of this metric will be to see the numbers, rates and locations of where doses of critical medicines exceed two hours from the time of prescribing to the time of administration.
    - In addition to this, exploration of thematic reasons for these missed doses will be gained from nursing documentation as at present, nurses can record in ePR the reason for missing a dose (e.g. “medicine not available”).
    - A list of critical medicines is to be supplied by Medicines Management to Business Intelligence.
    - Business Intelligence will liaise with our data vendor in order to ascertain how to pull this data from the data warehouse.
    - A member of the Business Intelligence Team will shadow a member of the Medicines Management Team in order to process map and understand the logic behind the process.

- Time data for discharge prescriptions
    - This metric will be broken down by the following time metrics:
        - Time from discharge prescription written to discharge supply checks by nursing staff
        - Time from Pharmacy generated task to Pharmacy checks
        - Time from the previous process point to Dispensary dispensing prescription
        - Time from the previous process point to final nurse check and patient discharge.
    - The rationale for these metrics is to understand the barriers that hold up a patient being discharged when waiting for discharge medication in an attempt to improve our discharge times, freeing beds earlier in order to maintain patient flow.
    - Currently there is a similar system in the Command Centre but Business Intelligence will explore how this time data can be extracted from the data warehouse to form these metrics.

The actions taken away are to be completed within six weeks of the discussion held on 4th September 2024.

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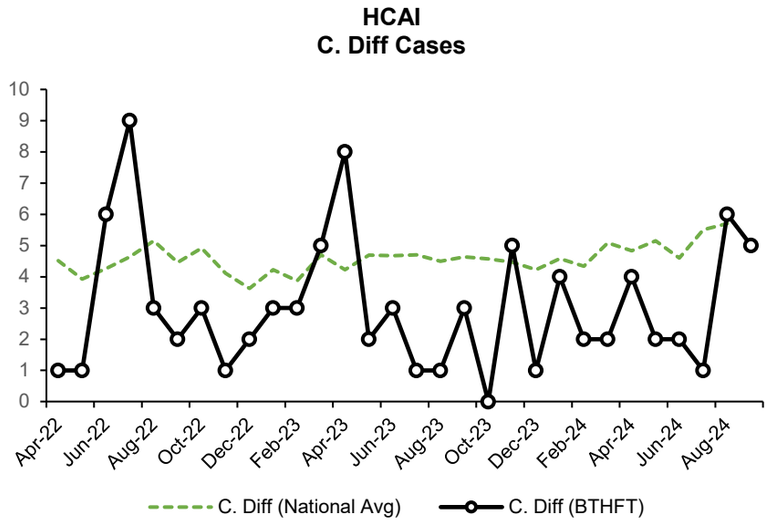
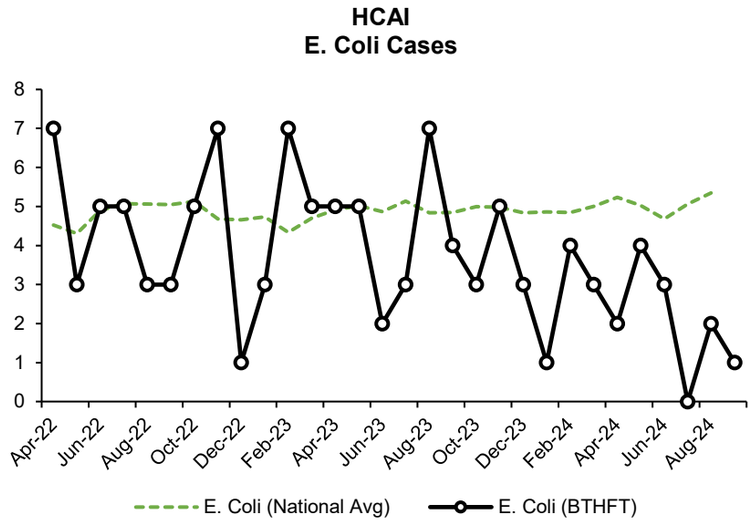
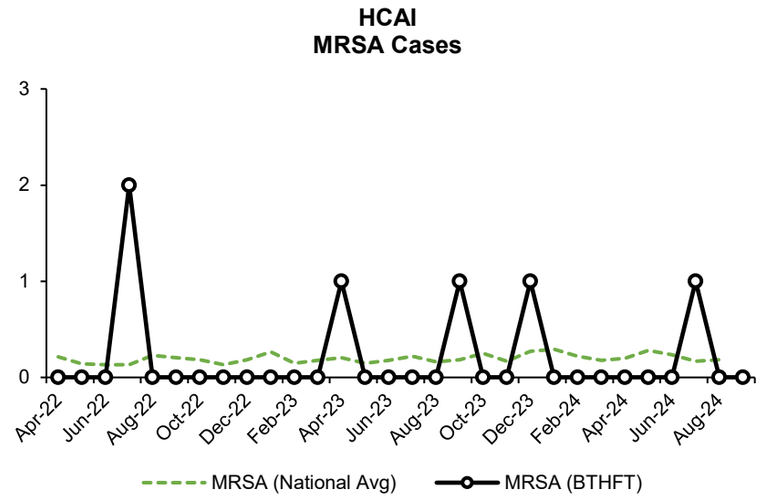
September 2024 – C. Diff Cases - 5



September 2024 – E. Coli Cases - 1



September 2024 – MRSA Cases - 0



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 was just one healthcare onset E. coli bacteraemia in September 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
No MRSA bacteraemia cases have been observed since 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

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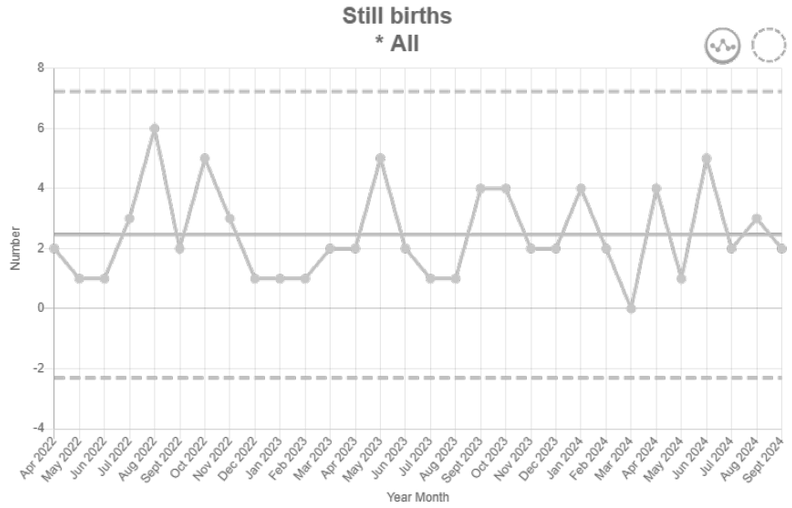
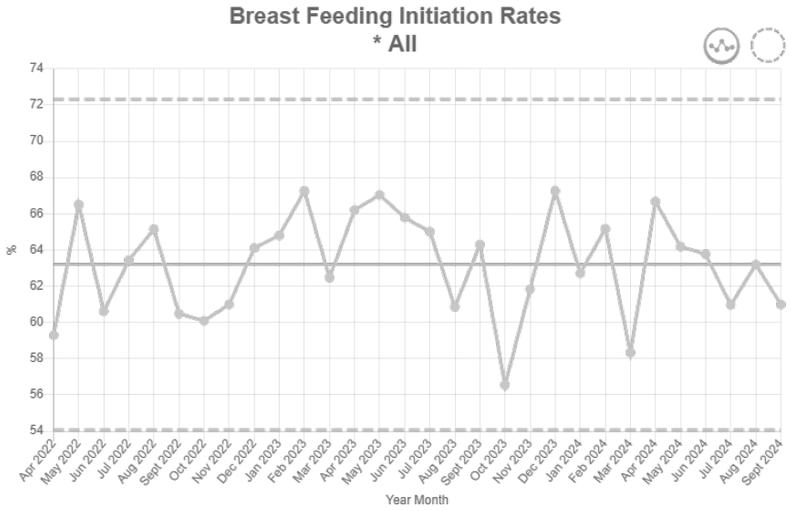
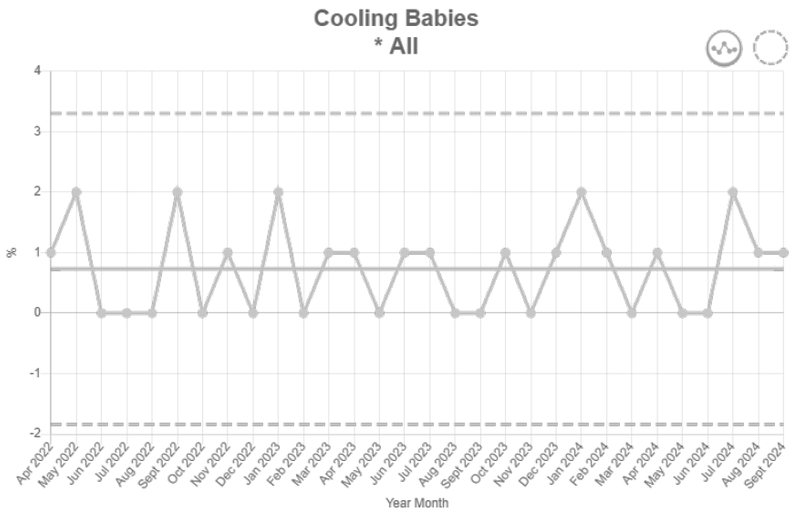
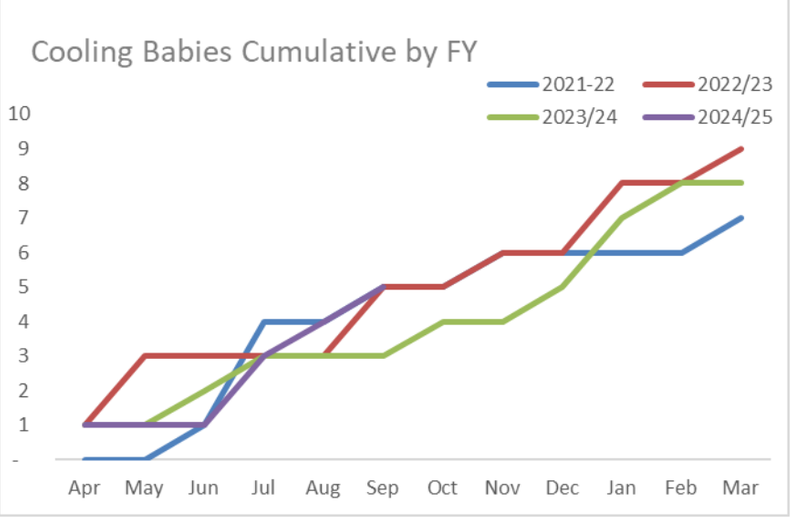
September 2024 - 2
Common cause variation





September 2024 - 1
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

E. PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

Bo.11.24.13e - Operational Performance Report Oct 24 (cover).pdf

Bo.11.24.13e - Operational Performance Report - Oct 2024.pdf

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.13e

PERFORMANCE REPORT – FOR THE PERIOD OCTOBER 2024

Presented by	Julie Lawreniuk, Non-Executive Director and Chair of F&P Committee	
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	Finance & Performance Academy – 20 November 2024	
Previously approved at:		**Date**

Key Options, Issues and Risks

This report provides an overview of performance against several key national and contractual indicators as at the end of October 2024.

Analysis

Ambulance Handovers:

- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 45.73% in October compared 48.47% in September. Ambulance arrivals has increased in October and into early November compared to previous months with acuity remaining comparably high.
- Overall handover times for the Trust continue to track below the regional average (~23 mins compared to a regional average of ~32 mins).
- The jointly approved handover process used to accurately record handover times is fully operational in the ED but has not resulted in any substantial changes to performance – YAS reported times remains an issue: internal validation has demonstrated that a high proportion of 30+ min as reported by YAS are completed in less than 30 mins.
- A Quality Improvement lead has now been nominated to support with further improvements in handover reporting and to help streamline ambulance self-handovers processes to reduce AAA congestion (currently BTHFT record zero self-handovers vs 4% across the region).
- YAS is currently recruiting to provide additional support to Hospital Trusts' during the winter period, the role will involve a Senior Paramedic being present on-site to assist crews with clearing times.
- 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 81.41% for a October 2024 and is currently forecast at 81.54% for November 2024. This remains in the upper decile of Acute Trusts in England.
- Daily attendances in October increased to 414 ED arrivals per day compared to 400 in September with demand increasing earlier than forecasted.

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.13e

- Streaming to the AECU service continues to remain effective, positively impacting a range of UEC metrics. However, high acuity and increased LoS continues to impact downstream capacity/patient flow resulting in increases to both admitted and non-admitted ED stays for October.
- G&A adult bed occupancy remained stable at 91.29% in October, compared to 91.97% in September with adult G&A occupancy (October 92.8%) remaining in line with September.
- High acuity patients and issues within the social care sector continue to impact the timely discharge of patients as reflected in an increase in the number of patients not meeting the criteria to reside during October (13.5% compared to 12.7% in September).
- 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.
- The Outstanding ED project presented in October will focus additional effort on reducing overcrowding and improving the experience of patients waiting in ED, subject to board sign off in November.

Long Length of Stay and Discharge Pathways:

- The daily average number of patients with a length of stay (LOS) > 21 days has remained stable at 103 in October 2024. BTHFT's strong partnerships with community, social care, and voluntary sectors are helping to alleviate occupancy and discharge pressures.
- Increasing 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, although H-Fast is now discharging up to 4 discharges per day and is expected to increase incrementally to 6 discharges per day (30 per week).
- A discharge coordinator position is being piloted 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 ‘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.
- 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.
- 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 increased but delivered below plan in October 2024. It is projected to remain below plan in November 2024.
- From October, the plan includes expected activity delivered through the day-case unit which was due to open at St Luke’s hospital. The opening of the unit has now been delayed to January 2025, resulting in a gap to plan expected of 39 patients per week until opening. Once open the unit will support an increase in sessions and an uplift in session productivity with the ability to run high volume low complexity lists.
- Day case volumes being behind plan is impacting on the closing the gap ERF opportunity and accurate recording of day case activity has become an area of focus in recent weeks with improvement opportunities identified.

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.13e

- Outpatient activity delivered above plan in October 2024 and is projected to deliver slightly below plan in November 2024.
- Outpatient, Day Case and Theatre improvement work has been aligned to a core workstream within CTG, with BAU improvement and GIRFT remaining in parallel. Counting and coding improvements are also being identified by this work.

Referral to Treatment:

- Referral to Treatment (RTT) performance reduced slightly in October 2024 at 61.77% and 52-week performance is improving and is now in line with 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.
- There were 4 patients reported over 78 weeks at the end of October 2024 with 2 patients projected to breach 78 weeks at the end of November 2024.
- 61 patients breached 65 weeks at the end of October 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. An arthroplasty consultant position is currently out to advert and will support longer term improvement for T&O alongside the actions agreed with ETM at the start of October. 54 patients are forecast above 65 weeks for November.

Diagnostic waiting times:

- DM01 performance for October improved on September performance to a position of 84.46%. This uplift is forecast to continue into November.
- CDC continues to provide additional capacity for all the modalities we had planned to include. Process and efficiency improvements are being explored to further capitalise on this resource.
- MRI performance has recovered in October, and this is expected to continue with equipment issues resolved and staff returning to work. There is a shortfall in staffing to support the ideal capacity model and further work is needed to maximise potential and realise improvements.
- Endoscopy services are expected to experience an extended period of high demand linked to national cancer awareness campaigns including Gastric cancers and preparations are underway. FIT testing alongside STT (Straight to Test) and the streamlining of waiting list management are improving waiting times despite this growth.
- 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 second cancer time out session took place in November and was well attended. These sessions are part of the Cancer Board program of work to develop a shared clinical vision for the Trust's Cancer Strategy. Improvement plans, a focus on 31-day performance, health inequalities, and patient experience all featured on the agenda.
- The go live of the new cancer IT system (Civica) has been delayed. 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 demand is high due to national cancer campaigns taking place throughout Autumn. Performance is being impacted as a result.

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.13e

- The 28-day faster diagnosis standard (FDS) performance remained above target at 79.02% in September. There has been significant focus on fast-track diagnostic turnaround times as part of the diagnostic improvement described in that section of this report.
- 31-day general treatment is forecast to remain below target for September being impacted by extended consultant leave. 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.
- 62-day performance achieved the 70% performance threshold for September, with the back log of patients waiting over 62 days starting to drop to an on-plan position in October. There is no single cause for 62 day delays, 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 – Open		
Date	28 November 2024	Agenda item	Bo.11.24.13e

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

Board of Directors

October 2024

Headline KPI Summary

Bradford Teaching Hospitals NHS Foundation Trust

Section	Headline KPI	Latest Month	National Target	BTHFT Plan	Perf.	3 M'th Trend
1	Avg. Ambulance Handover	Oct-24	15:00	18:00	23:20	↑
2	Emergency Care Standard	Oct-24	85.00%	78.74%	81.41%	↓
4	Length of Stay ≥21days	Oct-24	-	135	103	→
8	18 Week RTT Incomplete	Oct-24	92.00%	67.54%	61.77%	↓
8	52 Week RTT Incomplete	Oct-24	0.00%	1.25%	1.25%	↓
11	6 Week Diagnostic Standard	Oct-24	95.00%	80.19%	84.46%	↑
12	Cancer 28 Day FDS	Sep-24	77.00%	78.03%	79.02%	↓
13	31 Day General Treatment	Sep-24	96.00%	96.00%	91.00%	↓
13	Cancer 62 Day General Treatment	Sep-24	70.00%	74.48%	70.00%	↑

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement

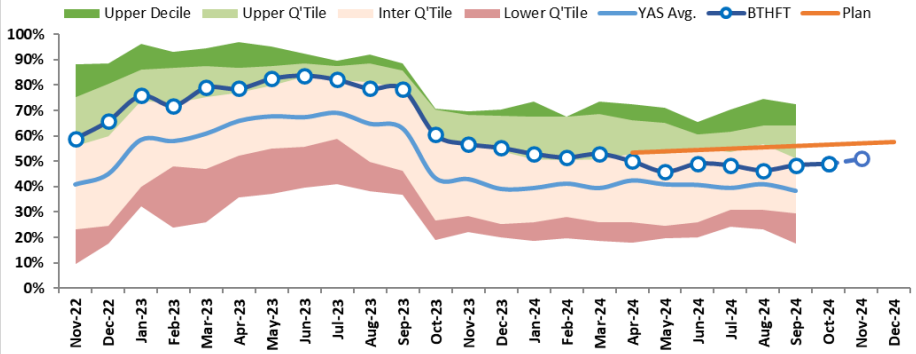
Urgent and Emergency Care (UEC)

1. Ambulance Handover Performance

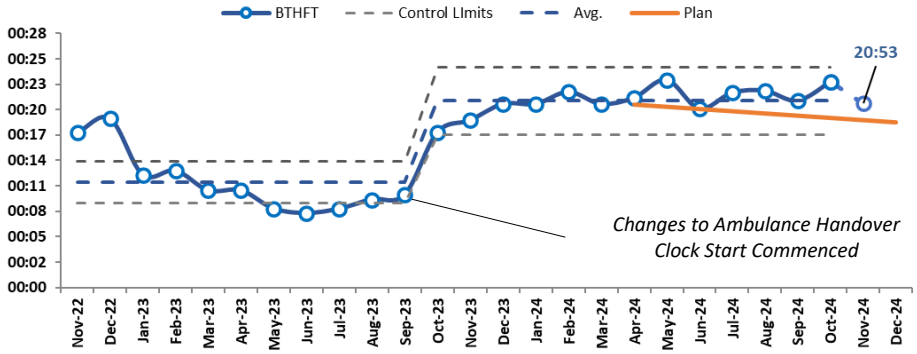
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Avg. Daily Arrivals -	111	118	113	115	113	109	107	105	111	108	105	111	114
Total Turnaroud Time (MM:SS)	44:02	47:50	46:59	49:00	46:13	47:53	50:25	47:54	49:54	50:46	49:54	52:03	47:52
Avg. Handover Time (MM:SS)	18:57	20:48	20:48	22:10	20:48	21:30	23:32	20:16	22:04	22:18	21:10	23:20	20:53
% Handovers <30 mins -	56.8%	55.3%	52.9%	51.5%	52.9%	80.3%	77.4%	82.0%	79.1%	79.6%	80.7%	76.3%	80.6%
% >60 mins -	3.9%	5.3%	4.6%	5.7%	3.1%	4.5%	5.9%	2.8%	5.0%	4.6%	4.0%	6.3%	4.3%

Latest position

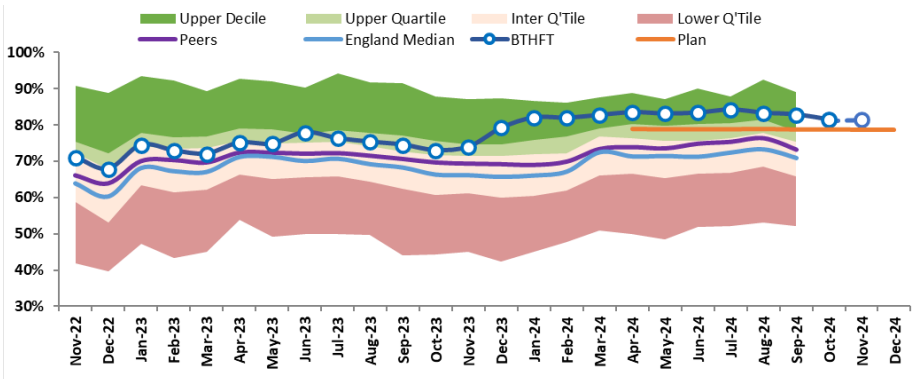
- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 45.73% in October compared 48.47% in September . The average number of ambulances arrivals has reduced, but patient acuity remains high.
- Higher than forecasted ED attendances (notably for care of the elderly patients) coupled with increased acuity has resulted in significant pressures in both HDU Resus and Amber Zone. High acuity and increased patient LoS continues to impact downstream capacity/patient flow resulting in increased delays in ambulance handovers. Even with these challenges, BTHFT has maintained a higher handover performance compared to the regional average.
- Ambulance handovers accuracy remains an issue: internal validation has demonstrated that a high proportion of 30+ min YAS reported handovers are completed in less than 30 mins.
- The handover process, jointly approved by YAS and BTHFT to accurately record handover times is fully operational in the ED. However, performance improvements have not yet been realised; validations continue to demonstrate YAS reported times are higher than BTHFT's internal data – further improvement work is now being explored.
- 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

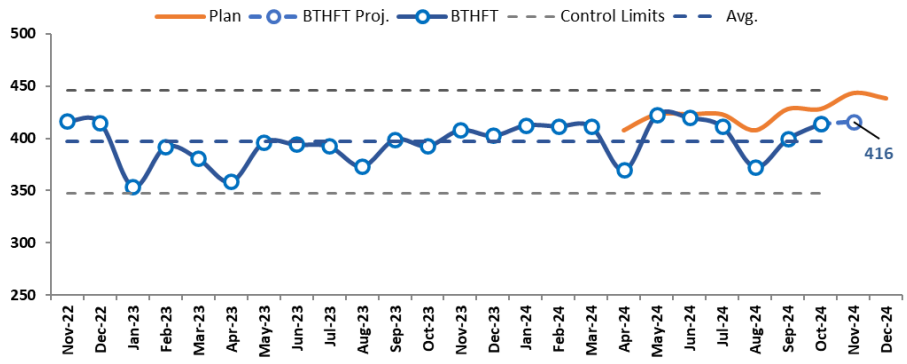
Bradford Teaching Hospitals NHS Foundation Trust

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

		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Type 1 Performance	-	65.2%	72.8%	75.7%	76.0%	75.1%	76.1%	75.2%	75.9%	76.5%	76.1%	74.6%	73.2%	73.6%
Arrival to Assessment	-	00:26	00:23	00:22	00:22	00:22	00:21	00:22	00:21	00:22	00:19	00:20	00:23	00:21
Assessment to Treatment	-	02:21	02:33	02:39	02:32	02:27	02:21	02:33	02:19	02:57	02:18	02:39	02:51	02:58
Treatment Length	-	02:39	02:40	02:36	02:41	02:29	02:35	02:34	02:26	02:28	02:35	02:39	02:45	02:37
LoS (Discharged P'ts)	-	03:46	03:06	02:56	02:58	02:53	02:54	02:59	02:56	02:47	02:49	03:04	03:08	03:02
LoS (Admitted & Discharged P'ts)	-	04:45	04:04	04:00	03:56	03:49	03:46	03:56	03:38	03:44	03:41	03:55	04:04	03:59

Latest position

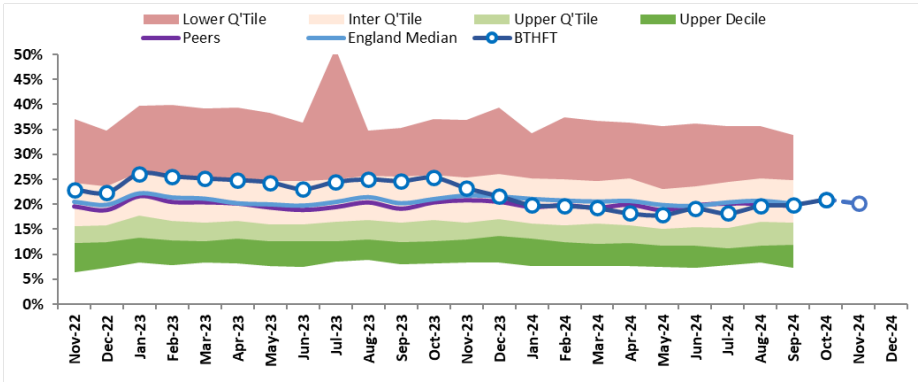
- ECS performance remains in the upper decile of Acute Trusts in England with average daily attendances increasing in October to 414. Increases in attendance have primarily been seen amongst care of the elderly and paediatrics.
- Streaming to the AECU remains consistent with activity and continues to 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

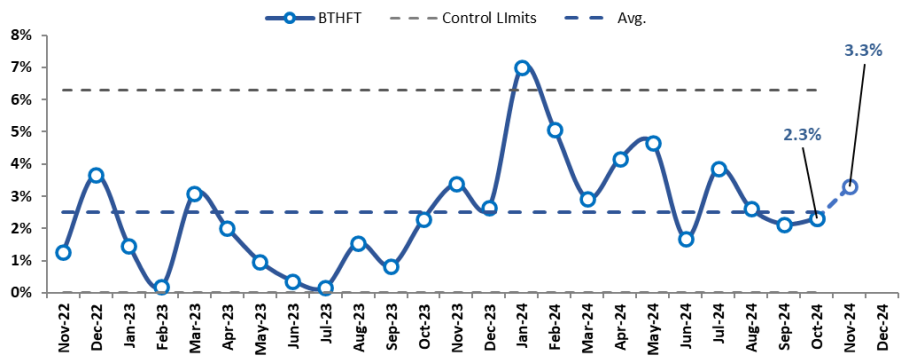
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Avg. # Daily Admissions -	94	87	81	80	84	75	81	85	81	79	87	96	85
Avg. DTA to Admit -	04:51	05:04	06:24	05:37	05:08	05:17	05:39	04:03	05:11	04:19	04:26	04:51	04:00
LoS (Admitted P'ts) -	08:04	07:34	08:25	07:56	07:27	07:26	07:59	06:24	07:35	06:53	07:02	07:33	06:38
% 12 Hour ED LoS -	6.8%	5.5%	6.3%	6.1%	5.3%	5.9%	6.3%	4.2%	5.6%	5.6%	5.6%	6.3%	5.0%
Bed Occupancy (Total)	92.8%	90.3%	94.5%	94.0%	93.9%	94.5%	93.6%	88.4%	89.3%	88.7%	92.0%	91.3%	90.5%

Latest position

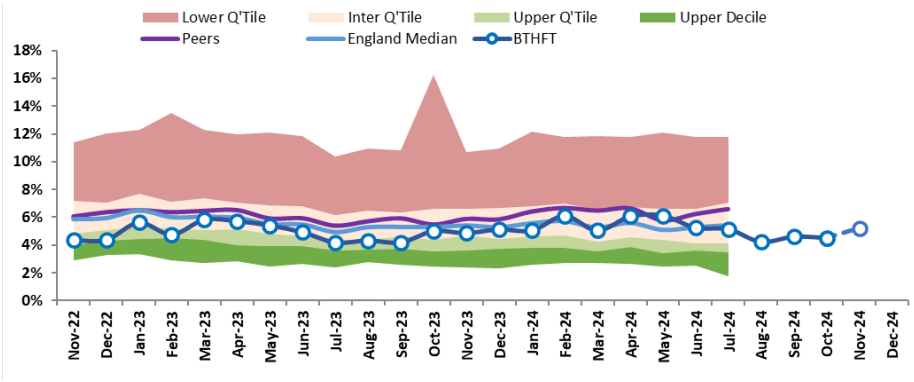
- The AECU continues to positively impact on ED and hospital admission metrics however the main ED can still have prolonged waits, and this remains a focus for ongoing improvement activity.
- ED attendances have increased earlier than forecast with similar increases being observed in the number of admissions, predominantly due to an uplift in Care of the Elderly/Paediatrics attendances although admission rates remain broadly comparable with the previous month.
- Total G&A bed occupancy has remained stable at 91.29% in October (compared to 91.97% in September) with Adult G&A occupancy at 92.8%. Patient flow delays continue to impact ED length of stay (LoS) metrics.
- 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.
- The Outstanding ED programme is focussed on reducing overcrowding and improving patient experience through a one team approach with membership from across the hospital. Whilst some schemes are addressing flow within the AED others are looking at wider hospital flow. This programme will accelerate existing initiatives of most benefit whilst increasing support for broader objectives.

4. Inpatient Length of Stay (LoS) and Discharge KPI

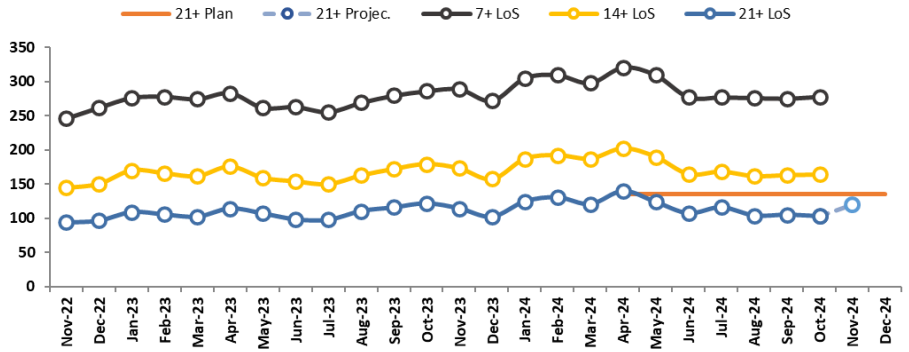
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
% of P'ts with Discharge Ready Date -	93.8%	94.3%	94.8%	94.8%	94.6%	94.5%	94.9%	94.6%	93.7%	94.7%	95.1%	94.2%	93.7%
% of P'ts Discharged on/before DRD -	81.6%	80.4%	82.3%	82.4%	82.3%	83.8%	82.4%	83.0%	82.1%	81.5%	83.2%	83.3%	81.6%
Avg. LoS stay beyond DRD -	5	4	4	5	4	5	5	4	4	3	3	4	2
% P'ts Not Meeting Criteria to Reside -	13.3%	14.5%	12.2%	14.2%	12.0%	12.4%	13.7%	14.3%	12.5%	11.9%	12.7%	13.5%	10.5%
Bed Occupancy (Adult) -	93.1%	90.7%	95.1%	94.7%	94.7%	96.1%	95.1%	89.4%	90.8%	90.7%	92.9%	92.8%	93.7%
Bed Occupancy (Paed) -	89.5%	84.1%	86.1%	85.0%	83.5%	73.3%	75.1%	75.4%	70.2%	63.7%	79.9%	71.4%	75.0%

Latest position

- The average number of patients with a LoS >21 remains stable at 103.
- 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.
- The H-FAST pathway has increased to 4 discharges per day via this pathway and the LoS for pathway 1 is reducing because of this.
- 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 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 review is underway to **streamline ambulance self-handover processes** at the front door/reception to reduce AAA congestion. A QI lead has now been nominated to support this initiative including wider Ambulance handover pathway improvement opportunities.
- YAS is currently recruiting to provide additional support to Hospital Trusts' during the winter period, the role will involve a Senior Paramedic being present on-site to **assist crews with clearing times**.

Emergency Department improvement:

- Following business case approval to recruit 6 additional ED consultants, 5 candidates have been shortlisted with interviews planned for December. This will ensure 24/7 consultant presence in ED. Overnight consultant coverage (where reg cover is down to one) is being tested in November to assess the impact on **improving patient flow**.
- 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.
- Outstanding ED project to focus effort on reducing overcrowding in the department – the initiative was presented at ETM in October and will be presented to the board in November for sign off.

Inpatient LoS and Discharge improvement:

- H-FAST weekly project meetings are being held, aiming to **increase daily discharges** to 6 per day via this pathway. The planned increase will not be achieved in the timescale initially suggested due to agreed pause for review of therapy readiness to adopt/adapt the model.
- The Pathway 3 DTA Trusted Assessor model launched in September 2024 and aims **discharge patients to independent sector providers** within 48hours of no longer meeting the criteria to reside. Weekly check-in meetings are being held to review and refine the pathway, but it is still too early to determine its efficacy.
- 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:

- The stroke response team is now fully recruited with extended hours now 8am to 8pm.
- The **Task to Finish** groups are now complete and recommendations have been made for how to sustain improvements in the future.
- There is an ongoing risk around **changes to the SSNAP reporting metrics** which will lead to a lower score for Bradford and Airedale.
- A presentation is being delivered to SQC on Thursday 14th November where a discussion with the ICB will be held around **commissioning for ESD / CST** to agree uniformity across Bradford and Airedale. The outcome presentation will then be delivered to both Bradford and Airedale appropriate committees in December and January.

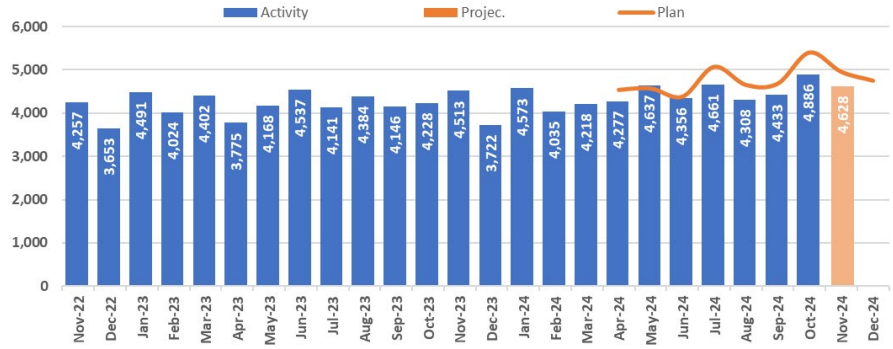
RTT and Planned Activity

6. Inpatient Activity

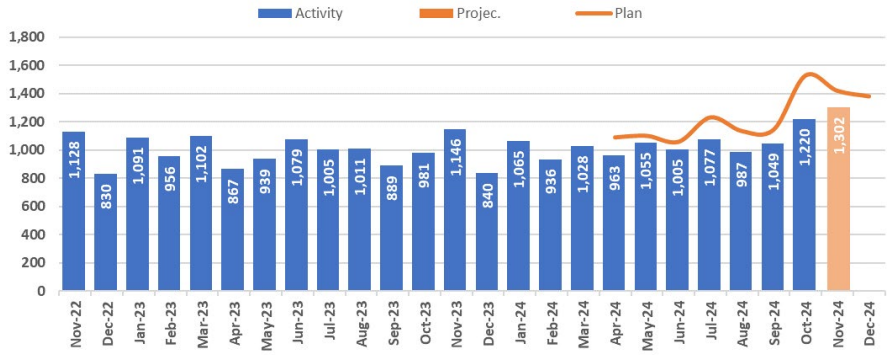
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Admitted Clock Stops -	1,430	1,057	1,307	1,156	1,279	1,247	1,319	1,276	1,372	1,177	1,378	1,459	1,264
Number of lists run -	579	456	572	535	539	527	534	517	596	524	566	616	620
Patients Per List -	2.0	1.9	1.9	1.8	1.9	1.9	2.1	2.0	1.9	2.0	1.9	2.0	2.1
Capped Utilisation -	82.84%	80.26%	83.27%	82.71%	83.90%	85.42%	86.09%	83.19%	83.15%	82.89%	79.61%	85.29%	83.40%
Total Cancellations -	151	110	200	135	119	145	153	138	135	113	144	140	141
28-day Rebooking Breaches -	1	0	3	7	9	3	5	2	11	9	7	1	5
Decisions to Admit -	5,424	4,533	5,550	4,937	4,921	5,187	5,323	4,867	5,530	4,935	5,190	5,685	4,099

Latest position

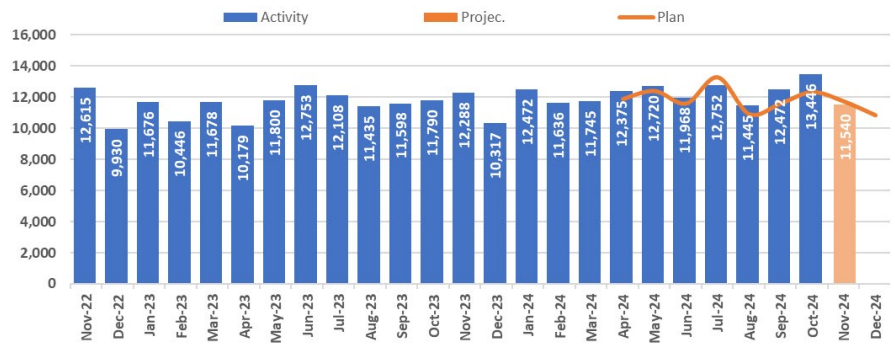
- Inpatient activity increased but delivered below plan in October 2024. It is projected to remain below plan in November 2024.
- From October, the plan includes expected activity delivered through the day-case unit which was due to open at St Luke's hospital. The opening of the unit has now been delayed to January 2025, resulting in a gap to plan expected of 501 cases and £938,930 ERF income.
- The number of lists run has increased in recent weeks while patients per list and capped utilisation remain relatively stable in October 2024. Endoscopy unit and CDC activity continue to track behind plan but are part of a specific CTG deliverable to support improvement.
- 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 (CTG) project. This includes an analysis of job plans to identify discrepancies with the current theatre session plan.
- A demand & capacity exercise for Anaesthetics is in progress and should identify capacity available to mitigate the DCU delay and any potential gaps when all theatres are running during Q4.

7. Outpatient Activity

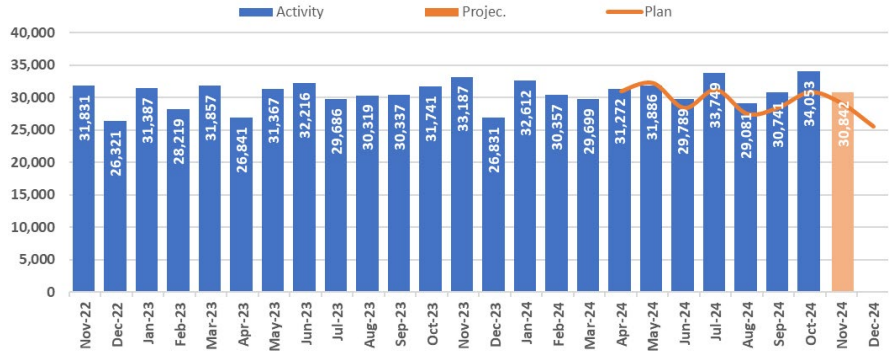
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Non Admitted Clock Stops -	6,933	5,461	6,810	6,230	5,909	6,474	6,589	6,255	6,713	5,699	6,353	6,804	6,132
DNA Rate -	8.62%	9.10%	8.16%	8.42%	8.34%	8.21%	8.50%	8.27%	7.92%	8.01%	8.03%	7.90%	7.39%
Follow Up Orders -	27,846	21,912	27,251	25,574	24,421	26,346	26,170	24,126	26,877	23,399	24,868	27,914	25,613
PIFU % -	1.90%	2.36%	2.07%	2.43%	2.45%	2.56%	2.66%	2.58%	2.56%	2.31%	2.48%	2.38%	2.63%
First to Follow Up Ratio -	2.70	2.60	2.61	2.61	2.53	2.53	2.51	2.49	2.65	2.54	2.46	2.53	2.67
Number of clinics run -	5,879	4,874	5,883	5,521	5,344	5,629	5,615	5,356	5,915	5,182	5,642	6,204	5,485
Patients Per Clinic -	7.7	7.6	7.7	7.6	7.8	7.8	7.9	7.8	7.9	7.8	7.7	7.7	7.7
GP Referrals -	7,340	5,558	7,435	7,065	7,002	6,992	7,439	6,708	7,541	6,465	6,871	6,543	4,480

Latest position

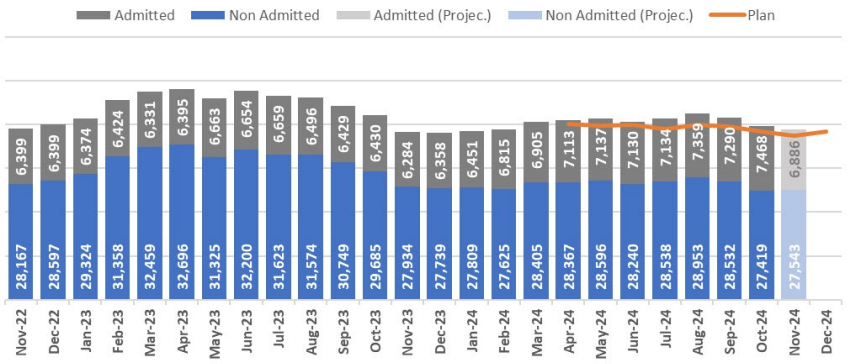
- Outpatient activity delivered above plan in October 2024 and is projected to deliver slightly below plan in November 2024.
- The work to improve activity levels of outpatients with procedures in line with the planning guidance is ongoing and is resulting in an increase in procedure recording. More 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. 99,516 patients have been contacted to date who meet the required criteria with 3,520 requesting discharge (3.5%).
- PIFU use remained stable in October and continues to be 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. Additional resource has been allocated to this project with a focus on clinic delivery and local GIRFT action logs.

8. Referral to Treatment

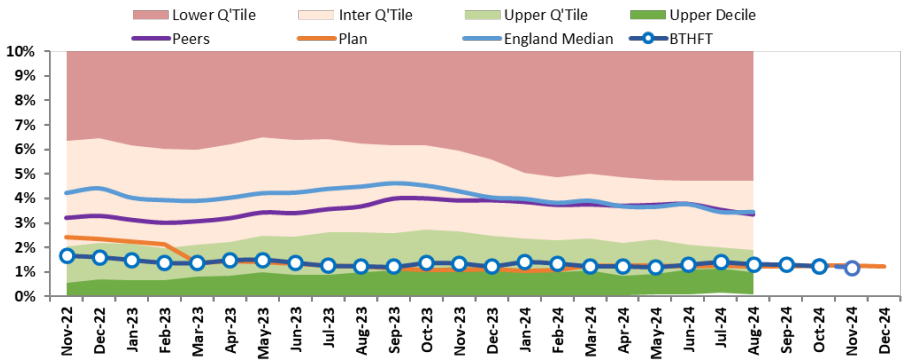
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
RTT Performance -	66.59%	64.60%	65.03%	65.13%	64.48%	64.35%	64.69%	64.31%	63.30%	62.27%	62.03%	61.77%	61.24%
Incomplete (<18) -	22,786	22,027	22,278	22,430	22,772	22,832	23,114	22,747	22,406	22,610	22,220	21,551	21,085
Incomplete (>18) -	11,431	12,069	11,982	12,010	12,542	12,648	12,619	12,623	12,992	13,702	13,602	13,336	13,344
Incomplete (52+) -	468	429	484	469	442	443	435	463	499	484	472	436	407
Incomplete (65+) -	64	63	75	67	34	58	67	75	65	55	69	61	54
Incomplete (78+) -	0	1	1	3	1	1	0	0	2	1	5	4	2
W/L Change -	-1,897	-121	+164	+180	+874	+166	+253	-363	+28	+914	-490	-935	-458

Latest position

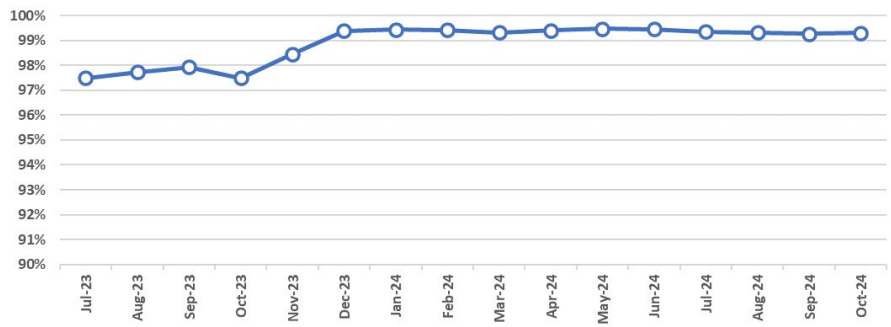
- The RTT waiting list size remained above plan in October but continues to reduce month on month. The number of patients waiting over 52 weeks is projected to reduce slightly in the same period. The number of patients waiting over 65 weeks reduced in October 2024. It is forecast to reduce further in November 2024 with clearance expected by January 2025. Mutual aid has been offered and patients are being contacted and asked if they are happy to transfer to other providers across the region.
- T&O, ENT and OMFS are being supported with weekly meetings to review patient level data and have 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.

9. Waiting List Management and Validation

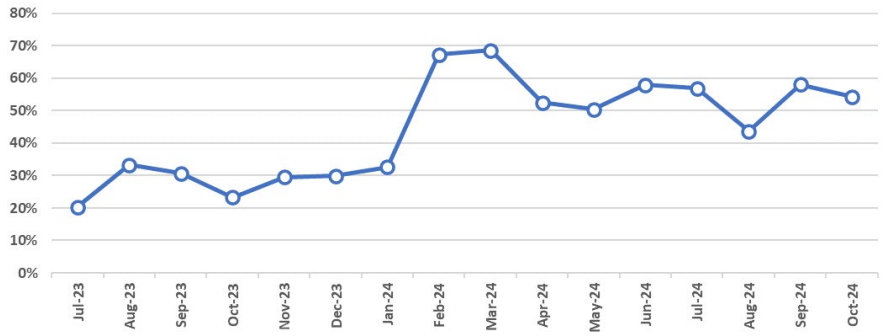
Bradford Teaching Hospitals NHS Foundation Trust

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

		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
RTT LUNA DQ Metrics	-	3,841	1,475	1,258	1,354	1,692	1,434	1,199	1,215	1,488	1,585	1,663	1,516
Correction Rate - Non RTT	-	17.63%	20.75%	14.84%	76.76%	81.69%	42.69%	29.32%	19.27%	17.99%	11.49%	27.27%	34.86%
Non-RTT DQ Process Failures	-	34,461	41,301	36,358	38,690	38,143	38,425	35,659	34,777	34,779	35,213	35,706	35,961

Latest position

- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.31% in October 2024. Targeted validation of incomplete pathways is sustaining the high confidence level.
- There is a slight increase in the number of DQ metrics on the RTT waiting list. Staff on long-term sick are returning on phased return, which is improving the position in November 2024 and this will improve further in December 2024.
- Technical validation of historic process failures (records with conflicting statuses) has been completed with 16,111 pathways being cleared and 4,268 escalated to CSUs for admin/clinical review. Next stage is to validate 14,331 more recent records.
- 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. A new pre-assessment booking process has been agreed which includes using of to be scheduled list to book patients for pre-assessment.
- Process failures related to IBD appointments have increased significantly. This is related to change of booking process in IBD team not placing future orders. New guidance to place future PIFU orders is being rolled out to the team.

10. Delivering RTT/Planned Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

RTT and Planned Activity Improvement

- 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. RTT and planning waiting lists will improve as activity increases.
- ETM have approved to start applying the job planning principle related to **quantum delivery** of Direct Clinical Care (DCC) sessions for 24/25. This should ensure that any mutually agreed deficit of DCC sessions from H1 is recovered in H2 to maximise the opportunity to deliver activity within normal rates.
- 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 to January 2025. The impact of lost activity against plan and lost income from ERF is significant and mitigation plans are being developed.
- 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 which have informed CSU action plans. Where appropriate cross cutting projects will be initiated to support adoption of best practice and many of these will fit within the CTG 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.
- Counting and coding opportunities have also been identified through this work and will be implemented by a specific workstream. This includes OPPROC and elective admission processes for planned acutes.

Waiting List Management and Validation

- Web-based **waiting list management tools** were successfully launched across the Corporate Access Team (CAT) and tracking of RTT pathways and Non-RTT orders for all CSUs. This has allowed 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.
- Development of further lists on the app is underway, including Active Monitoring, Planned past SBD and PIFU.
- Services are **clinically validating non-RTT patients** who are 12 months past their see by date in line with the validation toolkit. Text based validation and PIFU will be extended to this process as appropriate.
- Changes required to current **RTT sequencing on Cerner** has been approved by the EPR change board and EPR team has started the background work on implementing the changes. The output of this project will improve clinic outcome options for clinicians, in line with RTT pathway management.

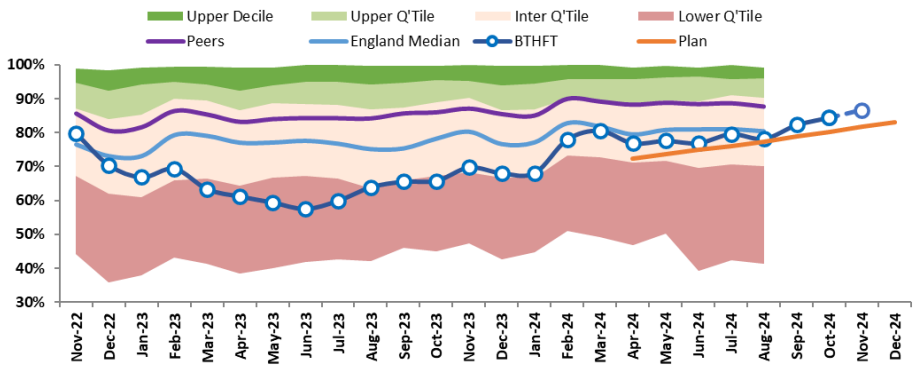
Cancer & Diagnostics

11. Diagnostic Waiting Times

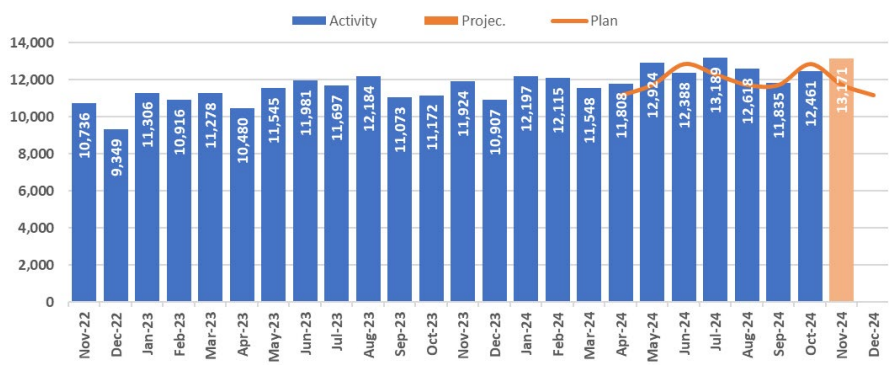
Bradford Teaching Hospitals NHS Foundation Trust

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

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
(Phys. M'ment) Activity -	1,273	1,102	1,522	1,671	1,850	1,754	1,781	1,563	1,992	1,856	1,669	1,760	1,758
(Phys. M'ment) Performance	64.9%	58.2%	50.7%	61.6%	73.4%	77.1%	83.2%	74.5%	84.6%	75.6%	80.9%	79.1%	79.9%
(Imaging) Activity -	9,817	9,085	9,765	9,755	9,058	9,399	10,350	9,991	10,412	10,113	9,328	9,914	10,401
(Imaging) Performance -	69.8%	68.7%	73.2%	83.7%	82.6%	76.8%	75.7%	76.4%	77.8%	78.7%	81.5%	84.8%	87.7%
(Endoscopy) Activity -	1,371	1,164	1,484	1,263	1,310	1,337	1,543	1,440	1,489	1,257	1,411	1,425	1,470
(Endoscopy) Performance -	78.4%	90.1%	85.1%	86.0%	90.8%	77.1%	77.7%	84.2%	81.7%	79.5%	88.8%	89.4%	89.7%

Latest position

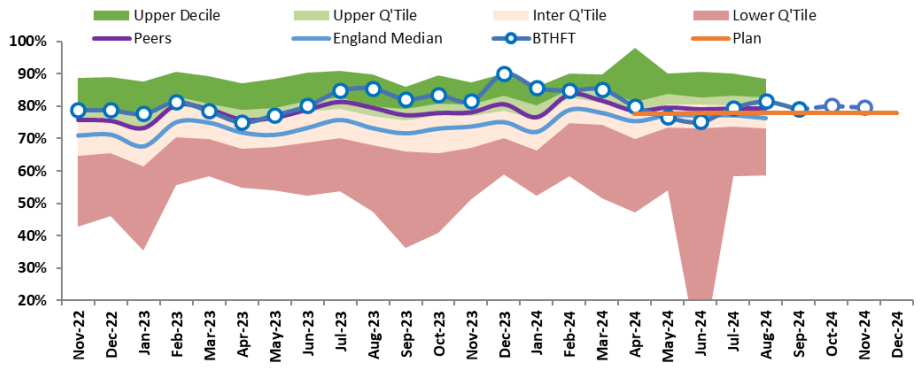
- The CDC continues to provide capacity for many diagnostic modalities including Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. Process and efficiency improvements are routinely being explored to further capitalise on this resource.
- Pressure on NOUS continues with sustained growth in obstetric ultrasound having an impact on radiology and imaging, with the number of vacant sonographer posts resulting in capacity challenges. A high volume of MSK referrals continues having an additional impact.
- MRI capacity improved in October and performance reached over 85% which is a significant upturn on previous months. 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 and performance has remained consistent despite pressures. Referrals are expected to increase in November and December due to it being Gastric Cancer Awareness month.
- Echocardiography additional capacity across August and September saw performance for these months improved to over 93%.
- Audiology performance has recovered to over 75% as gaps in clinical staffing have improved slightly. This is a national shortage issue, but the service are looking at a 5-year plan in response to mitigate as far as possible.

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)*

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Trust	80.0%	76.6%	75.2%	79.4%	81.5%	79.0%	80.2%	79.6%
Breast	96.2%	96.5%	96.0%	97.6%	97.2%	98.3%	95.3%	94.5%
Gynae	54.4%	46.8%	45.8%	46.4%	50.8%	37.5%	41.9%	40.5%
Haematology	21.4%	29.4%	33.3%	37.0%	33.3%	56.3%	57.9%	56.5%
Head & Neck	69.5%	75.4%	72.2%	79.0%	82.7%	80.7%	79.2%	77.9%
Lower GI	66.7%	56.7%	62.6%	65.5%	79.1%	82.7%	76.0%	76.1%
Lung	88.9%	92.5%	88.9%	84.3%	86.0%	82.6%	91.7%	88.9%
NSS	71.4%	95.2%	83.3%	92.3%	85.7%	69.2%	92.6%	87.5%
Upper GI	75.9%	75.8%	85.8%	90.6%	92.6%	87.6%	93.2%	91.7%
Skin	92.6%	86.0%	72.4%	82.8%	73.8%	71.8%	71.0%	73.3%
Urology	54.7%	74.7%	77.9%	80.3%	82.5%	75.0%	83.3%	83.5%

12.3 Additional Diagnostic Phase Metrics

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
# 2WW Refs	1,967	1,534	1,825	1,814	1,842	1,969	2,074	1,647	1,692	1,820	1,730	1,864	1,631
% 2WW Performance	96.4%	93.1%	82.1%	94.8%	92.3%	86.1%	89.9%	94.4%	92.9%	92.1%	93.9%	92.5%	93.1%
28 Day FDS Performance	81.4%	91.0%	85.7%	84.8%	85.2%	80.0%	76.6%	75.2%	79.4%	81.5%	79.0%	80.2%	79.6%
# Total Patients Seen FDS	1,652	1,188	1,536	1,510	1,374	1,666	1,959	1,827	1,722	1,716	1,692	1,619	1,738
# Undiag, unbooked >28 days	158	283	176	217	313	318	342	212	179	196	175	188	212

Latest position

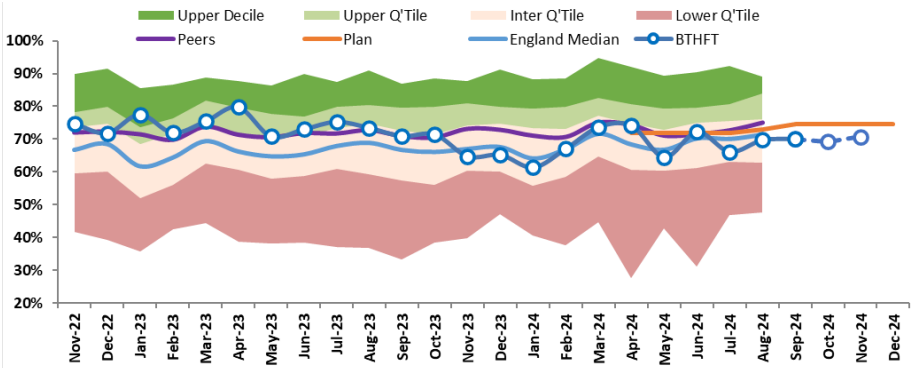
- Two week wait (2WW) performance recovered to an above target position of 93.91% in September due to increased capacity and patient availability. Sustained high referrals across a number of tumour sites are expected to remain in October and November for Breast and Breast Symptomatic, Gynae, Gastric and Lung cancer pathways due to national campaigns for which additional capacity is being sought on an ad hoc basis. A proposal for increased bespoke radiology support is underway to help to accommodate sustained volumes in the longer term.
- The Skin Lesions Investigations Clinic (SLIC) has continued to prevent referrals into the Skin pathway hitting historic levels and performance has sustained at a high level as a result although performance is expected to dip in October due to the impact of half term on staffing.
- FDS performance for September remained 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.
- Work on MDT streamlining continues with a targeted focus on system wide improvements for notifying patients of a benign cancer diagnosis and improving reporting processes.

13. Cancer Treatment

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the 62 Day Treatment Standard

13.1 62 Day Treatment Benchmarked *(Source: NHSE for Acute & Combined)*



13.2 62 Day Treatment Performance by Tumour Group vs 70% Target

(Source: PPM)

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Trust -	74.1%	64.5%	72.2%	66.1%	69.7%	70.0%	69.3%	70.8%
Breast -	88.6%	69.1%	83.3%	92.2%	95.1%	95.1%	81.4%	75.7%
Gynae -	62.5%	55.6%	70.0%	13.3%	100.0%	48.0%	20.0%	46.2%
Haematology -	62.5%	55.6%	70.0%	13.3%	100.0%	48.0%	70.0%	63.2%
Head & Neck -	62.5%	57.1%	35.5%	40.0%	25.0%	36.4%	40.7%	54.2%
Lower GI -	73.5%	56.5%	54.5%	84.2%	69.6%	57.1%	65.2%	69.2%
Lung -	60.0%	10.0%	46.2%	41.2%	40.0%	26.3%	38.5%	55.6%
Upper GI -	30.8%	50.0%	61.1%	50.0%	78.3%	36.8%	33.3%	50.0%
Skin -	76.7%	70.6%	87.2%	82.8%	82.8%	82.9%	91.2%	87.1%
Urology -	83.3%	80.9%	82.2%	62.0%	71.8%	75.8%	64.4%	74.2%

13.3 Additional Cancer Treatment Metrics

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
# 31 Day Treatments -	312	248	315	278	247	262	257	260	261	248	300	228	267
31 Day Performance -	87.5%	92.7%	87.0%	95.3%	91.9%	95.0%	93.8%	91.5%	92.3%	93.5%	91.0%	93.9%	94.8%
62 Day Performance -	65.8%	65.9%	60.9%	66.9%	74.3%	74.1%	64.5%	72.2%	66.1%	69.7%	70.0%	69.3%	70.8%
# of >62 (GP Referral) -	67	53	63	53	41	62	75	56	58	42	43	36	36
# of >62 (All Types) -	97	88	101	79	51	80	98	77	82	54	52	52	54

Latest position

- 31-day treatment (time from decision to treatment) performance continued below target at 91% for September having been impacted by a sustained period of holidays into September. However, performance against this standard is forecast to improve through October and November to over 94% as capacity improves.
- The 31day first Treatment Standard was a focus area for the Cancer timeout day in November, which provided an opportunity for greater understanding and scrutiny to highlight current challenges shape future planning.
- Cancer treatment within theatre remains a priority and early identification of capacity issues is in place. Head and Neck capacity is currently being reviewed but there are no other escalations at present.
- 62-day performance achieved the 70% target during September with clearance of patients who had already exceeded the 62-day target due to diagnostic delays being a priority. The performance is expected to dip in October due to the impact of half term on staff and patient availability, but this is forecast to improve through November.
- The backlog of patients waiting over 62 days is expected to continue to drop further in line with 24/25 forecasts.
- Although treatment volumes have impacted on performance against this standard, there is no single cause for this with tumour groups experiencing increased complexity, reduced treatment, diagnostic delays, and patient-initiated delays.

14. Delivering Cancer & Diagnostic Ops Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

Cancer Wait Times improvement

- The **cancer time out session** took place in November and was well attended. These sessions are part of the Cancer Board program of work to develop a shared clinical vision for the Trust's Cancer Strategy.
- 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.
- Original go live date for Civica/ Infoflex was 1st October but this is now not possible, and no revised date is known yet and this has been escalated. Integration work continues and design workshops are now in diaries. 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 and fixed term roles are now permanent. 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.
- IMD and patient demographic data is included in patient experience and cancer wait time reports being used to informed plans to improve services and reduce inequalities. This included a recent report to HOSC using PCN and demographics to show variation. Funding has been made available to pilot the use of free bus tickets for patients who are more likely to DNA or cancel their appointment. This is being aligned to work underway to predict DNA and reduce health inequalities.

- **Diagnostic Wait Times improvement**
- Business Intelligence dashboard development has made significant progress. Dashboards for a number of diagnostic modalities are now either ready for use or in final testing stage with data cleansing and sign off nearing completion. Centralised reporting is being developed to better support the **weekly access cycle** and month performance meetings.
- Digital transformation progressing with AI, e-referral and joint reporting systems schemes in place.
- Sonographer capacity for Non-Obstetrics Ultrasound (NOUS) improved and increases further from October. Some remaining issues with consultant capacity and alternative provision of specific tests are being explored.
- Work continues to analyse referrals and reach out to work collaboratively to assist reduction of unnecessary or inefficient referral patterns and re-direct where appropriate.
- **MRI 7-day model** being explored which will further enhance scanning resilience. Investment in workforce will be the main challenge.
- Endoscopy productivity is being explored as part of the CTG workstream. Solus data has been tested and is being used to provide the CSU productivity insights which we are also building into a power BI dashboard. This will test existing actions are the right ones and enhance the programme of work designed to **improve room utilisation** and patient throughput.

F. WINTER PLAN

REFERENCES

Only PDFs are attached

Bo.11.24.13f - Winter 2024-25 Operational Plan (cover).pdf

Bo.11.24.13f - Winter 2024-25 Operational Plan V1.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13f

Winter Operational Plan 2024/25

Presented by	Julie Lawreniuk, Non-Executive Director and Chair of F&P Committee	
Author	Shaun Milburn, Deputy Director of Operations (Unplanned Services)	
Lead Director	Sajid Azeb, Chief Operating Officer and Deputy Chief Executive	
Purpose of the paper	For Information Only	
Key control	To provide assurance to the Board that there is a robust plan to manage winter pressures	
Action required	For assurance	
Previously discussed at/ informed by	*Previously discussed and presented at ETM*	
Previously approved at:	*F&P Committee*	**Date 16/10/2024**

Key Options, Issues and Risks

The BTHFT Winter Operational plan is developed annually to ensure the operational team have a robust plan to manage the pressures arising during the winter months between November and March.

It has been developed by taking into account the 2-year National Priority for recovering urgent and emergency care and forms part of the over-arching ICB system-wide winter plan.

The plan is a live document that will change through the course of winter to support the operational team both in and out of hours.

Analysis

The plan has 8 key sections.

National Agenda: the winter principles, UEC 2-year recovery plan and the 10 high impact interventions

Demand and Capacity and Surge: how we manage winter demand, bed capacity including a fully costed forecast

Infection Prevention: vaccination, virology testing and side room utilisation and isolation

Overcrowding, Clinical Streaming, Ambulatory Emergency Care, UTC: managing flow within the AED and throughout the hospital.

Full Capacity Protocol (revised): managing surge

Paediatric winter plan: complex care, surge and escalation

Additional Winter Schemes: to support flow, surge and escalation and partnership working

Metrics and Measurements: 6 key metrics to measure patient safety over winter

Recommendation

To receive the winter plan

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13f

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):

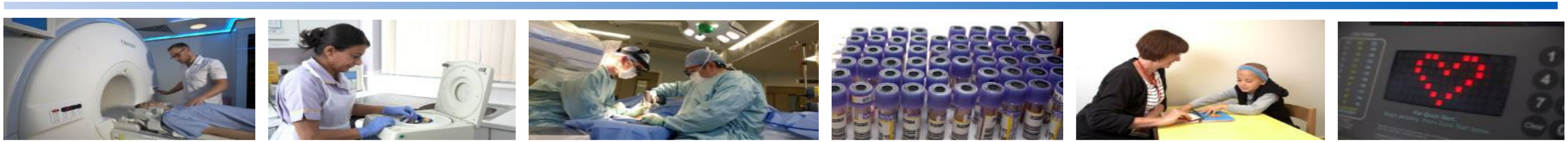
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☐	☐	☐	☐

Bradford Teaching Hospitals
NHS Foundation Trust

WINTER OPERATIONAL RESPONSE PLAN 2024-25

October 2024

This is a live document and will be updated in response to demand and capacity pressures



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Bradford Teaching Hospitals
NHS Foundation Trust

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SECTION 4 – Overcrowding, Clinical Streaming, Ambulatory Emergency Care, UTC

SECTION 5 – Full Capacity Protocol (revised)

SECTION 6 – Paediatric winter plan

SECTION 7 – Additional Winter Schemes

SECTION 8 – Metrics and Measurement

SECTION 1
NATIONAL AGENDA

NHSE Winter Principles

A letter published on 16th September 2024 outlined 4 core principles:

Adobe Acrobat Document

1. **Planning and financial framework**
2. **Providing safe care over winter**

Reference to the UEC 2 year recovery plan from 2023 onwards

Adobe Acrobat Document

3. Supporting people to stay well

a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign for flu, COVID and RSV

4. Maintaining patient safety and experience

At ICB/National level - 7 day reporting from 1st November, GIRFT data reviews, expanding OPEL framework, winter preparedness exercise in September.

Trust level - demand and capacity reviews, full capacity plans (with core principles of Temporary Escalation Spaces), decision making to minimise overcrowding in AED, patient flow

10 High Impact Interventions

Bradford Teaching Hospitals NHS Foundation Trust

Process and Flow

- Same Day Emergency Care
- Frailty
- Inpatient flow and length of stay (LOS)

Discharge & Intermediate Care

- Care Transfer Hubs
- Community bed productivity
- Intermediate care demand and capacity

Out of hospital care, Virtual Wards & Urgent Care

- Urgent Community Response
- Single point of access – CAS
- Acute respiratory infection hubs
- Virtual Wards

Latest Self-assessment outcomes

Bradford Teaching Hospitals NHS Foundation Trust

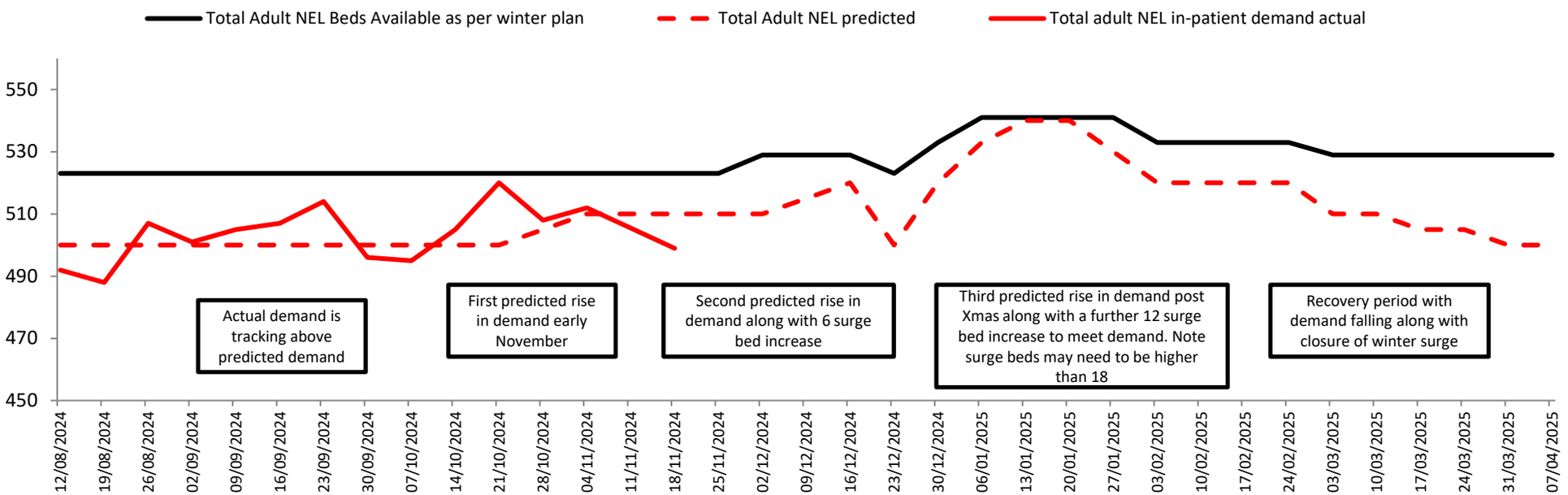
NHS West Yorkshire Integrated Care Board

ICS	Place	High-impact intervention (HII)	TO UPDATE: Maturity Scores (as of Aug '24)	TO UPDATE: If no progress, what have been the top three constraints	TO UPDATE: How could this score be improved?
West Yorkshire	Bradford District and Craven	ARI	4	We have a plan for ARI over winter dependent on the release of transformation money so scoring remains the same as it is expected we will have some capacity implemented between Nov and Feb to cover predicted respiratory peak but volume of appts will be lower than demand. Funding is only blocker to this being implemented effectively	increased national funding to allow us to match capacity to demand and a wider spread across both Bradford and Craven
West Yorkshire	Bradford District and Craven	Frailty	6	Currently recruiting ACPs and developing a frailty unit co-located next to the admissions ward	Once recruitment is finalised should improve score, currently AGH is colocated with ED
West Yorkshire	Bradford District and Craven	Intermediate care	5	Rescored and reflected on previous scoring - there has been much progress but this is more reflective of where we are	Lots of work currently taking place to implement our IMC Blueprint - really positive impacts from HFAST pilots, just rolling out new P3 DTA. Will take some more time to fully embed - culture/ways of working etc.
West Yorkshire	Bradford District and Craven	SDEC	8	Both sites have fully matured same day care that meets national specification	
West Yorkshire	Bradford District and Craven	Community beds	7		
West Yorkshire	Bradford District and Craven	Inpatient Flow	7 (average across both trusts)	BTHFT has been highlighted as being in the top 10 of providers for flow by NHSE.	AGH needs to improve 7 day cover, ward round consistency
West Yorkshire	Bradford District and Craven	SPOA	2	rescored based on criteria and how we match up to new spec. Work ongoing across WY to establish what this may look like. Constraints are funding, resource to map and implement e.g. Programme manager and technology to share information e.g. ambulance stacking etc.	match to new spec and prioritise pathways highlighted in spec
West Yorkshire	Bradford District and Craven	UCR	6		More work to be done as part of IMC Blueprint to enhance our community offer which will include UCR
West Yorkshire	Bradford District and Craven	Virtual Wards	7	Availability of Finance, VWs have become more BAU and system focus has been more on our IMC Blueprint	

SECTION 2 DEMAND AND CAPACITY AND SURGE

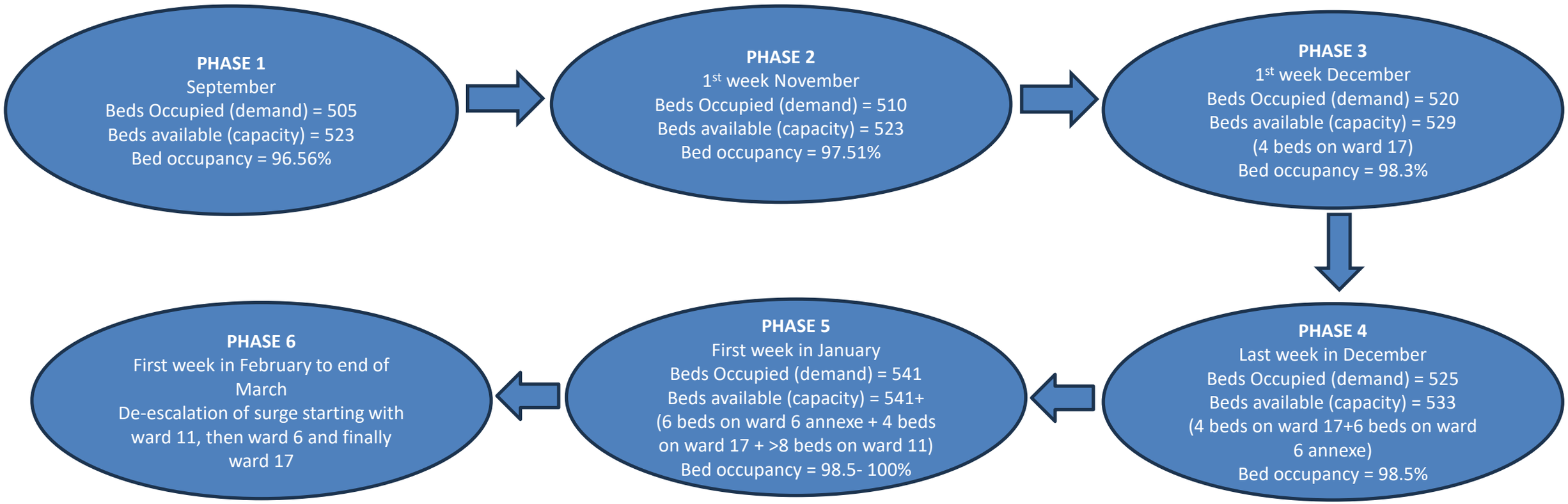
1. DEMAND – assumptions

Bradford Teaching Hospitals
NHS Foundation Trust



Capacity and Demand Summary Adult NEL

Bradford Teaching Hospitals NHS Foundation Trust



The above phasing will be detailed in a separate operational plan, including nursing equipment and planned opening and closing

Forecast cost and run rate implications

Bradford Teaching Hospitals NHS Foundation Trust

I/E	Scheme	Area	Requirement	Grade	Open	Close	WTE	Nov	Dec	Jan	Feb	Mar	Total	Source of Funds
Expenditure	Ward Nursing	Ward 6	1 RN 24/7	Band 5	1st Dec	28th Feb	5.25	£ -	-£ 18,938	-£ 18,938	-£ 18,938	£ -	-£ 56,815	Revised forecast
Expenditure	Ward Nursing	Ward 6	1 HCA 24/7	Band 2	1st Dec	28th Feb	5.25	£ -	-£ 12,693	-£ 12,693	-£ 12,693	£ -	-£ 38,080	Revised forecast
Expenditure	Ward Nursing	Ward 11	2 RN Sat to Mon	Band 5	1st Jan	15th Jan	2.49	£ -	£ -	-£ 4,153	£ -	£ -	-£ 4,153	Revised forecast
Expenditure	NIV enhanced care	Ward 23	1 b5 RN bank, 20 d/m	Band 5	1st Nov	31st Mar		-£ 12,500	-£ 12,500	-£ 12,500	-£ 12,500	-£ 12,500	-£ 62,500	Revised forecast
Expenditure	ED Nursing	New area in ED	1 RN 24/7	Band 5	1st Nov	31st Mar	6.58	-£ 28,583	-£ 28,583	-£ 28,583	-£ 28,583	-£ 28,583	-£ 142,917	From System Resilience budget
Expenditure	Patient Transport	Transport			1st Oct	31st Mar		-£ 7,250	-£ 7,250	-£ 7,250	-£ 7,250	-£ 7,250	-£ 36,250	From System Resilience budget
Expenditure	Elderly Care Consultant	Consultant PRA	1 consultant at weekends	Consultant	1st Nov	31st Mar			-£ 10,500	-£ 10,500	-£ 10,500	-£ 10,500	-£ 42,000	From System Resilience budget
Income	EOI for Palliative and EoL Care	Children's	Bid to ICB					£ 18,645	£ 18,645	£ 18,645	£ 18,645	£ 18,645	£ 93,223	Funded by West Yorkshire ICB
Expenditure	EOI for Palliative and EoL Care	Children's	8.5 hrs per week	Band 6	1st Nov	31st Mar	0.23	-£ 932	-£ 932	-£ 932	-£ 932	-£ 932	-£ 4,658	Funded by West Yorkshire ICB
Expenditure	EOI for Palliative and EoL Care	Children's	1.5 hrs per week	Band 8A	1st Nov	31st Mar	0.04	-£ 255	-£ 255	-£ 255	-£ 255	-£ 255	-£ 1,273	Funded by West Yorkshire ICB
Expenditure	EOI for Palliative and EoL Care	Children's	2.5 PAs	Consultant	1st Nov	31st Mar	0.25	-£ 3,962	-£ 3,962	-£ 3,962	-£ 3,962	-£ 3,962	-£ 19,810	Funded by West Yorkshire ICB
Expenditure	EOI for Palliative and EoL Care	Children's	Training Cost					-£ 6,750	£ -	£ -	£ -	£ -	-£ 6,750	Funded by West Yorkshire ICB
Income	PCC OND	Children's	Equipment					£ 4,074	£ -	£ -	£ -	£ -	£ 4,074	Funded by Sheffield Children's Hospital
Expenditure	PCC OND	Children's	Equipment					-£ 4,074	£ -	£ -	£ -	£ -	-£ 4,074	Funded by Sheffield Children's Hospital
Expenditure	Children's - Complex Young People	Children's	2 Physios	Band 6	1st Nov	31st Mar	2.00	-£ 8,621	-£ 8,621	-£ 8,621	-£ 8,621	-£ 8,621	-£ 43,103	From System Resilience budget
Expenditure	Children's - Complex Young People	Children's	1 Nurse	Band 7	1st Nov	31st Mar	1.00	-£ 5,216	-£ 5,216	-£ 5,216	-£ 5,216	-£ 5,216	-£ 26,079	From System Resilience budget
Expenditure	Children's - Complex Young People	Children's	Admin	Band 3	1st Nov	31st Mar	0.50	-£ 1,377	-£ 1,377	-£ 1,377	-£ 1,377	-£ 1,377	-£ 6,884	From System Resilience budget
Expenditure	Children's - Complex Young People	Children's	1.75 PAs	Consultant	1st Nov	31st Mar	0.18	-£ 2,202	-£ 2,202	-£ 2,202	-£ 2,202	-£ 2,202	-£ 11,009	From System Resilience budget
Total								**-£ 59,001**	**-£ 94,383**	**-£ 98,536**	**-£ 94,383**	**-£ 62,752**	**-£ 409,055**	**£ -**

Assumptions

- Zero avoidable internal delayed discharges (TTOs, transport and ward processes)
- All available NEL beds are ***ring fenced*** for NEL activity, with no DC or EL cases in NEL beds and all admitted to the ring-fenced elective bed base (with the exception of the approved pathway for vascular)
- Demand modelling assumes the benefits of the IMC blueprint for P1, P1 and P3 complex discharges are in place.

Admission avoidance schemes

- Rapid Assessment and Treatment, (RAT)
- Vetting of all bed requests by consultant/senior AED Dr
- Maximising the Program for reducing overcrowding in AED including Amber Zone Observation Room along with UTC and Ambulatory Emergency Care unit, medical day case unit expansion

Risk associated with Respiratory NIV capacity

Bradford Teaching Hospitals NHS Foundation Trust

Assumptions

Current capacity: total 28 beds

Respiratory ward beds = 22

Respiratory HDU = 6 beds

Demand indicates the following requirement (ETM ward 10 strategic review link here)

Adobe Acrobat Document

Total beds 36-38

Respiratory ward beds 28

Respiratory HDU beds 8 with option to surge to 10.

This could have been delivered if ward 10 had been available for this winter but this is not possible so respiratory bed capacity will remain fixed at 28 on ward 23, resulting in a capacity and demand gap of between 8-10 beds.

Risk associated with Respiratory NIV capacity

Risks

1. Insufficient NIV bed capacity – leads to long waits for admission in AED HDU (exacerbating crowding).
2. Inappropriate use of ICU beds for respiratory NIV – leading to cancellation of elective cases.
3. Insufficient respiratory ward beds – leads to respiratory patients outlying on AMU, other wards, at home awaiting GP admission, further impacting on ED crowding

Mitigation

Previous winter we have flexed the existing ratio of Ward:HDU 22:6 to 18:10 (plus utilisation of ICU in exceptional circumstances). This leads to an associated increased costs of nursing and therapy to meet the NIV demand of £12.5k per month.

We require this mitigation to continue for winter 24/25 to mitigate the 3 risks.

SECTION 3 Infection Prevention

Managing IPC Demand

Prevention

- 2023-2024 vaccination rates were lower than pre-pandemic levels and were especially low amongst health care workers.
- This resulted in a higher proportion of patients being admitted with avoidable flu/COVID related illness and higher levels of staff sickness
- Whilst the vaccination program begins at the end of September a pragmatic view is to expect similar levels of vaccination rates in 2024/25.

Managing IPC Demand

Bradford Teaching Hospitals NHS Foundation Trust

Testing

Point of care virology screening in AED, paediatrics and some high risk in-patient areas is essential to ensure rapid decision making

Costs:

Virology screening via laboratory PCR costs £42 per kit (Flu A,B COVID, RSV) plus staffing costs.

Virology screen via PoCT (flu A, B COVID, RSV) costs £6 per test plus staff costs.

Positive PoCT do not need confirmation by laboratory PCR

Negative screens **do** need confirmation by laboratory PCR

Cost comparison for 1,000 screens (kits only)

1. All laboratory testing = **£42,000**

2. Mix of PoCT and lab based on rpt screening of negative PoCT with 24% tests being positive: **£37,920**

PoCT will have a £4,000 cost benefit and has significant clinical benefits over 100% laboratory testing

Managing IPC Demand

Side Room Utilisation and Isolation

Audits still indicate 45-50% of side rooms are occupied by patients not requiring isolation for IPC reasons. This is significantly less than the same period last year (65%) prior to the new SOP which prioritised the utilisation of side rooms.

Flu is expected to peak Jan-Feb 2025.

Further work with ward staff is still required on side room prioritisation for those patients with the highest risk of spreading infection.

SECTION 4 – Overcrowding, Clinical Streaming Ambulatory Emergency Care, Urgent Treatment Centre

Clinical streaming, Overcrowding, SDEC

Bradford Teaching Hospitals
NHS Foundation Trust

In response the recent “Despatches” Chanel 4 program, NHSE release a letter in June 2024 “Maintaining focus and oversight on quality of care and experience in pressurised services”

Adobe Acrobat Document

It highlighted the actions set out in May 2024 “Urgent and emergency care recovery plan year 2: Building on learning from 2023/24” and the expectations of “corridor care”

Adobe Acrobat Document

BTHFT are already achieving or have plans to complete all the actions in the letter

In addition to this there are some further actions that have been proposed to further mitigate overcrowding in AED :

Microsoft verPoint Presentat

Clinical streaming, Overcrowding, SDEC summary

1. Clinical Streaming: 55% of attendances are streamed outside of the main AED footprint - a recognised and approved process by NHSE and RCEM to ensure patients who attend AED are in the right place, right time and receive the right treatment, it reduces over-crowding in the main AED and improves the emergency care standard by reducing waiting and treatment times.
2. Overcrowding and how this never occurred during the 44 days of junior Dr strikes
3. Patient flow, ECIST
4. SDEC – NHSE recently provided guidance on specifications and requirements for an SDEC. This assessment for BTHFT is being completed as part of the WYAAT SDEC Task and Finish Group but we are expected to meet or exceed the majority of the requirements.

Microsoft Word Document

Overcrowding – Proactive Program to prevent Overcrowding

6 key workstreams have been proposed

Microsoft
verPoint Presentat

3 workstreams are internal to AED, 2 are wider hospital and external partners and one is estates driven.

Getting from A to B – flow in AED

Saving Beds – Reducing decisions to admit

Waiting Room – Freeing up trolleys/cubicles for assessment

Sharing the Load – what the rest of the hospital can do to minimise the time patients spend in AED

Making Beds – Creating in-patient capacity earlier

Space – expanding the UEC footprint

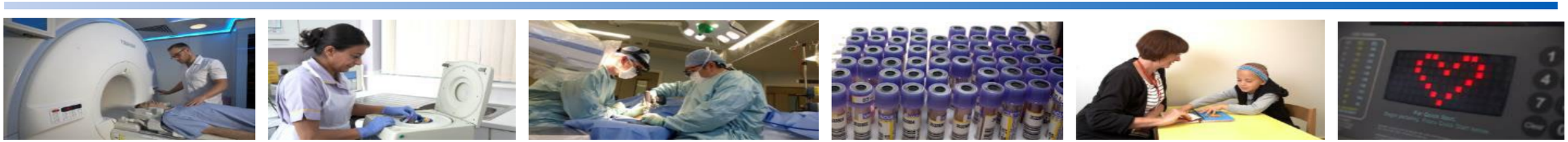
SECTION 5 Full Capacity Protocol

Bradford Teaching Hospitals
NHS Foundation Trust

FULL CAPACITY PROTOCOL 2024-25

October 2024

This is a live document and will be updated in response to demand and capacity pressures



Definition
Principles

Capacity in this context is workforce and senior decision making as an alternative to placing patients on corridors on wards.

During the 44 days of junior Drs strikes :
NEL admissions reduced by 25%
Conversion rates reduced from 26% to 19%
Over-crowding was never triggered
During times of escalation the full capacity protocol will engage the available consultant workforce to replicate the decision making outcomes during the junior Drs strike

In addition, we know:
57% of surgical admissions and 48% of medical admissions have a 0-1 day LoS.
Up to 60% of overnight bed requests are overturned after an AED consultant review and/or consultant speciality review

Triggers – all 6 must be Yes

Trigger – occupancy >100% for 4 or more cons hrs

- Are we in OPEL 3 or above?
- Are there 30 Bed requests in AED of which 25 are clinically ready?
- Is HDU/Resus and Amber Zone 100% occupied with TCIs ?
- Have all bed requests have been vetted by a consultant ?
- Is NEL bed occupancy at 100% (every bed occupied) & no further discharges predicted ?
- Is all Winter bed capacity open as planned ?

Action 1 – rapid senior decision making

Action (in hours)

- Command centre via the site huddle contact the relevant CSU representatives
- Assessment of need is undertaken by silver command with bronze leads
- Consultant resource where appropriate is diverted to AED

Outcome

- Patients in cubicles not requiring admission – treatment is completed and they are discharged
- Patients with a TCI - are post-taked in AED with a focus on rapid discharge and/or alternative pathways to admission
- Potential zero LoS patients in beds are rapidly discharged/sat out to make way for new admitted patients
- Rapid transfer of patients with no criteria to reside to appropriate pathway

Action (Out of Hours)

- AED consultant (on-site) contacts Command Centre
- Command Centre contacts 1st on call
- 1st on call (on site), site matron and AED consultant, AED shift leader assess situation

Outcome

- Appropriate speciality are contacted to review every AED bed requests and/or review new or recent admissions on their ward who may have not yet had a PTWR (this may be done virtually and appropriately documented)
- Rapid discharge or identification of appropriate patients who can sit out awaiting discharge to clear beds for new admissions

Action 2 - Rapid facilitation of discharges

Bradford Teaching Hospitals NHS Foundation Trust

- P0 Discharges
- Rapid facilitation of discharges/discharge lounge on ward 8
- MAIDt and partners to transfer medically optimised patients to appropriate place
- Escalate Repatriation to other acutes
- Escalate repatriation of MH patients in acute bed base to MH facility

Action 3 – additional surge capacity (only after completing actions 1 & 2)

Surge Beds ***(order TBD SF order is 3,1,2,4)***

1. Fill every NEL bed space (inc CCU, HDU, HASU, ward 27)

2. Open Surge
   Ward 6 6 beds
   Ward 17 4 beds
   Double side room that are currently single occupancy (17/19) 8 beds?
   Fill all SAU chairs

3. Fill empty elective beds (with short stay surgical or elective patients sitting in NEL beds)

4. Consider transfer <18yr olds in adult bed base to paeds (if paeds have capacity)

Support for using temporary escalation spaces (TES)

Adobe Acrobat Document

This tool has been developed by RCN. TES are not the spaces that are opened as part of winter pressure planning but refers to care given in any unplanned settings (such as corridors).

The BTHFT Full Capacity Protocol does not include the option of care in corridors

SECTION 6 PAEDIATRICS

Winter Resilience Funding for paediatrics

Bradford Teaching Hospitals
NHS Foundation Trust

Complex care pathway

Funding awarded for additional staff to support a pilot for Children with complex medical conditions and respiratory vulnerability. The aim of the project:

- Reduce A+E and other urgent attendances to hospital
- Reduce rates of hospitalisation and length of stay
- Reduce rates of readmission
- Improve perceived levels of family / carer support and confidence in dealing with respiratory symptoms at home
- Improve overall ability of service to deliver safe and appropriate care for CMC in a home environment
- Empower families / cares and deliver skills which allow them to manage respiratory symptoms at home
- Lead to a package of training for both staff and families
- Publish our model and findings in order to allow others to consider or continue to develop their services

Winter Resilience Funding for paediatrics

Bradford Teaching Hospitals NHS Foundation Trust

External funding bids

The CSU has submitted bids for external funding

Paediatric Critical Care Operational Delivery Network PCCODN Bid (Total £37,041.43) Decision October 24.

8 month pilot to work between Childrens AED and ward 30/32 to coordinate care, equipment and documentation

- Additional equipment (£4,074.43)
- Additional staff (£32,967.00

Palliative care bid (Total £238,757) Decision end Sept 24

For additional staff to

- Work together on care pathways / plans / documentation
- Establish training model with focus on symptom management
- Establish effective methods of communication, referral systems and MDT working
- Establish links in community and with faith leaders

Surge and escalations plans

Bradford Teaching Hospitals NHS Foundation Trust

Surge and Escalation model

A CYP specific Escalation process and OPEL scoring that covers Childrens AED, CCDA and in-patient ward is established and forms part of the Trust overall sitrep

Triggers detailed below:

Location	All	All	AED	AED	AED	AED	CCDA	CCDA	CCDA	CCDA	Ward	Ward	Ward	Ward	Ward
Escalation Status	Appropriate nurse staffing levels in all areas	Number of children requiring admission (ED, CDA, repats etc.)	Longest time to Triage	Number children in HDU/resus	Number of children in department	Longest time to 1st medical review	Number of children in CCDA	Number of GP & Direct access referred due to arrive	Longest time to Triage	Longest time to 1st medical review	Bed capacity	Number red patients	Number blue patients	Number of patients in Stabilisation	Patients to be transferred to other hospitals due to bed capacity

Surge and escalations plans

Actions-Dependant on OPEL score

Bradford Teaching Hospitals NHS Foundation Trust

Bed capacity outside of parameters.	Staffing establishment outside of normal parameters	Acuity
Check regional bed state, Transfer patients more clinically stable Identify with IPC cohorting bays Explore Expansion to full bed base (38), Identify with IPC chortling bays Transfer patients more clinically stable Use of cubicles and transfusion bay ward 12, with support of suitable trained staff Expansion to full bed base (38) Expand use of surgical area 1st and 2nd bay (5+4 beds) (5+4 beds)	Explore support from surgical area, ACE, Community, Neonates and agency Extend consultant hours, CCDA cover until 2100. Middle grade staff approached for additional support Review nurse and medical staffing numbers next 12-24hours support flow Support from surgical area, ACE, Neonates, On call consultant to be present on the unit Volunteer cover until 2100. Enhanced pay rates for Middle grade staff Explore support from surgical area, ACE, Community, Neonates, CNS, Reinstate Children's emergency rota	Transfer patients more clinically stable. All level 2 referred to embrace Ensure external service provide requested cover i.e. CAMHS Escalation of children not appropriate

Surge and escalations plans

Bradford Teaching Hospitals NHS Foundation Trust

Staffing model

The medical and nursing establishment has had significant investment to provide cover at times of peak activity.

Medical

Provide resident consultant cover at times of peak activity

- The CSU successful business case increased medical workforce to enable the doubling of the current job planned out of hours provision

	Previous Job Planned cover	New job planned sessions (Sept 24 onwards)
Mon - Fri 08:45-17.30	2 consultants	2 consultants
Mon - Fri 17.00-22.00	1 consultant on call 1700-0845	1 additional resident consultant
Mon - Fri night 22.00-08:45		1 non-resident on call consultant
Sat - Sun 08:45-14:30	2 consultants	2 consultants
Sat - Sun night 22.00-08:45	1 Non-resident on call consultant	1 Non-resident on call consultant

Nursing

Children's ED and CYPU Collaboration

- The CSU undertook a successful Children's ED and CYPU Collaboration between the nursing teams in children's ED and the Children and Young People's Unit.
- The areas now work in conjunction and flex staff according to the greatest clinical acuity/need

Nursing establishment

- The CSU are in Year 2 of a 4 year plan to increase the nursing establishment

SECTION 7 ADDITIONAL WINTER SCHEMES

Additional winter schemes

Bradford Teaching Hospitals NHS Foundation Trust

Additional geriatrician at weekends

TTO Dr based in the command centre

Additional winter PTS discharge vehicle

Working with the Homeless Team/voluntary sector , Ambulance services, Mental Health and social care partners

Revised national OPEL framework

Note: Financial pressures across the system will impact delivery across the system compared to previous years

Command Centre Operations meetings

Bradford Teaching Hospitals
NHS Foundation Trust

The Command Centre Operational Meeting is a meeting to ensure key stakeholders are aware of the daily position in terms of ED traffic, bed availability, expected admissions from routes other than ED and staffing.

The meeting is also a vehicle to cascade important messages from support departments which will directly impact on the site or patient flow with actions linked to the OPEL document

The aim of the meeting is to facilitate meeting the Emergency Care Standard on a daily basis, by encouraging appropriate and timely decision making relating to admissions and discharges.

Microsoft Word
Template

SECTION 8 Metrics and Measurement

Metrics and Measurement over winter

Bradford Teaching Hospitals
NHS Foundation Trust

A suite/dashboard of metrics will be established to measure the following against an expected trajectory

1. The Emergency Care Standard

2. Bed Occupancy

3. 12 hour trolley waits

4. Ambulance handover times

5. Harm and mortality (based on the established RCEM methodology also adopted by NHSE)
Link
https://rcem.ac.uk/wp-content/uploads/2023/03/Excess_deaths_associated_with_crowding_and_corridor_care.pdf

6. Patient complaints, especially relating to waits to be seen in AED

G. EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) AND NHSE CORE STANDARDS

REFERENCES

Only PDFs are attached

- Bo.11.24.13g - EPRR and Core Standards Update November 2024 (cover).pdf
- Bo.11.24.13g - Appendix 1 - NHS Core Standard for EPRR.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13g

Update on Emergency Preparedness Resilience & Response (EPRR) & NHS England (NHSE) Core Standards Self-Assessment

Presented by	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive/ Accountable Emergency Officer	
Author	Steve Amos, Emergency Planning Manager	
Lead Director	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive/ Accountable Emergency Officer	
Purpose of the paper	To provide an update to ETM on the NHS E Core Standards Self-Assessment and EPRR work.	
Key control	EPRR is a key control in relation to BAF Risk 5 – sustainable services	
Action required	For assurance	
Previously discussed at/ informed by	*Details of any consultation / previous meeting discussions* – previously approved policy that has had amendments made.	
Previously approved at:	**Committee/Group**	**Date**
	ETM 11/11/2024	
	F&P 20/11/2024	

Key Options, Issues and Risks

This paper is to update the Board on the final position of the NHSE core standards submission, which was returned to WYICB on 31/10/2024.

NHSE Core Standards submission

The Trust reported 50 core standards as fully compliant (up 2 from the October update) and 12 partially compliant, this is up from 20 fully compliant and 42 partially compliant standards last year. An action plan has been produced for standards that are partially compliant.

The deep dive for this year was on Cyber security, out of the 11 standards, we are fully compliant with 8 and partially compliant with which increased from 7 and 4 at the last update, so further progress was made, and actions have been identified to improve the deep dive audit.

The core standards return was presented to the Finance and Performance Committee on 21 November 2024 and is available on Team Engine. An overview is attached at Appendix 1.

Core standard 13- New and emerging pandemics

The Pandemic Influenza and Novel Viruses Policy was approved at the October IPCC and was ratified by the Finance and Performance Committee on 20 November 2024, after initially coming to the group last month.

Updated risk assessments- Pandemic flu and infectious diseases

These risk assessments have been updated and approved at the IPCC in October, and Finance and Performance Committee in November.

Update on PHC workbooks- to note

These have now been issued to all 1st and 2nd on call.

Each quarter we have to report our position to the WY Local Health Resilience Partnership, we are again reporting our position as we were in September:

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13g

Organisation name	TNA		Compliance against the relevant portfolio	0-24%	25-49%	50-74%	75-99%	100%
BTHFT	No. of Strategic	19	Strategic compliance against Portfolios	19				
	No. of Tactical Health	23	Tactical compliance against Portfolios	23				
	No. of EPRR advisors	1	EPRR compliance against Portfolios	1				

Analysis

The Trust's core standards submission was tabled at the November Local Health Resilience Partnership meeting on 21st November, and we are comparable with other local Acute Trusts' submissions.

Recommendation

For the Board to note the requested documents.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.13g

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
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: Safety, Premises & equipment, staffing, Good governance
NHS England Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities

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

Please select type of organisation: **Acute Providers**
Click button to format the workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	3	1	0
Response	7	7	0	0
Warning and informing	4	2	2	0
Cooperation	4	4	0	0
Business Continuity	10	5	5	0
Hazmat/CBRN	12	8	4	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	50	12	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	8	3	0
Total	11	8	3	0

Overall assessment:	Partially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 6: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 7: In the Action Plan tab, click on the 'Format Action Plan' button.

BO.11.24.14 - BUDGET SETTING PROCESS AND TIMETABLE

REFERENCES

Only PDFs are attached

Bo.11.24.14 - Budget Setting Process and Timetable 2025-26.pdf

Meeting Title	Board of Directors – Open		
Date	20 November 2024	Agenda item	Bo.11.24.14

Budget Setting Process & Timetable 2025/26

Presented by	Ben Roberts, Chief Finance Officer	
Author	Chris Smith, Deputy Director of Finance	
Lead Director	Ben Roberts, Chief Finance Officer	
Purpose of the paper	To inform the Board on the budget setting process and timetable for 2025/26	
Key control	Delivery of the Financial Plan	
Action required	For information	
Previously discussed at/ informed by	Finance & Performance Committee – 20 November 2024	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

This paper summarises the planned approach to setting internal departmental budgets for 2025/26, including the governance process that will be followed. The paper also sets out the timetable that will be followed to ensure all departments have clarity on their budgetary allocations and efficiency targets in advance of the commencement of the new financial year on 1 April 2025.

The paper provides a summary of a more detailed paper that will be discussed at the Executive Team Meeting (ETM) in November 2024.

Analysis

The paper summarises the principles that will be applied. The timetable is as follows:

Action	Deadline
CSU initial efficiency targets communicated	w/c 18 Nov 2024
Budget setting templates available to Finance teams	w/c 18 Nov 2024
Draft budget setting guidance available to Finance teams	w/c 18 Nov 2024
Budget setting guidance to ETM	25-Nov-24
Budget setting guidance issued to budget holders	26-Nov-24
Detailed Draft budget template completed	03-Jan-25
Rec from 24/25 FOT to 25/26 FOT to 25/26 budget completed	10-Jan-25
Snr Finance team review and meetings	04 Jan - 17 Jan
ETM review draft budgets	20-Jan-25
Moderation and amendments	21 Jan - 31 Jan
Final budgets to ETM	03-Feb-25
Final budget allocation letters issued to budget holders	07-Feb-25
Budget Allocation sign off form return to CFO	14-Feb-25
Budgets reported to F&P	19-Feb-25

Recommendation

The Board is asked to note and discuss the budget setting process and timetable described.

Meeting Title	Board of Directors – Open		
Date	20 November 2024	Agenda item	Bo.11.24.14

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

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

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

Relevance to other Board of Director's Committee:	
Regulation and Assurance Committee	Other (please state)
▪	

Meeting Title	Board of Directors – Open		
Date	20 November 2024	Agenda item	Bo.11.24.14

Budget Setting Process & Timetable 2025/26

1. Introduction

This paper summarises the planned approach to setting internal departmental budgets for 2025/26, including the governance process that will be followed. The paper also sets out the timetable that will be followed to ensure all departments have clarity on their budgetary allocations and efficiency targets in advance of the commencement of the new financial year on 1 April 2025.

The paper provides a summary of a more detailed paper that will be discussed at the Executive Team Meeting (ETM) in November 2024.

The internal budget setting process must necessarily be conducted in conditions of uncertainty deriving from the current absence of definitive published planning guidance and financial, operational and workforce planning parameters from NHS England (NHSE). To manage this uncertainty, a set of consistent budget setting principles will be shared and applied internally, with any deviation from these planning assumptions resulting in required changes to budget plans to be agreed via ETM and communicated transparently to the wider organisation as and when this may arise.

2. Budget Setting Principles

a) Devolved Budgets, no central reserves

In setting budgets for 2025/26, the core underlying principle is that all of the funding, to the full extent to which this is practicable, will be devolved to the Clinical Service Units (CSUs) and corporate departments[1]. A very limited number central reserves budgets may be set for very specific purposes and only in exceptional cases.

The absence of central reserves budgets is a departure from the historic approach to budget setting at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT). This revised approach is intended to increase autonomy and accountability for all budget holders and to devolve decision making closer to the front line of patient care, in line with the revised Accountability Framework.

This will effectively mean that the CSUs hold all of the Trust's available funding in 2025/26 and that any proposed investments or service developments must be self-

[1] ***For brevity, all spending departments, including CSUs, Estates & Facilities and corporate departments are referred to as CSUs in this document unless explicitly stated otherwise.***

funding from within existing budget control totals and run rates, inclusive of departmental Closing the Gap (CTG) efficiency targets.

The absence of any central reserves budgets also means that any non-recurrent windfall benefits or unplanned for corporate cost pressures that arise in-year will also be allocated to the CSUs in a transparent manner with oversight via ETM.

b) Budgets to reflect Outturn Run Rate

The Trust's overall financial plan for 2025/26 will be based on the true underlying outturn run rate of income and expenditure from 2024/25. Adjustments to this run rate will be made for:

- commissioner funding changes in 2025/26
- standard inflation assumptions for 2025/26
- non-recurrent items in 2024/25
- the full year effect of pressures and developments arising part way through 2024/25
- known pressures or funding streams arising in 2025/26
- a very limited number of unavoidable investments to maintain patient safety if any are identified
- the Board-approved efficiency target for 2025/26

The Trust's internal departmental budgets must necessarily align with these principles to ensure the corporate financial plan is consistent with the internal budget plan. The detailed budget setting guidance that will be issued to budget holders will ensure consistency with these principles.

c) Budget Setting Process

Standard budget setting templates will be issued to the CSUs for completion with their Finance teams. These templates will capture budget plans in alignment with the principles of the detailed budget setting guidance and will produce outputs which align to the categories set out in section b above.

Key principles:

- The baseline position for budget setting is October 2024's recurrent budgets and run rates

- Pay budgets and establishments will be set based on the existing funded establishments
- Non-pay budgets will be based on forecast outturn for 2024/25 at Month 7
- CSU income budgets will be based on forecast outturn for 2024/25 at Month 7
- Amendments to these baselines may be made by CSUs to flag the full year effect of 2024/25 part year issues or non-recurrent items in these baseline positions, but these amendments will require ETM approval for inclusion in final budget plans
- Any known departmental pressures for 2025/26 will be flagged in the templates for ETM discussion and approval
- Existing approved business cases will be highlighted for approval
- Any proposed additional expenditure or aspirational investments that are included by the CSUs will be subject to ETM approval
- To avoid over-stating budget requirements, adjustments to Pay expenditure budget plans will be made to reflect the ongoing impact of underspends due to vacancies. A number of revised approaches to the existing Vacancy Factor mechanism are being considered and will be presented to ETM for discussion and approval.
- CSUs may not include any pressures in their final budget plans that cannot be self funded or which do not have ETM approval.
- During the draft budget setting stages and the forecasting stage set out in *section d,* central reserves budgets will be set for inflation. This allows comparability between financial years in the budget and forecast reconciliations.
- The final budget plans presented to ETM for approval and which will be communicated to budget holders will include full allocations of all reserves budgets to relevant departments.
- Part year budgets for agreed investments and pressures will be allocated to CSUs in the final budget letters, based on the expected phasing of these costs. Underspends against these new budget allocations will not usually be considered to be valid CTG contributions.

d) Alignment of Budget Plans to Run Rates and Forecasts

Alongside the budget setting process, CSUs and their Finance teams will be required to produce income and expenditure forecasts for 2025/26. These forecasts will build on existing forecasts for the remainder of 2024/25 and will be required to factor in elements such as recruitment trajectories and approved service developments etc.

A reconciliation from 2024/25 forecast outturn to the 2025/26 forecast will be required and a further reconciliation from the 2025/26 forecast to the budget proposals for 2025/26 will also be required.

e) Alignment of Budget Plans with Workforce and Activity Plans

It is crucial that the financial, workforce and activity plans are aligned at both a Trust and departmental level. As part of the forecasting process, CSUs will be requested to work with HR, Performance and Finance colleagues to ensure that all recruitment trajectories and workforce changes are factored into the financial plan for ETM approval and that projected changes in activity are fully costed to ensure transparency and clarity of their implications, again subject to ETM approval.

f) Efficiency Targets 2025/26

The working assumption at the draft planning stage is that the Trust will seek to deliver a £25m efficiency target in 2025/26, equating to 4% of turnover. This target will be fully devolved to the CSUs on the basis of the two year departmental targets agreed bv ETM in the 2024/25 planning round.

A letter will be issued to the CSUs in the week commencing 18 November 2024 communicating these targets and asking budget holders to develop their efficiency plans in a phased way to meet a number of gateways in the remainder of 2024/25. A defined percentage of plans will be required to be scoped out by the end of December 2024, with firmed up plans for at least 75% of targets required to be in place by March 2025.

All efficiency plans must result in improved income and expenditure run rates to ensure a bottom line benefit for the Trust. Budget adjustments will not be recognised as valid CTG contributions in planning or delivery for 2025/26.

Any brought forward financial pressures from 2024/25 that are not approved for additional 2025/26 budget allocations by ETM will be retained within the CSUs as additional budget pressures to manage over and above their 2025/26 CTG targets. This ensures the link between the CSUs' financial performance in 2024/25 and their respective share of the financial challenge in 2025/26.

Any change to the Trust's overall efficiency target resulting from revised external planning assumptions will be shared in a transparent manner across all of the Trust's departments.

g) Accountability and Formal Acceptance of Budget Control Totals

In line with good governance requirements, the triumvirates and accountable officers of each CSU and corporate department will be requested to review and sign off their final budget allocations, and to submit formal confirmation of this acceptance to the Chief Financial Officer.

Sufficient information on the details of the final budget allocation will be provided to the budget holders to inform this acceptance, although close working with their Finance teams throughout the process should ensure they are already familiar with their budget plans.

3. Budget Setting Timetable

The below table sets out the timetable that will be followed to ensure approved budgets for 2025/26 are in place, communicated and signed off by February 2025.

Action	Deadline
CSU initial efficiency targets communicated	w/c 18 Nov 2024
Budget setting templates available to Finance teams	w/c 18 Nov 2024
Draft budget setting guidance available to Finance teams	w/c 18 Nov 2024
Budget setting guidance to ETM	25-Nov-24
Budget setting guidance issued to budget holders	26-Nov-24
Detailed Draft budget template completed	03-Jan-25
Rec from 24/25 FOT to 25/26 FOT to 25/26 budget completed	10-Jan-25
Snr Finance team review and meetings	04 Jan - 17 Jan
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Final budget allocation letters issued to budget holders	07-Feb-25
Budget Allocation sign off form return to CFO	14-Feb-25
Budgets reported to F&P	19-Feb-25

END

BO.11.24.15 - STRATEGY - EMERGING ISSUES

A. SUMMARY OF BOARD DEVELOPMENT SESSION - HEALTH INEQUALITIES

REFERENCES

Only PDFs are attached

Bo.11.24.15a - Summary of Board Development Session - Health Inequalities.pdf

Meeting Title	Board of Directors		
Date	28.11.2024	Agenda item	Bo.11.24.15

Summary of the Board Development Session – Health Inequalities

Presented by	Mark Hindmarsh, Director of Strategy and Transformation	
Author	Naveed Saddique, Service and Business Development Manager Alison Smith, Head of Partnerships and Transformation Programmes	
Lead Director	Mark Hindmarsh, Director of Strategy and Transformation	
Purpose of the paper	To provide an update on the Board Development Session on Health Inequalities which took place on 23 October 2024	
Key control	This paper relates to strategic objectives 1 – to provide outstanding care for our patients, delivered in kindness and objective 5 – to collaborate effectively with regional partners, to reduce health inequalities and achieve shared goals. 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.	
Action required	For assurance	
Previously discussed at/ informed by	*N/A*	
Previously approved at:	*N/A*	**Date**

1. Key Options, Issues and Risks

This paper summarises the Health Inequalities Board Development Session which took place on 23rd October. This was the first in a series of seven Board Development Sessions scheduled over the next year and focused exclusively on health inequalities.

1.1 Structure of the session

The session was structured to have a balance of speakers and group discussions with the intention that the speakers would provide thought provoking content that would be explored further in group discussions. The speakers who presented on health inequalities included colleagues from the Reducing Inequalities Alliance, Bradford Institute of Health Research, Performance and Clinical Psychology. In addition to the four presentations, two group discussions were also held.

1.2 Purpose of the session

The aim of the session was to provide an overview of the population we serve, highlight the opportunities to address inequalities and provide assurance that work was already underway at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) to tackle inequalities. The three core purposes in further detail –

1. Awareness - for Board members to increase knowledge of Bradford's population, the people more likely to experience health inequalities, and the inequalities they experience.

   To consider BTHFT's sphere of influence and all the opportunities to improve health and wellbeing, and address inequalities. The diagram below, 'BTHFT's sphere of influence', details five roles of BTHFT with opportunities to influence and tackle health inequalities -

   Fig.1 – BTHFT's sphere of influence

Meeting Title	Board of Directors		
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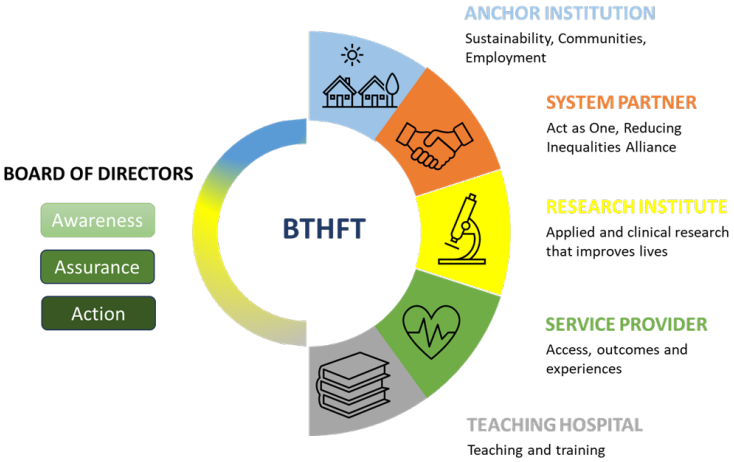

2. Assurance - for the Board to be assured that there's a strategy in place and actions already happening.
3. Action - create space and time for the Board to consider what more they can do, and how to maximise the impact.

2. Analysis

2.1 Attendance

15 Board members attended and the speakers stayed to contribute to the discussion.

2.2 Use of Mentimeter

Mentimeter, an online polling tool allowing real time feedback visualisation, was used during the session to gain input from participants. After the session, Mentimeter was also used to poll the Board members for their reflections and commitments to reducing health inequalities.

2.3 Speakers

The presentations focused on tackling inequalities and were aligned to the 'sphere of influence' roles–

- Reducing Inequalities Alliance
- Bradford Institute of Research
- Performance
- Clinical Psychology and Health Equity Fellowship Programme

2.4 Group discussions

Three groups of 5-6 individuals consisted of a mix of executive directors, non-executive directors and speakers. Each group was also assigned a scribe to take notes of the discussions and a facilitator who relayed key aspects of the discussions. The topics discussed across the two discussions were -

1 - How can we as a Board work most effectively with partners to improve health and wellbeing in Bradford? Do we have established relationships with key partners? Is there more we can do?

2 - What is our Board ambition going to be that will move us from pockets of excellent practice within BTHFT to an organisation-wide focus on reducing health inequalities? What? How? When?

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2.5 Outcomes of the group discussions

The outcomes of the discussions provided insight into how BTHFT could approach tackling health inequalities. Each facilitator relayed the most powerful item that was raised in their respective groups. The key points raised within each of the discussions were –

Discussion 1 –

- As an organisation, our focus should be on what we can control to drive the agenda forward
- There are boundaries which limit individuals from being able to achieve things. How do we remove the boundaries and work towards becoming a boundary-less organisation?
- Research data is available to help address inequalities however there is a lack of awareness of the data available. Learning also needs to be developed across the trust.

Discussion 2 –

- There is a need to rewrite our ambitions to promote health equity instead of reducing inequalities. Our approach to change needs to adopt a social movement and promote initiatives that can be emulated
- The use of appreciate inquiry and different ways of engaging staff (such as TikTok and Go Viral)
- A change in language in our approach to health inequalities would be beneficial. The trust could focus on improving equity as opposed to reducing inequalities which would potentially be more engaging for staff and ultimately gain further buy in to the improving equity work programme.

2.6. Feedback received in Mentimeter

Two questions were asked in Mentimeter to gauge the Board's thoughts on health inequalities –

- What concerns you the most about health inequalities?
- What's the most striking thought you had so far?

The results from the first question –

Fig 2 – results from first Mentimeter question

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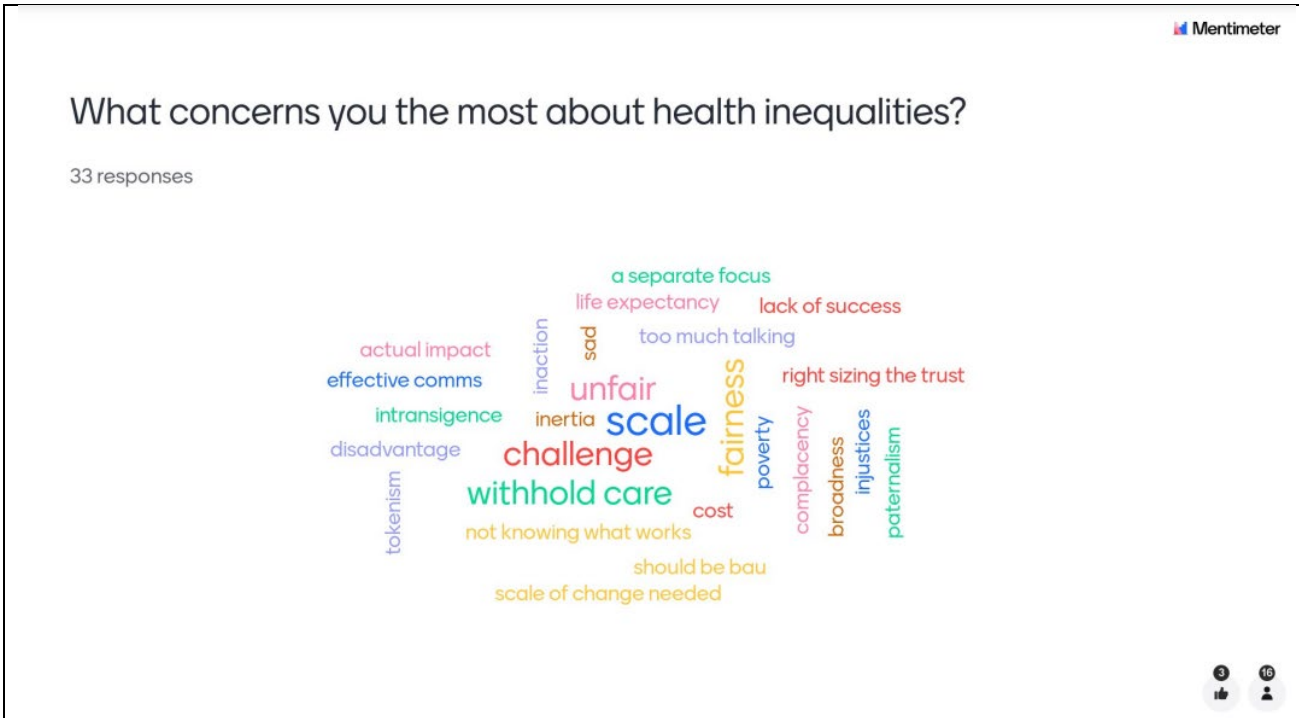
Date	28.11.2024	Agenda item	Bo.11.24.15



In response to the second question, responses ranged from taking a measured approach with small changes, working with other Executive teams and understanding what we as a trust can influence. There were also suggestions which stated we could explore opportunities to use research to influence operational teams, better insights into inequalities could lead to better outcomes and addressing inequalities requires a collaborative approach with partners.

At the end of the session, members were asked to provide feedback on how they felt about the session:

- 14 out of 15 respondents stated the session exceeded expectations and was delivered excellently. One respondent felt it was delivered as expected.
- 56% felt ‘a lot more informed’ about health inequalities with 44% feeling ‘a little more informed’
- There were positive comments around the structure of the session and presentations.
- To improve the session, respondents suggested using a different room, drawing on board members experiences and potentially adding patient stories.

The next day after the session, the Board were emailed requesting them to share their reflections and the actions they will commit to undertaking. These commitments will be reviewed in a year’s time at the last session in the series of Board Development Sessions.

2.6 Actions

Within the group discussions and feedback gained from participants, actions were identified which will be led by the Strategy and Transformation team in conjunction with teams around the trust:

- To refocus actions around achieving health equity as a positive way of framing ambitions to reduce health inequalities
- To focus on what is within our influence to change
- Promote and build on examples of good practice such as the clinical psychology project and the access to care project that were presented in the session and empower teams to promote health equity in their work

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- Build health equity into key organisational training, communications and governance processes. In particular, relating to the recommendation from the NHS Providers guidance 'Reducing Health Inequalities – A guide for NHS Trust board members' the Trust induction will include a health inequalities aspect ensuring new colleagues have an understanding of the population they serve and the challenges they face.
- Health inequalities objectives will be revised as part of the EDI strategy refresh
- An action plan will be drafted which will include input from colleagues from the Reducing Inequalities Alliance, Research and teams across the trust.
- To make the programme more robust and add structure to the trust's health inequalities/improving equity approach and oversee delivery of the Acton Plan. As such, a health inequalities/improving equity oversight group will be formed.
- Promote and encourage the opportunities in the West Yorkshire Health Equity Fellowship programme
- To identify opportunities to put research into practice for the clinical/operational teams

Health inequalities are due to be reported to the Board next in March 2025.

Recommendation

The Board is asked to note the detail of this paper and the intended actions.

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

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

Meeting Title	Board of Directors		
Date	28.11.2024	**Agenda item**	**Bo.11.24.15**

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)
☐	☒	☐	☐

BO.11.24.16 - CORPORATE STRATEGY ANNUAL UPDATE

REFERENCES

Only PDFs are attached

Bo.11.24.16 - Corporate Strategy Update.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.16

Corporate Strategy Progress Update

Presented By	Mark Hindmarsh, Director of Strategy and Transformation	
Author	Matthew Howson, Head of Service and Business Development	
Lead Director	Mark Hindmarsh, Director of Strategy and Transformation	
Purpose of the Paper	To propose that an alternative method is used for providing Board assurance that the Trust is making satisfactory progress towards the delivery of the commitments in the Trust Corporate Strategy.	
Key Control	N/A	
Action Required	For assurance	
Previously Discussed At/Informed By		
Previously Approved At:	**Academy/Group:**	**Date:**

Key Options, Issues and Risks

The Corporate Strategy sets out the Board approved long-term direction and development path for the Trust. Board members require regular assurance that we are making satisfactory progress towards delivery of the commitments and ambitions set out in the strategy.

Since the publication of the strategy the Trust has done this in two ways. Mostly, assurance has been provided through the workplans of each Board Academy or Committee. As an additional, secondary piece of assurance, this work had been summarised on an annual basis through the updating of the Trust's Corporate Strategy "Logic Model". However, the Logic Model, fails to bring the various and often inspiring workstreams to life and is largely a duplicate of work that has already been through the assurance and scrutiny process within the sub-groups of the Trust Board.

Given that assurance is mainly delivered by Board members making their way through the workplans of the monthly Board Committees and Academies, there would appear to be scope to do something new and provide a second tier of assurance that engages Board members and the people that deliver our services, to work together and to make the delivery of the Trust strategy something more meaningful to a wider group of staff.

Analysis

Shortly after the publication of the Corporate Strategy in 2022, the Trust undertook work to review and change the workplans and agenda of what were then Board Academies. This work was led by Non-Executive Directors. The agreed redesign of Board Academy agenda and workplans now provides Board members with an ongoing "real-time" (monthly) view of progress towards the achievement of the Trust's strategic ambitions.

For example, the workplans for the Finance and Performance (F&P) Committee, Quality and Patient Safety Committee and People Academy include regular items relating to each of the "4Ps" in the strategy:

- Patients
  - F&P - Recovery of Planned Care (performance data, operational highlight reports, F&P Dashboard)

- People – Delivering Outstanding Nursing and Midwifery Care (Looking after our people, Workforce Growth and Transformation, workforce Report, Nursing Recruitment and Retention, Staffing Establishment Review, Medical and Nursing appraisals)
- Quality – Provide Outstanding Patient Experience (CLIP Report, PLACE report)
- Quality – Delivering High Quality Services (Safeguarding reports, Quality Dashboard, High Level Risks, Maternity and Neonatal update, Moving to Outstanding reports)
- Quality – Virtual Hospital (Digital report)

- People
  - F&P - New ways of working (capital programme, Pathology JV, Operational Plan, Service Development PIRs, Winter Plan)
  - People – New ways of working (Workforce Growth and Transformation)
  - People – Looking After Our People (has its own agenda item plus Staff Survey, Thrive)
  - People – Growing for the future (Workforce report, People Plan, Education Report
  - People – Engendering a Feeling of Belonging (Civility Report, Staff Story, Organisational Culture, EDI Improvement Plan)
  - Quality – Looking After Our People – (Freedom to Speak Up)

- Place
  - F&P - Acting As One with Partners Across BDC (Act as One reports, Winter Planning, Bradford Place and ICS System Financial Updates)
  - F&P – Tackling Health Inequalities (Prioritising LD Patients)
  - People - Acting as One (Act as One People Perspective report, BDC People committee updates)
  - Quality – Strategic Estate: Fit for Purpose Facilities (Estates and Facilities Report)

- Partners
  - F&P – Working with other providers to meet the needs of our shared populations (WYAAT/ICS Programme Updates)
  - People – A hub for specialist services (Workforce Growth, Training and Education)
  - People – Improve Health Inequalities across WY (Improving EDI)
  - Quality – Address health inequalities (Equality Delivery System reports)

The ongoing work of the Board Committees and Academies throughout the year provides a “real-time” view of progress towards our strategic ambitions. The re-design of the workplans also allows attendees to take corrective actions as issues emerge. With this in mind, there appears to be scope to develop a more innovative way of engaging colleagues and board members in the delivery of our strategy beyond just the initiatives listed above. Additionally, consideration needs to be given to help awareness of the Trust strategic objectives to a wider audience beyond the board to make the strategy a reality to more areas across the Trust.

For example, this may include regular presentations to Board Committees or Academies, department visits for non-executives throughout the year or six-monthly half day “World-Café” style events to showcase some of the work usually presented in report format to committee and academy members.

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Recommendation
The Board is asked to confirm that it is satisfied that delivery of the Trust strategy through it's committee and academy structure is robust, and provides sufficient oversight of progress and implementation. The Board is asked to support the Director of Strategy and Transformation in developing a further way to engage colleagues across the Trust in the development of local plans, aligned to the overall strategy to improve awareness and connectivity between the aims of the Trust and local department/service/CSU level plans.

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

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☐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)
☐	☐	☐	☐

BO.11.24.17 - PARTNERSHIPS - STRATEGIC VIEW

REFERENCES

Only PDFs are attached

Bo.11.24.17 - Partnerships Strategic View.pdf

Meeting Title	Board of Directors		
Date	27th November 2024	Agenda item	Bo.11.24.17

Partnerships – Strategic View

Presented by	Mark Hindmarsh, Director of Strategy and Transformation	
Author	Alison Smith, Head of Partnerships and Transformation Programmes	
Lead Director	Mark Hindmarsh, Director of Strategy and Transformation	
Purpose of the paper	This paper is the first of a regular strategic view of partnership risks and opportunities.	
Key control	This paper relates to strategic objective 5 – to collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals. 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	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:		**Date**

Key Options, Issues and Risks

The Trust has a strategic objective to collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals. This paper provides a strategic and forward-looking view of current opportunities and risks in partnership working with key partners at place and West Yorkshire.

There is a strategic risk in the Board Assurance Framework that addresses the risk of not working effectively with partners:

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.

The Chief Executive and Executive Directors regularly attend partnership meetings and the detail of these is reported in the Board report from the Chief Executive.

Analysis

To collaborate effectively with local and regional partners, the first key step is to understand who those partners are. At the recent Board Development Session about health inequalities we used the diagram below to highlight all the functions of BTHFT that could impact health equity and health inequalities. In all these spheres of influence there are partners to work with to improve patient and staff experience, improve outcomes for patients and improve health equity.

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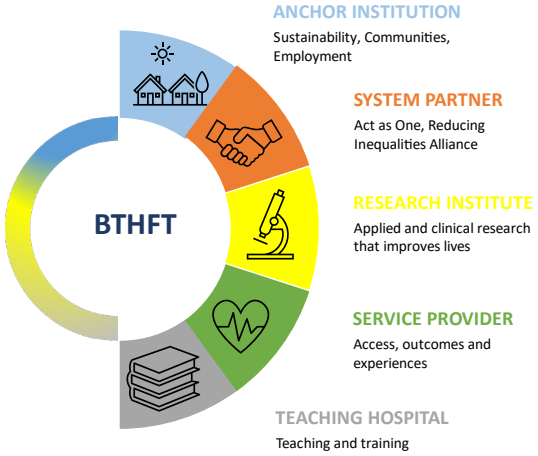

The table below highlights key partners in each sphere of influence.

Sphere of influence	Key Partners
Anchor Institution	VCS organisations Bradford Metropolitan District Council Job Centres Faith organisations
System Partner	Bradford District & Craven Health and Care Partnership and signatories to the Strategic Partnering Agreement: Airedale NHS Foundation Trust Bradford District Care Foundation Trust West Yorkshire ICB VCS Alliance Bradford Care Alliance and Primary Care Networks Bradford Metropolitan District Council Community Partnerships WYAAT provider collaborative West Yorkshire ICS
Research Institute	University of Bradford
Service Provider	Airedale NHS Foundation Trust Bradford District Care Foundation Trust Primary Care Providers Bradford Metropolitan District Council Independent Sector Providers
Teaching Hospital	University of Bradford University of Leeds Bradford College NHS England (was Health Education England)

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Risks and Opportunties

There is a strong history of partnership across Bradford District & Craven place. Back in 2019, the system partners signed up to a Strategic Partnering Agreement that sets out how partners should "Act as One" to keep people happy, healthy, at home. A recent review concluded that it was still valid and relevant and just needed a few changes to bring the wording up to date. These updates are underway.

Under the ethos of Act as One, several members of the executive team have leadership roles outside BTHFT in the Bradford District & Craven place-based partnership, the West Yorkshire ICB and working with colleagues across the West Yorkshire Association of Acute Trusts. Specifically, the Chief Executive is a member of the Bradford District & Craven Partnership Board, the WYAAT Committee in Common and the West Yorkshire Partnership Board. The Chief Digital and Information Officer holds the same portfolio at Airedale NHS Foundation Trust.

Our partnership with Airedale NHS Foundation Trust (Airedale) is particularly important to our patients and our collective delivery of high-quality care so a programme of joint work is being developed. The WYAAT Service Review is commencing now and will ask the acute Trusts to work in natural geographic partnerships requiring us to work even more closely with Airedale. The aim is to determine how we provide, as individual organisations and through partnerships, health services that meet the needs of our populations within available resources.

Airedale is also part of the national New Hospital Programme and is developing a Strategic Outline Case for their new hospital development. BTHFT Executive Directors have had several meetings with Executive Director colleagues at Airedale to ensure that plans are developed collaboratively, the opportunity is taken to look at healthcare facilities across the place, and the new hospital build meets the needs of everyone in Bradford District & Craven.

A recent meeting between BTHFT Executive Directors and University of Bradford colleagues highlighted opportunities for effective partnership working. The meeting discussed working together to increase recruitment to adult nursing and support career development for international nurses, partnering to establish innovative roles such as Nurse Associates, and build research collaborations with the University's Centre for Digital Innovations in Health and Social Care.

In terms of service provision there are already excellent examples of collaborative working with partners and all place-based partners sit on the Access to Care Board that is chaired by the BTHFT Director of Operations. Examples include:

- The Proactive Care Team (BTHFT and BDCT)
- Multi-agency Integrated Discharge Team (BTHFT and BMDC)
- MyCare 24 COPD support (BTHFT and ANHSFT)
- Community Diabetes Care (BTHFT and General Practices)
- Multi-Agency Support Team (BTHFT, ANHSFT and VCS)

BTHFT has also worked in partnership with various Independent Sector Providers to support the elective recovery programme and reduce waiting times for elective care.

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However, there are barriers to partnership working. The sheer number of partners and connections at different levels is a challenge. It must also be recognised that all partners have financial constraints and are working hard to achieve efficiencies and cost savings. This can limit everyone's capacity to work collaboratively on innovative projects and risks making partners more inward looking. It can also create tensions where patient pathways between organisations and between health and social care are not funded equally. However, many of the solutions to long-term financial sustainability and achieving the ambitions for a neighbourhood health service set out in the Government's recent Change NHS consultation will require a step change in collaborative working.

Recommendation

The Board is asked to:

- note this strategic view of partnership working
- identify any other partners that might be crucial to achieving the strategic objective
- highlight any further risks/opportunities that should be considered

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**

Meeting Title	Board of Directors		
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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	Finance & Performance	Other (please state)
☐	☐	☐	☐

BO.11.24.18 - REPORT FROM CHAIR OF THE AUDIT COMMITTEE ? 19 NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.11.24.18 - Report from the Chair of Audit Committee Nov 24.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.18

Committee Escalation and Assurance Report

Report from the: Audit Committee

Date of meeting: 19 November 2024

Key escalation and discussion points from the meeting
Alert:
There were no issues considered at the meeting which the Board needs to be alerted to.
Advise:
Year end review – the Committee considered a report from the Chief Financial Officer following his conservations with the External Auditors, the Trust Finance Team and the Audit Committee Chair. The report sought to learn lessons from the 2024/25 financial year-end processes to support an effective and timely 2025/26 year-end. The CFO and the External Auditor reported improved engagement already this year and the Audit Committee noted and approved of the actions already taken and planned. One of the actions is to ensure that early engagement takes place with the External Auditors and the Audit Committee if any changes to accounting policy or accounting interpretation is being considered. The Committee noted the implications of the Trust's changed approach to annual leave carry forward and a specific issue regarding capitalisation of some staff costs. The Committee will continue to monitor actions against the recommendations in the ISA 260 report from Deloitte. One action concerning vesting certificates was included in a wider update to the Standing Financial Instructions and Scheme of Delegation which the Committee approved. **Internal Audit Recommendation Tracking** – The Committee noted the introduction of a new system for tracking progress on actions in response to internal audit recommendations. However, there remains room for considerable improvement in provision of and timeliness of Executive sign-off of reporting. The Committee had not seen the improvement in the number of significantly overdue recommendations it had expected from its previous meeting and had not, in many cases, been provided with an update to explain why an action remained overdue. The CFO will work closely with Executive colleagues to ensure significant improvement by the net meeting of the Audit Committee in February. The Audit Committee will consider referring overdue recommendations to the relevant Committee for them to assess the risk of any action not being completed by the agreed deadline. **Procurement Waivers** – the Strategic Head of Procurement provided the Committee with an overview of his work in overseeing the controls concerning procurement waivers. Whilst there is no concern over the controls in place, the Audit Committee will continue to scrutinise the information presented to it to ensure that controls are being followed and

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value for money is being obtained, with particular focus on waivers citing an emergency or urgent requirement that genuinely precludes competitive tendering.

Charity Annual Accounts – the Audit Committee confirmed its members' prior agreement to a change in the audit arrangements for the Charity, also noting the approval of the Charitable Funds Committee. Rather than a full audit, because of the level of income, a "light touch" independent examination was approved for the 2023/24 audit.

Assure:

Internal Audit – the Committee received the following reports and noted the High and Significant assurances given.

Report No	Report	Final	Draft	Opinion
BH/07/2025	Waiting List Management (to include Long Waits and Cancer Waits)	✓		Significant
BH/08/2025	Backlog maintenance and critical risk remedial works	✓		Significant
BH/09/2025	Business Continuity Disaster Recovery; Estates Critical Infrastructure report	✓		Significant
BH/10/2025	Care of the Deteriorating Patient	✓		High
BH/11/2025	Fit and Proper Persons	✓		Significant

The team at Audit Yorkshire remain on track to complete the audit programme for the year with the continued cooperation of Trust Directors and managers.

Counter Fraud – the Audit Committee noted and were assured by the report from the Local Counter Fraud Specialist which provided information on strategic approaches to countering fraud and updated information of suspected frauds within the Trust,

Cyber Security – the Committee welcomed the Deputy Chief Digital and Information Officer and the Cyber Security Manager who provided an overview of the Trust's progress on cyber security and a description of the Trust's arrangements for patch management in response to a benchmarking report from Audit Yorkshire. The report showed BTHFT compared positively to most other organisations in the Audit Yorkshire client base, and the Committee was assured about the Trust's arrangements. However, the Committee agreed with the attending colleagues' view that the risk level of 16 on the Trust's risk register was appropriate.

Policies – the Committee approved the required annual policy review for the use of external audit for non-audit purposes. The Committee also took assurance from the annual report on the random sample audit of 20 policies and procedures. The audit and action plan seeking to ensure that the system for managing the development, approval, ratification and dissemination and review of trust wide procedure documents is operating effectively.

Report completed by:
Bryan Machin
Committee Chair and Non-Executive Director
20 November 2024

BO.11.24.19 - REPORT FROM CHAIR OF THE CHARITABLE FUNDS COMMITTEE ? 6 NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.11.24.19 - Report from the Chair of the Charitable Funds Committee - 6 November 2024.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.19

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: CHARITABLE FUNDS COMMITTEE

Date of meeting: 6 November 2024

Key escalation and discussion points from the meeting

Alert:

Nothing to report.

Advise:

Finance Report

Key points of the report, which covers up to Month 5 and explained that due to changes in the Charity Team the organisation is reporting as behind plan.

- The value of the fund is currently £105,000 less than plan, due to a significant reduction in in-year spend, in particular the independence work. There has been a reduction in income of £107,000.
- The forecast position has been pending the commencement of the new Charity Director in post and a review of the plan and timeframe for independence.
- Return on investment is currently 49p spent for every £1 raised, with the aim being 25p.

The Deputy Director of Finance to discuss the revised plan with the new Charity Director due course.

Investment Report

The representative from Rathbones reported and highlighted the main points:

- The value of the fund at the end of September was £1.25 million, revealing an increase of approximately £12,000 this fiscal year.
- Over the last 12 months the charity has been making an average return of around 9.4% on investment, greater than the CPI plus 2%, but slighter lower than two of the benchmark indices of around 12%. Adrian will attend the next meeting to further expand on this.

The Committee has requested Rathbones to assess their performance at the next meeting.

Charity Operational Committee Report

The private phase launch of the neonatal appeal will happen in February 2025, with the public launch in June.

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Assure:

Laura Riach, the new Charity Director is now in post from week commencing 4th November 2024.

Laura Riach will work with Sajid Azeb, Chief Operating Officer/Deputy Chief Executive to develop the five-case model for independence, for which the timeline will be further developed, and a report will be provided to the Committee at the next meeting.

Report completed by:

Altaf Sadique

Academy Chair and Non-Executive Director

26/11/2024

BO.11.24.20 - CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

REFERENCES

Only PDFs are attached

Bo.11.24.20 - CFC Terms of Reference (cover).pdf

Bo.11.24.20 - Appendix 1 - Charitable Fund Committee TOR - draft 30.09.24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.20

Charitable Funds Committee terms of reference

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Lead Director	Reneé Bullock, Chief People and Purpose Officer	
Purpose of the paper	To present proposed amendments to the Committee's terms of reference	
Key control	N/A	
Action required	For approval	
Previously discussed at/ informed by	Charitable Funds Committee held on 6 November 2024	
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

The Charitable Funds Committee terms of reference were last reviewed and approved by the Board in May 2024 where some minor amendments were agreed.

At that time, it was noted that the status of Committee members and the definition of 'corporate trustee' were not fully clear within the terms of reference and it was agreed that this would be reviewed.

The terms of reference have been fully reviewed and updated in order to to clarify the position with regard to the status of the members of the Committee (i.e. to confirm that they are acting on behalf of the Trust as a corporate trustee, rather than being individual trustees of the charity).

The format of the document has also been updated to align with the other Committees of the Board.

The Charitable Funds Committee agreed the proposed terms of reference for presentation to the Board for approval on 28 November 2024, subject to the removal of reference to the strategic objectives, which apply to the Trust rather than the Charity.

The draft terms of reference are attached at Appendix 1 including tracked changes.

Recommendation

The Board of Directors is asked to approve the Charitable Funds Terms of Reference.

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

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

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

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: WellLed.

Care Quality Commission Fundamental Standard: Good Governance.

NHS England Effective Use of Resources: Choose an item.

Other (please state):

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

Bradford Hospitals Charity

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Charitable Fund Committee
Terms of Reference

Purpose	**Status and overall purpose of the Charitable Fund Committee** Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") is the sole Corporate Trustee of Bradford Hospitals Charity ("the Charity"). The responsibility for the management and use of funds held by the Charity lies with the Trust's Board of Directors. The Charitable Fund Committee ("the Committee") is a Committee of the Board of Directors. Its purpose is to ~~give additional~~provide assurance to the Board that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the charity's own governing document. It does not remove from the Board the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary. ~~The Board Members of the Committee shall act as Trustees of the Charity and in this Terms of Reference are together called "the Trustees".~~ **Scope and Objects of the Charity** The Charity has as its sole objective to use its funds: "For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust". The Charity seeks to achieve this objective, giving consideration to general guidance on public benefit, by two main routes. Firstly, the Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality. Secondly, there are hundreds of staff working at a sub-fund level to identify small but valuable differences where Charitable Fund monies can deliver benefits to patients / staff, such as attendances at extra training courses or conferences. **What is Public Benefit?** To be charitable, spending must demonstrate sufficient public benefit in

	what it aims to achieve. Patient focused expenditure within the NHS (unless directed mainly towards private patients) will generally meet this public benefit test. ~~**Corporate Strategy**~~ ~~To achieve the strategic objectives of the Charity, the Trustees' priorities should be:~~ ~~1. To provide outstanding care for patients, delivered with kindness~~ ~~2. To deliver our financial plan and key performance targets~~ ~~3. To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion~~ ~~4. To be a continually learning organisation and recognised as leaders in research, education and innovation~~ ~~5. To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals~~
Responsible to	Board of Directors
Delegated authority	The Committee is authorised by the Board of Directors to monitor all aspects of ~~charitable~~ activity within Bradford ~~Teaching~~ Hospitals Charity as set out within its governing document registered with the Charity Commission. The Committee is authorised by the Board of Directors to obtain as and when required external independent professional advice through normal business processes and to secure the attendance of outside parties with relevant experience and expertise if this is considered to be appropriate.
Powers of Trustees and their responsibilities	Trustees have and must accept ultimate responsibility for directing the affairs of a Charity, and ensure that it is solvent, well-run, and delivering the charitable outcomes for which it has been set up. Bradford Teaching Hospitals NHS Foundation Trust is a corporate body and is the Corporate Trustee of the Charity, acting through the Trust's Board of ~~the Foundation Trust~~Directors. Members of the Board of Directors and the Committee must act in accordance with the responsibilities and duties of charity Trustees as set out below. 1. Ensure the Charity is carrying out its purposes for the public benefit

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	2. Comply with the Charity's governing document and the law 3. Act in the Charity's best interests 4. Manage the Charity's resources responsibly 5. Act with reasonable care and skill 6. Ensure the Charity is accountable ~~**Compliance – Trustees must:**~~ ~~• Ensure that the Committee complies with charity law, and with the requirements of the Charity Commission as regulator; in particular ensure that the Committee prepares reports on what it has achieved and annual returns and accounts as required by law.~~ ~~• Ensure that the Committee does not breach any of the requirements or rules set out in its governing document and that it remains true to the charitable purpose and objects set out there.~~ ~~• Comply with the requirements of other legislation and other regulators (if any) which govern the activities of the charity.~~ ~~• Act with integrity, and avoid any personal conflicts of interest or misuse of charity funds or assets.~~ ~~**Duty of prudence – Trustees must:**~~ ~~• Ensure that the charity is and will remain solvent.~~ ~~• Use charitable funds and assets reasonably, and only in furtherance of the charity's objects.~~ ~~• Avoid undertaking activities that might place the charity's endowment, funds, assets or reputation at undue risk.~~ ~~**Duty of care – Trustees must:**~~ ~~• Use reasonable care and skill in their work as Trustees, using their personal skills and experience as needed to ensure that the charity is well-run and efficient.~~ ~~• Consider getting external professional advice on all matters where there may be material risk to the charity, or where the Trustees may be in breach of their duties.~~
Duties	The duties of the Committee are to: • Ensure that the Charity complies with current legislation; • Review new legislation and its impact on the Charity; • Set and review an investment policy for the Charity; • Appoint brokers to manage the Charity's funds if required; • Review the performance of the Charity's investments as managed by its brokers; • Set and review an investment policy including the use of investment gains; • Review individual fund balances within the overall Charity on a regular basis; • Seek expenditure plans from individual fund holders where

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funds are currently not being used;
- Agree guidance and procedures for fund holders;
- Review audit recommendations;
- Review the Annual Accounts for the Charity; and
- Review the Annual Reports for the Charity.

The ~~Trustees~~ Committee may delegate any of its~~their~~ powers or functions to a subcommittee of two or more ~~Trustees~~ members but the terms of any such delegation must be recorded in the minute book.

The ~~Trustees~~ Committee ha~~ve~~s the power to delegate all investment decisions to the appointed investment broker.

Financial Controls

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

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

- Expenditure policy
- Investment policy
- Reserve policy

Annual Report and Return of Accounts

Acting on behalf of ~~T~~the Corporate Trustee~~s~~, the members of the Committee must comply with their obligations under the Charities Act 2011 (as amended) with regard to~~:~~:

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

	Accounts must be prepared in accordance with the provisions of any Standard of Recommended Practice (SORP) issued by the Charity Commission.
Sub-Groups	Charity Operational Committee
Chairing arrangements	General meetings shall be chaired by the ~~Trust Chair~~Non-Executive Director appointed as Chair of the Committee. If there is no such person or he or she is not present, a Non-Executive Director nominated by the ~~Trustees~~ Committee members shall chair the meeting.
Membership	~~The Charity and its property shall be managed and administered by a Committee comprising Board Members elected by the Board of Directors.~~ The Committee membership shall comprise: ~~The Chairman~~ ~~Up to four other~~Three Non-Executive Directors, one of whom shall be appointed as Chair of the Committee The Chief Executive The ~~Director of Finance~~Chief Finance Officer The Chief Operating Officer A ~~Trustee~~n individual shall cease to ~~hold office~~be a member of the Committee if he or she; • Ceases to be a Director of the ~~Charity~~Trust; or • ~~Resigns as a Trustee~~ • Is disqualified from acting as a Trustee by virtue of section 178 of the Charities Act 2011 (as amended).
In attendance	The Deputy ~~Finance~~ Director of Finance and ~~Trust~~ Board Secretary will be in attendance.
Secretary	Secretarial support will be provided by an Executive Assistant.
Quorum	No business shall be transacted at any general meeting unless a quorum is present. A quorum is a minimum of three ~~Trustees~~ Committee members including at least one Executive and one Non-Executive Director.

	Each member~~Trustee~~ shall have one vote but if there is an equality of votes the person who is chairing the meeting shall have a casting vote in addition to any other vote he or she may have.
Frequency of meetings	The Committee shall meet four times per year unless the Committee agrees a different meeting schedule. A minimum period of notice is required to hold any general meetings of the Committee of at least ~~fourteen~~ seven calendar days. The ~~Trustees~~ members present at a meeting may resolve that the meeting shall be adjourned. 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 four clear working days in advance of the meeting.
Reporting	The ~~Trustees~~ Committee must keep minutes of all: ~~• proceedings at meetings of the Charity;~~ • meetings of the ~~Trustees and committees of Trustees~~Committee and sub-committees including the names of the ~~Trustees~~ members present at the meeting; and • the decisions made at the meetings and where appropriate the reasons for the decisions.~~;~~ • ~~the draft minutes as agreed with the Chair of each Committee will be presented to the next Board of Directors meeting. Any amendments to those minutes agreed at the subsequent Committee will also be reported to the next Board of Directors meeting.~~ The Chair of the 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 Committee shall also be submitted to the Trust Board for information and assurance. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The 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.

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Date agreed by the Charitable Fund Committee:	6 November 2024
Date approved by the Board:	TBC
Review date:	TBC The Committee shall review the terms of reference annually, and any amendments required shall be put before a meeting of the Board of Directors for approval.

BO.11.24.21 - BOARD ASSURANCE FRAMEWORK, RISK APPETITE REVIEW AND HIGH-LEVEL RISKS

REFERENCES

Only PDFs are attached

- Bo.11.24.21 - BAF & HLRR - Board cover paper.pdf
- Bo.11.24.21 - Appendix 1 - BAF - Q2.pdf
- Bo.11.24.21 - Appendix 2 - Risk appetite 2024-25 DRAFT.pdf
- Bo.11.24.21 - Appendix 3 - GGI-Board-Guidance-on-risk-appetite.pdf
- Bo.11.24.21 - Appendix 4 - HLRR.pdf
- Bo.11.24.21 - Appendix 5 - Risk on a Page Report.pdf
- Bo.11.24.21 - Appendix 6 - Target Mitigation Dates.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.21

Board Assurance Framework, Risk Appetite review 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 assurance and approval	
Previously discussed at/ informed by	ETM: 14 October 2024 and 11 November 2024 Committees: • Quality Committee; 17 October 2024 and 21 November 2024 • People Academy: 24 October 2024 and 13 November 2024 • Finance and Performance Committee: 16 October 2024 and 20 November 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 BAF has been reviewed and updated by the Executive leads to reflect the position at the end of Q2.

The key points to note are included on the summary pages of the BAF (page 1), and in particular the Board is asked to note that the score for risk 12 (partnerships) has increased from 8 to 12 due to additional expectations from partnership working, and the score for 13 (board governance) has been reduced from 20 to 12 due to the progress around reviewing board and committee terms of reference and work plans, and the board development programme.

Originally it was agreed not to create a separate risk relating to quality/patient care, however upon review the Quality Committee questioned whether this was a gap. This was considered further and the executive team and Quality Committee have agreed that the risks aligned to strategic objective 1 (outstanding care) should be further strengthened to incorporate patient care, rather than adding a new risk.

Risk appetite statement

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

threats that change inevitably brings. The Board agrees the risk appetite statement for the Trust and it is reviewed on an annual basis.

The draft risk appetite statement for 2024/25 is presented at Appendix 2 for approval. The proposed appetite levels are the same as those agreed in 2023/24. The Committees have reviewed the draft statement in relation to the objectives related to their remit, and no changes have been proposed. Once approved, the risk appetite levels will be added to the BAF.

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 14 October 2024 and 11 November 2024, ETM considered a summary of all high level risks, including any new risks, closures and changes in score, and those risks which had passed their review date.

The Committees reviewed the high level risks within their remit at their meetings during October and November 2024.

The HLRR, showing all high level risks rated 15+ for November 2024, is attached at Appendix 4.

High Level Risks Report on a Page

The document at Appendix 5 provides a visual overview of all high level risks at BTHFT as at November 2024, and shows trends over a number of cycles and flags areas that ETM, the Committees 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
There are no risks beyond their target mitigation date.

Changes to target mitigation dates
The document at Appendix 6 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, six new risks have been accepted onto the HLRR. Risks 2652 and 2573 were combined into one risk as ETM determined that the solution would be the same for both risks.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.21

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Committee:
October 2024						
2629	**15**	**6**	Violence and Aggression in Emergency Department	Karen Dawber, Chief Nurse	31 May 2025	People Academy and Quality Committee
56	**15**	**6**	Loss of Nuclear Medicine Capability Due to Ageing Equipment	Ben Roberts, Chief Finance Officer	1 March 2025	Quality Committee and Finance & Performance
2612	**15**	**6**	Emergency Department (ED) Consultant review of pathology and radiology results	Ray Smith, Chief Medical Officer	3 December 2024	People Academy and Quality Committee
November 2024:						
2653	**16**	**4**	Lack of consistent archiving of Trust clinical research records including patient information has caused legal and regulatory risk across the organisation.	Ray Smith, Chief Medical Officer	30/06/2025	Quality Committee
2652	**16**	**8**	No dedicated H&S risk management resource supporting Operational Maintenance. Namely, inability to: a) to provide expert H&S advice and support capacity for both internal and external maintenance staff. b) to ensure appropriate H&S governance being coordinated and managed for both internal and external maintenance staff.	David Moss, Director of Estates and Facilities	31/03/2025	Finance and Performance Committee
2573	**16**	**12**	There is a risk to the Trust of reputational damage and enforcement action because of the lack of assurance with statutory obligations during delivery of capital and revenue projects due to inconsistent monitoring of works as a result of no appropriately trained or skilled staff available	David Moss, Director of Estates and Facilities	31/03/2025	Finance and Performance Committee

Risks which have been removed/closed

No risks have been removed/closed since the previous report.

Risks which have changed in score

Three risks have changed in score since the last report to the Board:

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.21

Risk ID:	Current Score:	Previous Score	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:	Reason:
October 2024:								
187	**12**	**16**	**8**	There is a risk of harm to patients, staff and visitors within planned and un-planned care due to the Trust's inability to maintain safe staffing levels as a result of the sustained Covid-19 pandemic.	Karen Dawber, Chief Nurse	31 October 2024	People Academy and Quality Committee	Reassessed following the appointment of the newly qualified nurses and midwives who commenced in September / October.
November 2024:								
605	**12**	**16**	**12**	There is a risk to the delivery of the Haemoglobinopathy service due to staffing constraints which will have an impact on quality and patient safety	Ray Smith, Chief Medical Officer	31/03/2025	People Academy and Quality Committee	Risk downgraded from 16 to 12 since agreement has been reached that the Consultant from Sheffield will continue to provide 3 PAs of in reach service. However, there still remains a lack of local service specification.

Although risk 605 is scored at its target score, the risk has not been closed as there still remains a lack of local service specification. ETM agreed to the changes in score.

A third risk was decreased in score from 20 to 16. This is a ‘closed board risk’ and will be reported as such.

Risks beyond their review date

There were no risks beyond their review date during October and November 2024.

Recommendation

The Board is asked to:

- review and approve the risk appetite statement; 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		
Date	28 November 2024	Agenda item	Bo.11.24.21

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)						

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)
▪	Committees

Board Assurance Framework – Summary

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	Further commentary added to illustrate progress and assurance. Additional governance papers delivered to F&P. £1B additional backlog funding nationally for 25/26. Space utilisation work commenced.
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	No change to overall risk score. Staffing across areas remains closely managed. Informatics staffing vacancies continue to be high.
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	External review actions being progressed. Mitigating actions to achieve plan have been identified and progressing. Follow-up external review commissioned by the ICB.
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	Risk score remains at 12. Continue to progress with actions and mitigate impact. EPRR submission was reported as overall partially compliant at 80%, an improvement from the previous position. SSNAP score improved from a 'C' rating to an overall rating of 'B' during the last quarter. Contracts have been awarded and work has commenced on the new Endoscopy Unit. St Luke's Day Case Unit practical completion/handover has been delayed to mid-December 2024 due to supply chain issues. First patients expected January 2025. 65-week waits for elective patients remains at 69 as at October 2024.
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 Estates & Facilities	Further commentary added to illustrate progress and assurance. Sustainability manager to be recruited in early 2025. Submitting PSDS 4 bid late November 24 for access to Bradford's heat network. CEF commenced on BRI to identify an energy partner. GPIG meetings recommenced.
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.	12 ↑	3	Director of Strategy & Transformation	The risk score has increased in Q2 because of increased expectations from partnership working (e.g. WYAAT service review), financial constraints that can make partnership working more challenging, and because the deadline is approaching for Airedale's Strategic Outline Case for the new build under the New Hospital Programme which will require collaboration across the system – with Airedale and other system partners (e.g. BDCT and the ICB).
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.	12 ↓	8	Chief People & Purpose Officer	Score reduced from 20 to 12 – review of TORs, work plans etc complete, board development programme agreed and first session delivered in October 2024.

Heat Map – September

= current score

LIKELIHOOD	CONSEQUENCE				
	Negligible (1)	Low (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)					
Likely (4)			3		2 4
Possible (3)			7 8 9	1 5 6 11 12 13	
Unlikely (2)			10		
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.

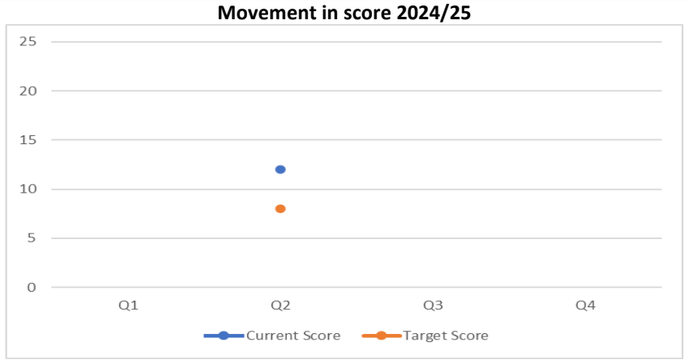
Risk Appetite: TBC

Date added: 6 September 2024

Date of last review: 7 November 2024

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?)

- A Board Development Session held on 23 October focused on health inequalities. Outcomes included reframing of health inequalities to focus on improving health equity, adopting a social movement approach through focused comms and weaving health equity into key Trust processes and governance.
- Trust-wide Health Inequalities Action Plan being developed: Addressing health inequalities and improving health equity as a priority by increasing awareness, providing training (include in induction, leadership training), adding health equity to governance processes.
- Health Equity Communications Plan to increase awareness and share good practice.
- Promote Health Equity Fellowship Scheme.
- Utilising data and insight to deliver the 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.
- 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 for Closing the Gap projects.

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

Internal
Positive:

- EDI strategy
- Annual Report
- Health inequalities and Access to Care
- Strengthening role as an anchor organisation
- Reports to Equality and Diversity Council
- Reports to Quality Committee
- A number of colleagues across the Trust have already completed the WY ICB initiative to become "Health Equity 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 controls or assurance (what more should we be doing and what additional assurance do we need?)

Gaps in control	**Action**	**Timescale**
Routine forum on Health inequalities and health equity	To develop a health equity oversight group	March 2025
Oversight of health equity across the Trust with action plan and comms plan	To revise the BTHFT HI objectives within the EDI strategy for the 2025 refresh	
Add health equity to Trust meeting agendas e.g. Board Committees, Exec to CSU		
Gaps in assurance		
Clear definition on what we mean by Health Inequalities and health equity and an agreed method of how we are going to monitor progress against this definition.	Work with colleagues in Business Intelligence roles Utilise Board Development Session feedback to guide the HI approach	March 2025

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

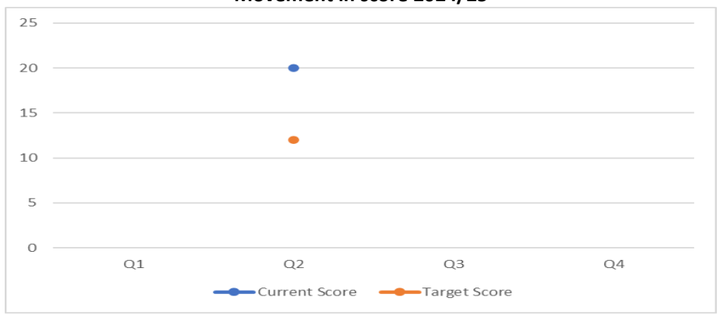
Risk Appetite: TBC

Date added: 30 August 2024

Date of last review: 30 October 2024

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 Committee. • 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. • 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 commenced on site. • Main entrance BIHR – due to complete 2024. • Ward 1 Side room / PPVL project complete. • Hand Theatre complete. • Additional £1B announced in October 24 budget to address backlog maintenance in 25/26. • Scoping a project to review space utilisation to reduce estate and to increase the utilisation of existing estate. • Patient Experience Group monitoring E&F KPIs that impact the care environment.	**Internal** **Positive:** • IPC Quarterly Reports • PAM Report to Board September 2024 (next one due in Sept 2025) • Estates Return Information Collection (ERIC) returns show an extensive knowledge base • 6 monthly reports on compliance, water, fire, health and safety and ventilation presented to Finance and Performance Committee. **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 has commenced • Review of Skipton Hospital space and external options. Agreed additional demise from ANHSFT	**Timescale** Ongoing Ongoing Ongoing
Related risks on the high level risk register (operational risks)	• **290** – 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 correctly resourced (inc. talent and skills), nor adhere to professional standards, **then** there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, completeness and pace of delivery, **resulting in** a reduced ability for the Trust to achieve its strategic ambitions.

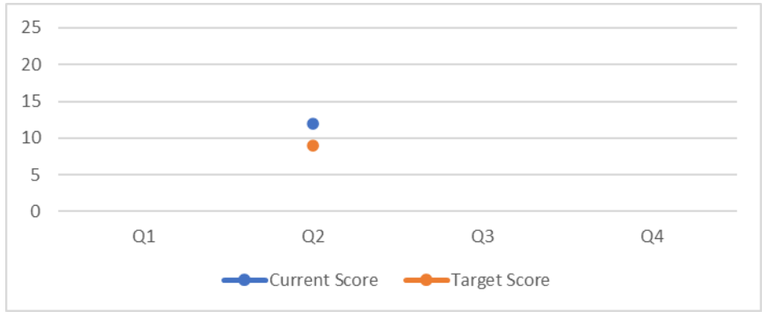
Risk Appetite: TBC

Date added: 30 August 2024

Date of last review: 6 November 2024

Lead Director: Chief Digital and Information Officer

Movement in score



Initial Score (CxL): 3x4=12

Current Score (CxL): 3x4=12

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 the Workforce Control Panel for relevant approval of key roles. • A refresh of the Digital Strategy is about to be launched which seeks to optimise existing resources, services, investments and technologies. • Embracing a strategic approach to talent management focusing on improving how we attract, develop, retain, and optimise our workforce. • 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. • Informatics shall be migrating to a new set of cyber security controls which will see the Trust adopt over the next 18-24 months. • The appointment of a Head of Applications and Development, which is a senior role, will support the formulation of future application and development strategy in order to guide the Trust through transformation and optimisation initiatives. • Continued professional development is essential to retaining and developing our existing workforce. Enabling colleagues to access degree-level apprenticeships and training courses, including cyber incident responder training, Microsoft developer training and digital clinical safety training for our Informatics Clinicians. This commitment ensures we are continually enhancing the skills and capabilities of our workforce to better meet the digital needs of our organisation. • 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. • 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. We have seen a reduction in sickness absence and improvements to mandatory training and appraisal rates to ensure a well led function. **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 Positive progress in the BI and Data Warehouse functions with collaborative work ongoing following an external assessment **Negative:** External application assessment showing areas which require improvement	**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. Maintain ongoing budget allocations for CPD and recruitment to key positions, ensuring we have the right people with the necessary skills and capabilities to implement the digital strategy effectively. **Gaps in assurance** Informatics oversight is provided by Quality Committee, 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 Develop workforce learning and development plan Review of Committee TOR and work plans	**Timescale** 3 months January 2025 January 2025
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 and/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.

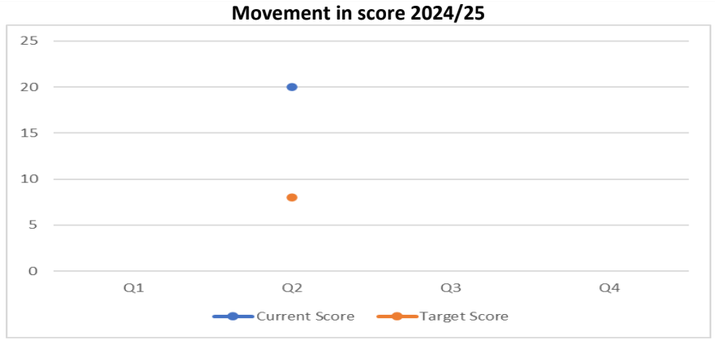
Risk Appetite: TBC

Date added: 24 August 2024

Date of last review: 4 November 2024

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	
• Continued evolution of the Clinical Service Unit (CSU) financial management arrangements and framework, with associated accountability and performance management framework. • Introduction of the Closing the Gap (CTG) financial efficiency programme structure across the CSUs and 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 CSU to support with delivery of cash releasing efficiencies and budgetary management. • Quality Impact and Financial Impact Assessment processes. • Action plan to deliver recommendations of external review of financial governance arrangements and efficiency opportunities. • Scheme of Delegation, internal financial control environment revised and updated. • Financial governance and control arrangements. • Financial controls: Recruitment Approval Panel, Variable Pay Panel, Non-Pay Review Group • Budgetary Management Framework and CSU accountability framework. • The cash & liquidity position is managed and monitored by the Cash Committee with updates provided to the Finance & Performance Committee via the monthly Finance Report and monthly Treasury Management Report. • Intensified oversight and governance of the capital programme via Capital Strategy Group and Capital Operational Group. • 5 year financial and capital plan. • WYAAT CEO-led efficiency workstreams. • BDC Place Closing the Gap programme.	**Internal** **Positive:** • Monthly Finance report to July 2024 F&P Committee and Board demonstrating improvement in the run-rate position. • Closing the Gap report F&P Committee highlighting progress with scheme development. • Monitoring Closing the Gap Scheme Scoping Documents for each workstream. • Capital plan approved for 2024/25. **Negative:** • Treasury Management report to F&P Committee highlighting forecast cash risks in Quarter 3 or 4. • CSU Monthly finance reports forecasting material overspends in many departments.	**Independent** **Positive:** • External review providing assurance on the Closing the Gap governance and programme structure. Internal Audit Reports: • Waste Reduction Programme – Significant Assurance (June 2024) • Financial Transactions – Significant Assurance (April 2024) • Contract Management – Significant Assurance (May 2024) **Negative:** • External review identified opportunities to improve financial control.	**Gaps in control** Budget holder capacity and capability to deliver a £38.9m cost improvement target in 2024/25 **Gaps in assurance** CSUs and corporate departments have not identified the full value of their Closing the Gap targets. Ability to submit a balanced financial plan for 2025/26. 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. 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.	**Action** Budget holder training is in place, with an increased focus on financial control measures and techniques for identifying efficiency opportunities. Dedicated Closing the Gap week in giving budget holders dedicated time to focus on CTG delivery. CTG governance structure Exec to CSU budget / CTG meetings CSU named Exec sponsor roles external review action plan. CTG multi-year planning to be developed. Budget setting process for 2025/26 to commence early. Working capital controls. Cash Committee to develop further strategies to maximise cash balances. Capital Strategy Group and Capital Operational Group oversight.	**Timescale** Quarters 3 & 4 of 2024/25 September 2024 – complete. Already introduced but still maturing throughout Quarters 2 -4 November 2024 Quarter 3 Quarter 3 Ongoing 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

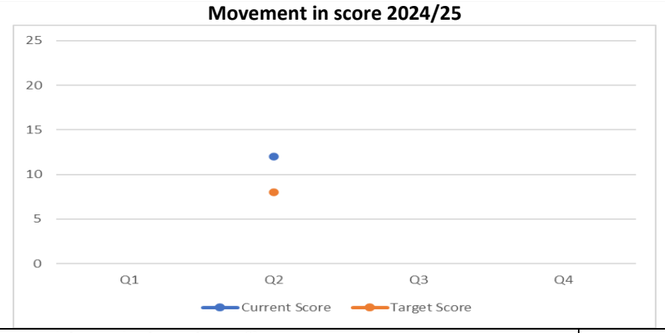
Risk Appetite: TBC

Date added: 27 August 2024

Date of last review: 6 November 2024

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 • ED Improvement Programme approved by ETM. Presentation at Board in November 2024.	**Internal** **Positive:** • Act as One Updates to F&P Academy – latest October 2024 • Partnerships Dashboard – latest as at June 2024 • WYAAT ICS Programme Updates – latest October 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 October 2024 • Urgent & Emergency Care Improvement Plan to F&P Academy – latest September 2024 • Winter Response Plan – F&P Academy – October 2024 • Performance Report to F&P – latest October 2024 • EPRR self-assessment core standards – 50 out of the 62 were fully compliant and 12 were partially compliant – overall partially compliant 80% – improved position **Negative:** • WYAAT reports (e.g. Non-Surgical Oncology, Haematology) • Histopathology and renal performance • 65-week wait remains at 69 at October 2024.	**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 and Leeds Teaching Hospital Vascular Services • Human Tissue Act assessment • SSNAP (Stroke Audit Programme) – Nov 24 Overall ‘B’ Rating. Improvement from previous position. • 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) ➢ Discharge Management – Significant assurance (September 2024) **Negative:** • GIRFT Reports • Joint venture – loss of UKAS accreditation	**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 mid-December 2024. • Development of new endoscopy unit at BRI. Contractor appointed. Groundbreaking ceremony held and work underway. • Work with IS and internal task and finish group to reduce reliance on IS	**Timescale** Ongoing Ongoing Ongoing 31 January 2025 October 2025 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.

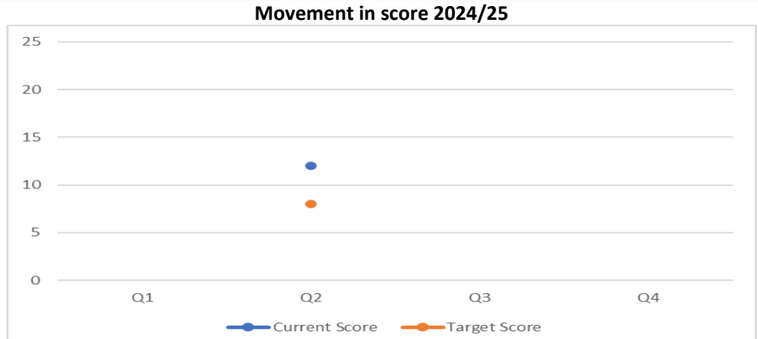
Risk Appetite: TBC

Date added: 4 September 2024

Date of last review: 30 October 2024

Lead Director: Director of Estates & Facilities

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**	**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. Updated guidance on the green plan expected to be provided in late 24. • 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. • Plans to recruit an 8A Sustainability Manager in early 2025. • Submitting a Public Sector Decarbonisation Scheme (PSDS) 4 bid in late November for St Lukes to join the Bradford heat network to significantly reduce Carbon, Bid expected to be £6-8m and if successful go live in 2027. • The Carbon Energy Fund have visited BRI to be appointed to identify an energy partner to develop a strategy for decarbonisation through private funding avenues which will be repaid through future savings on energy. • Reviewing partnership with EV charging company. • Green Plan Implementation Group (GPIG) has recommenced meetings following not formally meeting since summer 2023. • Reviewing waste contract and recycling options as part of the tender. Increased use of the offensive waste stream.	**Internal** **Positive:** • Annual report 2023/24 • Annual Report to Board – January 2024, next report due 2025. **Negative:** N/A	**Independent** **Positive:** WY ICB BD&C Health & Care Partnership NHSE NE&Y CQC (outcome TBC) **Negative:** N/A	**Gaps in control** Engagement on sustainability/green issues across the trust is not consistent and depends on personal interest from individual members of staff. No recycling	**Action** New Green Plan to be developed on receipt of new guidance 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 (awaiting new guidance before updating) 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.

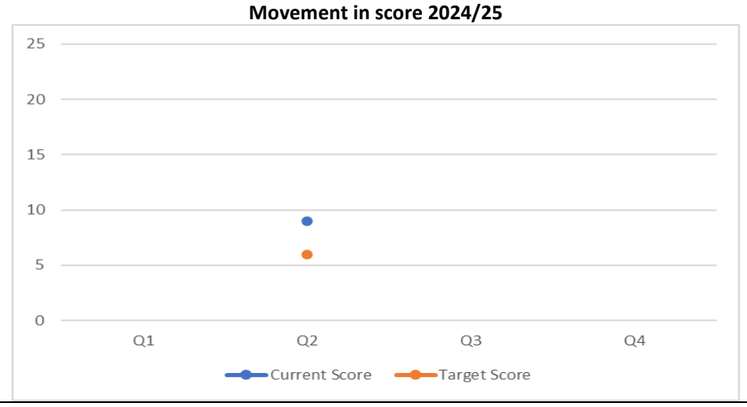
Risk Appetite: TBC

Date added: 13 September 2024

Date of last review: 7 November 2024

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.	Q3
• 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.

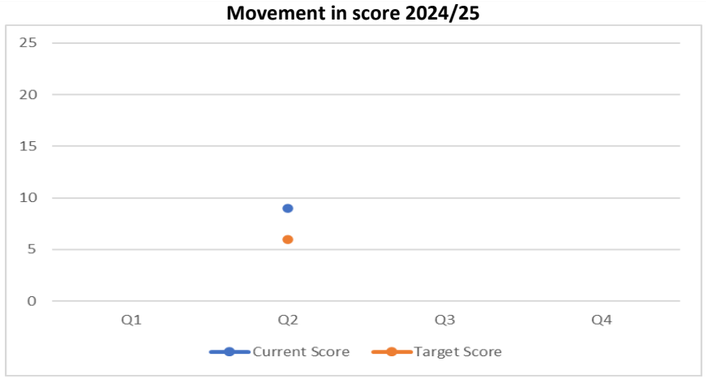
Risk Appetite:
TBC

Date added: 28 August 2024

Date of last review: 4 November 2024

Lead Director: Chief People & Purpose Officer

Movement in score 2024/25



Initial Score (CxL): 3x3 = 9

Current Score (CxL): 3x3=9

Target Score (CxL): 3x2=6

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

- 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
- 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.

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

Internal
Positive:
- EDI Strategy Implementation Plan shows a range of activity to support the progress of our 5 strategic EDI Objectives as outlined in the EDI Strategy (EDC Oct 24)
- People Dashboard: BAME overall workforce and representation at Senior Management year on year improvements – latest as at November 2024
- Gender Pay Gap – improving position – latest as at March 2023
- WRES/WDES/EDI Update report -People Academy October 2024, with some notable improvements and with refreshed action plans approved for 2024/2025
- 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 November 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 comparable with other local Trusts.
- 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 controls or assurance (what more should we be doing and what additional assurance do we need?)

Gaps in control
- Remaining improvements to Recruitment & Selection from an EDI perspective (e.g. finalisation of managers inclusive recruitment 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

Actions to address gaps in controls or assurance

Action	**Timescale**
•In development	November 2024
•To continue to roll out the equality impact assessment guidance and proforma.	Ongoing
•Continue targeted engagement with CSU/ departments and developing local EDI action plans/ Continue to develop our EDI Implementation plan supporting the delivery of the EDI Objectives assigned with the EDI strategy.	Ongoing
•Working to meet the requirements	Ongoing

Action	**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

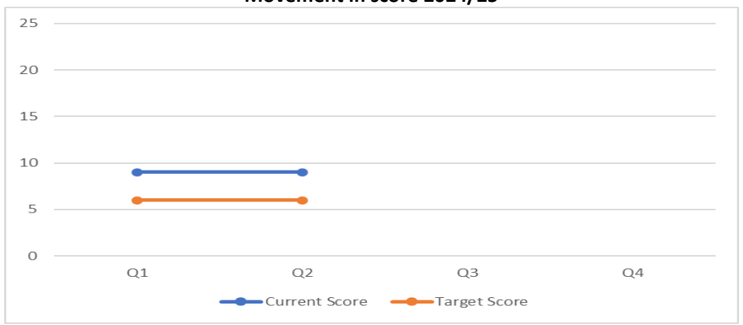
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 7 November 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

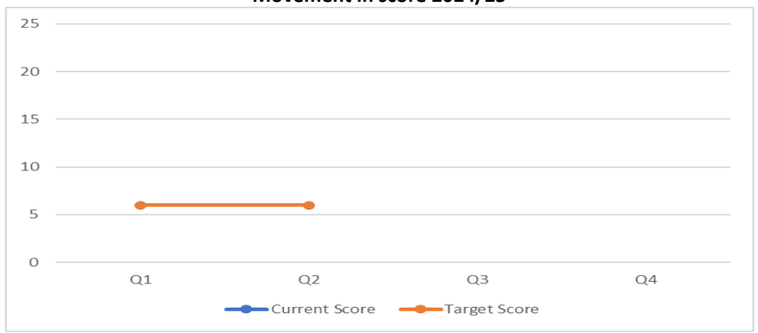
Risk Appetite: TBC

Date added: 1 April 2022

Date of last review: 7 November 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 Committee – 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. **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

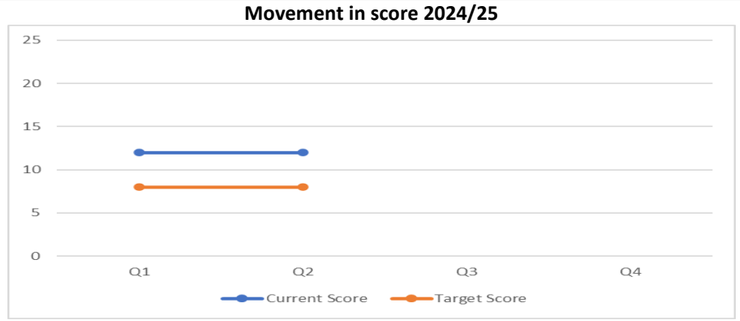
Risk Appetite: TBC

Date added: 1 April 2022

Date of last review: 7 November 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. • 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 – quarterly – latest report as at Q2 2024/25. • Serious Incident Report – latest as at October 2024. • 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. • Renew/replace – InPhase commissioned.	**Timescale** Complete. 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.

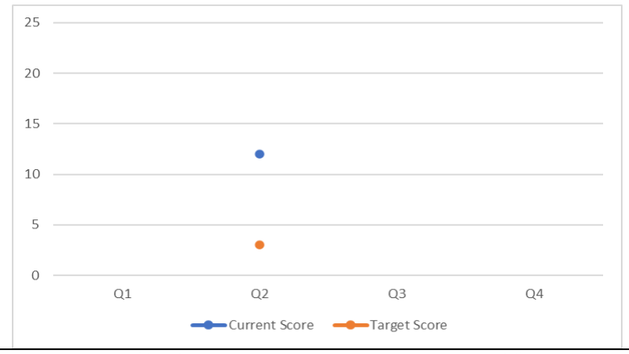
Risk Appetite: TBC

Date added: 13 September 2024

Date of last review: 7 November 2024

Lead Director: Director of Strategy & Transformation

Movement in score 2024/25



Initial Score (CxL): 4x3 = 12

Current Score (CxL): 4x3 = 12

Target Score (CxL): 3x1 = 3

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

- 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. Another Exec to Exec meeting scheduled with Airedale team in Feb 2025
- Strategic Partnership Agreement (SPA) in place across the BD&C place. This agreement has been in place now for over five years and has recently been refreshed.
- Number of examples of working with the local Voluntary and Community Sector in ED and Maternity in particular.
- Board to Board partnership meeting with University of Bradford in November 2024

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

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:

- Engagement in developing Strategic Outline Case for New Hospital Programme with partners.
- Financial pressures can challenge partnership working e.g. if partners enter NHS Recovery Support Programme.
- Financial pressures at BMDC are likely to impact on their capacity for partnership working.
- Some national drivers around acute hospital performance and finance can act to drive time and focus away from strategic partnership arrangements.

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

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

Actions to address gaps in controls or assurance

Action	**Timescale**
Meeting with Airedale exec to develop workplan. After that, develop work programme with timelines. Engage with CEOs and WYAAT leadership Meet with counterparts in organisations, identify areas to focus on and develop work plan.	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.

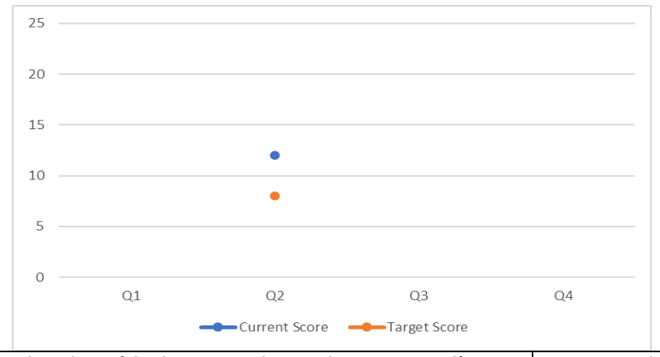
Risk Appetite:
TBC

Date added: 6 December 2023

Date of last review: 7 November 2024

Lead Director: Chief People and Purpose Officer

Movement in score 2024/25



Initial Score (CxL): 5x4 = 20

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**	
• 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:** • 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) ➢ Fit and Proper Person Test – Significant assurance (November 2024) **Negative:** • Annual VFM assessment – significant risk re: governance	**Gaps in control** • Improvements to 'technical' governance e.g. Board/Committee/Academy arrangements • Improvements to Board 'dynamics' • Separation of SID and Deputy Chair roles **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 • New report template and guidance to be developed • Creation and delivery of Board development programme • New SID to be appointed • Review to be commissioned	**Timescale** September 2024 – complete January 2025 12-18 months – June 2025 November 2024 TBC
Related risks on the high level risk register (operational risks)	N/A				

Bradford Teaching Hospitals NHS Foundation Trust's Board of Director's Risk Appetite Statement 2024-25 DRAFT

The Board of Directors recognises that the Trust's long term stability and continued development of effective relationships with our patients, their families and carers, our staff, our community, and our strategic partners is dependent upon the delivery of our strategic objectives. It also recognises that the "Good" rating applied to the Trust by the CQC in 2020 has an influence on the risk appetite of the organisation.

The Board of Directors believes that our risk appetite appropriately reflects the progress that the Trust has made in implementing and assuring its Corporate Strategy 2022-2027 and its associated strategies and plans and is fully aligned to our ambition. A balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective by the Board of Directors, and without exception, there is a minimal appetite in relation to any risks to patient safety, staff safety or regulatory compliance.

	Strategic objective	Risk appetite	Description
1	**To provide outstanding care for our patients, delivered with kindness**	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*Our mission is to provide high quality care to our patients at all times and we will not accept risks that could affect our ability to do this. Our mission is our key organisational driver that directly supports our strategic objective to provide outstanding care for patients, delivered with kindness, improving outcomes for our patients and their carers by providing safe, effective, personal and responsive care. We will hold patient safety in the highest regard and are strongly averse to any risk, clinical, operational, workforce or related to strategic partnerships that may jeopardise it. But we have insight, we manage risk, we engage and involve, we improve and innovate and we assure, which enables us to have an open risk appetite in relation to our strategic objective to provide outstanding care for our patients, we are willing to consider all potential delivery options and choose, while also providing an acceptable level of reward.*
2a	**To deliver our financial plan**	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*We will not tolerate risk to patient safety in order to deliver the Financial Plan, however we will accept a degree of compromise on optimum levels of care, but actively avoiding any safety concerns. We will strive to meet regulatory requirements but will not set unrealistic challenges that compromise the delivery of clinical strategic ambitions. We will provide realistic forecasts to regulators under 'no surprises' expectation. We will maintain an open and honest relationship with our Integrated Care Board colleagues and jointly recognise the financial challenges we face. The Trust will ensure that cash balances will be maintained at a level that protects the Trust's ongoing trading liabilities. Subject to sufficient reserves the Trust will invest to transform, but only when the realisable benefits are fully tested and assured and adequate liquidity is preserved.*

	Strategic objective	Risk appetite	Description
2b	**To deliver our key performance targets**	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*Patient safety is our highest priority in all aspects of performance management and operational delivery. Where we have the ability to increase activity in order to achieve our performance targets. We will do this as long as it does not create other areas of unacceptable risk in relation to quality, patient safety, workforce and finance. We will work with other acute providers, other health and social care agencies including the independent sector and voluntary services to deliver activity, day to day operations to safely achieve our performance targets.*
3	**To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion**	**Seek -** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	*The Trust is clear that we will not accept risk where it involves potential exposure to significant harm for employees. Examples include:* • *Bullying or harassment of employees by their managers or colleagues* • *Discrimination of employees by their managers or colleagues* • *Exposing employees to faulty machines or equipment* • *Exposing employees to machines or equipment where this may result in a detrimental known impact on the health of the employee.* *However in relation to all other elements of achieving our strategic objective to be one of the best NHS employers the Trust will pursue workforce innovation and be pro-active around developing and trialling new ways of working and new job role/career pathway opportunities. By doing this we will seek to both increase workforce supply and improve the skills and capabilities of our people, ensuring we provide high quality care to our patients at all times.*
4	**To be a continually learning organisation and recognised as leaders in research, education and innovation**	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*The Trust recognises that to be a continually learning organisation it must have a broadly open approach that aligns the different areas of risk. These areas of risk include those associated with education and training, research translation, new technology, engagement and the learning management system. We are committed to identifying, developing, deploying and embedding learning at every level of the organisation to improve the quality of care for patients.*
5	**To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals**	**Seek -** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	*We will actively collaborate to increase our influence. We will actively explore opportunities for value added innovation.*

Applying risk appetite matrix

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

All Open Operational Risks with a current risk rating of >=15 (as at 05/11/2024)

Consequence	Likelihood	Rating
(1) Negligible	(1) Cannot believe that this will ever happen again	15 to 25 Extreme
(2) Minor	(2) Do not expect it to happen again but it is possible	8 to 12 - High
(3) Moderate	(3) May recur occasionally	4 to 6 - Moderate
(4) Major	(4) Will probably recur, but is not a persistent issue	1 to 3 - Low
(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	

Risk Register Id	Legacy ID	Date of Entry	Lead Director	Risk Lead	Source of risk	Assuring Committee or Academy Summary	Risk Title	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)	Likelihood (current)	Rating (current)
2605		08 Jul 2024	Ray Smith	Jen Green	Risk Assessment	Quality & Patient Safety Academy Finance and Performance	The Meadows - Chemotherapy Day Unit Capacity	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	30 Nov 2024	25	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	8	(2) Minor	(4) Will probably recur, but is not a persistent issue	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.	09/09/24 The CSU is looking to assess the chairs and staffing needed when the current chemotherapy capacity becomes saturated in order to pro-actively manage the demand and plan for the resource required. 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 2025	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
290	3627	10 Feb 2021	David Moss	Chris Davies	Business Continuity	Health and Safety Quality & Patient Safety Academy Finance and Performance	Estates Critical Infrastructure Risk	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 Dec 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.	31 Mar 2025	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
2566		12 Apr 2024	Sajid Azeb	Sarah J Buckley	Risk Assessment	Quality & Patient Safety Academy	Delayed Discharges to Adult Social Care	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 Nov 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)	13/09/2024 - There are several improvement projects as described in the Intermediate Care (IMC) Framework blueprint for implementation across the district, the programme of work is being led by the integrated care board. The projects are to support us to achieve timely hospital discharge and improve our length of stay on acute wards post meeting the criteria to reside, in turn enabling us to have bed availability earlier in the day for patients who need to be admitted to acute specialist ward areas from AED. H-FAST was launched in BTHFT 22nd July 2024, initial data analysis is indicating that the project may achieve the desired outcomes, however, still in its infancy and requires scaling up to include all pathway 1 discharges. The number of daily discharges via H-FAST should increase to 6 maximum slots per day by October 2024, but there are some patients currently excluded from the model and further ongoing work required to be undertaken to address this. Therefore, we cannot reduce the level of current risk across pathways 1-3, until there have been further improvements through the integrated workstreams 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)	30 Nov 2024	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

2604		04 Jul 2024	Karen Dawber	Mayada Elsheikh	Risk Assessment	Quality & Patient Safety Academy Finance and Performance	Emergency Department Overcrowding	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.	31 Dec 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	12	(4) Major	(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 Service	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.	30 Sep 2025	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2542		04 Apr 2024	Ray Smith	Jill Parkinson	Risk Assessment	Quality & Patient Safety Academy	Haemonetics Blood Track Kiosks End of Life	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 Dec 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	19 Dec 2024	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
171	3748	15 Feb 2022	Ray Smith	Jen Green	Business Meeting	Quality & Patient Safety Academy Finance and Performance	(Service delivery/Capacity) Renal Services Capacity	Renal Services Capacity There is a risk that as the demand for hemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity and that it will not be possible to provide timely dialysis for some patients. Increasing demand within the local demographic and an aging and limited foot print has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organizations both within and without the region.	31 Dec 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	26/10/24 - Last remaining twilights at Skipton have now opened. A paper was submitted to ETM in September to increase capacity by opening Sundays at St Luke's. Consultation with staff and patients required, capacity not expected to come on line until February 2025 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.	31 Mar 2025	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

607	3309	26 Nov 2018	Ray Smith	Nima Maleki	Risk Assessment	Quality & Patient Safety Academy	Constraints within the Histopathology Reporting Service	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 Dec 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	26/10/24 - some success in appointments, we have appointed a 6 month NHS locum and x3 12 month NHS locums (subject to finders fee) who are currently undergoing recruitment checks . Unfortunately x2 consultants leave in October. EP post has been drafted and with HR to be matched under AfC 09/09/24 - Recruitment thus far has not yielded any appointments, with a further 2 consultants due to leave the Trust from October meaning there will be 50% consultants in post. The CSU are currently reviewing bank and locum opportunities as well as re-advertising the substantives posts. Outsourcing to SBS will continue to be used. EP/AP business case has been submitted to ETM to develop a BMS dissection model which should create reporting capacity in the longer term if approved 06/07/24 - 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	31 Mar 2025	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
221	3696	18 Aug 2021	Saijid Azeb	Philip Moore	Business Continuity	Finance and Performance Quality & Patient Safety Academy	Deteriorating Condition of the Pharmacy Aseptic Unit Facility and Equipment	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	30 Dec 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	8	(4) Major	(2) Do not expect it to happen again but it is possible	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	05/11/2024 - LW update Cleaning of the unit now progressing well, 5 good validation results, isolators also have first lot of cleaning validation results passed. 2 more validations required of each of the four different cleans. Delays in releasing aseptic staff over to St Luke's to continue cleaning and validations due to increase in chemotherapy demand workload for Meadows Unit and issues encountered with authorization of chemotherapy in time for working in advance. Colleagues have been fully operational since demand increased at Meadows Unit to reduce/remove waiting list, impacting ability to send colleagues to perform the necessary validations required before using the St Luke's unit for patient treatments, Plan to mitigate by sending colleagues to St Luke's on their rostered Saturdays to complete the validations, this will take a minimum of seven weeks to complete all staff, if urgent aseptic work is needed for a patient, the team will abort the visit to St Luke's that week. There has also been a delay in completing the servicing and recommissioning by Cleanroom Projects due to the ongoing discussions regarding over payment for the rent, payment is now agreed and payment to Cleanroom Projects should be this week, once payment received by	27 Jan 2025	(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 Quality & Patient Safety Academy	Haematology Consultant Team & Haemophilia Service Delivery	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 Dec 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		26/10/24 - a number of key principles from the service review have been agreed with the COO an CMO. The CSU is currently undergoing individual job planning meetings with the consultants and will be aiming to build in the agreed key principles into the job plans going forward subject to agreement 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.	31 Mar 2025	(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 Quality & Patient Safety Academy	(Staffing) CYPU high levels of activity and complex acuity combined with reduced staffing numbers	• 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)	28 Apr 2026	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	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 & Patient Safety Academy	CYP Autism and ADHA Assessment Waiting Times	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	31 Jan 2025	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	1. BTHFT Autism Assessment Pathway Implementation Project-ongoing changes to pathway 2. Ongoing involvement in System wide Autism pathway development reviewed 17/09/2024 no changes further review of RA in 3 months Reviewed October 2024 - no change to score Internal review of pathways and new Follow up pathway to implement Nov 24. This will reduce requirement for number of follow ups and focus on PIFU. BDCT developed a proposal for Centre of Excellence, new pathway that streamlines all 3 providers. For presentation at PLE in Nov and anticipated start date April 25. Summary paper of changes presented at AGA and ETM Oct 24 by the CSU	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 Quality & Patient Safety Academy	Workforce Constraints within Non-Surgical Oncology (NSO)	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	31 Jan 2025	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	26/10/24 - NSO implementation group established, first meeting 31/10/24. NSO options paper submitted with preferred option is that Oncology at BTHFT do not have a bed base 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 Mar 2025	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2652		11 Oct 2024	David Moss	Neil Harvey	Quality and Safety Committee	Health and Safety Finance and Performance	Estates Operational Maintenance H&S Management Resource	No dedicated H&S risk management resource supporting Operational Maintenance. Namely, inability to: a) to provide expert H&S advice and support capacity for both internal and external maintenance staff. b) to ensure appropriate H&S governance being coordinated and managed for both internal and external maintenance staff.	01 Dec 2025	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	Peripheral support and technical advisory	Continue to support the current position and maintain operational maintenance with no in-house H&S management or specific technical supportive resource. Explore joint resource with Capital (who also have a H&S vacancy) at a more senior level and combine the two positions	31 Mar 2025	(4) Major	(4) Will probably recur, but is not a persistent issue	16

2653		16 Oct 2024		Jane Dennison	Risk Assessment	Quality Committee	Retention and Archiving of Clinical Research Records	Lack of consistent archiving of Trust clinical research records including patient information has caused legal and regulatory risk across the organisation.	30 Nov 2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue	4	(2) Minor	(2) Do not expect it to happen again but it is possible	Current archiving arrangements have been identified and a working group has been set up and an action plan developed and is starting to be implemented.	Action plan developed and is being implemented. Some steps will be completed by March 2025 with full implementation by June 2025	30 Jun 2025	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2573		24 Apr 2024	David Moss	John Pointon	Governance and Risk Committee	Finance and Performance	There is a risk to the Trust of reputational damage and enforcement action because of the lack of assurance with statutory obligations during delivery of capital and revenue projects due to inconsistent monitoring of works as a result of no appropriately trained or skilled staff available	Project/work demand, whether pre or during construction, exceeds the available capacity within the estate capital team. This means that on and off site performance cannot be adequately monitored/checked/challenged at a level deemed necessary to ensure that all statutory/regulatory obligations are satisfied throughout the life of any project. External service providers are in place, however cannot/are unable to carry out all the necessary duties to ensure full compliance on behalf of the Employer. There is a real and evident risk that this will trigger mental health and wellbeing risk of existing NHS staff, as ALL work/process is subject to regular audit. This risk will not only remain during design/development/construction. If non compliance is experienced and potentially identified too late in the process, this risk will transfer into post construction activity i.e. maintenance and operation. There is also a risk to the general health of both staff, public and patients if for example, contaminated materials are identified and not appropriately managed/monitored.	30 Dec 2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	12	(4) Major	(3) May recur occasionally	Temporary funding, until permanent funding provided, to procure appropriately skilled resource within the capital team. Appointment of external providers where able to satisfy 'some' of the employer/client obligations. Development of necessary H&S process/protocol(s) to satisfy statutory obligations.	"Business case for additional permanent resource. Temporary appointment of 3x competent external (consultant/agency) professional - 1x H&S, 2x PM. Allocating 'some' internal duties to external service providers (consultancy and/or agency), however cannot be 100% due to appointment and PI coverage. Appoint an appropriate consultant service provider to develop a H&S protocol/policy that recognises condition and demands upon the estate, providing necessary infrastructure, process and governance and assurance arrangements to ensure the trust satisfies its statutory obligations under statutory regulation, utilising the staff identified within said business case. Implement a work plan that reflects capacity of the team, ensuring risk of exceedance is mitigated. "	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 People	Pharmacy Accommodation - Cramped and not fit for purpose	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 now	30 Dec 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 05/11/2024 Ongoing (see risk 221) Update 07/10/2024 Ongoing validation of temporary aseptic facility. Operator validations (material transfer tests and broth simulations) starting this month (risk 221) 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	31 May 2025	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
30	3890	30 Aug 2023	Karen Dawber	Carly Stott	Risk Assessment	Quality & Patient Safety Academy	USS capacity	There is a risk that the service cannot achieve the 72 hour timeframe for undertaking fetal ultrasound scans due to a lack of scan capacity	31 Mar 2025	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	31 Mar 2025	(5) Catastrophic	(3) May recur occasionally	15

95	3824	14 Sep 2023	Ray Smith	Farah Naz	Risk Assessment	People Quality & Patient Safety Academy	Emergency Department Medical Staff Coverage - weekend and evenings	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	07 Feb 2025	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	10/09/24 - Business case for additional consultants has now been approved and is in the process of phased implementation. When partially recruited the risk can be lowered. When fully implemented the risk can be closed 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 Mar 2025	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
512	3404	31 May 2019	Karen Dawber	Carly Stott	Escalated from Division	People Quality & Patient Safety Academy	(Staffing) Maternity staffing issues due to long and short term sickness	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	31 Jan 2025	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2601		28 Jun 2024	John Kurian	Liz Kelley	Risk Assessment	Quality & Patient Safety Academy	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.	30 Nov 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	See risk assessment Architect redrawing options to include shell for 2nd lab, visit planned 17/10/24	31 Dec 2024	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2612		15 Jul 2024	Ray Smith	Jacob Mushlin	Risk Assessment	Quality & Patient Safety Academy People	Emergency Department (ED) Consultant review of pathology and radiology results	Consultants are allocated a 4 hour admin session per week to complete patient centred admin roles. This includes reviewing all radiology reports placed in the ED pool for review. The number of additional investigations has significantly increased since AECU came under the ED footprint with the medical teams requesting additional investigations under the ED Consultant name. IF we are overwhelmed with the number of results from pathology and radiology coming into the ED review pool THEN the significance of some results might get missed and there may be delays actioning the results. This will RESULT in potential harm to patients by missing results that may require further investigation or repeating and consequently missing potentially life-threatening conditions e.g cancers.	28 Feb 2025	15	(5) Catastrophic	(3) May recur occasionally	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	- Consultants are allocated admin time of 4 hours per week to complete such tasks. However, the task is becoming increasingly onerous given the volume of tests ordered. - Radiology will write "CRIT" next to results such as an obvious fracture. - Consultants try to prioritise reviewing and actioning the critical radiology reports. - Consultants are having to contact Inpatient teams or refer to specialty consultants to ensure patients are followed up appropriately. - Consultants are having to order additional diagnostic investigations and allocate to the ACU pool or VDW to follow up. - Staff advised to use 20-20-20 guidance.	03/10/2024 ACPs/trainees not yet able to assist in reviewing results. No admin support yet for remove results for patients already admitted to the Trust - expected date for completion revised to Nov 24 To explore whether specialty teams with patients in AECU can review all own investigations ordered through ED as part of the Outstanding programme in ED Early emerging ideas about whether a 'radiology liaison consultant' could look at unpicking issues relating to results in ED List of email contacts and pathways for use in ED to refer patients with abnormal results to the relevant MDT has been compiled and ED consultants have access to this - will continue to be added to Encouragement of regular breaks and looking after welfare whilst reviewing results has been discussed at ED and CSU governance. SOP required for this - completion date revised, now expected Nov 24 (new lead for this Jacob Mushlin) Expression of concern re volume of results in the pool to the UEIC tri-team and Exec team is ongoing (lead Jacob Mushlin) No further changes to controls since last update	28 Feb 2025	(5) Catastrophic	(3) May recur occasionally	15

2629		09 Aug 2024	Karen Dawber	Emma Clinton	Risk Assessment	Quality & Patient Safety Academy People	Violence and Aggression in Emergency Department	Violence and aggression continues to occur in ED resulting in a risk of harm to staff and patients both of physical and psychological harm. This will result in higher sickness/absence and reduced recruitment and retention. Incivility within a clinical setting has a significant adverse impact on staff performance and patient health outcomes. This also results in a poor patient experience and damage to the reputation of the Trust. There has been an increase in verbal abuse incidents in ED towards staff from patients and carers. The risk of abuse is directly correlated to longer waiting times, increased mental health presentations, misuse of substances including alcohol, and overcrowding. There is also a cohort of high intensity users with complex psychosocial needs that have no duty to be housed and seek refuge in ED and book in regularly as patients. There is currently no constant supervision of the waiting area by security or ED staff to identify escalating issues. This results in no intervention at a low level to prevent further escalation.	20 Dec 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	• Policy for withholding treatment form violent and abusive adult patients and behaviour letters sent to patients/carers that are verbally abusive. • High Intensity user group- to devise management plans alongside police, substance team, mental health, security, homeless team, voluntary sector including social prescribing. • Close working with Security management to gather evidence for Anti-Social Behaviour interventions by West Yorkshire Police and Criminal Behaviour Orders imposed by the courts. • Daily weekday MDT huddles to discuss all patients needing social and medical interventions. • Encouraging staff to report incidents via IRIS and report incidents to the police when necessary, with a view to pursuing prosecution and providing victim or witness statements. • Environment action plan to reduce incidents of violence and aggression. • Incident debriefs • Staff offered support services such as psychology and counselling after involvement in incidents	03/10/2024 BodyCams due to arrive w/c 07/10/24 Discussed at CSU tri-team risk meeting (02/10/24) it is too soon to downgrade this risk, not yet had time to review effectiveness of mitigation. Incidents of V&A on patients and staff still occurring. Increase in incidents reported, though this may reflect active encouragement to report V&A incidents. A thematic analysis of these incidents could be useful to better understand whether there has been a change - would need to be planned and resourced. To add to QIP plan for ED/CSU 1. Body worn cameras to be purchased- business case 2. Increased security presence in ED business case 3. De-escalation/Mental Health training for staff Trust wide 4. Environment action plan actions to be funded and completed	31 May 2025	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
56	3864	10 May 2023	Ben Roberts	Mike Page	Corporate Objective	Quality & Patient Safety Academy	Loss of Nuclear Medicine Capability Due to Ageing Equipment	hybrid imaging units old and unreliable- failures result in reportable to cqc incidents under irmer and poor patient experience and diagnostic quality	01 Dec 2024	10	(2) Minor	(5) Will undoubtedly recur, possibly frequently	6	(2) Minor	(3) May recur occasionally	Currently two cameras which can be each used. However both are aged. 23.10.24	Capital replacement of Gamma Camera Equipment	01 Mar 2025	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

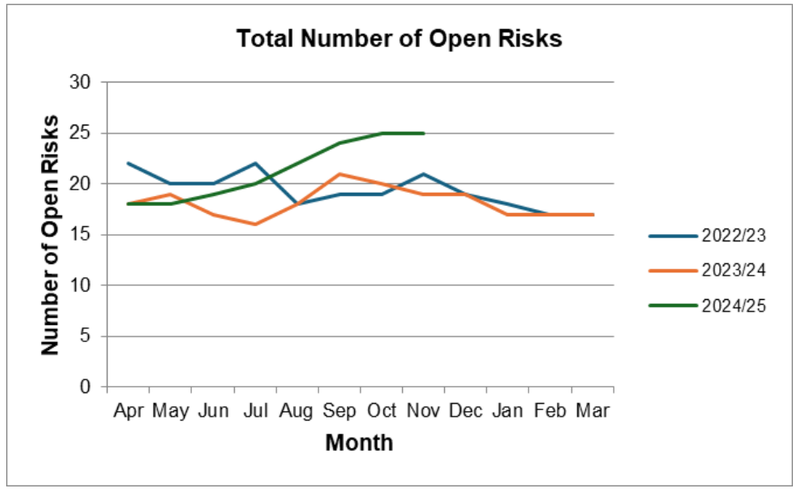
Bradford Teaching Hospitals
NHS Foundation Trust

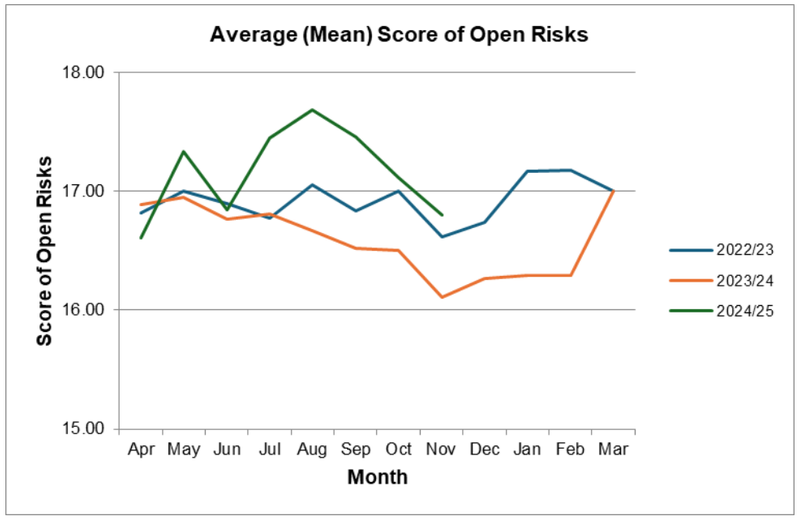
High Level Risks Report on a Page – November 2024

Total High Level Risks	25*
Aligned to F&PA	8
Aligned to QA	19
Aligned to PA	8
Aligned to Board	2

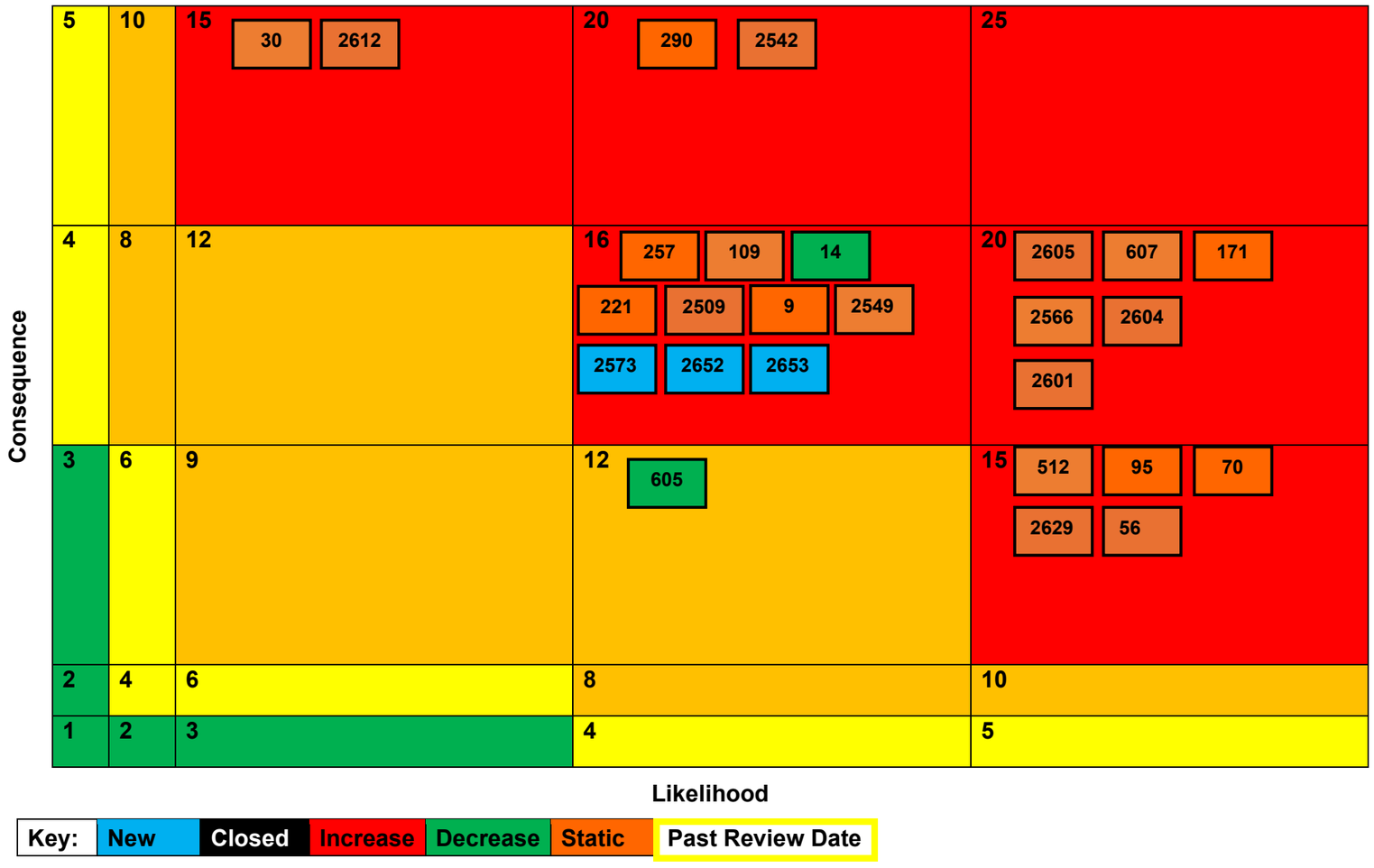
*Note some risks are aligned to more than one Academy

Movement of Risks	
New	3
Marked for closure	0
Risk score increased	0
Risk score static	21
Risk score decreased	2

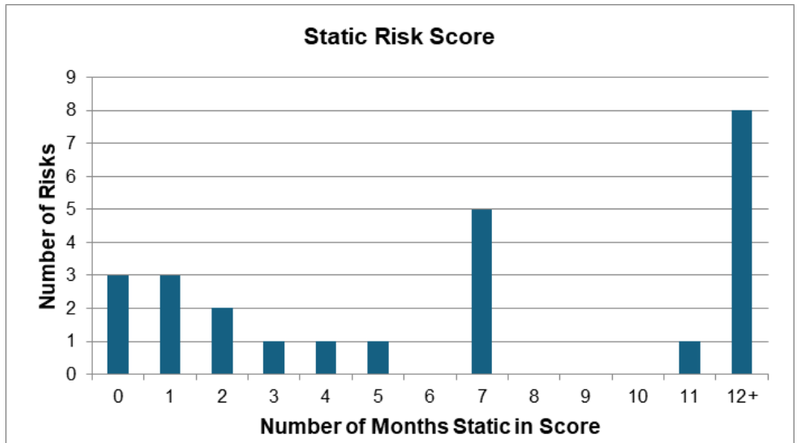


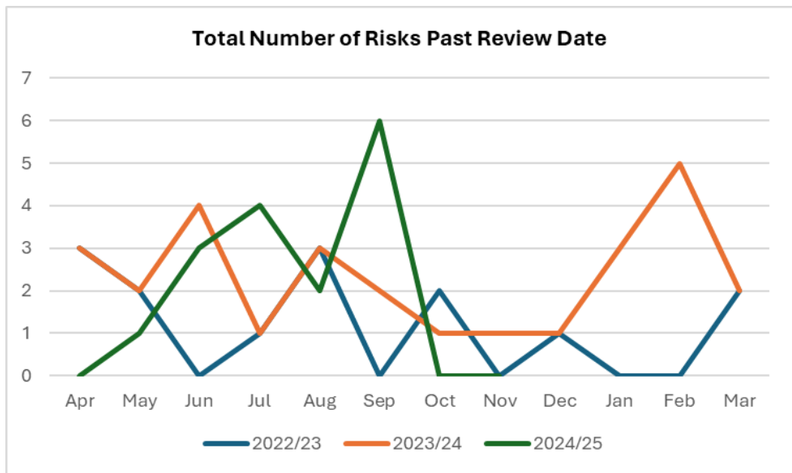


Risk Overview



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





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

IRIS ID	Legacy ID	Date of entry	Academy/ Committee	Current Score - November 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 & QC	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	06/12/2024	27/01/2025		
607	3309	26/11/2018	QC	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	31/03/2025									
290	3627	10/02/2021	QC	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025											
171	3748	15/02/2022	QC	20	3	31/01/2023	31/01/2024	30/09/2024	31/12/2024	31/03/2025										
14	3906	17/10/2023	Board	20	10	30/11/2023	31/03/2024	30/09/2024	31/03/2025											
30	3890	30/08/2023	QC	15	5	31/08/2024	31/05/2024	30/09/2024	31/12/2024	31/03/2025										
2549	N/A	05/04/2024	PA & QC	16	4	31/03/2025	31/05/2024	31/10/2024	31/03/2025											
2542	N/A	04/04/2024	F&P & QC	20	1	11/06/2024	05/08/2024	19/11/2024	19/12/2024											
95	3824	14/12/2022	PA & QC	15	6	28/02/2024	31/08/2024	31/10/2024	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	QC	16	9	01/04/2024	27/12/2025													
9	3911	10/11/2023	Board	16	8	30/09/2024	31/03/2025													
2566	N/A	12/04/2024	QC	16	12	30/11/2024														
2604	N/A	04/07/2024	C	20	9	01/10/2024	30/06/2025													
2605	N/A	08/07/2024	QC	20	8	24/06/2024	31/03/2025													
2601	N/A	28/06/2024	QC	15	8	31/12/2024														
56	3864	10/05/2023	QC	15	6	01/03/2025														
2629	N/A	09/08/2024	PA & QC	15	6	31/05/2025														
2612		15/07/2024	PA & QC	15	6	30/09/2024	03/12/2024	28/02/2025												
2573		24/04/2024	F&P	16	12	31/03/2025														
2652		11/10/2024	F&P	16	8	31/03/2025														
2653		16/10/2024	QC	16	4	30/06/2025														

Key:

Target mitigation date changed since last report

Past the target mitigation date

BO.11.24.22 - CONSTITUTION AMENDMENTS

REFERENCES

Only PDFs are attached

- Bo.11.24.22 - Constitution Amendments (Cover).pdf
- Bo.11.24.22 - Appendix 1 - Make up of the Council of Governors.pdf
- Bo.11.24.22 - Apendix 2 - BTHFT Constitution - October 2024 DRAFT.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.22

Constitution amendments

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Katie Shepherd, Corporate Govenrance Manager	
Lead Director	Renee Bullock, Chief People and Purpose Officer	
Purpose of the paper	To propose revisions to the Constitution following review by the Constitution Task and Finish Group.	
Key control	N/A	
Action required	For approval	
Previously discussed at/ informed by	• Constitution Task and Finish Group held 1 October and 8 October 2024 • Council of Governors held 17 October 2024	
Previously approved at:		**Date**
	Council of Governors	17 October 2024

Key Options, Issues and Risks

At the Council of Governors meeting on 18 July 2024, the Council agreed to support the establishment of a Constitution review task and finish group. The Group comprised the following members:

- Sarah Jones, Chair
- David Wilmshurst, Governor
- Farideh Javid, Governor
- Dermot Bolton, Governor
- John Waterhouse, Governor
- Karen Walker, NED
- Sajid Azeb, Chief Operating Officer/Deputy Chief Executive

Laura Parsons, Associate Director of Corporate Governance/Board Secretary and other members of the Corporate Governance team were in attendance to provide support and guidance to the task and finish group.

The group met twice; on 1 October 2024 and 8 October 2024. Two key questions were considered, increasing the number of Governors and any other key changes to the Constitution.

1. Increasing the number of Governors on our Council

Increase in staff governors

The task and finish group considered and supported a proposal to increase the staff governor cohort by two to ensure better representation for our staff groups. Namely, an additional staff governor to represent the 'All other staff group' and an additional staff governor to represent our 'Nursing and midwifery staff group'.

Included at **Appendix 1** is the supporting information considered by the task and finish group which includes our current Council of Governors make-up along with the additional detailed information on the make-up of our staff membership cohorts.

To support the recommendation regarding the increase of staff governors, the task and finish group consulted with the four current staff governors and, our staff side representatives. All were in favour of the increases proposed.

Increase in partner governors

The task and finish group also considered and supported a proposal to increase the number of our partner governors to better represent the Trust's communities. In addition to our partner governors from Bradford University, Leeds University and Bradford Metropolitan District Council, the task and finish group determined that benefits would be had from the inclusion of representatives on our Council from Healthwatch Bradford and District, and from an organistion involved with mental health, learning disabilities and autism, which is not currently represented on the Council.

Representation for our younger population

As Bradford is the youngest city in the UK, the task and finish group considered how the younger members of the Trust's communities could be better represented. The group considered the addition of a 'young person membership constituency', however the membership figures were too low to sustain an additional membership constituency group solely for young people (aged 16 to 25).

As an alternative, the group was informed of an initiative implemented by Calderdale and Huddersfield NHS Foundation Trust (CHT) whereby two 'Associate Youth Governors' have been appointed, both of whom are patients at CHT. These are non voting roles, but are able to attend Council meetings and take part in discussions. The group was supportive of implementing this at BTHFT. We would also continue to seek to grow the number of members between the ages of 16-25, with the support of the Associate Youth Governors.

2. Further key changes considered

Removal of Vice Chair role

The Vice Chair role is not common practice and BTHFT is the only Trust in West Yorkshire ICB with this role. Usual practice is for the Deputy Chair to deputise for the Trust Chair (including at COG meetings), and this is the case at the other Foundation Trusts in West Yorkshire ICB.

Therefore it is proposed that the Vice Chair role is removed and that the Deputy Chair deputises at COG meetings in the absence of the Chair.

The task and finish group supported this proposal, noting that this was to ensure that the Trust was working in line with common practice at other trusts and also supports the premise that the Chair provides a link between the Council and the Board. The group noted that the informal support and co-ordination role provided by the Vice Chair has been very much valued by governors and the removal of the role from the Constitution does not impact on this.

Declaration of political affiliations

The group noted that there is currently only a requirement for governors to declare a policial affiliation at election, rather than during their tenure as a governor. The group supported a proposal to include a requirement to declare political affiliations within the Conflicts of Interest policy, and this will apply to governors, NEDs and employees of the Trust.

Scheduling of governor elections

The group considered a proposal to include reference to the scheduling of elections and that this wold be in line with NHS Providers guidance, in relation to avoiding local and general elections. It was noted that there was not an appropriate place to include this in the Constitution, however we will ensure that

elections take place at appropriate times in future so that there are no clashes with local elections, or general elections wherever possible.

List of all proposed amendments

All proposed amendments to the Constitution are listed in the table below.

Section:	Current Wording:	Proposed Wording:
Throughout	Chairman	Chair
Throughout	-	Correction to typographical / grammatical errors
1	Other Partnership Governor	Partner Governor
1	-	Addition of definition: Lead Governor - means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England);
5.3.1	-	Addition of wording: The minimum number of members in each class of the staff constituencies is specified in Annex 2.
6.1.2	1 being elected by the registered Nurses and Midwives Class 1 being elected by the All Other Staff Class	2 being elected by the registered Nurses and Midwives Class 2 being elected by the All Other Staff Class
6.1.2	4 Staff Governors	6 Staff Governors
6.1.2	-	Addition of: (f) 2 Partner Governors
6.8	-	Addition of: 6.8 Partner Governors 6.8.1 Healthwatch Bradford and District and a Mental Health, Learning Disabilities and Autism representative organisation (to be determined by the Trust) shall each appoint one Partner Governor.
6.16.1	6.16.1 The Chairman of the Foundation Trust or, in their absence, the Vice Chair, appointed under paragraph 6.16.2, is to preside at meetings of the Council of Governors.	6.17.1 The Chairman of the Foundation Trust or, in their absence, the Deputy Chair of the Board is to preside at meetings of the Council of Governors.
6.16.2	The Council of Governors shall appoint from the public or patient Governors a Vice Chair who shall preside at meetings of the Council of Goernors in the absence of the Chair or when the Council of Govenors is considering matters relating to the Non Executive Directors or the Board of Directors. The appointment of the Vice Chair shall be by majority vote at a general meeting.	Removed.
Annex 2	-	Addition of Annex 2: Staff Constituencies of the Foundation Trust
Annex 3	-	Addition of Annex 3: Local Authority, University and Partner Governors of the Foundation Trust
Annex 4	Was previously Annex 2 Model Election Rules 2014.	Now listed as Annex 4 Model Election Rules.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.22

The revised Constitution, including tracked changes is attached at **Appendix 2.** The Board is asked to note there are no changes proposed to the 'model election rules' listed at 'Annex 4' on the contents list. As such they are not included for review as part of **Appendix 2**.

Council of Governors meeting held 17 October 2024

The Council of Governors approved the proposed amendments to the Constitution at their meeting held on 17 October 2024.

Recommendation

Amendments to the Constitution require the approval of both the Council of Governors and the Board of Directors. Further to the approval of the Council of Governors the proposed amendments are now presented to the Board of Directors for approval.

The Board of Directors is asked to approve the following proposed amendments to the Trust Constitution:

- Increase the staff governor constituencies from 4 to 6, so that there are two representatives from the Nursing and Midwifery staff class and two representatives from the All Other Staff class;
- The addition of a Partner Governor Healthwatch;
- Addition of Partner Governor to represent mental health, learning disabilities and autism;
- Removal of the Vice Chair role;
- All other amends presented in the table above.

The Board of Directors is also asked to support the appointment of two (non voting) Associate Youth Governors to the Council.

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	28 November 2024	Agenda item	Bo.11.24.22

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

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

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

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

Appendix 1:

Current make-up of our Council of Governors

Patient - (Out of Bradford)	Elected
Patient - (Out of Bradford)	Elected
Public - Bradford East	Elected
Public - Bradford East	Elected
Public - Bradford South	Elected
Public - Bradford South	Elected
Public - Bradford West	Elected
Public - Bradford West	Elected
Public - Keighley	Elected
Public - Keighley	Elected
Public - Rest of England and Wales	Elected
Public - Shipley	Elected
Public - Shipley	Elected
Staff – Allied Health Professionals and Scientists (AHP&S)	Elected
Staff - All other staff groups (Admin & Clerical, Estates and Facilities and Additional Clinical Services)	Elected
Staff - Medical and Dental	Elected
Staff - Nursing & Midwifery	Elected
Partner Governor - BMDC	Appointed
Partner Governor - University of Bradford	Appointed
Partner Governor - University of Leeds	Appointed

Staff Governors

The percentage of membership within each of the staff membership groups is included in the table below.

The staff figures represent permanent FTE (full time equivalent) staff.

Staff Constituency - membership groups			Totals	
'All Other Staff Groups'			**3,032.76**	**47%**
	Estates and Ancillary	454.1	15%	
	Additional Clinical Services	1,093.79	36%	
	Admin & Clerical	1,484.87	49%	
Allied Health Professionals and Scientists (AHP&S)			**700.68**	**11%**
	Add Prof Scientific & Technic	154.68	22%	
	Allied Health Professionals	438.89	63%	
	Healthcare Scientists	107.11	15%	
Medical and Dental			**898.87**	**14%**
	Medical & Dental	898.87	100%	
Nursing and Midwifery			**1,821.18**	**28%**
	Nursing & Midwifery Registered	1,821.18	100%	
	Total permanent staff		6,453.49	

End

Bradford Teaching Hospitals
NHS Foundation Trust

Constitution

Approved by Council of Governors: 17 October 2024
Approved by the Board of Directors: ~~18th January 2024~~

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BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

Unless the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the National Health Service Act 2006 (as amended).

References in this Constitution to legislation include all amendments, replacements, or re-enactments made.

1. DEFINITIONS

In this Constitution:-

"the 2006 Act"	means the NHS Act 2006 (as amended);
"Annual Members Meeting"	means the Annual Meeting of Members open to members of the public;
"Area of the Foundation Trust"	means the area, consisting of all the areas, specified in Annex 1, as an area for a public constituency;
"Board of Directors"	means the Board of Directors as constituted in accordance with this Constitution;
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution;
"Director"	means a member of the Board of Directors;
"Financial year"	means- (a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31st March; and (b) each successive period of twelve months beginning with 1st April;
"Governor"	means a member of the Council of Governors;
"Lead Governor"	means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England);

“Local Authority Governor”	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area of the Foundation Trust~~.~~;
"Member"	means a member of the Foundation Trust;
“Non-Executive Director”	means the Non-Executive Directors of the Board of Directors including the Chair;
~~“Other Partnership Governor”~~	~~means a member of the Council of Governors appointed by a partnership organisation other than a local authority or university providing a medical or dental school to the Foundation Trust;~~
“Patient”	means an individual who has attended any of the Foundation Trust’s hospitals or clinics, whether NHS or private, at any time;
“Carer”	means an individual who has attended any of the Foundation Trust’s hospitals or clinics as a carer of a patient other than an individual providing care in pursuance of a contract (including a contract of employment), or as a volunteer for a voluntary organization;
“Partner Governor”	means a member of the Council of Governors appointed by a Partner Organisation specified in Annex 3~~.~~;
“Patient Governor”	means a member of the Council of Governors elected by the members of the Patient Constituency;
“Public Governor”	means a member of the Council of Governors elected by the members of the Public Constituency;
"Secretary"	means the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary of the Foundation Trust;
“Staff Governor”	means a member of the Council of Governors elected by the members of a Staff Class;
“Standing Orders”	means the Standing Orders of the Foundation Trust;

“the Foundation Trust”	means Bradford Teaching Hospitals NHS Foundation Trust;
“University Governor”	means a member of the Council of Governors appointed by a University providing medical or dental hospital or professional training to the Foundation Trust.

2 NAME

2.1 The name of the Foundation Trust is "Bradford Teaching Hospitals NHS Foundation Trust”.

3 PRINCIPAL PURPOSE

3.1 The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Foundation Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Foundation Trust may provide goods and services for any purposes related to –

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 Subject to paragraph 15 the Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

4 POWERS

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5 MEMBERS

5.1 **Constituencies**

The Foundation Trust is to have members, each of whom shall be a member of one of the membership Constituencies, namely -

(a) The “Public Constituencies”,

(b) a “Staff Constituency” and,

(c) a “Patients’ Constituency”.

5.2 **Public Constituency**

5.2.1 The Public Constituencies are to be known by the names listed in column 1 of Annex 1.

5.2.2 Members of the Foundation Trust who are members of the Public Constituency listed in column 1 of Annex 1 are to be individuals:

(a) who are at least 16 years old and live in the area specified for that Constituency in the corresponding entry in column 2 of that Annex; and

(b) who are not eligible to become a member of the Staff Constituency and are not members of any other constituency or are otherwise disqualified from membership under paragraph 5.5; and

(c) who have made an application for membership to the Foundation Trust. Membership is potentially available to all these individuals, and the Foundation Trust is to use its best endeavours to ensure that, taken as a whole, the actual membership of the Foundation Trust’s Public Constituencies that fall within the Bradford Metropolitan District Council area is representative of those eligible for membership.

5.2.3 The minimum number of members required for each Public Constituency is to be the number given in column three of Annex 1.

5.3 **Staff Constituency**

5.3.1 The staff constituency shall be divided into four classes of individuals as follows:

a) Medical and Dental practitioners staff class;

b) Nurses and Midwives staff class

c) Allied Health Professionals and Scientists class

d) All Other Staff Class

The minimum number of members in each class of the staff constituencies is specified in Annex 2.

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5.3.2 The members of the Medical and Dental Staff Class are individuals who are members of the Staff Constituency who are fully registered within the meaning of the Medicines Act 1956.

5.3.3 The members of the Nurses and Midwives Staff Class are individuals who are members of the Staff Constituency who are registered Nurses or registered Midwives.

5.3.4 The members of the Allied Health Professionals and Scientists Staff Class are members of the Staff Constituency whose regulatory body falls within the remit of the Council for the Regulation of Health Care Professionals established by section 25 of the NHS Reform and Health Care Professionals Act 2002, except that they are not registered Nurses or Midwives

5.3.5 The members of the All Other Staff Class are members of the Staff Constituency who do not come within paragraphs 5.3.2 to 5.3.4 above.

5.3.6 Members of the Foundation Trust who are members of the Staff Constituency are to be individuals who:

a) are employed under a permanent contract of employment by the Foundation Trust; or

b) are individuals who are not so employed but who nevertheless exercise functions for the purposes of the Foundation Trust; and

c) who satisfy the minimum duration requirements set out in paragraph 3 of Schedule 7 to the 2006 Act; and

d) have made an application for membership of the Foundation Trust; or

e) on appointment shall become a member of the appropriate class within the Staff Constituency without an application being made, unless they inform the Foundation Trust that they do not wish to become a member.

5.3.7 The minimum number of members of each Staff class is to be 100.

5.3.8 A person who is eligible to be a member of the Staff Constituency may not become or continue to be a member of any Constituency other than the Staff Constituency and may not become or continue

to be a member of more than one Staff class.

5.4 **Patients Constituency**

5.4.1 The members of the Foundation Trust who are members of the Patient Constituency are individuals:

a) who are at least 16 years old and have attended any of the Foundation Trust's hospitals or clinics as a patient (as defined within this Constitution), or

b) the carer of a Patient as identified in 5.4.1 a);

c) is not eligible to become a member of the Staff Constituency and are not members of any other Constituency and are not otherwise disqualified from membership, and has a postcode outside of the BMDC area; and

d) has made an application for membership of the Foundation Trust.

5.4.2 The minimum number of members required for the Patients' Constituency is to be 100.

5.5 **Disqualification for Membership**

5.5.1 A person may not be a member of the Foundation Trust ;

(a) Unless they are of 16 years of age or over.

(b) If they have demonstrated aggressive or violent behaviour towards Foundation Trust staff, that is, if a Warning Letter has been issued to them under Stage 3 of the Foundation Trust's Policy for Withholding Treatment from Violent and Abusive Patients, a final Written Warning has been issued under Stage 4, or, they have been asked to leave, have been removed or excluded from the Foundation Trust's premises under the Policy.

5.5.2 It is the responsibility of the member to ensure their eligibility and not the Foundation Trust, but where the Foundation Trust is on notice that a member may be disqualified from membership, the Secretary shall carry out all reasonable enquiries to establish if this is the case.

5.6 **Termination of Membership**

5.6.1 A member shall cease to be a member if they:-

(a) Resign by notice to the Secretary

(b) Cease to fulfil the requirements of paragraphs 5.2, 5.3 or 5.4

(c) Become disqualified from membership by reason of paragraph 5.5.1(b)

5.7 **Voting at Governor Elections**

5.7.1 A person may not vote at an election for a Public or Patient Governor unless within the specified period they have made a declaration in the specified form stating the particulars of their qualification to vote as a member of the Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in any material particular.

5.8 **Annual Members' Meeting**

5.8.1 The Foundation Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

5.8.2 The following documents shall be presented to the members of the Foundation Trust at the Annual Members Meeting by at least one member of the Board of Directors:

a) the Annual Accounts;

b) any report of the External Auditor on the Annual Accounts; and

c) the Annual Report

The Foundation Trust may combine a meeting of the Council of Governors convened for the purposes of being presented with the above documents with the Annual Members' Meeting.

5.8.3 In accordance with paragraph 18 of this Constitution where an amendment has been made to the Constitution in relation to the powers or duties of the Council of Governors, members must be given the opportunity to vote at the Annual Member's' Meeting on whether they approve the amendment.

6 COUNCIL OF GOVERNORS

6.1 **Composition of the Council of Governors**

6.1.1 The Foundation Trust shall have a Council of Governors. It shall consist of Public Governors, Staff Governors, Patient Governors, University Governors, Local Authority Governors and other

Partner~~ship~~ Governors.

6.1.2 The Council of Governors shall include:

(a) 11 Public Governors

(b) 2 Patient Governors

(c) ~~4~~ 6 Staff Governors

(i) 1 being elected by the Medical and Dental Practitioners Class
(ii) ~~1~~ 2 being elected by the registered Nurses and Midwives Class
(iii) 1 being elected by the Allied Health Professionals and Scientists Class
(iv) ~~1~~ 2 being elected by the All Other Staff Class

(d) 1 Local Authority Governor

(e) 2 University Governors

~~(e)~~(f) 2 Partner Governors

6.1.3 The aggregate number of members of Public Governors and Patient Governors is to be more than half the total membership of the Council of Governors.

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6.2 **Public Governors**

6.2.1 Members of a Public Constituency may elect any of their number to be a Public Governor from within their constituency according to the Election Scheme.

6.2.2 If contested, the election will be by secret ballot.

6.2.3 The Election Scheme, including the process for ratifying Governors if the election is uncontested, is set out in ~~Annex 2~~Annex 4.

6.2.4 A person may not stand for election to the Council of Governors as a Public Governor unless they have made a declaration in the form specified in ~~Annex 2~~Annex 4 of their qualification to vote as a member for the Public Constituency for which the election is being held and is not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or paragraph 6.1~~10~~ below. It is an offence to knowingly or recklessly make a declaration under paragraph 60 of the 2006 Act which is false in a material particular.

6.2.5 Paragraph 5.7.1 (voting at Governor elections) applies.

6.3 **Patient Governors**

6.3.1 Members of the Patient Constituency may elect any of their number to be a Patient Governor.

6.3.2 If contested the election must be by secret ballot.

6.3.3 The election scheme is set out in ~~Annex 2~~Annex 4

6.3.4 A person may not stand for election to the Council of Governors as a Patient Governor unless within the period specified in ~~Annex 2~~Annex 4 they have made a declaration in the form specified in ~~Annex 2~~Annex 4 of the particulars of their qualification to vote as a member of the Patients' Constituency and is not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or paragraph 7.10 below. It is an offence to knowingly or recklessly make a declaration under paragraph 60 of the 2006 Act which is false in a material particular.

6.3.5 Paragraph 5.7.1 (voting at Governor elections) applies.

6.4 **Staff Governors**

6.4.1 Members of a Class of the Staff Constituency may elect any of their number to be a Staff Governor from within that Class.

6.4.2 If contested, the election will be by secret ballot.

6.4.3 The Election Scheme is set out in ~~Annex 2~~Annex 4

6.5 **Role of Local Authority, University and Partner~~ship~~ Governors**

6.5.1 Subject to the overriding principle that the Governors' first responsibility is to the Council of Governors and the Trust the role of Governors appointed as Local Authority Governors, University Governors and other Partner~~ship~~ Governors shall in addition to their general responsibilities as Governors be:

a) to speak with authority for the organisation they represent and be able to explain its policies;

b) to support the role of the Council of Governors as set out in paragraph 6.13~~2~~;

c) to represent the Foundation Trust to the organisation they represent.

6.5.2 The appointment of Local Authority Governors, University Governors and other Partner~~ship~~ Governors shall be in accordance with a process agreed with the Secretary of the Foundation Trust.

6.6 **University Governors**

6.6.1 The University of Leeds and the University of Bradford shall each appoint a University Governor.

6.7 **Local Authority Governors**

6.7.1 The Bradford Metropolitan District Council shall appoint one Local Authority Governor.

6.8 **Partner Governors**

6.8.1 Healthwatch Bradford and District and a Mental Health, Learning Disabilities and Autism representative organisation (to be determined by the Trust) shall each appoint one Partner Governor.

~~6.8~~6.9 **Terms of Office**

~~6.8.1~~6.9.1 Public Governors, Staff Governors and Patient Governors;

(a) may hold office for a period of three years

(b) are eligible for re-election at the end of that period; and

(c) may not hold office for longer than nine consecutive years.

~~6.8.2~~6.9.2 Local Authority Governors;

(a) may hold office for a period of three years

(b) are eligible for reappointment at the end of that period; and

(c) may not hold office for longer than nine consecutive years.

~~6.8.3~~6.9.3 University Governors;

(a) may hold office for a period of three years;

(b) are eligible for reappointment at the end of that period; and

(c) may not hold office for longer than nine consecutive years.

~~6.8.4~~6.9.4 Other Partner~~ship~~ Governors;

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(a) may hold office for a period of three years;

(b) are eligible for reappointment at the end of that period; and

(c) may not hold office for longer than nine consecutive years.

~~6.9~~6.10 **Termination of tenure**

~~6.9.1~~6.10.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary.

~~6.9.2~~6.10.2 If the Governor fails to attend two consecutive meetings of the Council of Governors their tenure of office is to be terminated one month following the second meeting unless in the meantime they have satisfied the Chair that:

a) the absence was due to a reasonable cause; and

b) they will be able to start attending meetings of the Council of Governors again within such a period as the Chair considers reasonable.

~~6.9.3~~6.10.3 If the Governor fails to attend a training session for Governors as recommended by the Secretary and approved by the Council of Governors by a date six months from the date of the Governor's election or appointment then their tenure in office is to be terminated six weeks from the said date unless in the meantime they have satisfied the Chair that:

a) the absence was due to a reasonable cause; and

b) they will be able to attend a training session within such a period as the Chair considers reasonable.

~~6.10~~6.11 **Disqualification and Removal of a Governor**

~~6.10.1~~6.11.1 A person may not become or continue as a Governor of the Foundation Trust if:

a) In the case of a Patient Governor, Staff Governor or Public Governor, they cease to be a member of the Constituency they represent;

b) in the case of a University Governor, Local Authority Governor or other Partner~~ship~~ Governor, the appointing organisation withdraws their appointment of them;

c) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

d) they are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

e) they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

f) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

g) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

h) they are a person whose tenure of office as the Chair~~man~~ or as a member or Director of a Health Service body has been terminated on the grounds that their appointment is not in the interests of the Health Service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

i) they are an Executive or Non-Executive Director of the Foundation Trust, or a Governor, Non-Executive Director, Chair, Chief Executive Officer of another NHS Foundation Trust;

j) they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs~~.~~; or

k) they have failed to declare an interest as required by this Constitution or Standing Orders or, have spoken or voted at a meeting on a matter in which they have an interest contrary to this Constitution or Standing Orders, and in this Paragraph interest includes a pecuniary and a non- pecuniary interest in either case whether direct or indirect.

~~6.10.2~~6.11.2 Where a person has been elected or appointed to be a Governor and they become disqualified under paragraph 6.1~~0~~1.1 to hold that office, they shall immediately notify the Secretary in writing of such disqualification and upon giving such notice that Governor's term of office, if any, shall terminate and they shall cease to act as a Governor.

~~6.10.3~~6.11.3 If it comes to the notice of the Secretary that a person elected or appointed to be a Governor may be disqualified under

Paragraph 6.1~~10~~.1 to hold that office and the Secretary has not received a notice under Paragraph 6.1~~10~~.2 from that person, the Secretary shall make such enquiries as they think fit and, if satisfied that the person may be so disqualified, the Secretary shall give notice in writing to that person that the Foundation Trust proposes to declare the person disqualified as a Governor. In this notice, the Secretary shall specify the grounds on which it appears to them that the person is disqualified and give that person a period of at least 14 but no more than 28 days in which to make representations, orally or in writing, on the proposed disqualification. Any representations shall be to, and considered by, a committee of the Directors which in this case shall determine the proposal. If no representations are received within the specified time or the committee of Directors upholds the proposal to disqualify having heard representations, the Secretary shall immediately declare that the person in question is disqualified and notify them in writing to that effect. On such declaration the person's tenure of office shall be terminated and they shall cease to act as a Governor.

~~6.10.4~~6.11.4 At the commencement of their term of office a Governor shall sign the 'Governor's Code of Conduct' as agreed by the Council of Governors. A Governor may be subject to removal from office for non-compliance with the 'Governor's Code of Conduct'. The process to be undertaken is specified with the 'Governor's Code of Conduct'.

~~6.11~~6.12 **Vacancies**

~~6.11.1~~6.12.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

~~6.11.2~~6.12.2 Where the vacancy arises amongst appointed Governors, the Secretary shall request that the appointing organisation appoint a replacement to hold office for the remainder of the term of office.

~~6.11.3~~6.12.3 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

a) to call an election within three months, provided that the period of the vacancy exceeds three months; or

b) to invite the next highest polling Candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next scheduled election, at which time the seat will become vacant and subject to election.

c) If no-one is available under 6.1~~2~~1.3 (b) and the vacancy is for

three months or less the seat will remain vacant until the next scheduled election.

~~6.12~~6.13 Duties and Responsibilities of Governors

~~6.12.1~~6.13.1 The general duties of the Council of Governors are to: –

a) ~~to h~~Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors~~,~~; and

b) ~~to r~~Represent the interests of the members of the Foundation Trust as a whole and the interests of the public.

~~6.12.2~~6.13.2 The roles and responsibilities of the Council of Governors are to:

a) Represent the views of their respective members and organisations to the Trust, in order that the Foundation Trust may undertake its business in ways consistent with the needs of its members and the wider community, and to represent the views of the Foundation Trust to their members and organisations in a reciprocal manner.

b) Appoint or dismiss the Chair and the other Non-Executive Directors and to decide their remuneration, allowances and other Terms and Conditions of their offices. The removal of the Chair or a Non-Executive Director requires a motion in accordance with Standing Orders approved by three-quarters of the Governors.

c) Approve (by a majority vote) the appointment (by the Non-Executive Directors) of the Chief Executive.

d) Appoint or remove the Foundation Trust's External Auditor.

e) Give the views of the Council of Governors to the Board of Directors for the purposes of their preparation by the Board of Directors of the document containing the information as to the Foundation Trust's forward planning in respect of each financial year to be given to the Integrated Care Board (ICB) and NHS England (NHSE).

f) Respond appropriately when consulted by the Board of Directors in accordance with this Constitution.

g) Consider and receive the Annual Accounts, any report by the External Auditor on them and the Annual Report.

h) Receive and consider the views of the members on matters

of significance to the future plans of the Foundation Trust.

6.12.36.13.3 The Foundation Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

6.136.14 **Declaration of Interests**

6.13.16.14.1 A Governor must declare to the Secretary:

a) any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Foundation Trust;~~,~~

b) any interests which are relevant and material to the business of the Foundation Trust;~~,~~

c) any other interest as set out in the Standing Orders;~~,~~ and

d) any other interest as set out in the 'Conflicts of Interest Policy for Bradford Teaching Hospitals NHS Foundation Trust'.

6.13.26.14.2 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared in accordance with this Constitution or Standing Orders and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within 28 days of becoming aware of the existence of an ~~relevant or material~~ interest. In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if they have declared a pecuniary interest, they shall not take part in the consideration or discussion of the matter. This Paragraph applies to any Committee or Sub-Committee of the Council of Governors as it applies to the Council of Governors and applies to any member of any such Committee or Sub-Committee (whether or not they are also a Governor) as it applies to a Governor. The provisions of this Paragraph are subject to Paragraph 6.1~~43~~.7.

6.13.36.14.3 "relevant and material" interests are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership or Directorships of private companies, businesses or consultancies likely or possibly

seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of Health and Social Care;

e) Any connection with a voluntary or other organisation contracting for or commissioning NHS services; and

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Foundation Trust, including but not limited to, lenders or banks.

~~6.13.4~~6.14.4 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

~~6.13.5~~6.14.5 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

b) they are a partner of, or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

~~6.13.6~~6.14.6 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person with which they are connected as mentioned in paragraphs 6.14~~3~~.3 and 6.14~~3~~.5 which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

~~6.13.7~~6.14.7 Where a Governor:

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

The Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

~~6.13.8~~6.14.8 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of this Constitution to be also an interest of the other.

~~6.13.9~~6.14.9 If, during the course of a meeting of the Council of Governors, a conflict of interest is established, the Governor concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. If there is a dispute as to whether a conflict of interest exists, the majority of the Governors present at the meeting shall resolve the issue, with the Chair having a casting vote.

~~6.14~~6.15 **Expenses**

~~6.14.1~~6.15.1 The Foundation Trust may pay travelling and other expenses to Governors at such rates as it decides. These are to be published in the Annual Report.

~~6.15~~6.16 **Remuneration**

~~6.15.1~~6.16.1 Governors are not to receive remuneration.

~~6.16~~6.17 **Meetings**

~~6.16.1~~6.17.1 The Chair~~man~~ of the Foundation Trust or, in their absence, the ~~Vice~~ Deputy Chair of the Board~~, appointed under paragraph 6.16.2,~~ is to preside at meetings of the Council of Governors.

~~6.16.2 The Council of Governors shall appoint from the public or patient Governors a Vice Chair who shall preside at meetings of the~~

~~Council of Governors in the absence of the Chair or when the Council of Governors is considering matters relating to the Non-Executive Directors or the Board of Directors. The appointment of the Vice Chair shall be by majority vote at a general meeting.~~

~~6.16.3~~6.17.2 Meetings of the Council of Governors are to be open to members of the public except in the following circumstances:

a) The Council of Governors may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest or the interest of the Foundation Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or the proceedings.

b) Without prejudice to the generality of (a) above, the Council of Governors may treat the need to consider the following matters as of a confidential nature:

- approval of the appointment or dismissal of the Chief Executive;
- any disciplinary or other matter arising from a contract of employment with the Foundation Trust;
- any matter which involves the consideration of information held by the Foundation Trust in confidence, whether that confidentiality covers clinical, commercial or other information;
- commercial matters where publication may be to the detriment of the Foundation Trust;
- legal advice; and~~,~~
- litigation actual or anticipated, including any arbitration or dispute resolution process or any matter of a litigious nature whether in a Court, Tribunal or Inquiry.

c) Without prejudice to the generality of (a) above and without regard to the subject or purport of the recommendation or advice, the Council of Governors may treat as a special reason the need to receive or consider recommendations or advice from sources other than a Director, or the Board of Directors, or the Council of Governors Nominations and Remuneration Committee in accordance with paragraph 7.1.4 to 7.1.7 of this Constitution.

~~6.16.4~~6.17.3 The Council of Governors will meet at least 5 times per year inclusive of the Annual General Meeting.

~~6.16.5~~6.17.4 At a general meeting in September of each year or on such other date approved by the Chair, the Council of Governors are to

receive and consider the Annual Accounts, any report of the Auditor on them, and the Annual Report. These documents shall be presented by at least one member of the Board of Directors. This meeting may be combined with the Annual Members' Meeting as set out in paragraph 5.8.

~~6.16.6~~6.17.5 The Council of Governors shall adopt its own Standing Orders for its practice and procedure.

~~6.16.7~~6.17.6 The proceedings of a Meeting of the Governors shall not be invalidated by any vacancy in its membership.

~~6.16.8~~6.17.7 A Governor elected to the Council of Governors by a Public Constituency, the Patients' Constituency or a Class of the Staff Constituency may not vote at a meeting of the Council unless, immediately prior to the commencement of each meeting, they have made a declaration in a form as determined by the Secretary stating which Constituency or Class they are a member of and is not prevented from being a member of the Council of Governors by paragraph 9 of Schedule 7 to the 2006 Act or under this Constitution.

~~6.16.9~~6.17.8 The Council of Governors may require one or more of the Directors to attend a meeting for the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance).

7 BOARD OF DIRECTORS

7.1 Composition of the Board of Directors

7.1.1 The Foundation Trust is to have a Board of Directors. It is to consist of Executive and Non-Executive Directors

7.1.2 The Board is to include–

(a) The following Non-Executive Directors-

(i) a Chair
(ii) a Non-Executive Director appointed by the Leeds Medical School, and may include a Non-Executive Director appointed by the University of Bradford, such appointments being subject to approval of the Council of Governors at a general meeting,
(iii) at least 5 other Non-Executive Directors

(b) The following Executive Directors –

(i) a Chief Executive (and Accounting Officer),
(ii) a Finance Director,
(iii) a Medical Leader, who must be a registered Medical or Dental practitioner (within the meaning of the Dentists Act 1984),
(iv) a Chief Nurse, who must be a registered Nurse or registered Midwife,
v) a Chief Operating Officer, and
vi) a Director of Strategy and Transformation.

7.1.3 Only a member of the Public or the Patients' Constituency, or an individual exercising functions for the Leeds Medical School, or the University of Bradford, is eligible for appointment as a Non-Executive Director.

7.1.4 All current Directors and future appointments must clearly satisfy and continue to meet the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation.

7.1.5 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Foundation Trust and the other Non-Executive Directors in accordance with the Governors Standing Orders.

7.1.6 Further provisions for the appointment of the Chair and the other Non-Executive Directors and the role of the Council of Governors in the said appointments are set out in the Terms of Reference of the Council of Governors Nominations and Remuneration Committee.

7.1.7 The Council of Governors will not consider nominations for membership of the Board of Directors other than the recommendations of the Council of Governors Nominations and Remuneration Committee.

7.2 **Terms of office**

7.2.1 The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Terms and Conditions of office decided by the Council of Governors at a general meeting.

7.2.2 The Chief Executive (and Accounting Officer) shall hold office for a period in accordance with the Terms and Conditions of office decided by the relevant committee of Non-Executive Directors.

7.2.3 The Executive Directors other than the Chief Executive shall hold

office for a period in accordance with the Terms and Conditions decided by the relevant committee of Non-Executive Directors advised by the Chief Executive.

7.2.4 On termination of their contract of employment an Executive Director shall cease to be a member of the Board of Directors.

7.2.5 If an Executive Director is suspended from their contract of employment or on long term sick leave, the Non-Executive Directors in the case of the Chief Executive and the Non-Executive Directors and the Chief Executive in the case of the other Executive Directors may appoint another person as an Executive Director in an acting capacity in their place.

7.3 **Disqualification**

7.3.1 A person may not be a Director of the Foundation Trust if–

(a) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

(b) they are a person in relation to whom a moratorium period under a debt relief order applies (under Part7A of the Insolvency Act 1986);

(c) they have made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

(d) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

(e) they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

(f) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

(g) in the case of a Non-Executive Director, they no longer satisfy paragraph 7.1.3;

(h) they have failed to declare an interest as required by this

Constitution or Standing Orders or, any other interest as set out in the 'Conflicts of Interest Policy for Bradford Teaching Hospitals NHS Foundation Trust'; or

(i) have spoken or voted at a meeting on a matter in which they have an interest contrary to this Constitution or Standing Orders, and in this Paragraph interest includes a pecuniary and a non- pecuniary interest in either case whether direct or indirect.

7.4 **Duties, Roles and Responsibilities**

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public.

7.4.1 The powers of the Foundation Trust are to be exercisable by the Board of Directors on its behalf.

7.4.2 Any of those powers may be delegated to a Committee of Directors or to an Executive Director.

7.4.3 A Committee of Non-Executive Directors established as an Audit Committee is to monitor, review and carry out such other functions in relation to the External Auditor as appropriate.

7.4.4 It is for the Non-Executive Directors to appoint (subject to the approval of the Council of Governors) or remove the Chief Executive.

7.4.5 It is for a Committee of the Chair, Chief Executive and the other Non-Executive Directors to appoint or remove the Executive Directors.

7.4.6 The process for removal of the Executive Directors will be for the Chief Executive to make such a recommendation to the Board of Directors in writing setting out the case for removal and for the Board to dispose of the recommendation by way of a resolution in accordance with Standing Orders.

7.4.7 The Foundation Trust is to establish a Committee of all Non-Executive Directors to decide the remuneration and allowances, and the other Terms and Conditions of office, of the Chief Executive.

7.4.8 The Foundation Trust is to establish a Committee of Non-Executive Directors advised by the Chief Executive to decide the remuneration and allowances, and the other Terms and Conditions of office, of the Executive Directors.

7.4.9 The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Foundation Trust's forward planning in respect of each financial year to be given to the ICB and NHSE.

7.4.10 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the External Auditor on them, and the Annual Report.

7.4.11 The functions of the Foundation Trust under subparagraphs (a) and (b) of paragraph 13.6 below are delegated to the Chief Executive as Accounting Officer.

8 MEETINGS OF THE BOARD OF DIRECTORS

8.1 The Board of Directors, in consultation with the Council of Governors, is to adopt Standing Orders covering the proceedings and business of its meetings and such other matters relating to the conduct of the Foundation Trust's business and functions as it considers appropriate. These are to include setting a quorum for meetings, both of Executive and Non-Executive Directors. The proceedings of the Board of Directors shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

8.2 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

a) The Board of Directors may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest or the interest of the Foundation Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or the proceedings.

b) Without prejudice to the generality of (a) above, the Board of Directors may treat the need to consider the following matters as of a confidential nature:

- approval of the appointment or dismissal of the Chief Executive;
- any disciplinary or other matter arising from a contract of employment with the Foundation Trust;
- any matter which involves the consideration of information held by the Foundation Trust in confidence, whether that confidentiality covers clinical, commercial or other information;
- commercial matters where publication may be to the

detriment of the Foundation Trust;
- legal advice; and,
- litigation actual or anticipated, including any arbitration or dispute resolution process or any matter of a litigious nature whether in a Court, Tribunal or Inquiry.

8.3 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

9. CONFLICTS OF INTERESTS DIRECTORS

9.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include in particular:

9.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust.

9.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

9.2 The duty referred to in sub-paragraph 9.1.1 is not infringed if:

9.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

9.2.2 The matter has been authorised in accordance with the Constitution.

9.3 The duty referred to in sub-paragraph 9.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

9.4 In sub-paragraph 10.1.2, “third party” means a person other than:

9.4.1 The Foundation Trust, or

9.4.2 A person acting on its behalf.

9.5 If a Director of the Foundation Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Foundation Trust, the Director must declare the nature and extent of that interest to the other Directors.

9.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

9.7 Any declaration required by this paragraph must be made before the

Foundation Trust enters into the transaction or arrangement.

9.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

9.9 A Director need not declare an interest:

9.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

9.9.2 if, or to the extent that, the Directors are already aware of it;

9.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –

9.9.3.1 By a meeting of the Board of Directors, or

9.9.3.2 By a Committee of the Directors appointed for the purpose under the Constitution.

9.10 If, during the course of a meeting of the Board of Directors, a conflict of interest is established, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. If there is a dispute as to whether a conflict of interest exists, the majority of the Directors present at the meeting shall resolve the issue, with the Chair having a casting vote.

10 REGISTERS

10.1 The Foundation Trust shall have:

10.1.1 a register of Members showing, in respect of each Member, the Constituency or class to which they belong;

10.1.2 a Register of Members of the Council of Governors;

10.1.3 a Register of interests of Governors;

10.1.4 a Register of Directors; and

10.1.5 a Register of interests of Directors.

10.2 The Secretary shall be responsible for compiling and maintaining the Registers. Removal from any Register shall be in accordance with the provisions of this Constitution.

a) Register of Members

Members must complete and sign an application in the form

prescribed by the Secretary.

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b) Register of Governors

The Register shall list the names of Governors, their category of membership of the Council (Public, Staff or organisation represented) and an address through which they may be contacted which may be that of the Secretary.

c) Register of Interests of the Governors

The Register shall contain the names of each Governor, whether they have declared any interests and, if so, the interests declared in accordance with this Constitution or Standing Orders.

d) Register of Directors

The Register shall list the names of Directors, their capacity on the Board and an address through which they may be contacted which may be the address of the Secretary.

e) Register of interests of Directors

The Register shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with this Constitution or Standing Orders.

11 PUBLIC DOCUMENTS

11.1 The following documents of the Foundation Trust are to be available at the Foundation Trust's Headquarters for inspection by members of the public free of charge at all reasonable times:

a) a copy of the current Constitution;

b) a copy of the latest Annual Accounts and of any report of the Auditor on them; and

c) a copy of the latest Annual Report.

11.2 The Foundation Trust shall also make the following documents relating to a special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times:

a) a copy of any order made under section 65D (appointment of Foundation Trust Special Administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Foundation Trusts coming out of administration) or

65LA (Foundation Trusts to be dissolved) of the 2006 Act.

b) a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

c) a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

d) a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

e) a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

f) a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHSE/I's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

g) a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

h) a copy of any final report published under section 65I (administrator's final report).

i) a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

j) a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

11.3 Any person who requests it is to be provided with a copy or extract from any of the above documents.

11.4 The Registers mentioned in the paragraph 10.1 above are also available for inspection by members of the public, except in circumstances prescribed by regulations made under the 2006 Act; and insofar as those Registers are required to be available:

a) they are to be provided free of charge at all reasonable times

b) a person who requests it is to be provided with a copy of or extract from them

11.5 If the person requesting a copy or extract is not a Member of the Foundation Trust, the Foundation Trust may impose a reasonable charge

for providing the copy or extract.

12 EXTERNAL AUDITOR

12.1 The Foundation Trust is to have an External Auditor and is to provide the External Auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.

12.2 A person may only be appointed as the External Auditor if they (or in the case of a firm each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 to the 2006 Act.

12.3 Appointment of the External Auditor by the Council of Governors is covered in paragraph 6.132.2, and monitoring of the External Auditor's functions by a Committee of Non-Executive Directors is covered in paragraph 7.4.3.

12.4 The External Auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and comply with any directions from NHSE on standards, procedures and techniques.

13 ACCOUNTS

13.1 The Foundation Trust must keep proper Accounts and proper records in relation to the Accounts.

13.2 The Foundation Trust is to keep Accounts in such form as NHSE may with the approval of the Secretary of State direct.

13.3 The Accounts are to be audited by the Foundation Trust's External Auditor.

13.4 The following documents will be made available to the Comptroller and Auditor General for examination at their request–

(a) The Accounts;

(b) any records relating to them; and

(c) any report of the External Auditor on them.

13.5 The Foundation Trust is to prepare in respect of each financial year Annual accounts in such form as NHSE may with the approval of the Secretary of State direct.

13.6 In preparing its Annual Accounts, the Foundation Trust is to comply with any directions given by NHSE with the approval of the Secretary of State as to –

(a) the methods and principles according to which the Accounts are to be prepared; and

(b) the information to be given in the Accounts.

13.7 The Foundation Trust must –

(a) lay a copy of the Annual Accounts, and any report of the External Auditor on them, before Parliament; and

(b) once it has done so, send copies of those documents to NHSE.

13.8 The functions of the Foundation Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

14 ANNUAL REPORTS, FORWARD PLANS AND NON-NHS WORK

14.1 The Foundation Trust is to prepare Annual Reports and send them to NHSE.

14.2 The Reports are to give:

a) information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual Membership of its Public Constituency is representative of those eligible for such membership; and

b) information on any occasion in the period to which the report relates on which the Council of Governors exercised its power under paragraph 6.1~~7~~6.9;

c) information on the Foundation Trust's policy on pay and on the work of the Committee established under paragraph 7.4.7 and such other procedures as the Foundation Trust has on pay;

d) information on the remuneration of the Directors and on the expenses of the Governors and the Directors; and

e) any other information NHSE requires.

14.3 The Foundation Trust is to comply with any decision NHSE makes as to -

a) the form of the Reports;

b) when the Reports are to be sent to it; and

c) the periods to which the Reports are to relate.

14.4 The Foundation Trust is to give information as to its Forward Planning in

respect of each financial year to the ICB and NHSE. This information is to be prepared by the Board of Directors, having regard to the views of the Council of Governors.

14.5 Each Forward Plan must contain information about-

14.5.1 the activities other than the provision of goods and services for the provision of the health service in England that the Foundation Trust proposes to carry on, and

14.5.2 the income it expects to receive from doing so.

14.6 Where a Forward Plan contains a proposal that the Foundation Trust carry on an activity of the kind mentioned in sub-paragraph 14.5.1 the Council of Governors must –

14.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its principal purpose or the performance of its functions, and

14.6.2 notify the Directors of the Foundation Trust of its determination.

14.7 If the Foundation Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the Health Service in England, it may implement the proposal only if more than half of the Members of the Council of Governors of the Foundation Trust voting approve its implementation.

15 INDEMNITY

15.1 Governors and Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Foundation Trust functions, save where they have acted recklessly. Any costs arising in this way will be met by the Foundation Trust.

16 INSTRUMENTS

16.1 A document purporting to be duly executed under the Foundation Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

16.2 The Foundation Trust has a seal, but this is not to be affixed except in accordance with Standing Orders (adopted under Paragraph 8.1 of this Constitution).

17 DISPUTE RESOLUTIONS PROCEDURES

17.1 The Foundation Trust will establish appropriate dispute resolution procedures with its contractors and Members.

17.2 In the case of a dispute between the Board of Directors and the Council of Governors both parties shall first use their best endeavours to resolve the dispute through a joint meeting of the Council and the Board. Should such a joint meeting fail to resolve the dispute the parties shall seek mediation through the appointment of mutually agreed mediators, who shall not be members of the Foundation Trust. Should such mediation fail the dispute will be determined through reference to arbitration under the terms of the Arbitration Act 1996.

18 AMENDMENT OF THE CONSTITUTION

18.1 The Foundation Trust may make amendments of its Constitution only if –

18.1.1 More than half of the members of the Council of Governors of the Foundation Trust voting approve the amendments, and

18.1.2 More than half of the members of the Board of Directors of the Foundation Trust voting approve the amendments.

18.2 Amendments made under paragraph 18.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

18.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

18.3.1 at least one member of the Council of Governors must attend the next Annual Members Meeting and present the amendment, and

18.3.2 the Foundation Trust must give the members an opportunity to vote on whether they approve the amendment.

18.4 If more than half of the members voting under paragraph 18.3.2 approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.

18.5 Amendments by the Foundation Trust of its Constitution are to be notified to NHSE. For the avoidance of doubt, NHSE's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

19 MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

19.1 The Foundation Trust may only apply for a merger, acquisition, separation

or dissolution with the approval of more than half of the members of the Council of Governors.

19.2 The Foundation Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

19.3 “Significant Transaction” means:

19.3.1 the acquisition of, or an agreement to acquire, assets the value of which is more than 25% of the value of the Foundation Trust's gross assets before the acquisition; or

19.3.2 the disposal of, or an agreement to dispose of, assets of the Foundation Trust the value of which is more than 25% of the value of the Foundation Trust's gross assets before the disposal; or

19.3.3 a transaction that has or is likely to have the effect of the Foundation Trust acquiring rights or interests or incurring obligations or liabilities, the value of which is more than 25% of the value of the Foundation Trust's gross assets before the transaction.

19.4 For the purpose of this paragraph "gross assets" means the total of the Foundation Trust’s fixed assets and current assets

19.5 Where the Foundation Trust has a single requirement for goods, services or works, and a number of transactions are to be entered into to fulfil that requirement, the value of the transaction for the purpose of paragraph 19.3 is the aggregate of the value of each of those transactions.

ANNEX 1: PUBLIC CONSTITUENCIES OF THE FOUNDATION TRUST

Name of Constituency	Area	Minimum number of members	Number of Governors
Keighley	Craven, Ilkley, Keighley Central, Keighley East, Keighley West, Worth Valley	100	2
Shipley	Baildon, Bingley, Bingley Rural, Shipley, Wharfedale, Windhill and Wrose	100	2
Bradford East	Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, Eccleshill, Idle and Thackley Little Horton,	100	2
Bradford South	Great Horton, Queensbury, Royds, Tong, Wibsey, Wyke	100	2
Bradford West	City, Clayton and Fairweather, Heaton, Manningham, Thornton and Allerton, Toller	100	2
Rest of England and Wales	Remaining electoral wards that do not form part the BMDC area	100	1

Area means the electoral wards as listed.

ANNEX 2: STAFF CONSTITUENCIES OF THE FOUNDATION TRUST

Name of Constituency	Minimum Number of Members	Number of Governors
Medical and Dental Practitioners class	100	1
Nurses and Midwives class	100	2
Allied Health Professionals and Scientists class	100	1
All Other Staff class	100	2

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ANNEX 3: LOCAL AUTHORITY, UNIVERSITY AND PARTNER GOVERNORS OF THE FOUNDATION TRUST

Organsation	Number of Governors
Bradford Metropolitan District Council	1
University of Bradford	1
University of Leeds	1
Healthwatch Bradford and District	1
Mental Health, Learning Disabilities and Autism representative organisation (to be determined by the Trust)	1

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BO.11.24.23 - STANDING FINANCIAL INSTRUCTIONS (SFIS) AND SCHEME OF DELEGATION

REFERENCES

Only PDFs are attached

- Bo.11.24.23 - Proposed Changes to the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) (Cover).pdf
- Bo.11.24.23 - Appendix 1 Standing Financial Instructions Version 1.1 (tracked changes).pdf
- Bo.11.24.23 - Appendix 2 Scheme of Delegation Version 1.1 (tracked changes).pdf

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.23

Proposed Changes to the Standing Financial Instructions and Scheme of Delegation

Presented by	Ben Roberts, Chief Finance Officer	
Author	Michael Quinlan, Deputy Director of Finance	
Lead Director	Ben Roberts, Chief Finance Officer	
Purpose of the paper	To review and approve the draft Standing Financial Instructions and Scheme of Delegation	
Key control	Update the Standing Financial Instructions	
Action required	For approval	
Previously discussed at/informed by	Audit Committee – 29 November 2024	
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

The Trusts' Standing Financial Instructions are due for review by 30 November 2024.

The Audit Committee approved the changes in the Standing Financial Instructions at its meeting on 19 November and these are now presented to the Board of Directors to ratify the changes.

This paper presents the current changes made to the Standing Financial Instructions (tracked changed) at appendix 1..

Key changes to the SFIs (at appendix 1) include:

- Update section regarding prepayments (section 9.2.7)
- Include the new Procurement Act 2023 (section 21.2)
- Include the new Provicer Selection Regime 2024 (section 21.3)
- Change Director of Finance job title to Chief Finance Officer;
- Change Director of Human Resources job title to Chief People and Purpose Officer;
- Change Strategic Head of Procurement to Assistant Director of Procurement

Key changes to the SoD (at appendix 2) include:

- Reference to the non pay review panel (SFI 9.1)
- Included section if the Trust is financially distressed (SFI 9.1)
- Prioritisation of Supplier Payments (SFI 9.1)
- Amendments to prepayments approval limits (SFI 9.2.7)
- Included a section on special payments (SFI 18)
- Included vesting certificates (section 4.5)
- Change Director of Finance job title to Chief Finance Officer;
- Change Director of Human Resources job title to Chief People and Purpose Officer;
- Change Strategic Head of Procurement to Assistant Director of Procurement

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.23

The Trusts Board of Directors have previously approved a business case to change the Bradford Hospitals Charity from a corporate Trustee to an indepdent Charity. It is not known when the Charity will become independent. Once it is known the Trusts SFIs and SoD will need to be ammedned to reflect the changes.

Recommendation

The Board is asked to note and approve the changes to the SFIs and SOD.

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)

Meeting Title	Board of Directors – Open		
Date	28 November 2024	Agenda item	Bo.11.24.23

☐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: Finance	
Other (please state):	

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☐	☒	☐	☐	☐

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

Bradford Teaching Hospitals
NHS Foundation Trust

Document control

Policy reference	CG01 2020
Category	Corporate Governance
Strategic objective	To deliver our financial plan and key performance targets

Author:	Michael Quinlan, Deputy Chief Finance Officer
Version:	1.1
Status	Final
Supersedes:	April 2023
Executive Lead:	Chief Finance OfficerChief Finance Officer
Approval Committee:	Audit Committee
Ratified by:	Board of Directors
Date ratified:	
Date issued:	November 2024
Review date:	November 2025

Target audience	All Managers
Summary	The Standing Financial Instructions, including associated policy and procedure notes, set the business rules which Board members and officers must follow when taking action on behalf of the Board.
Changes since last revision	
Monitoring arrangements	Internal audit process and reports to the Audit Committee.
Training requirements	Not applicable
Equality Impact Assessment	Not applicable

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Foreword

The National Health Service Act 2012 as amended by Health and Social Care Act 2022 and the Foundation Trust's Constitution require that all the powers of the Foundation Trust are exercisable by the Board on its behalf. Standing Orders, Reservation of Powers to the Board and Scheme of Delegation, together with these Standing Financial Instructions and such other locally generated rules and instructions, including financial procedure notes, as may exist for use within the Foundation Trust provide a regulatory and business framework for the conduct of the Board. Collectively these documents must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which Board members and officers must follow when taking action on behalf of the Board.

1 Introduction

1.1 General

1.1.1 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Foundation Trust. They are designed to ensure that the Foundation Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board and Scheme of Delegation adopted by the Foundation Trust. As stated in Standing Order No.4.7, they shall have effect as if incorporated in the Standing Orders of the Foundation Trust.

1.1.2 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance OfficerChief Finance Officer must be sought before acting. All Foundation Trust staff involved in the management of Foundation Trust funds or committing the Foundation Trust to expenditure must be familiar with and comply with the provisions of the Foundation Trust's Standing Orders and these Standing Financial Instructions.

1.1.4 Variations to the Standing Financial Instructions shall only be made by the Board, and normally, on the recommendation of the Foundation Trusts Audit Committee.

1.1.5 **The failure to comply with these Standing Financial Instructions and the Foundation Trust's Standing Orders can in certain circumstances be regarded as a disciplinary matter which could result in dismissal.**

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. The Board and all staff have a duty to disclose any non- compliance with these Standing Financial Instructions to the Chief Finance OfficerChief Finance Officer as soon as possible.

1.1.7 **Outsourced Services** – Where any operation is carried out on the Foundation Trust's behalf by NHS Shared Business Services or any other Board approved outsourced service provider, detailed procedures will be the responsibility of such a provider. The following are the principal areas for which some or all processes are currently the responsibility of such a provider:

- Accounts payable;
- Accounts receivable;
- Treasury and cash;
- General ledger;

- VAT services;
- IT system administration services.

These may be subject to variation.

However, the ultimate responsibility lies with the Foundation Trust to ensure prior to award or renewal of any contract, that they are satisfied that the detailed procedures exist and are sufficiently robust through its contract management processes.

1.1.8 **Terminology**

1.1.9 Any expression to which a meaning is given in Health Service Acts or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions and in addition:

(a) '**Academy**' means an academy of the Board of Directors;

(b) '**Board**' means the Chair, Executive Directors and Non Executive members of the Foundation Trust collectively as a body;

(c) '**Budget**' means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust;

(d) '**Budget Holder**' means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

(e) "**Chair of the Board (or Foundation Trust)**" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Foundation Trust as a whole;

(f) '**Chief Executive**' means the Chief Executive Officer of the Foundation Trust;

(g) "**Committee**" means a committee or sub-committee appointed by the Foundation Trust;

(h) '**Committee Members**' means persons formally appointed by the Board to sit on or to chair specific committees.

(i) "**Constitution**" means the constitution of the Foundation Trust;

(j) '**Contracting and Procuring**' means the systems for obtaining the supply of goods, materials, manufactured items, services, buildings and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

(k) '**Contractor**' means any external organisation providing goods or services to the Foundation Trust.

(l) "**Council of Governors**" means the Council of Governors of the Foundation Trust as constituted by the Constitution;

(m) '**Chief Finance Officer**' means the Chief Financial Officer of the Foundation Trust;

(n) '**Funds held on trust**' shall mean those funds which the Foundation Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977 as amended and S.51 of the National Health Service Act 2006. Such funds may or may not be charitable.

(o) '**Foundation Trust**' means the Bradford Teaching Hospitals NHS Foundation Trust.

(p) "**NHSE**" means the body NHS England

1.1.10 Wherever the title Chief Executive, Chief Finance Officer or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

1.1.11 Wherever the term 'officer' is used and where the context permits it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust.

1.1.12 All references to the masculine gender will be deemed to apply equally to the feminine gender when used with these instructions.

1.2 Responsibilities and Delegation

1.2.1 **The Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) approving annual budgets including the overall income / expenditure and departmental allocations;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on the Board and officers as indicated in the Scheme of Delegation document.

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document. All other powers have been delegated to such other committees as the Foundation Trust has established.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Foundation Trust.

1.2.4 **The Chief Executive and the Chief Finance Officer**

1.2.5 Within the Standing Financial Instructions it is acknowledged that the Chief Executive is ultimately accountable to the Board and, as accountable officer, to NHSE, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Chairman and the Board for ensuring

that its financial obligations and targets are met and has overall responsibility for the Foundation Trust's system of internal control. The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.2.6 It is a duty of the Chief Executive to ensure that the Board and officers and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

1.2.7 **The Chief Finance Officer**

1.2.8 The Chief Finance Officer is responsible for:

(a) implementing the Foundation Trust's financial policies and co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time;

1.2.9 and, without prejudice to any other functions of the Foundation Trust, and officers of the Foundation Trust, the duties of the Chief Finance Officer include:

(a) the provision of financial advice to the Board and officers;

(b) the design, implementation and supervision of systems of internal financial control;

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

1.2.10 **Board Members and Officers**

All Board members and officers, severally and collectively, are responsible for:

(a) the security of the property of the Foundation Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.2.11 **Contractors and their Employees**

1.2.12 Any contractor or employee of a contractor, who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to

ensure that such persons are made aware of this.

1.2.13 For the Board and any officers who carry out a financial function, the form in which financial records are kept and the manner in which the Board and such officers discharge their duties must be to the satisfaction of the Chief Finance Officer.

2 Audit

2.1.1 **Audit Committee**

2.1.2 In accordance with Standing Orders, the Board shall formally establish an AuditCommittee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook published by the Healthcare Financial Management Association ("HFMA") and updated from time to time, which will provide an independent and objective view of internal control.

2.1.3 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit Committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board (with the Chief Finance Officer in the first instance). Exceptionally, the matter may need to be referred to NHSE.

2.1.5 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided, and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.2 Anti-Fraud, Bribery and Corruption

2.2.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on anti-fraud, bribery and corruption.

2.2.2 The Foundation Trust shall, via the Internal Audit function, have access to a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud and Corruption Manual and guidance.

2.2.3 The Local Counter Fraud Specialist shall provide regular reports and advice to the Foundation Trust via the Audit Committee and shall work with staff in NHS Counter Fraud Authority (previously known as NHS Protect) in accordance with the NHS Counter Fraud Standards.

2.2.4 The Local Counter Fraud Specialist will provide a written annual report, on counter fraud work within the Foundation Trust to the Audit Committee.

2.2.5 In accordance with the NHS Standard Contract, the Foundation Trust must put in place and maintain appropriate anti-fraud, bribery and corruption arrangements. The Anti-Fraud, Bribery and Corruption Policy outlines the Foundation Trusts approach.

2.3 Chief Finance Officer

2.3.1 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and, as appropriate, the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of internal audit recommendations;

(iv) progress against plan over the previous year;

(v) strategic audit plan covering the coming three years;

(vi) a detailed plan for the coming year.

(e) ensuring there is an annual review of the continued appropriateness of the spend commitment and invoice authorisation limits of designated authorising officers within the Foundation Trust.

2.3.2 The Chief Finance Officer and designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or Board member or officer of the Foundation Trust;

(c) the production of any cash, stores or other property of the Foundation Trust under the control of a Board member or officer;

(d) explanations concerning any matter under investigation.

2.4 Role of Internal Audit

2.4.1 The main purpose of Internal Audit activity within the NHS is to provide the Accountable or Accounting Officer with an objective evaluation of, and opinion on, the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control, in an economical, efficient and timely manner.

2.4.2 The Internal Audit Charter provides a formal definition of the purpose, authority and responsibilities of the Foundation Trust's Internal Audit Service. The Charter defines

the scope of Internal Audit Activity and establishes Internal Audit's position within the Trust; in addition; it authorises access to records, personnel, and physical properties relevant to the performance of audits.

2.4.3 Internal Audit will fulfil its Charter by a systematic review and evaluation of risk management, control and governance process in place for:

(a) Making strategic and operational decisions;

(b) Overseeing risk management and control;

(c) Promoting appropriate ethics and values within the Foundation Trust;

(d) Ensuring effective organisational performance management and accountability;

(e) Communicating risk and control information to appropriate areas of the Foundation Trust;

(f) Coordinating the activities of and communicating information among the Board of Directors, External and Internal Auditors other assurance providers and management;

(g) Designing and implementing ethics-related objectives, programmes and activities;

(h) Ensuring information technology governance of the Trust supports the organisation's strategies and objectives;

(i) Responding to risks within the Foundation Trust's governance, operations and information systems regarding the:

- Achievement of the Trust's strategic objectives;
- Reliability and integrity of financial and operational information;
- Effectiveness and efficiency of operations and programmes;
- Safeguarding of assets; and
- Compliance with laws, regulations, policies, procedures and contracts

2.4.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and the Chief Executive of the Foundation Trust.

2.4.5 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.4.6 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the timescales specified in the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit

recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer. Changes implemented must be maintained in the future and not viewed as merely satisfying an immediate audit point.

2.4.7 Working with Executive Directors, Internal Audit will produce a 3 year rolling Audit plan with a detailed one year audit plan reflecting a review of the corporate risk register, statutory requirements, management requested audits and internal / external guidelines that would prompt a internal audit review

2.5 External Audit

2.5.1 The external auditor is appointed by the Council of Governors.

2.5.2 The Audit Committee is responsible for ensuring a cost-efficient service,

2.5.3 The Code of Audit Practice issued by the National Audit Office sets out the standards, procedures and techniques to be adopted by the auditor.

2.5.4 The external auditor shall comply with the Audit Code.

2.5.5 The Audit Committee is responsible for the Non-Audit Work Policy which defines the limited extent to which External Audit may be appointed to carry out activities not directly connected to their audit role.

2.6 Security Management

2.6.1 In line with his responsibilities, the Foundation Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

2.6.2 The Foundation Trust shall nominate suitable individuals to carry out the duties of the Local Security Management Specialist (LSMS) and Security Management Director (SMD) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3 Allocations, Business Planning, Budgets, Budgetary Control and Monitoring

3.1.1 Detailed procedural guidance on managing budgets is covered by the Budgetary Management Framework.

3.2 Preparation and Approval of Annual Operational Plans and Budgets

3.2.1 The Chief Executive, Chief Operating Officer, Chief People and Purpose Officer and Chief Finance Officer will compile and submit to the Board an annual operational plan which takes into account national operating planning expectations inclusive of financial targets and forecast limits of available resources. The annual operational plan will contain:

(a) a statement of the significant assumptions on which the plan is based, relating to activity / access performance, workforce and finances.

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.2.2 The Foundation Trust has a statutory duty to deliver a balanced financial plan. As such the Board of Directors will need to test the validity of assumptions and robustly evaluate the deliverability of a balanced plan, noting that the Operational Plan will need to be approved by the Board of Directors before submission to the ICS and subsequently to NHSE.

3.2.3 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare a financial plan and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual operational plan;

(b) accord with workload and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds available to the Trust;

(e) identify potential risks; and

(f) set out the implications to the Trusts Use of Resources assessment framework.

3.2.4 The Chief Finance Officer shall monitor financial performance against budget and operational plan, periodically review them, and report to the Board.

3.2.5 Budget holders shall provide the Chief Finance Officer with all financial, statistical and other relevant information as necessary, for the compilation of such budgets, plans, estimates and forecasts.

3.2.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.2.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2.8 The Chief Finance Officer shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.2.9 Operating surpluses may be used to:

(a) spend on revenue;

(b) meet locally determined health needs;

(c) build cash reserves for future investments, subject to the national capital framework and allocative methodology allowing for such an investment;

(d) finance an investment or purchase, subject to the national capital framework and allocative methodology allowing for such investment;

(e) make payments on a loan

3.3 Budgetary Delegation

3.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

3.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.3.4 Non-recurring budgets should not be used to finance recurring expenditure.

3.4 Budgetary Control and Reporting

3.4.1 The Chief Finance Officer will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) monthly financial reports to the Finance & Performance Academy and regular financial reports to the Board in a form approved by the Board, containing:

(i) income and expenditure to date, showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) summary cash flow and forecast year-end position ;

(iv) summary balance sheet;

(v) capital project spend and projected outturn against plan;

(vi) performance against any permissible borrowing or covenants;

(vii) explanations of any material variances from plan supported by recovery

plans;

(viii) details of any corrective action where necessary and the view of the Chief Executive and/or Chief Finance Officer as to whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers.

3.4.2 Financial reports shall be received monthly by the Board of Directors.

3.4.3 All budgetary matters and responsibilities will be detailed in the Budgetary Management Framework.

3.4.4 Each budget holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Finance Officer;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without giving due consideration of the ongoing financial resources required to fund the post within the approved budget;

(d) the systems of budgetary control established by the Chief Finance Officer are complied with fully.

3.4.5 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual business plan and a balanced budget.

3.4.6 The Chief Executive is responsible for ensuring the Trust is financially viable, meets its financial duties, and takes such action as is necessary.

3.4.7 Should the Foundation Trust require an adverse off plan forecast to be reported, the Trust will need to enact the nationally prescribed 'Protocol for changes to in year revenue forecasts' with any off-plan forecast requiring Board Approval before submission.

3.5 Capital Expenditure

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 11.) All items of capital expenditure must be referred to the Chief Finance Officer for inclusion in the capital planning and approval processes.

3.6 Monitoring Returns

3.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the ICS and NHSE within the specified timescales.

4 Annual Accounts and Reports

4.1.1 The Chief Finance Officer, on behalf of the Foundation Trust, will prepare financial returns in accordance with the accounting policies and guidance laid down within International Financial Reporting Standards, as modified by the guidance given by NHSE with the approval of the Treasury.

4.1.2 The procedures to be followed in relation to annual accounts and reports are set out in the Foundation Trust's Constitution, paragraph 14, 'Accounts' and paragraph 15, 'Annual reports and forward plans'.

4.1.3 The Council of Governors, in general meeting, shall receive and consider the annual accounts, any report by the external auditor on them and the annual report, as provided by paragraph 5.8.2 of the Foundation Trust's Constitution.

4.1.4 The Foundation Trust's Audited Annual Accounts must be presented to the Board of Directors for approval and received by the Council of Governors at a public annual members meeting. A copy will be laid before Parliament and copies forwarded to NHSE.

5 Bank and GBS Accounts

5.1.1 **General**

5.1.2 The Chief Finance Officer is responsible for managing the Foundation Trust's banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. This advice will take into account guidance / directions issued by NHSE. In line with 'Managing Public Money' the Foundation Trust will minimise the use of commercial bank accounts and use Government Banking Services ("GBS").

5.1.3 The Board shall approve the banking arrangements.

5.1.4 **Bank and GBS Accounts**

5.1.5 The Chief Finance Officer is responsible for:

(a) bank accounts and GBS accounts and other forms of working capital financing;

(b) establishing separate bank accounts for the Foundation Trust's non-exchequer funds;

(c) ensuring payments made from bank and GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn, together with the remedial action taken.

5.1.6 All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust

or for the purpose of furthering Foundation Trust activities.

5.1.7 **Banking Procedures**

5.1.8 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft;

(c) those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

5.1.9 The Chief Finance Officer shall approve security procedures for any cheques issued without a handwritten signature, e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

5.1.10 All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

5.1.11 **Review of Banking Arrangements**

5.1.12 The Chief Finance Officer will review the commercial banking arrangements of the Foundation Trust at regular intervals, including non-exchequer accounts, to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's commercial banking business.

5.1.13 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6 Income, Fees, Charges and security of cash, cheques and other negotiable instruments

6.1 Income Systems

6.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Foundation Trust shall follow relevant Department of Health and NHSE advice in setting prices for contracts with NHS organisations and non NHS organisations.

6.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or NHSE or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department

of Health's 'Commercial Sponsorship – Ethical standards in the NHS' shall be followed.

6.2.3 All officers must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Where the Trust provides services to organisations other than NHS Commissioners a signed contract or official purchase is required before services are provided.

6.2.5 The Chief Finance Officer can order service provision to be halted where services are discretionary and the Trust payment terms are not being met.

6.3 Private Health Care

6.3.1 General Managers in conjunction with the Medical Director and the Chief Finance Officer shall be responsible for the maintenance and operation of procedures for the management of private practice in the Foundation Trust. The procedure shall also cover Fee Paying work, overseas visitors and amenity beds.

6.3.2 All consultants and associated specialists undertaking private practice and Category II work within the Foundation Trust shall be responsible for informing the responsible officer(s) as nominated by the Foundation Trust when private / Fee Paying Work patients are seen, to ensure that the Foundation Trust receives all amounts due to it.

6.4 Debt Recovery

6.4.1 The Chief Finance Officer is responsible for:

(a) the appropriate recovery action on all outstanding debts including legal action where appropriate.

(b) writing off income not received and ensuring processes are in place to report losses.

(c) detecting (or preferably preventing) and initiating recovery of overpayments.

6.5 Security of Cash, Cheques and other Negotiable Instruments

6.5.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable (no form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

6.5.2 Official money shall not under any circumstances be used for the encashment of private

cheques or IOUs.

6.5.3 All cheques, postal orders, cash, etc. shall be banked promptly intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

6.5.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

6.5.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and internal audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption, this process should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided by NHS Counter Fraud Authority (formally NHS Protect) and Security Management Service. Where there is no evidence of fraud or corruption, the loss should be dealt with in line with the Foundation Trust's Losses and Special Payments procedures.

7 NHS Contracts for provision of Services

7.1 NHS Contracts for services provided by the Trust

7.1.1 The Chief Executive, as the accounting officer, is responsible for ensuring that the Foundation Trust enters into suitable NHS Contracts with service commissioners for the provision of NHS services.

7.1.2 All NHS Contracts should aim to implement the agreed priorities contained within the annual operational plan and, wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on cost and volume of services;

(d) the NHS National Performance Assessment Framework;

(e) ensuring that NHS Contracts build where appropriate on existing Joint Investment Plans;

(f) ensuring that NHS Contracts are based on integrated care pathways.

7.2 Non-NHS Contracts for services provided to the Foundation Trust

Non-NHS Contracts provided to the Foundation Trust requires approval by the Chief Finance Officer or his Deputy/Assistant Finance Director and the relevant Manager and Executive Director in line with the Scheme of Delegation.

8 Terms of Service and Payment of Board Members and Employees

8.1 Remuneration Committee (see also Annex 7 to Standing Orders)

8.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (see NHS guidance contained in the Higgs report).

8.2 Funded Establishment

8.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

8.3 Staff Appointments

8.3.1 No officer may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive;

(b) beyond the limit of his approved budget and funded establishment.

8.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, etc, for employees.

8.3.3 Appointment of new Consultant Medical Staff is subject to approval of a business case.

8.4 Processing of Payroll

8.4.1 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) making payment on agreed dates;

(c) agreeing method of payment.

8.4.2 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and payments to employees and of allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payment by cheque, bank credit, or cash to employees;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty

(b) submitting time records and other notifications in accordance with agreed timetables;

(c) completing time records and other notifications in accordance with the instructions of the Chief Finance Officer and in the form prescribed by the Chief Finance Officer;

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest he has left without notice, the Chief Finance Officer must be informed immediately.

8.4.4 If circumstances are such that fraud or corruption might be expected, this fact also must be reported to the Chief Finance Officer.

8.4.5 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of Employment

8.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

9 Non-Pay Expenditure

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out in the Scheme of Delegation:

(a) The list of managers who are authorised to approve requisitions for the supply of goods and services; and

(b) The maximum level of each requisition and the system for authorisation above that level.

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1 **Requisitioning & Use of Purchase Orders**

9.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) must assess the need and the suitability of the selected supply. Best value for money must always be demonstrably sought for the Foundation Trust and the Tendering and Contracting Procedure set out in paragraph 21 of these Standing Financial Instructions must always be followed. In so doing, the advice of colleagues in Procurement or (where applicable), Pharmacy shall be sought.

9.2.3 All goods, services and works must be ordered by raising a requisition (using iProc) and a Purchase Order (PO) through the Trust's electronic ordering system save in respect of categories of supply or spend listed on the PO Exception List, as maintained and updated by the Chief Finance Officer from time to time.

9.2.4 **System of Payment and Payment Verification**

9.2.5 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or, otherwise, in accordance with national guidance.

9.2.6 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and

payment of all amounts payable. The system shall provide for:

(i) A list of Board members and officers (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles and plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment. Provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 9.2.4.

9.2.7 **Pre-payments**

9.2.8 In general prepayments will not be permitted. Exceptionally they will be permitted in instances relating to payments for rent, subscription-based software licences, maintenance contracts, insurance and for instances where they are accepted as normal business practice (e.g. training and publications). All other pre-payments require prior approval as specified in the Scheme of Delegation and must meet the following criteria:

(a) the prepayment is specified in the agreed contractual arrangement;

(b) the proposed arrangement is compliant with UK public procurement rules, where the contract is above the stipulated financial threshold;

(c) the financial advantages are shown to outweigh the disadvantages and risks including the effect on the Trust should the supplier by unable to meet its commitments and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.9 **Official Orders**

9.2.10 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Foundation Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.11 **Duties of Managers and Officers**

9.2.12 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) no order is issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or officers, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits. (This provision needs to be read in conjunction with Standing Order No. 7 and the principles outlined in the national guidance contained in HSG 93 (5) 'Standards of Business Conduct for NHS Staff' and NHSE Guidance on managing Conflict of Interest w/e June 2017)

(c) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(d) verbal orders are issued only very exceptionally, by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked 'Confirmation Order';

(e) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(f) goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future uncompetitive purchase;

(g) changes to the list of Board members/officers authorised to certify invoices are notified to the Chief Finance Officer;

(h) purchases from petty cash and on purchase cards are restricted in value and by

type of product or service in accordance with instructions issued by the Chief Finance Officer;

(i) petty cash records are maintained in a form as determined by the Chief Finance Officer.

9.2.13 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estate code. The technical audit of these contracts shall be the responsibility of the relevant Board member.

9.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

9.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with this Act.

9.3.2 The financial limits for officers' approval of payments are set out in the Scheme of Delegation.

10 External Borrowing, Leasing and Investments

10.1 General

10.1.1 The Board will approve policies concerning all external borrowing and investments. The Chief Finance Officer will prepare detailed procedural instructions concerning all external borrowing and investments and the records to be maintained.

10.2 External Borrowing

10.2.1 The Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed new borrowing, within the limits set by NHSE. The Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans and overdrafts.

10.2.2 The Foundation Trust will secure the most preferential interest rate for borrowing;

10.2.3 Any application for a loan or overdraft will only be made by the Chief Finance Officer or by an employee so delegated by him, and within the limits set and governance processes prescribed by NHSE.

10.2.4 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

10.2.5 Any borrowing in excess of one month must be authorised by the Chief Finance Officer. All long-term borrowing must be consistent with plans outlined in the current Business Plan.

10.2.6 Assets protected under the authorisation agreement with the Independent Regulator shall not be used as collateral for borrowing. Non-Protected assets will be eligible as security for loan.

10.3 Public Dividend Capital

10.3.1 The Chief Finance Officer should be made aware of all applications for Public Dividend Capital or central Department of Health and Social Care funding.

10.3.2 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health and Social Care Cash Funding Team and is subject to approval by the Secretary of State.

10.3.3 All Utilisation Requests must be signed by two authorised signatories.

10.4 Leasing

10.4.1 All lease agreements must be authorised by the Chief Finance Officer (or deputy), prior to a final agreement being made.

10.4.2 The Chief Finance Officer has authority to determine if an asset should be purchased or leased.

10.4.3 The Chief Finance Officer has authority to determine which contracts are considered to fully, or partly contain a lease.

10.4.4 The Chief Finance Officer will keep a register of all finance leases. Divisional managers will keep a register of all operational leases.

10.5 Investments

10.5.1 Detailed procedural guidance on managing investments is covered by the Treasury Management Policy.

10.5.2 Temporary cash surpluses must be held only in such investments and with such financial institutions as approved by the Board and with the terms of guidance issued by the Financial Regulator.

10.5.3 The Chief Finance Officer is responsible for advising the Board on investment strategy and shall report periodically to the Board concerning the performance of the investments held.

10.5.4 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and records to be maintained.

10.6 Foreign Exchange Contracts

10.6.1 Foreign exchange contracts can only be entered into for the purpose of obtaining best value for money when contracts are taken out in foreign currencies. Foreign exchange contracts will not be entered into for the purpose of trading for profit in foreign currencies.

10.6.2 Foreign exchange contracts can only be entered into with the direct knowledge and

authorisation of the Chief Finance Officer. All contracts must be signed on behalf of the Trust by the Chief Finance Officer (or in his absence his deputy). The goods and services which are being purchased with foreign exchange currency will have the appropriate order and duly authorised in accordance with the SFIs.

10.6.3 The Board will be informed of any such foreign exchange contracts entered into.

11 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

11.1.1 Detailed procedural guidance on managing capital schemes is covered by the Capital Programme Management Policy.

11.2 Capital Investment

11.2.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences, including capital charges.

11.2.2 For every new capital expenditure proposal the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

(a) that a business case (in line with the guidance contained with the NHSE *"Capital regime, investment and property business case approval guidance for NHS Providers"* is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Foundation Trust personnel and external agencies;

(iii) appropriate project management and control arrangements;

(b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

(c) The business cases will be monitored through the Capital Strategy Group and where there is 10% variance, both positive and negative, this will be escalated and reported to the Finance and Performance Academy.

(d) that the Chief Executive has certified to indicate endorsement of the operational assumptions.

(e) that the business is submitted and approved in accordance with the delegated powers set out in the Scheme of Delegation.

(f) That all proposal to lease, hire or rent fixed assets have been subject to appraisal of their impact on the Trust's ability to achieve its financial targets.

11.2.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management.

11.2.4 The Chief Finance Officer shall assess the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs guidance.

11.2.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.2.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

11.2.7 The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender

(c) approval to accept a successful tender

11.2.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Foundation Trust's Standing Orders.

11.2.9 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.3 Private Finance

11.3.1 The Foundation Trust may test for PFI when considering capital procurement. The following procedures shall apply:

(a) The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board.

(c) The selection of a contractor / finance company must be on the basis of competitive tendering or quotations (see also SFI 21, Tendering and Contracting Procedure).

11.4 Capital Asset Registers

11.4.1 The Chief Executive is responsible for the maintenance of a capital asset register, taking

account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating. A physical check of capital assets against the register should be conducted every two years.

11.4.2 The Foundation Trust shall maintain an asset register recording capital assets. The minimum data set to be held within these registers shall be as specified in the Annual Reporting Manual issued by NHSE.

11.4.3 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.4.4 The Chief Finance Officer shall approve procedures for reconciling balances on capital assets accounts in ledgers against balances on capital asset registers.

11.4.5 Indexation and depreciation should be in line with guidance issued by NHSE.

11.5 Protected Property

11.5.1 A register of protected property must be maintained in accordance with the requirements of the Independent Regulator.

11.5.2 No protected property may be disposed of without the approval of the Independent Regulator.

11.5.3 Non-protected assets may be used to raise funds for the development of services.

11.6 Security of Assets

11.6.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.6.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. These procedures shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.6.3 All discrepancies revealed by verification of physical assets to fixed asset register shall

be notified to the Chief Finance Officer.

11.6.4 Whilst each officer has a responsibility for the security of property of the Foundation Trust, it is the responsibility of Board members and senior officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

11.6.5 Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies, must be reported by Board members and officers in accordance with the procedure for reporting losses.

11.6.6 Where practical assets should be marked as Foundation Trust property.

11.6.7 The Trust's asset may only be used in pursuance of the Trust's business. Private use of the Trust's assets is only allowable with written approval of the Chief Operating Officer.

12 Stores and receipt of Goods

12.1 General Position

12.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer, the control of fuel oil and the Estates Stores the responsibility of a designated Estates Officer.

12.2.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated officer. Wherever practicable, stocks should be marked as health service property.

12.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

12.2.5 Where a complete system of stores control is not justified, alternative arrangements

shall require the approval of the Chief Finance Officer.

12.2.6 The designated officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also SFI 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.3 Goods supplied by NHS Supply and Bunzl Healthcare

12.3.1 For goods supplied via the NHS Supply and Bunzl Healthcare central warehouses, the Chief Finance Officer shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer, who shall satisfy himself that the goods have been received before accepting the recharge.

13 Disposal and Condemnations, Losses and Special Payments

13.1 Disposals and Condemnations

13.1.1 **Procedures**

13.1.2 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.1.3 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine, and advise the Chief Finance Officer of, the estimated market value of the item, taking account of professional advice where appropriate.

13.1.4 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an officer authorised for that purpose by the Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Chief Finance Officer.

13.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

13.2 Losses and Special Payments

13.2.1 **Procedures**

13.2.2 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments. The Chief Finance Officer must also prepare a 'fraud and corruption response plan' that sets out the action to be taken both by persons detecting a suspected fraud or corruption and those persons

responsible for investigating it.

13.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then as appropriate inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the Local Counter Fraud Specialist and NHS Protect (previously known as NHS Counter Fraud and Security Management Service) Area Anti- Fraud Specialist in accordance with Directions of the Secretary of State for Health.

13.2.4 The Chief Finance Officer must notify the external auditor of all frauds.

13.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Board,

(b) the external auditor.

13.2.6 Approval of the writing off of losses and special payments shall be in accordance with the Scheme of Delegation.

13.2.7 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

13.2.8 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

13.2.9 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write offs are recorded, which will be presented to the Audit Committee.

14 Information Technology

14.1 Responsibilities and Duties of the Chief Finance Officer and of the Director of Strategy and Integration

14.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's financial data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and the Computer Misuse Act 1990;

(b) ensure that adequate (reasonable) controls exist over financial data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the financial computer operation is

separated from development, maintenance and amendment;

(d) ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

(e) ensure that an adequate management (audit) trail exists through the financial computerised system and that such computer audit reviews as he may consider necessary are being carried out.

14.1.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

14.1.3 The Director of Strategy and Integration shall publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Foundation Trust that it makes publicly available.

14.2 Responsibilities and Duties of other Board Members and Officers in relation to Financial Computer Systems of a General Application

14.2.1 In the case of financial computer systems which are proposed general applications (i.e. normally those applications which the majority of NHS organisations in the region wish to sponsor jointly), all responsible Board members and officers will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.3 Contracts for Financial Computer Services with other Health Bodies or Outside Agencies

14.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

14.4 Risk Assessment

14.4.1 The Chief Finance Officer shall ensure that risks to the Foundation Trust arising from the use of IT in a financial context are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation

and testing of appropriate disaster recovery plans.

14.5 Requirements for Computer Systems which have an impact on Corporate Financial Systems

14.5.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an information technology strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

15 Patient's Property

15.1.1 The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

15.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets (notices are subject to sensitivity guidance),
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions, that the

15.1.3 Foundation Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

15.1.4 The Chief Nurse will provide detailed procedures to promote a consistent and cohesive way of working within the Foundation Trust for the safekeeping of patients' property, money and valuables.

15.1.5 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

15.1.6 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

15.1.7 Staff should be informed, on appointment, by the appropriate departmental or senior

manager, of their responsibilities and duties for the administration of the property of patients.

15.1.8 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16 Charitable Funds - Funds held on Trust

16.1.1 The discharge of the Charitable Fund's corporate trustee responsibilities are distinct from its responsibilities for corporate funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. In particular, the purchasing rules and delegated financial limits that apply to Trust purchasing also apply to charitable funds purchasing. These delegated limits, including the associated authorisation requirements, are summarised in the Bradford Hospitals Charity Policy. Trustee responsibilities cover both charitable and non-charitable purposes. The Chief Finance Officer shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

16.1.2 The Chief Finance Officer is responsible for ensuring that these SFIs are applied.

16.1.3 The Charitable Funds Committee (CFC) is a Committee of the Corporate Trustee of the Charitable Funds (the Trust's Board of Directors). Its purpose is to undertake the routine management of the Charitable Funds and to give additional assurance to the Trustee that the Trust's Charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales. The CFC on behalf of the Charitable Trustee is responsible for fundraising in compliance with all statutes and regulations. The Directors with responsibility for Fundraising and Finance will advise the CFC.

16.2 Existing Charitable Funds

16.2.1 The Chief Finance Officer shall arrange for the administration of all existing charitable funds. He shall ensure that a governing instrument exists for every charitable fund and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and officers. Such guidelines shall identify the restricted nature of certain funds where applicable.

16.2.2 The Chief Finance Officer shall periodically review the funds in existence and shall make recommendations to the Charitable Fund's corporate trustees regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The Chief Finance Officer may recommend an increase in the number of funds where this is consistent with the Charitable Funds corporate trustee policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific wards or departments.

16.3 New Charitable Funds

16.3.1 The Chief Finance Officer shall arrange for the creation of a new charitable fund where funds and/or other assets, received in accordance with the Charitable Funds corporate trustee's policies, cannot adequately be managed as part of an existing fund.

16.3.2 Where no fund matches a donor's specific purpose the advice of the CFC should be sought to establish if a new fund is required or whether the donation should be rejected

if the donor's wishes cannot be accommodated.

16.4 Sources of New Funds

16.4.1 In respect of Donations, the Chief Finance Officer shall:

(a) provide guidelines to the Charitable Fund corporate trustees as to how to proceed when offered funds. These include:

(i) the identification of the donors' intentions;

(ii) where possible, the avoidance of new trusts;

(iii) the avoidance of impossible, undesirable or administratively difficult objects

(iv) sources of immediate further advice

(v) treatment of offers for personal gifts

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Charitable Funds and that the donor's intentions have been noted and accepted.

16.4.2 In respect of Legacies and Bequests, the Chief Finance Officer shall:

(a) provide guidelines to officers of the Charitable Funds covering any approach regarding:

(i) the wording of wills;

(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Charitable Funds are the beneficiary;

(c) be empowered, on behalf of the Charitable Funds corporate trustees, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;

(d) be directly responsible for the appropriate treatment of all legacies and bequests;

(e) be kept informed of all enquiries regarding legacies and keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Chief Finance Officer, who alone shall be empowered to give an executor a good discharge.

16.4.3 In respect of Fund-raising, the nominated Executive lead shall:

(a) deal with all arrangements for fund-raising by and/or on behalf of the Charitable Funds and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge;

(c) be responsible for alerting the Board to any irregularities regarding the use of the Charitable Fund's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source;

(e) be required to advise the Board on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

16.4.4 In respect of Charitable Fund's Trading Income, the Chief Finance Officer shall:

(a) be primarily responsible, along with other designated officers, for any trading undertaken by the Charitable Fund's as corporate trustee;

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

16.4.5 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.5 Investment Management

16.5.1 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he shall be required to provide advice to the Charitable Fund's corporate trustees, or the Charitable Funds Working Group, shall include:

(a) the formulation of investment policy within the powers of the Charitable Funds under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Chief Finance Officer shall agree the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive or a duly authorised officer;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by the Charitable Funds corporate trustees in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

16.6 Disposition Management

16.6.1 The exercise of the Charitable Funds dispositive discretion shall be managed by the Chief Finance Officer in conjunction with the Charitable Funds corporate trustees. In so doing he shall be aware of the following:

(a) the objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of Trust funds to discharge Charitable Fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Trust shall be discharged by Charitable Funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Charitable Funds;

(f) the definitions of "charitable purposes" as agreed with the Charity Commission.

16.7 Banking Services

16.7.1 The Chief Finance Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the Charitable Funds as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 Asset Management

16.8.1 Assets in the ownership of or used by the Charitable Funds as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Charitable Fund. The Chief Finance Officer shall ensure:

(a) that appropriate records of all assets owned by the Charitable Fund as corporate trustee are maintained and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for.

16.9 Reporting

16.9.1 The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds corporate trustees with regard to, inter alia, the receipt of funds, investments and the disposition of resources.

16.9.2 The Chief Finance Officer shall prepare annual accounts in the required manner which

shall be submitted to the Charitable Funds corporate trustees within agreed timescales.

16.9.3 The Chief Finance Officer shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Independent Regulator and the Charity Commission for adoption by the Charitable Funds corporate trustees.

16.10 Accounting and Audit

16.10.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

16.10.3 The Charitable Funds corporate trustees shall be advised by the Chief Finance Officer on the outcome of the Charitable Funds annual audit. The Chief Executive shall submit the Management Letter to the Charitable Funds corporate trustees.

16.11 Administration Costs

16.11.1 The Chief Finance Officer shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Charitable Funds Working Group, shall charge such costs to the appropriate trust accounts.

16.12 Taxation and Excise Duty

16.12.1 The Chief Finance Officer shall ensure that the Charitable Funds liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17 Retention of records

17.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

17.1.2 The records held in archives shall be capable of retrieval by authorised persons.

17.1.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

18 Risk management and insurance

18.1 Programme of Risk Management

18.1.1 The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, which must be approved and monitored by the Board.

18.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements, including internal audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

18.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement (AGS) within the annual report and accounts.

18.2 Insurance: Risk Pooling Schemes administered by the NHS Litigation Authority

18.2.1 It is the responsibility of the Board to decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority. The decision whether the Trust will join the pooling schemes, self-insure or procure insurance cover for some or all of the risks covered by these schemes shall be reviewed annually.

18.3 Insurance Arrangements with Commercial Insurers

18.3.1 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

18.4 Arrangements to be followed by the Board in agreeing Insurance Cover

18.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

18.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19 Research and development

19.1.1 All research and development activities within the Foundation Trust shall be notified to the Director of Research.

19.1.2 The Chief Finance Officer shall ensure that procedures are put in place to ensure that all such activities are properly accounted for and that all funding is utilised appropriately.

19.1.3 The Chief Finance Officer shall ensure that procedures are put in place to ensure that appropriate governance and approvals are in place for Research and Development bid submissions and contract acceptance.

20 Acceptance of gifts by staff, standard of business conduct

20.1.1 The Trust Secretary shall ensure that all staff are made aware of the Foundation Trust's policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the NHSE Guidance June 2017 and Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff', NHS England guidance 'Managing Conflicts of Interest in the NHS ref 06419 and is also deemed to be an integral part of Standing Orders and Standing Financial Instructions (see also SO No. 7).

21 Tendering and Contracting Procedure

21.1 Duty to comply with these Standing Financial Instructions

21.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with these Standing Financial Instructions.

21.2 Procurement Act 2023 (comes into force on 24 February 2025)

21.2.1 The procurement of all goods, services and works must be undertaken in accordance with all applicable laws and the requirements set out in these Standing Financial Instructions. The Procurement Act 2023 and Procurement Policy Notes issues by the Government from time to time shall have effect as if incorporated in these Standing Financial Instructions.

21.3 Provider Selection Regime 2024 (came into force on 01 January 2024)

21.3.1 The provider selection regime is a set of rules for procuring health care services in England by organisations termed relevant authorities.

21.3.2 The provider selection regime does not apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by relevant authorities.

21.4 Public Contracts Regulations 2015 (replaced by the Procurement Act 2023 and Provider Selection Regime 2024)

21.4.1 The procurement of all goods, services and works must be undertaken in accordance with all applicable laws and the requirements set out in these Standing Financial Instructions. The Public Contracts Regulations 2015 ("PCR 2015") and Procurement Policy Notes issues by the Government from time to time shall have effect as if incorporated in these Standing Financial Instructions.

21.4.2 Orders must not be placed for goods, services or works which have been split or

otherwise placed in a manner to avoid the financial thresholds for tendering.

21.5 Electronic Tendering/Quotation

21.5.1 The Foundation Trust shall have processes and procedures in place for electronic quotation and tendering.

21.6 Guidance on Capital Investment

21.6.1 The Foundation Trust will comply with the requirements of NHSE "Capital Regime, Investment and Property Business Case Approvals Guidance for NHS Trust and Foundation Trusts", and the "Estate code" in respect of capital investment and estate and property transactions. The Foundation Trust should also comply with the requirements of the Department of Health NHS Finance Manual for Accounts (Department of Health Group Manual for Accounts).

21.7 Competitive Tendering

21.7.1 As a general rule, the procurement of any and all goods, services and works by or on behalf of the Foundation Trust must be tendered in an open, transparent and fair manner and so as to promote economy, efficiency and effectiveness in the Foundation Trust's expenditure.

21.7.2 The relevant tender process to be followed depends on the estimated total value of the proposed contract (including any extension period and any applicable VAT).

21.7.3 In limited circumstances, the requirement for competitive tendering may be waived in accordance with the provisions of paragraph 21.10 below.

21.7.4 Once awarded, all contracts with an aggregate value (inclusive of VAT) of:

(a) over £30,000, must be advertised on Contracts Finder; and

(b) over £138,760, must be advertised on the Find a Tender service.

21.8 Procurements below £15,000

21.8.1 There is no requirement for competitive quotes or a formal tender process for the purchase of goods, services or works with an estimated value of less than £15,000 (including VAT). The budget holder must, however, be able to demonstrate (and evidence) that the purchase represents good value for money.

21.9 Procurements between £15,000 and £30,000

21.9.1 The purchase of goods, services or works with an estimated value of more than £15,000 (including VAT) but less than £30,000 (including VAT) requires a minimum of 3 quotations to be obtained (or where the market is limited such lower number as may be reasonably practicable provided this is notified to, and approved by, the Assistant Director of Procurement).

21.10 Procurements between £30,000 and the PCR 2015 Procurement Threshold

21.10.1 The purchase of goods, services or works with an estimated value of more than £30,000 (including VAT) but less than the procurement threshold (currently £138,760 (including VAT)) requires a competitive tendering process or other compliant route to market.

21.11 Procurements above the PCR 2015 Procurement Threshold

21.11.1 The purchase of goods, services or works with an estimated value in excess of the PCR 2015 threshold for the procurement of goods and services (currently £138,760 (including VAT)) requires a full formal competitive tendering process (in accordance with the procedures and timescales set out in the PCR 2015) or other compliant route to market.

21.11.2 The requirement to tender or follow another compliant route to market in accordance with the PCR 2015 is, in these circumstances, an absolute obligation which cannot be waived.

21.12 Exceptions to Competitive Tendering Requirements

21.12.1 For proposed tenders with an estimated aggregate value (including any extension period and any applicable VAT) that is below the threshold for the procurement of goods and services as set pursuant to PCR 2015 (currently, £138,760 inclusive of any applicable VAT), competitive tendering procedures may be waived where it can be established to the reasonable satisfaction of the Assistant Director of Procurementthat:

(a) there is an urgent or emergency requirement and the timescales genuinely preclude competitive tendering (note: the failure to plan procurement activity in a timely manner is not a justification for seeking to rely on this ground);

(b) there is only one supplier and there is no reasonably satisfactory alternative supply;

(c) the requirement is essential to complete an existing project and engaging a different supplier for the requirement would lead to a technically inferior outcome;

(d) there is a clear benefit to be gained from maintaining continuity with an earlier project; however, in such cases, the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(e) the supply is of legal advice and services, provided that any legal firm commissioned by the Foundation Trust is regulated by the Solicitors Regulation Authority for the conduct of its business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and is generally recognised as having sufficient expertise in the area of work for which it is commissioned;

(f) a consortium or a national arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(g) it is a contract with another public body;

(h) it is a contract for works which is related to the procurement of capital equipment; and

(i) it is a contract pursuant to and in accordance with the requirements of a research

grant or award.

21.12.2 A budget holder or procurement officer seeking to rely on an exception to the competitive quote/ tendering requirements as otherwise required by these Standing Financial Instructions must complete a Waiver of Tender Application Form which must be approved by a relevant Senior Procurement Manager/ category lead and the Assistant Director of Procurementto any supplier being awarded a contract.

21.12.3 An exception to competitive tendering requirements should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

21.13 National Arrangements and Framework Agreements

21.13.1 Where a national arrangement for the supply of goods and services has been established by or on behalf of the Department of Health and Social Care in compliance with PCR 2015 and all other applicable laws for the benefit and use of NHS providers, the Foundation Trust may utilise such national arrangement in lieu of an open competitive tendering process.

21.13.2 Where a Framework Agreement has been established by or on behalf of the Foundation Trust or by a third party (but to which the Foundation Trust has secured access) in accordance with the requirements of the PCR 2015, then the Foundation Trust may utilise such Framework Agreement in lieu of an open competitive tendering process provided that the Foundation Trust complies with the requirements of the relevant Framework Agreement in awarding a contract pursuant to it.

21.14 Building, Engineering & Construction Works

21.14.1 For the avoidance of doubt, the competitive tendering requirements set out in these Standing Financial Instructions shall apply to the procurement of building, engineering and construction works.

21.15 Estimated Contract Values

21.15.1 All estimates of contract values for the purpose of establishing the appropriate procurement route must be made in good faith and supported by appropriate documentary evidence. Contract values should include any extension period allowed under the proposed contract and any applicable VAT. Where, subsequent to the commencement of a procurement process, it transpires that an estimated contract value breaches a financial threshold then such procurement shall be cancelled and recommenced using the appropriate procurement route unless the Assistant Director of Procurementis satisfied that, on balance, it is in the interests of the Foundation Trust to continue with the existing procurement.

21.16 Contract Variations & Extensions

21.16.1 Contract variations and extensions are allowed only in the following limited circumstances:

(a) where the modifications have been provided for in the original procurement

documents in clear, precise and unequivocal terms;

(b) for additional goods, services or works that have become necessary and were not included in the initial procurement, where a change of contractor:

(i) cannot be made for economic or technical reasons; or

(ii) would cause significant inconvenience or substantial duplication of costs, provided that any increase in price does not exceed 50% of the value of the original contract;

(c) where:

(i) the need for the modification has been brought about by circumstances which could not have been foreseen; and

(ii) the modification does not alter the overall nature of the contract, provided that, any increase in price does not exceed 50% of the value of the original contract;

(d) where the modification does not:

(i) render the contract materially different in scope or character from the one originally concluded;

(ii) introduce any terms or conditions which, had they been part of the original procurement, would have impacted on the participation in that procurement; or

(iii) change the economic balance of the contract in favour of the supplier.

21.16.2 A budget holder or procurement officer seeking to vary or extend a contract must complete a Contract Variation or Extension Form which in respect of any contract variation or extension with a value:

(a) up to the PCR 2015 threshold for the procurement of goods and services (currently £138,760), must be approved by the Operational Head of Procurement;

(b) greater than the PCR 2015 threshold for the procurement of goods and services (currently £138,760) but not more than £250,000, must be approved by the Assistant Director of Procurement; and

(c) greater than £250,000 but not more than £1m, must be approved by the Assistant Director of Procurementand a Deputy Chief Finance Officer; and

(d) greater than £1m, must be approved by the Assistant Director of Procurementand the Chief Finance Officer,

such approval must be obtained prior to any supplier being awarded such variation or extension to a contract PROVIDED THAT any change that with a value greater than 33% of the original contract value must in all circumstances be specifically approved by the Assistant Director of Procurement.

21.17 Evaluation of Tenders

21.17.1 Tenders must be evaluated strictly in accordance with the evaluation criteria and scoring methodology disclosed to the bidders in the tender documents.

21.17.2 The evaluation criteria must be based on securing the Most Economically Advantageous Tender (MEAT), taking into account both cost and quality.

21.17.3 A weighting of less than 40% cannot be allocated to the cost criterion without the prior written agreement of the Assistant Director of Procurement. Total life cycle costing should be included, wherever possible.

21.17.4 All tenders must include a minimum weighting of 10% for Social Value.

21.18 Awarding of Contracts

21.18.1 Provided that all the conditions and requirements set out in these Standing Financial Instructions have been complied with, formal authorisation and awarding of a contract must be undertaken by levels of staff appropriate to the value of the contract as set out in the Scheme of Delegation.

21.19 Contract Management

21.19.1 Budget Holders are primarily responsible for the operational management of their Contracts and must scrutinise and, where necessary, challenge supplier performance.

21.19.2 Budget Holders must ensure that Contract specifications contain suitable key performance indicators to incentivise appropriate service delivery and to highlight poor performance.

21.19.3 The Chief Finance Officer will support the delivery of the Foundation Trusts contractual supply relationships. These include:

(a) undertake supplier assessment and segmentation to identify the key strategic contracts held by the Foundation Trust.

(b) establish and maintain a contracts database and provide support to budget holders and service users on contract management issues;

(c) plan and carry out performance monitoring audits and identify, report and mitigate any risks identified;

(d) lead the development and rollout of a Foundation Trust-wide contract management methodology taking full account of contract management principles and the Trust's strategic objectives to support the delivery of contractual commitments and the realisation of benefits and efficiencies.

(e) ensure the timely and accurate production of written reports to provide assurance to the Executive Management Team that the Foundation Trust's contracts are being appropriately managed and value for money is being delivered;

(f) design and deliver contract management training to support to colleagues to manage their contracts;

(g) support the development of commercial initiatives;

(h) support negotiations on contract extensions, variations, and renewals;

(i) develop and manage the Trust's contract management team and function;

(j) support the management and resolution of contractual disputes;

(k) promote the role of contract management in good governance.

21.20 Engagement of Staff & Pay Rates

21.20.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts.

21.20.2 Agreement of any off-payscale pay rates outside of the national agenda for change and medical and dental payscales may only be done with the prior written approval of the Chief Finance Officer and the Chief People and Purpose Officer.

21.21 Cancellation of Contracts

21.21.1 A contract for the supply of goods, services or works may only be cancelled prior to the expiry of its term with the prior written approval of the Assistant Director of Procurement.

21.22 Procurement Manual

21.22.1 The detailed procurement processes and procedures set out in the Foundation Trust's Procurement Manual, as amended and updated from time to time with the approval of the Assistant Director of Procurement, must be followed save to the extent otherwise agreed in advance and in writing with the Assistant Director of Procurement.

21.23 Disposals (see also SFI 13, Disposals and Condemnations, Losses and Special Payments)

21.23.1 Tendering or quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the policy of the Foundation Trust;

(c) items to be disposed of with an estimated sales value of less than £10,000 (exclusive of VAT), this figure to be reviewed periodically;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which any relevant guidance has been issued, subject to compliance with such guidance.

(f) Disposal of items on the asset register, which originally cost not less than £5,000 must be notified to the Finance Department. Capital Equipment costs which originally cost not less than £5,000 should include VAT.

21.24 In-House Services

21.24.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested.

21.24.2 The findings shall be documented and reported to the Chief Finance Officer, for onward communication to the Board.

21.25 Applicability of SFIs on Tendering and Contracting to Funds Held on Trust (see also SFI 16, Funds Held on Trust)

21.25.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's funds held on Trust.

21.26 Confidentiality of Contract Information

21.26.1 All documentation and minutes relating to contract prices shall at all times be treated as confidential save to the extent otherwise required by law.

Reservation of Powers to the Board

and

Scheme of Delegation

Document control

Policy reference	CG04 2020
Category	Corporate Governance
Strategic objective	To deliver our financial plan and key performance targets

Author:	Michael Quinlan, Deputy Director of Finance
Version:	1.1
Status	Draft
Supersedes:	April 2023
Executive Lead:	Chief Finance Officer
Approval Committee:	Audit Committee
Ratified by:	Board of Directors
Date ratified:	
Date issued:	November 2024
Review date:	November 2025

Target audience	All Managers
Summary	The Code of Accountability for NHS Boards and Monitor's Code of Governance requires that there should be a formal schedule of matters specifically reserved to the Board. The purpose of this document is to define those powers specifically reserved to the Board.
Changes since last revision	
Monitoring arrangements	Internal audit process and reports to the Audit Committee.
Training requirements	Not applicable
quality Impact Assessment	Not applicable

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1. Introduction

1.1.1 The Code of Accountability for NHS Boards and NHSEI's Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved to the Board. The purpose of this document is to define those powers specifically reserved to the Board. However, the Board remains accountable for all of its functions, including those delegated to the Chairman, Chief Executive and Board members, and will therefore receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.1.2 All powers of the Foundation Trust which have not been retained as reserved by the Board or delegated to a committee shall be exercised on behalf of the Board by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those which are delegated to other Board members and officers. All powers delegated by the Chief Executive can be re-assured by him/her should the need arise.

1.1.3 In the absence of the Chief Executive the powers delegated to him/her may be exercised by the Chairman after having consulted at least two non-Executive Directors.

2. Governors' Legal Responsibilities

2.1.1 The Foundation Trust has a body of elected individuals that make up the Council of Governors. Governors have a number of legal rights and responsibilities. These include:

- the appointment or dismissal of the Chairman and non-Executive Directors
- the approval of the appointment of the Chief Executive at a general meeting the Council of Governors will:
    - receive the annual accounts, annual report, quality report and annual audit letter from the external auditors
    - approve the remuneration and allowances and other terms and conditions of the office of the Chairman and non-Executive Directors
    - appoint or replace the Foundation Trust's auditor at a general meeting
- providing the views of the Council of Governors to the Board for the purposes of the preparation by the Board of the document containing information as to the Foundation Trust's forward planning in respect of each Financial Year to be given to NHSE
- receiving and considering the views of the Members on matters of significance to the future plans of the Foundation Trust
- approval of any amendments to the Constitution

- hold the non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- represent the interests of the NHS Foundation Trust members and the public served by the Foundation Trust
- approving significant transactions that fall within the definition
- appointment and removal of the External Auditors
- approval of the increase in non-NHS income where it is 5% or more in any one year

2.1.2 A 'Council of Governors Engagement Policy' is in place for those circumstances where the council has concerns about the performance of the Board of Directors, compliance with the provider licence, or other matters related to the general wellbeing of the NHS Foundation Trust.

3. Reservation of Powers to the Board

3.1 General Enabling Provision

3.1.1 The Board may determine any matter (for which it has delegated or statutory authority) it wishes in full session within its statutory powers.

3.1.2 Powers are reserved to the Board to:

3.2 Regulation and Control

3.2.1 Approval, suspension, variation or amendment of Standing Orders, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business.

3.2.2 Approve a Scheme of Delegation of powers from the Board to Committees or Officers.

3.2.3 Require and receive the declarations of Board members' interests which may conflict with those of the Foundation Trust and determine the extent to which a Board member may remain involved with the matter under consideration.

3.2.4 Require and receive the declarations of interests from Officers which may conflict with those of the Foundation Trust.

3.2.5 Appoint, appraise, discipline and dismiss executive directors (subject to SO 2.6 and section 7 of the Constitution). Discipline Board members who are in breach of statutory requirements or SOs.

3.2.6 Approve arrangements for dealing with complaints.

3.2.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and agree modifications thereto.

3.2.8 Ratify any urgent decisions taken by the Chairman (and Chief Executive) in accordance with SO 4.2.

3.2.9 Approve arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.

3.2.10 Approve the Foundation Trust's Major Incident Plan.

3.2.11 Approve arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property.

3.2.12 Approve proposals for action on litigation against or on behalf of the Foundation Trust.

3.3 Appointments

3.3.1 Appoint and dismiss Board Committees.

3.3.2 Establish terms of reference and reporting arrangements for Board Committees.

3.3.3 Appoint members of all Board Committees.

3.3.4 Receive reports from all Board Committees and take appropriate action on these.

3.3.5 Confirm the recommendations of Board Committees where the committees do not have executive powers.

3.3.6 Appointment of the Vice Chairman.

3.3.7 Appointment of any representative body outside the organisation.

3.4 Strategy, Business Plans and Budgets

3.4.1 Define the strategic aims and objectives of the Foundation Trust.
3.4.2 Approve annually revenue and capital budgets.

3.4.3 Approve and monitor the Foundation Trust's policies and procedures for the management of risk.

3.4.4 Ratify proposals for the acquisition, disposal or change of use of land and/or buildings (subject to meeting the requirements set by Monitor in the Foundation Trust's Provider Licence).

3.4.5 Approve proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust.

3.4.6 Approve proposals for ensuring equality and diversity in both employment and the delivery of services.

3.4.7 Approve the Foundation Trust's investment policy and authorise institutions with which temporary cash surpluses may be held.

3.4.8 Approve the Foundation Trust's borrowing policy, which will include other long- term financing arrangements such as leases.

3.4.9 Authorise any necessary variations to total budget spends of capital schemes of more than 20% or £500,000, whichever is greater. Authorise any increase in the total capital programme.

3.5 Financial and Performance Reporting Arrangements

3.5.1 Continuously appraise the affairs of the Foundation Trust by means of the receipt of reports as it sees fit from Board members, committees, and officers of the Foundation Trust as set out in management policy statements. All monitoring returns required by NHSEI and the Charity Commission shall be reported, at least in summary, to the Foundation Trust.

3.5.2 Approve the opening and closing of all bank and investment accounts.

3.5.3 Consider and approve the Foundation Trust's Annual Report, including the annual accounts, prior to submission to the Council of Governors.

3.5.4 Receive and approve the annual report(s) for funds held on trust.

3.5.5 Receive reports from the Chief Finance Officer on financial performance against budget and annual business plan.

3.6 Audit Arrangements

3.6.1 Receive reports of Audit Committee meetings and take appropriate action.

3.6.2 Receive the annual management letter from the external auditor and agree action on the recommendation where appropriate of the Audit Committee.

4. Reservation of Powers to the Board and Scheme of Delegation

4.1.1 The following delegation table below provides a framework for decision making responsibilities within the Foundation Trust. Directors are responsible for ensuring that all staff operates within the Scheme of Delegation and in accordance with Standing Orders and Standing Financial Instructions. The Scheme of Delegation identifies the lowest level to which a particular responsibility may be delegated. There is no requirement for Directors to delegate to this level.

4.1.2 The levels of management/delegation referred to in this scheme are as follows:

- Chief Executive (In the absence of the Chief Executive, urgent matters may be dealt with by the Deputy Chief Executive).

- Chief Finance Officer (In the absence of the Chief Finance Officer, urgent matters may be dealt with by the Deputy/Assistant Director of Finance)

- Other Executive Directors

- the Foundation Trust Secretary

- Relevant General Managers

4.1.3 It is for Executive Directors to identify within their directorate those officers whom they wish to authorise (Authorised Signatories) to exercise delegated authority within this Scheme of Delegation. The Finance Department maintain a register of authorised signatories and will require sample signatures to support the register. Forms for this purpose of registering authorised signatories are available from the Financial Management section staff within the Finance Directorate.

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
4.1 Delegation of budgets and approval to spend funds		
SFI 3.2.3	Annual Business Plan	The Board
SFI 3.4	Budgetary Control	Chief Finance Officer
SFI 8.3	Approval of new staff appointments and re-grading	Chief People and Purpose Officer
SFI 8.4	Approval of pay expenditure (staff timesheets)	General Manager, Executive Director, Director of Estates and Facilities, Director of Pharmacy, Director of Research
	Approval of business cases seeking additional revenue internal funding (excluding Research and Development). Up to £1,000,000 (in year costs) Over £1,000,001 (in year costs)	 Planning Committee and Executive Management Team Board of Directors
SFI 9.1	Authorisation of requisitions/invoices for non-pay expenditure: NB. The relevant Executive Director and the Chief Finance Officer will determine and agree appropriate values for further delegation. The Non Pay Review Panel (chaired by the Chief Finance Officer) will review all non pay expenditure that requires a commitment of additional expenditure over £4,000 which will add to the expenditure run rate. Expenditure limit may change throughout the year. - If the Trust is not financially distressed final approval of all non purchase order invoices over £150,000 will be approved by the Chief Finance Officer. - If the Trust is financially distressed final approval of all non purchase order invoices over £50,000 will be approved by the Chief Finance Officer.	
	Up to £5,000	Ward Manager

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
		Service Manager
	Over £5,000 up to £25,000	Matron Deputy General Manager
	Over £25,000 up to £50,000	Deputy Director of Nursing Senior General Manager General Manager
	Over £50,000 up to £75,000	CSU Clinical Director
	Over £75,000 up to £100,000	Deputy Director of Estates Deputy Director of Operations Director of Nursing
	Over £100,000 up to £150,000	Executive Directors Deputy Chief Operating Officer Deputy Director of Finance
	Over £150,000 up to £250,000	Chief Operating Officer
	Over £250,000 up to £500,000	Chief Finance Officer
	Over £500,000 up to £1,000,000	Chief Finance Officer and Chief Executive
	Over £1,000,000	Board of Directors
	Non-pay expenditure for which no specific budget has been set within delegated budget plans.	Chief Executive or Chief Finance Officer
	Approval of routine expenses claims	Line Manager
	Prioritisation of Supplier Payments	Executive Team Meeting

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
SFI 9.2.7	Pre-payments (payment to suppliers before goods or services are received)	
	up to £25,000	Assistant Director of Finance
	Over £25,000 up to £100,000	Assistant Director of Finance and Deputy Director of Finance
	Over £100,000	Deputy Director of Finance and Chief Finance Officer
4.2 Operation of all detailed financial matters		
SFI 5	Approve the opening, closing and management of all bank and investment accounts.	Chief Finance Officer
SFI 8.4	Payroll	Chief Finance Officer
SFI 9.2	Purchase ledger/creditor payments	Chief Finance Officer
SFI 9.2	Petty cash and purchase card	Chief Finance Officer
SFI 6.4	Debtors	Chief Finance Officer
SFI 10.5	Treasury management	Chief Finance Officer
4.3 Income Systems		
SFI 6	System design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, for provision of adequate facilities and systems for employees whose duties include collecting or holding cash.	Chief Finance Officer
4.4 Annual capital / finance lease programme and capital / finance lease expenditure proposals		
SFI 11	Approval of Five Year Capital and Finance Lease Programme	Capital Strategy Group and Board of Directors

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
SFI 11.1	Total budget spend of each capital and finance lease scheme may be varied by £500,000, subject to capital programme remaining within budget. Total budget spend of each capital and finance lease scheme may be varied by £1,000,000, subject to capital programme remaining within budget. A business case is required for capital and finance lease expenditure proposals of value over £500,000 (excluding VAT) where this is related to the replacement of existing assets. For the new items the Foundation Trust' Service Development Guidelines must be followed.	Chief Finance Officer Chief Executive Relevant General Manager
4.5 Capital Approval		
	Replacement of existing capital assets Up to £150,000 (excluding VAT) Over £150,001	 Capital Operational Group Capital Strategy Group
	Vesting Certificates (Managing Public Money Guidance must be followed)	Relevant General Manager and Deputy Director of Finance
4.6 Arrangements for the management of land, buildings and other assets belonging to or leased by the Foundation Trust		
SFI 11.3–5	Physical management and maintenance of assets including notifying discrepancies to Chief Finance Officer, and reporting losses in accordance with Trust procedure.	
	Land and buildings.	Director of Estates and Facilities.
	Equipment.	Relevant General Manager.

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Asset register and capital charges.	Chief Finance Officer.
4.7 Management and control of stocks		
SFI 12	Theatres.	General Manager
	Pharmacy	Director of Pharmacy
	Estates	Director of Estates
	Other stocks.	Relevant General Manager.
4.8 Recording, monitoring and approval of payments under the losses and special payments regulations		
SFI 13.2	Monitoring and approval of losses and special payments.	Chief Executive and Chief Finance Officer
	Accounting for losses and special payments.	Chief Finance Officer.
	General Administration.	Relevant General Manager.
	Write-offs NB. Written reports on write-offs are provided to the Audit Committee	
	Drugs Up to £5,000 Over £5,000	 Director of Pharmacy Chief Finance Officer

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Other items Up to £10,000 Over £10,001 up to £50,000 Over £50,001 up to £100,000 Over £100,001	 Divisional Clinical Director Chief Finance Officer Chief Finance Officer and Chief Executive Board of Directors
	Cash losses and bad debts: NB. A bad debt write-off for these purposes is the writing off of any income due to the Foundation Trust, whether or not invoices – it does not include adjustments relating to invoices raised in error. These write-offs once agreed will impact on individual budgets – there is no central provision. If the budget holder does not agree to a write-off being charged to their budget, this should be escalated to the Chief Finance Officer. NB. Written reports on write-offs are provided to the Audit Committee.	
	Up to £500	Credit Income Manager
	Over £501 up to £5,000	Deputy Director of Finance
	Over £5,001 up to £10,000	Chief Finance Officer
	Over £10,001	Chief Executive and Chief Finance Officer
	Overpayment of Staff Salaries There is the expectation that any overpayment of salary to staff or leavers will be fully recovered.	
	Up to £10,000	Chief Finance Officer

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Over £10,001	The Board
	Losses of equipment and property: NB. These write-offs once agreed will impact on individual budgets – there is no central provision. NB. Written reports on write-offs are provided to the Audit Committee.	
	Up to £10,000	Chief Finance Officer
	Over £10,001	The Board
SFI 18	Claim	
	Clinical negligence/personal injury	
	All payments over the relevant excess (zero for clinical negligence, £3,000 for employer's liability and £10,000 for public liability) are approved and made directly by the NHS Litigation Authority – however, the NHSLA still requires the agreement of the Foundation Trust for all admissions.	NHS Litigation Authority (NHSLA) and Chief Executive or Divisional Clinical Director
	Claims settled without legal advice:	
	Total costs, including damages, claimant and defence costs up to £10,000	Claims Manager
	Over £10,001 up to £50,000	Any two of: Claims Manager, Medical Director, Chief Finance Officer or Deputy Chief Executive

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Over £50,001	Claims Management Group, Chief Finance Officer and Chief Executive
	Negotiated settlements with legal advice (i.e. out of court settlements):	
	Total costs up to £100,000	Claims Manager and Chief Finance Officer
	Over £100,001	Claims Management Group and Chief Executive
	Payments made under full legal obligation:	
	Total cost approved by the NHSLA	Claims Manager and reported to Claims Management Group
	Other Claims (not clinical negligence/personal injury):	
	Compensation claims arising out of legal action	Such payments may require NHSEI and HM Treasury approval. Advice should be obtained from Chief People and Purpose Officer or Trust Secretary.
	Up to £50,000	Chief Finance Officer
	Over £50,001	The Board
	Extra-contractual payments to contractors; other compensatory payments:	
	Up to £5,000	Chief Finance Officer

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Over £5,001	The Board
SFI 18	Complaints	
	Ex-gratia payments made in respect of complaints	
	Up to £1,000	Relevant General Manager with notification to Claims Manager
	Over £1,001 up to £5,000	Relevant General Manager and Claims Manager
	Over £5,001	The Board
	Special Payments	
	(Other payments made in line with the Losses and Special Payments policy not included in approval above)	
	Up to £50	Relevant General Manager following submission of a completed Losses and Special Payment Checklist
	Over £50 up to £1,000	Relevant General Manager and Deputy Director of Finance
	Over £1,000 up to £10,000	Relevant General Manager and Chief Finance Officer
	Over £10,000	The Board
4.9 Disposal of a deceased patients' property:		
SFI 15.5	Property value up to £5,000:	

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Cash up to £100 and all valuables may be released to relatives who sign form of indemnity.	Deputy/Assistant Director of Finance
	Cash over £100 may be released by cheque together with all valuables to relatives who sign a form of indemnity.	Deputy/Assistant Director of Finance
	Property value over £5,000:	
	Cash over £100 may be released by cheque together with all valuable on production of probate letters or administration.	Chief Finance Officer
4.10 Management of non-exchequer funds		
SFI 16	Charitable Funds	
	Approval of expenditure	
	Up to £500	Fund Holder
	Over £501 up to £10,000	General Manager, Patient Services Manager and Chief Finance Officer
	Over £10,001 up to £50,000	Chief Finance Officer and Chief Executive
	Over £50,001 to £100,000	Chief Executive, Chairman and Chief Finance Officer
	Over £100,001	Bradford Hospitals Charity Committee
	Financial administration	Chief Finance Officer
	General administration	Charity Director

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Patients' Monies	
	Nursing	Chief Nurse
	Financial administration	Chief Finance Officer
4.11 Insurance Arrangements		
SFI 18.3	Ensure that insurance arrangements exist in accordance with the risk management programme.	Chief Finance Officer
4.12 Non-Clinical Risk Management		
SFI 18	Ensure that Foundation Trust has a programme of risk management in place.	Chief Executive
4.13 Business Conduct and Hospitality		
SFI 20	Ensure staff members are aware of the Foundation Trust Policy on acceptance of gifts and Standards of Business Conduct for NHS Staff in accordance with the Standing Orders and Financial Instructions.	Foundation Trust Secretary
4.14 Tendering and Contracting (including Grants and Contract Execution) (Aggregate contact value, including extensions and VAT)		
SFI 21	less than £15,000	General Manager or Budget Holder (minimum Band 8a)
	Over £15,000 to £138,760	Deputy Director of Finance or Assistant Director of Procurement (all contracts) Director of Estates and Facilities (Estates & Facilities contracts) Director of Pharmacy (Pharmacy contracts) Director of Research (Research contracts and grants)

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Over £138,761 to £250,000	Deputy Director of Finance or Assistant Director of Procurement (all contracts) Director of Estates and Facilities (Estates & Facilities contracts) Director of Pharmacy (Pharmacy contracts) Director of Research (Research contracts and grants) AND Deputy Director of Finance
	Over £250,001 to £1,000,000	Deputy Director of Finance or Assistant Director of Procurement (all contracts) Director of Estates and Facilities (Estates & Facilities contracts) Director of Pharmacy (Pharmacy contracts) Director of Research (Research contracts and grants) AND Chief Finance Officer
	Over £1,000,001 to £2,000,000	Deputy Director of Finance or Assistant Director of Procurement (all contracts) Director of Estates and Facilities (Estates & Facilities contracts) Director of Pharmacy (Pharmacy contracts) Director of Research (Research contracts and grants) AND

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
		Chief Finance Officer and Chief Executive
	Over £2,000,001	Deputy Director of Finance or Assistant Director of Procurement (all contracts) Director of Estates and Facilities (Estates & Facilities contracts) Director of Pharmacy (Pharmacy contracts) Director of Research (Research contracts and grants) AND Chief Finance Officer and Chief Executive PROVIDED THAT the Board of Directors have specifically approved the execution of the contract by the Trust
4.15 Research and Development Applications (for Research Grants and Commercial Research Contracts)		
SFI 19	less than £250,000	General Manager and Finance Manager

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
	Over £250,001 to £1,000,000	Director of Research and Deputy Director of Finance
	Over £1,000,001 to £2,000,000	Medical Director and Chief Finance Officer
	Over £2,000,001	Medical Director and Chief Finance Officer AND Paper shared at Executive Team Meeting (before or after)
4.16 Research Grants and Commercial Research Contracts (commitment to proceed after successful application)		
SFI 19	less than £250,000	General Manager and Finance Manager
	Over £250,001 to £1,000,000	Director of Research and Deputy Director of Finance
	Over £1,000,001 to £2,000,000	Medical Director and Chief Finance Officer
	Over £2,000,001 to £3,000,000	Medical Director and Chief Finance Officer AND Paper shared at Executive Team Meeting
	Over £3,000,001	Medical Director and Chief Finance Officer Paper shared at Board of Directors (delegated to Chair if time constraints)
4.17 Management and control of computer systems and facilities		
SFI 14.1.1	Accuracy and security of computerised financial data systems	Director of Informatics
SFI 14.1.3	Publish and maintain Freedom of Information (FOI)	Communications Manager
4.18 Appointment of consultant medical staff		
SFI 8.3.3	Approval of business cases for appointment of new Consultant Medical Staff.	The Executive Team

SCHEME OF DELEGATION		
Reference (where applicable)	Delegated Responsibility	Delegated Officer
4.19 Pay Rate Controls		
SFI 21.12	Agreement of any off-payscale pay rates outside of the national agenda for change and medical and dental payscale.	Chief Finance Officer and Chief People and Purpose Officer.
4.20 Engagement of temporary workers, particularly agency staff		
SFI 21.11	Authority to enter into contracts of employment for staff, agency staff or temporary staff service contracts.	
	Professional groups other than Nursing and Medical	Vacancy Approval Panel
	Nursing staff via the Flexible Workforce Team Office	Director of HR
	Medical Staff via the Flexible Workforce Team at Human Resources	Director of HR
4.21 Use of directed surveillance		
	Directed surveillance that is carried out by the Foundation Trust is subject to strict controls.	This can only be authorised by the Police or NHS Protect (Counter Fraud Service).

BO.11.24.24 - MODERN SLAVERY STATEMENT

REFERENCES

Only PDFs are attached

Bo.11.24.24 - Modern Slavery Statement (cover).pdf

Bo.11.24.24 - Appendix 1 - BTHFT Slavery and Human Trafficking Statement 24-25 - DRAFT.pdf

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.24

Modern Slavery Statement

Presented by	Laura Parsons, Associate Director of Corproate Governance/Board Secretary	
Author	Laura Parsons, Associate Director of Corproate Governance/Board Secretary	
Lead Director	Renee Bullock, Chief People and Purpose Officer	
Purpose of the paper	To present the draft Modern Slavery Statement for 2024/25 for approval	
Key control	N/A	
Action required	For approval	
Previously discussed at/informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	ETM	18.11.24

The Modern Slavery Act 2015 is designed to consolidate various offences relating to slavery and human trafficking. The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking. Section 54 of the Act specifically relates to transparency in supply chains. It states that commercial organisations with a total turnover in excess of £36million per year must publish a written slavery and human trafficking statement. This should include the steps taken to ensure that slavery and human trafficking is not taking place, including within its supply chain.

Whilst the Trust (as a public body) is not required to publish a statement, there have been some instances where research funders have requested to see our statement as part of their funding conditions. Publishing a statement also demonstrates our commitment to combatting slavery and human trafficking. Many other NHS trusts have also chosen to publish statements.

The Trust's first statement was approved in September 2023 and is subject to an annual update. It has been reviewed by colleagues in HR, finance, procurement, safeguarding and FTSU. Minor amendments are proposed (attached at Appendix 1 in tracked changes) to ensure that the statement remains up to date. The procurement team has its own statement and this has also been incorporated into the overall Trust statement.

The format of the statement includes the suggested information as outlined within the Act, and statements produced by other NHS organisations have also been reviewed to ensure we are in line with best practice.

The statement must be approved by the board of directors and signed by a director, and must then be published on the Trust's website.

Recommendations

The Board is asked to approve the proposed amendments to the Modern Slavery and Human Trafficking Statement.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.24

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

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 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
Other (please state):

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

Bradford Teaching Hospitals
NHS Foundation Trust

Modern Slavery and Human Trafficking Statement 2023~~3~~4-25~~4~~

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking, and recognises the significant role the NHS has to play in both combatting it and supporting victims. This includes being strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses.

We aim to follow good practice and take all reasonable steps to prevent slavery and human trafficking. We are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be or is at risk of modern slavery/human trafficking.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the current financial year.

Our structure, our business and supply chains

On 1 April 2004, BTHFT was authorised to become an NHS Foundation Trust by Monitor, the then Independent Regulator of NHS Foundation Trusts, under Section 6 of the Health and Social Care (Community Health and Standards) Act 2003.

BTHFT is an integrated Trust that provides acute, community, inpatient and children's health services. The acute services are provided from the Bradford Royal Infirmary site.

In addition to Bradford Royal Infirmary and St Luke's Hospital, we provide a range of services from community sites at Westbourne Green, Westwood Park, ~~Shipley,~~ Eccleshill, Skipton and the Bradford Macula Centre. We serve a population of around 6~~5~~50,000 people from Bradford and the surrounding area. We have approximately 630 acute beds, employ over ~~6,750~~7,000 members of staff, and have more than ~~5~~100 volunteers supporting our services~~, and we have been delighted to continue welcoming back our valued volunteers this year following a pause during the pandemic~~. In 2023~~2~~/2~~4~~3 we delivered 5,~~068~~ 314 babies, performed ~~16,872~~17,087 operations in theatre and handled ~~446,204~~ 504,333 outpatient appointments. We had ~~141,064~~145,016 attendances at our Emergency Department.

Our policies in relation to slavery and human trafficking

We have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. These include:

- **Safeguarding Adults Policy and Procedure** - includes information on modern day slavery/human trafficking and the actions that staff are expected to take if they suspect that a patient may be a victim of human trafficking.
- ~~**Incident Reporting and Investigation**~~ **Patient Safety Incident Response Policy** – advises staff to report incidents of all types, includes concerns regarding modern slavery and human trafficking. ~~By using the local incident management system,~~ A~~a~~ppropriate teams, including safeguarding and Freedom to Speak Up are made aware of any relevant incidents raised.

- **Freedom to Speak Up: Raising Concerns (Whistleblowing)** - which details how staff can raise any concerns that they may have confidentially.
- **Procurement Policies** – see below.
- **Human resources policies** - provide processes and procedures to ensure that our employees and those employed in our supply chains are treated fairly at all times.

All staff have access to our safeguarding team for support and guidance when they are concerned about modern day slavery or trafficking.

An Equality Impact Assessment (EQIA) is completed for all relevant Trust activities and policies.

Our due diligence processes in relation to slavery and human trafficking in our business and supply chains

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our organisation or supply chain.

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We are committed to taking all reasonable steps to ensure that we trade with suppliers in a chain that is free from slavery, servitude and forced or compulsory labour and human trafficking.

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All staff involved in the procurement of goods and services are aware of, and cognisant of, the risks of modern slavery and techniques to minimise and eliminate such risks. We use clear and transparent procurement processes to diligently assess our suppliers, including their commitment to an ethical and fair workforce. We review the requirements for all eligible suppliers to produce a published Modern Slavery Act Statement and track the progress they are making.

When we deal with third party distributors such as NHS Supply Chain or use Framework Agreements, we ensure that their procurement systems and processes are compliant with Modern Slavery Act requirements.

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~~We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business.~~

~~Our procurement tenders include a question regarding the Modern Slavery Act. Any suppliers who declare that they do not comply with the legislation will be excluded or disqualified from the procurement process. Additionally, when procuring goods and services, we apply NHS Terms and Conditions which requires suppliers to comply with legislation.~~

~~Section 10 (Warranties) of those standard terms and conditions states the following:~~

~~*10 Warranties*~~

~~*10.1 The Supplier warrants and undertakes that:*~~

~~*10.1.21 it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;10.1.22 it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.22 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy;*~~

Human Resources processes in place to ensure staff are treated fairly at all times include:

- Confirming the identities of all new employees and their right to work legally in the UK.
- To have assurance from approved agencies that pre–employment clearance has been obtained for agency staff and to safeguard against human trafficking.
- All staff appointed are subject to references, immigration and identity checks, this is to ensure staff have the legal right to work in the UK.
- The Trust has a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the recruitment selection process.
- By adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated, fairly and that pay, terms and conditions will comply with the latest legislation.
- The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers and also to comply with the relevant legislation. These are accessible on the intranet.
- The Trust is committed to creating and ensuring a non–discriminatory and respectful working environment for all staff.
- The Trust's Equality, Diversity and Inclusion, Grievance, Harassment & Bullying Policies and Freedom to Speak Up policies and procedures additionally give a platform for all employees the freedom to speak up and to raise concerns about anything that gets in the way of staff doing their job.
- Ensuring appropriate mechanisms to regularly review and monitor progress on promoting and supporting equality, diversity and inclusion within the Trust.
- All staff are required to undertake mandatory training in relation to equality, diversity and inclusion and safeguarding.

The parts of our business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps we have taken to assess and manage that risk

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain:

- The Trust adheres to the National NHS Employment Checks / Standards (this includes employees' UK address, right to work in the UK and suitable references).
- The Trust has systems to encourage the reporting of concerns and the protection of staff who do raise a concern.

- The Trust purchases a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour. Other contracts are governed by standard NHS Terms & Conditions. High value contracts are effectively managed and relationships built with suppliers.
- The majority of our purchases use existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract, these all have the requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes in place. Where a suitable framework exists we use them in preference to tendering. These are run by NHS procurement hubs and contain the standard Terms & Conditions.
- The Trust will request all suppliers to comply with the provisions of the UK Modern Slavery Act 2015, through agreement of our 'Supplier Code of Conduct', purchase orders and tender specifications. All of which will set out our commitment to confirming there is no modern slavery or human trafficking related to BTHFT service delivery and business.
- The Trust upholds professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply (CIPS). Our operational staff are all CIPS members and the majority of them have passed CIPS level 4 which is a part of their PDP objectives.

Our effectiveness in ensuring that slavery and human trafficking is not taking place in our business or supply chains

The Trust is committed to social and environmental responsibility and has zero tolerance for modern slavery and human trafficking. Any identified concerns regarding modern slavery and human trafficking are escalated as part of the organisational safeguarding process.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

A Freedom to Speak Up report is submitted to the People Academy on a quarterly basis (and to the Quality ~~& Patient Safety Academy~~Committee and Board of Directors for information), which includes an overview of the number of concerns raised by staff and the category that they fall into.

The training about slavery and human trafficking available to our staff

Safeguarding training is mandatory for all staff and includes information on trafficking and modern day slavery in order to promote the knowledge and understanding of escalating concerns via the Home Office national referral mechanism/duty to notify process.

This is our ~~first~~ second Modern Slavery and Human Trafficking Statement. We will review it on an annual basis and present it at an open Board of Directors meeting for approval. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

Approved by the Board of Directors on: ~~21 September 2023~~

Next review: ~~September 2024~~November 2025

Signed:

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Professor Mel Pickup, Chief Executive

BO.11.24.25 - HEALTH & SAFETY ANNUAL REPORT

REFERENCES

Only PDFs are attached

Bo.11.24.25 - Health & Safety Annual Report (cover).pdf

Bo.11.24.25 - Health and Safety Annual Report 2023-24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.25

Health and Safety Annual Report 2023/24

Presented by	David Moss, Director of Estates and Facilities	
Author	Caroline Nicholson, Head of Non-Clinical Risk	
Lead Director	David Moss, Director of Estates and Facilities	
Purpose of the paper	The Health and Safety annual report provides summary information relating to principal activities associated with the management and promotion of Health and Safety issues during 2023/24	
Key control	This paper is a key control for the operation of the Board Assurance Framework.	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	*e.g. Academy / ETM / CSU group*	**Date**

Key Options, Issues and Risks

The Health and Safety annual report provides summary information relating to principal activities associated with the management and promotion of Health and Safety issues during 2023/24. It also highlights the current key priorities for the Health and Safety team during this current financial year. The report provides a summary of a gap analysis undertaken in relation to key areas of legislation, guidelines and Trust performance. This approach of identifying gaps and risks associated with any health and safety regulations benefits the Trust as it provides a clear picture of health and safety compliance.

Whilst the Trust's performance in relation to Health and Safety is generally good, there are opportunities for change and improvement.

Analysis

During 2023/24 the Health and Safety Committee have had a challenging year reviewing all areas of health and safety and refocusing what on what is required to move the Trust forward.

The Health and Safety Team have worked closely with the Care Groups and Corporate Departments. The report highlights any gaps in health and safety that the Trust need to be aware of as well as providing detail of what has moved forwards such as fire risk assessments that are now 100% complete for all high risk areas. Priorities have changed for the health and safety team during 2023/24, to move forward with the requirements of the Trust whilst working with a significantly reduced team.

Unfortunately, several of the actions from the 2022/23 action plan have not been completed with the outstanding actions going forward onto 2023/24. Some of these actions are impacted by the financial restrictions that the Trust and wider NHS face.

However, the implications of the current "Closing the Gap" financial constraints, and the freeze on recruitment to Health and Safety and Fire Safety roles, pose a significant risk to the wider Trust. This increases the likelihood of safety incidents, and if realised the possibility of actions from enforcement bodies, criminal and civil legal proceedings and reputational damage.

The largest risks for the Trust sit within Fire, medical devices and general maintenance and age of the building, which is impacting of electrical safety, ventilation and working at height. There are a number of risks such as violence and aggression to staff that are impacting on health a wellbeing of staff.

Meeting Title	Board of Directors		
Date	28 November 2024	Agenda item	Bo.11.24.25

It should be noted that improvements have been made with Control of Substances Hazardous to Health (COSHH) with more engagement with the end user. Relationships with enforcement agencies and regional health and safety colleagues remain strong with regular communication.

The report details changes in legislation that have taken place during 2023/24 or planned to take place in 2024/25. The Trust has appropriate Health and Safety policies and procedures in place.

Recommendation

The findings of the report have led to an action plan which will assist with the focus of the Health, Safety for the Trust. It is recommended that this report is accepted as the current position as the Trust annual Health and Safety report for 2022/23.

Risk assessment

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

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

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

Regulation, Legislation and Compliance relevance

Meeting Title	Board of Directors		
Date	28 November 2024	**Agenda item**	**Bo.11.24.25**

NHS England: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☒Code of Governance ☒Annual Reporting Manual
Care Quality Commission Domain: Safe
Care Quality Commission Fundamental Standard: Safety
NHS England Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities
Other (please state):

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

1 PURPOSE/ AIM

The purpose of the 2023/2024 annual report is to provide the Trust's Board of Directors with an overview of health and safety performance for Bradford Teaching Hospitals NHS Foundation Trust ('The Trust') during the year and to summarise The Trusts key risks to achieving its objectives. All matters relating to health and safety are essential factors and are integral to all corporate and management decisions, and as such are embedded within the Strategic Objectives of the organisation.
This report is being presented for assurance and approval by the Trust's Board of Directors.

2 BACKGROUND/CONTEXT

The report provides details of the work undertaken during the financial year and key areas of consideration for 2023/24.

The Health and Safety annual report provides summary information relating to principal activities associated with the management and promotion of Health and Safety issues during 2023/24 in relation to Health and Safety. It also highlights the current key priorities for the Health and Safety team during this current financial year. The report provides a summary of a gap analysis undertaken in relation to key areas of national policy and Trust performance. This approach of identifying gaps and risks associated with any health and safety regulations benefits the Trust as it provides a clear picture of health and safety compliance.

The Health and Safety risk profile across the Trust has a clear defined governance structure, including a Health and Safety Committee. The Committee provides the Trust's Board with assurance, through the work of the People Academy.

Whilst the Trust's performance in relation to Health and Safety is generally good, there are opportunities for change and improvement.

3 PROPOSAL

This report provides an assessment of the level of compliance with health and safety legislation and to identify areas which require further attention to improve compliance. This report therefore provides analysis of health and safety performance across the Trust for the year April 2023 to March 2024 by reviewing and assessing:

- The internal structure for the management of health and safety
- The arrangements in place to identify and remove/reduce significant risks.
- How the Trust is performing year on year (both internally and benchmarking with similar organisations)

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- Compliance with relevant health and safety legislation
- Consultation with employees
- External stakeholders/influences (e.g. HSE, Estates and Facilities alerts, best practice)

It is proposed that this report is shared with the Board of Directors to provide them with an overview of the Trusts performance for Health and Safety for 2023/24 in line with the Health and Safety at Work Act 1974 and ING417- Leading health and safety at work.

4 BENCHMARKING IMPLICATIONS

Not Applicable

5 RISK ASSESSMENT

There are a number of areas of concern that have been highlighted within this report via a gap analysis. The gap analysis highlights the risk rating for the Trust against legislation/regulations linked to subject within the health and safety remit.

As a result of any gaps that have been highlight a Trust wide action plan has been produced. The action plan and gap analysis will assist with the focus of the health and safety plan for 2024/25 for the Trust.

6 RECOMMENDATIONS

It is recommended that this report is accepted by the Board as the current position for health and safety and approved as the Trust annual Health and Safety report for 2023/24.

7 Appendices

Appendix 1: The Health and Safety Annual Report 2023/24

Bradford Teaching Hospitals
NHS Foundation Trust

Health and Safety Annual Report 2023-2024

Caroline Nicholson
Head of Non-Clinical Risk

November 2024

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Executive Summary

The purpose of the 2023/2024 annual report is to provide the Trust's Board of Directors with an overview of health and safety performance for Bradford Teaching Hospitals NHS Foundation Trust ('The Trust') during the year and to summarise The Trust's key risks to achieving its objectives. All matters relating to health and safety are essential factors and are integral to all corporate and management decisions, and as such are embedded within the Strategic Objectives of the organisation.

The report provides details of the work undertaken during the financial year and key areas of consideration for 2023/2024 This annual report provides the Board with a risk rated overview of the status of these work streams. The report highlights any gaps in health and safety that the Trust needs to be aware of as well as providing detail of what has moved forwards such as fire risk assessments that are now 100% complete for all high-risk areas. Unfortunately, several of the actions from the 2022/23 action plan have not been completed with the outstanding actions going forward onto 2023/24. Some of these actions are impacted by the financial restrictions that the Trust and wider NHS face. Priorities have changed for the Health and Safety Team during 2023/24 because of staffing whilst also moving forward with the requirements of the Trust. However, the implications of the current "Closing the Gap" financial constraints, and the freeze on recruitment to Health and Safety and Fire Safety roles, pose a significant risk to the wider Trust. This increases the likelihood of safety incidents, and if realised the possibility of actions from enforcement bodies, criminal and civil legal proceedings and reputational damage.

The largest risks for the Trust sit within Fire, medical devices and general maintenance and age of the building, which is impacting of electrical safety, ventilation and working at height. There are a number of risks such as violence and aggression to staff that are impacting on health a wellbeing of staff. There is also a risk within the construction design and management regulations to ensure that health and safety is picked up at every stage of the building work with both Capital projects and operational works.

Improvements have been made with Control of Substances Hazardous to Health (COSHH) with more engagement with the end user. Relationships with enforcement agencies and regional health and safety colleagues remain strong with regular communication.

This report details changes in legislation that have taken place during 2023/24 or planned to take place in 2023/24 and confirms that the Trust has appropriate Health and Safety policies and procedures in place.

Introduction

The management of health and safety across the Trust has a clearly defined governance structure, including a Health and Safety Committee, which provides the Trust Board with assurance, through the People's Academy.

The Health and Safety Committee met bimonthly throughout 2023/24 and was mainly quorate, however there was no Executive or Non-Executive attendance since June 2023 and the meeting was Chaired by the Deputy Director of Estates in the absence of the Chair. There has also not been a replacement for the Non-Executive who left the Trust, this has been escalated. The Terms of Reference were up to date. The Committee reported its performance and assurances to the People's Academy.

This report provides an assessment of the level of compliance with health and safety legislation and to identify areas which require further attention to improve compliance. This report therefore provides analysis of health and safety performance across the Trust for the year April 2023 to March 2024 by reviewing and assessing:

- The internal structure for the management of health and safety.
- The arrangements in place to identify and remove/reduce significant risks.
- How the Trust is performing year on year (both internally and benchmarking with similar organisations).
- Compliance with relevant health and safety legislation.
- Consultation with employees.
- External stakeholders/influences (e.g. HSE, Estates and Facilities alerts, best practice).

Background

The basis of the United Kingdom's Health and Safety Law is the Health & Safety at Work Act (HASAWA) (1974). The Act sets out the general duties which employers have towards employees and members of the public, and employees have to themselves and to each other.

The Trust therefore has a legal duty to put in place suitable arrangements to manage for Health and Safety. As this can be viewed as a wide-ranging general requirement, the Health and Safety Executive encourages a common-sense and practical approach. It should be part of the everyday process of running an organisation and an integral part of workplace behaviours and attitudes. The key to effectively manage health and safety are:

- leadership and management (including appropriate business processes).
- a trained/skilled workforce.
- an environment where people are trusted and involved.

HSE advocates that all of these elements, underpinned by an understanding of the profile of risks the organisation creates or faces, are needed. This links back to wider risk management and can be pictured in Figure 1.

Figure1: the Core elements of managing for health and safety

The Management of Health and Safety at Work Regulations (1999) require employers to put in place arrangements to control health and safety risks. As a minimum, the Trust should have the processes and procedures required to meet the legal requirements, including.

- a written health and safety policy.
- assessments of the risks to employees, contractors, customers, partners, and any other people who could be affected by your activities – and record the significant findings in writing.

- arrangements for the effective planning, organisation, control, monitoring and review of the preventive and protective measures that come from risk assessment.
- access to competent health and safety advice.
- providing employees with information about the risks in the workplace and how they are protected.
- instruction and training for employees in how to deal with the risks.
- ensuring there is adequate and appropriate supervision in place.
- consulting with employees.

HASAWA places the overall responsibility for Health and Safety with the Trust Board of Directors (as the employer). The Director of Estates & Facilities had delegated responsibility from the Chief Executive for the overall management of Health and Safety during 2023/24, this changed in September to the Chief Operating Officer and Deputy Chief Executive.

The legislation is enforced by the Health and Safety Executive (HSE) who have far reaching powers which include:

a) Access to work premises at any reasonable hour.
b) Freedom to interview staff and visitors, contractors or patients.
c) Confiscation of equipment and applicable documents.
d) Taking statements, photographs, measurements and samples.
e) Issuing notices (Improvement and Prohibition) requiring respectively improvements within a certain timeframe or stopping work until improvements are made also within a timeframe.
f) Initiating criminal court proceedings for alleged breaches of health and safety legislation.

The HSE highlighted priorities including:

- A reduction in the work-related ill-health especially mental health and stress.
- Increase and maintain trust to encourage people to feel safe where they live and work.
- Maintain Great Britain's record as one of the safest countries to work in.

The HSE have developed a ten-year strategy (2022-2032): protecting people and places. This is a strategy that reflects the HSE's role in the broadest sense. A role that goes beyond worker protection, to include public safety assurance on a range of issues. The strategy is written to focus on tackling both new and traditional risk at the right time and in the right way. The HSE now has added responsibilities such as becoming the appointed Building Safety Regulator and extended role in chemical regulation.

1. Plan

1.1 Health and Safety Governance

The Trust has a Health and Safety Committee (HSC); it reports to the Trust Board via People's Academy, it is chaired by the Director of Estates & Facilities and subsequently Chief Operating Officer and Deputy Chief Executive. Staff Side health and safety representatives are involved in all aspects of health and safety decision making, they are a key part of the membership on the HSC. During 2023/24 the Committee was quorate for all except August 2023, when unfortunately, there was no union representation, and the Terms of Reference were in date (date July 2023). There was no Executive or Non-Executive attendance at the HSC since June 2023 and the meeting was Chaired by the Deputy Director of Estates in the absence of the Chair. There has also not been a replacement for the non-executive who left the Trust, this has been escalated.

The business and governance of the HSC is supported by an infrastructure of sub-groups representing and assuring key areas of legislation or regulation (including the Compliance Risk Assurance Group (CRAG) Safer Sharps, Control of Substances Hazardous to Health (COSHH), radiation protection, medical devices, Emergency Preparedness and waste. An organogram of the governance infrastructure is presented in Appendix 1.

The HSC uses a range of assurances to support its scrutiny of health and safety performance, level 1 assurance in the form of management reports in relation to specific issues, level 2 assurances from its oversight groups and also level 3, independent assurance from Internal Audit and other external specialist assurance providers. The Committee also reviews changing requirements from the Trust's regulators.

All staff, volunteers and contractors are provided with health and safety induction training, with all staff being given access to Datix and Iris (January 2024) to report any adverse events. There are a number of oversight groups for health and safety risk, including the Safety Event Group, and Quality of Care Panel. The Trust proactively undertakes risk assessments to minimise risks where possible.

Competent advice regarding Health and Safety is provided by a Head of Non-Clinical Risk (competent Person for the Trust) and Non-Clinical Risk Manager, unfortunately this post has been vacant for the majority of 2023/24. This post was successfully recruited to in March 2024.

1.2 Policies and Procedures

The Trust has an overarching Health and Safety Policy, which describes the health and safety management system that the Trust adheres to. The Trust's policy acts as a pivotal document in implementing the Trusts safety management system (SMS), following the Health and Safety Executive HSG65 'Managing for Health and Safety' and to ensure, so far as reasonably practicable, a healthy and safety environment for all people who work, use, or visit the Trust. The policy is designed to ensure communication of health and safety duties and benefits throughout the organisation. The Health and Safety Policy requires the Trust to set annual objectives designed to continually improve and refine the Trust's:

- compliance with legislation.
- management of risk.
- engagement with staff, patients and others,

The Trust's Health and Safety Policy is supported by several policies and procedures such as the fire policy, security policy and the working at height policy.

1.3 Roles and responsibilities

Roles and responsibilities regarding Health and Safety are clearly defined within the Trust's Health and Safety Policy. The **Director of Estates and Facilities** had delegated responsibility from the Chief Executive for the overall management of Health and Safety with this changing in September 2023 to Chief Operating Officer and Deputy Chief Executive.

The day-to-day management of health and safety at a local level lies with individual staff members, and local team managers, for instance Ward Sisters, Ward Managers and/or Heads of Department.

Non-Clinical Risk Managers:

There is one Non-Clinical Risk Manager, who provides health and safety and risk management advice and assists the Head of Non-Clinical Risk in providing the Trust with assurance related to health and safety and the Head of Non-Clinical Risk who is there to offer specialist advice on legislation and other health and safety matters pertaining to the Trust and will ensure the development of systems and arrangements to achieve compliance. The Head of Non-Clinical Risk is also employed by the Trust to act as the 'Competent Person' as required by Regulation 7 of the Management of Health and Safety at Work Regulations 1999.

Unfortunately, the Non-Clinical Risk (Health and Safety) Team have had a vacant role for all of 2023-2024 despite advertising the post on a number of occasions; this has impacted on the capacity of the team.

Health and Safety Advisor, Sypol Manager:

The Health and Safety Advisor assists with the management of the electronic Sypol system. This role provides training to Control of Substance Hazardous to Health (COSHH) assessors on the use of the Sypol system. The specialist advise for COSHH is provided by Pharmacy. This role also focuses on assurance for Health and Safety for the Trust and monitors the incident reporting system.

Fire Wardens:

Fire Wardens are nominated by the Ward/Department Manager. Their role is broadly twofold; fire prevention and responding to an incident. They also maintain the required fire safety logbook.

Trade Union (TU) Safety Representatives

There are several TU Safety Representatives, who perform a valuable role in raising concerns on an ad-hoc basis and through their attendance at the Trust HSRC.

The TU Reps are also able to assist the Non-Clinical Risk Manager with workplace inspections and some risk assessments.

Estates Health and Safety Advisor:

The implications of the current "Closing the Gap" financial constraints, has resulted in the freeze on recruitment to Health and Safety and Fire Safety roles within the Estates department, Capital and Operational which has the highest level of health and safety risk by the nature of its operations. This poses a significant risk to the wider Trust. This increases the likelihood of safety incidents, and if realised the possibility of actions from enforcement bodies, criminal and civil legal proceedings and reputational damage.

The recent Estates Operations Health and Safety Audit recommended an increase in health and safety advice/support for the size of the department. But currently there is no Estates & Facilities specialist

health and safety advisor. While managers have undertaken IOSH (Institution of Occupational Safety and Health) Managing Safely training giving a broad overview of low-risk health and safety management, and an understanding of their legal responsibilities. It does not however provide training on high-risk operations such as managing work at height, construction, or the specific legal requirements of relevant acts of parliament or underpinning regulations such as COSHH and PUWER. This is a significant risk to the department and Trust.

1.4 Objective setting

The Trust's Health and Safety Annual Report (2022/23) identified a suite of objectives for 2023/24. These are described and analysed in Appendix 2. For objectives where a review has resulted in the identification of outstanding actions and recommendations are made. All recommendations made because of the reviews undertaken to support the content of this report are summarised in Appendix 4 of this report and have been used to develop the following objectives for 2024/25:

- To ensure that the Health and Safety team provides contemporaneous and consistent assurance that the Trust complies with the requirements of its Health and Safety Policy.
- To ensure that all risks associated with compliance with legislation are mitigated effectively and assured appropriately through the governance of the health, and Safety Committee
- To raise the profile of Health and Safety in the Trust increasing the profile of allied work-streams such as strengthening risk assessments.
- To develop a suite of generic and work environment specific risk assessments.
- To ensure the appropriate escalation of health and safety risk through care group governance systems.

1.5 Work-planning

In order to deliver the Trust's Health and Safety Objectives set for 2023/24 the Health and Safety Committee agreed and monitored a work-plan. This work-plan is derived from the objectives for 2022/23, and the actions identified as a result of the analysis required for this report (Appendix 4).

1.6 Changes in legislation

The Non-Clinical team and the specialist advisors work to ensure that policies and procedures are kept up to date with the latest health and safety legislation through the governance structures. Relevant new and updated legislation is assessed throughout the year by the Trust Directorate most appropriate to the subject matter, raised at the H&S Committee and addressed accordingly:

1.6.1 The Higher-Risk Buildings (Descriptions and Supplementary Provisions) Regulations 2023

The purpose of the Higher-Risk Buildings (Descriptions and Supplementary Provisions) Regulations 2023 is to specify descriptions of buildings to be included in the definition of "higher-risk building" in the Building Act 1984, and the Building Safety Act 2022.

These Regulations specify that buildings containing at least two residential units will fall within the new regime where they are over 18 metres tall or have 7 or more storeys (the height threshold having been set in the 1984 Act).

Hospitals and care homes will also fall within the scope of the design and construction part of the new regime (but are not included in the in-occupation part as they are regulated as workplaces through the Regulatory Reform (Fire Safety) Order 2005.

The reason for this inclusion is to help make sure that high-rise buildings which may be occupied by those who are unable to evacuate quickly, or without assistance, are designed and constructed in accordance with the new regime.

1.6.2 Retained EU Law (Revocation and Reform) Bill

The Retained EU Law (Revocation and Reform) Bill is progressing through Parliament and has now reached the House of Lords. If passed, all UK secondary legislation derived from EU law and retained direct EU legislation (such as EU regulations) will "sunset" (automatically fall away) on 31 December 2023.

In health and safety terms, a significant number of occupational health and safety regulations would “sunset”, including the:

- Management of Health and Safety at Work Regulations 1999 – including risk assessment and 'Competent Person' requirements.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Construction (Design and Management) Regulations 2015 (CDM), and
- Control of Substances Hazardous to Health Regulations 2002.

The Health and Safety at Work etc. Act 1974 (HASAWA) will remain in force.

This does not mean that businesses will no longer have any health and safety legal duties, the Legal requirements that are not derived from EU law and primary legislation will not cease. Therefore, the HASAWA will remain in place, requiring organisations to continue to ensure, so far as is reasonably practicable, the health, safety and welfare of employees and others affected by their business undertaking.

This being the case, it seems likely that the HSE will encourage the status quo – pointing to regulatory principles that would disappear in law but would remain in HSE guidance.

Further information will be provided to the Health and Safety Committee as the Bill progresses.

1.6.3 The Health and Safety and Nuclear (Fees) (Amendment) and Gas Safety (Miscellaneous Amendment) Regulations 2024

This is an amendment to The Health and Safety and Nuclear (Fees) 2022 and Gas Safety (management) Regulations 1996. The changes relate to the fees payable under legislation.

1.6.4 The HSE Focus for 2024/25

- The HSE focus will be more around managing mental health in the workplace.
- Adapting hybrid working for employees
- The new fire regulations for high-rise residential buildings
- Manual handling and musculoskeletal disorders.

2024 marks the 50th anniversary of the introduction of the Health & Safety at Work Act 1974 (HSWA 1974), which remains the umbrella legislation that underpins all legal health & safety requirements for both employers and employees in the UK.

2.1 Risk profiling

The Trust has in place a detailed Risk Management Strategy (RM51) which provides an overarching framework for the management of risk within the Trust.

Identified risks are risk assessed using a risk scoring matrix from which a current (taking into account existing control measures), target and residual risk score and rating is derived. Identified risks that require active and monitored mitigation are added to the Trust's risk register via the incident Management system (Datix until January 2023 and then Inphase, Iris) in line with the Trust's Risk Management Strategy. This strategy includes detailed guidance for staff on the identification, assessment, mitigation and monitoring of risk. The Trust manages risk at a strategic, organisational, Care Group and service level. Strategic risks are risks that have the potential to impact significantly on the achievement of the Trust's strategic objectives. These are reflected in the Board Assurance Framework as 'principal risks. Organisational risks are risks that apply to the organisation as a whole, cannot be managed at Care Group level or are considered a risk to the delivery of the Trust's strategic objectives. These are reflected on the Strategic Risk Register. Care Group risks are risks that have been assessed as being active in relation to their likelihood and consequence and following assessment it is considered can be appropriately managed and mitigated at a local level.

Where appropriate, risk assessments were completed for:

- Manual handling.
- Lone Working.
- Stress.
- Display screen equipment.
- COSHH.
- New and expectant mothers.
- Violence & aggression.

There are several staff based at, or working out of premises which are not owned or controlled by the Trust. To ensure their safety, a monthly compliance report is completed by each landlord, and forwarded to the Estates and Facilities Directorate; the report covers the following areas (where applicable):

- Fire safety.
- Water safety.
- Lifts and lifting equipment.
- Gas safety.
- Electricity.

The reports are reviewed by the Estates and Facilities Directorate to ensure compliance with legislation both statutory and implied.

2.2 Organising for health and safety

Co-operation and Communication

The Non-Clinical Risk Manager has meetings with the Trade Union to discuss health and safety issues. Unfortunately, during 2023/24 due staffing within the Non-Clinical team these were reduced to when required and for joint investigations. The membership for the Trust's Health and Safety Committee includes Trade Union representatives.

Health and safety related policies/procedures are forwarded to the Trust Health and Safety Committee and disseminated to all members of the Committee for comment; this includes the TU Representatives.

The Trust communicates health and safety information through a variety of mediums, such as:

- Screensavers.
- Posters (e.g. the HSE health and safety law poster).
- Leaflets.
- Training sessions.
- Rapid responses.
- Safety huddles.
- Learning matters publications.

Competence: Providing competent advice to the Trust:

The Head of Non-Clinical Risk is employed by the Trust to act as the 'Competent Person'.
In addition, there are subject matter experts in key areas:

- Fire.
- Asbestos.
- Legionella.
- Manual handling.
- COSHH.
- Occupational Health.
- Security.

Competence: Ensuring staff competency:

A training needs analysis (TNA) is completed for all job roles; this determines the types of training the job holder should receive. However, training alone does not equate to competency.

3.1 Proactive health and safety measures

The Trust uses both proactive and reactive methods to assure compliance with Health and Safety regulations. The Trust Health and Safety Committee receive a summary of related key performance indicators at every meeting for review and challenge. The key performance indicators will be reviewed following this annual report so that the Trust Health and Safety Committee can assure the Trust that good progress in relation to management for Health and Safety is being made. Unfortunately, the key performance indicators have not been available since the introduction of Iris.

Proactive safety management is a planned approach to understanding effectiveness of the health and safety management. It allows the opportunity to resolve issues before an incident occurs. It includes:

- Training (Key Performance Indicators).
- Internal Audit.
- Number of risk assessments undertaken.
- Workplace Inspections.

Proactive safety management will enforce a positive safety culture and help to prevent accidents happening as health and safety is recognised as everyone's responsibility.

The performance and outcome of each method are described below in the following sections:

- **Training attendance 2022/23 and 2023/24**

Table 1 shows the average percentage compliance for 2023/24 with a range of Health and Safety related training. The table shows that overall compliance with health and safety training has remained at a high level. The Manual Handling team continue to deliver face to face training. Although demonstrating a slight reduction over 2021/22, the levels are within 1% of the previous year. An alternative to the Strategic Risk Management Training has yet to be sourced and implemented to replace this training for senior managers within the Trust. This training should be reviewed as it included an element of health and safety and covered the legal requirement for senior managers. However, the Health and safety training was delivered for The Board in October 2022. The Board members received training related to INDG417 Leading Health and safety at work (for Directors and Board members) should take place, to ensure the Board are correctly informed of their responsibilities.

Table 1: percentage compliance with mandatory training type

Training type	2022/23 (Current position)	2023/24 (Current position)	Trend
Fire safety (one or two yearly)	86 %	88 %	⇧
Moving & handling (Low risk three yearly)	99%	99%	⇨
H&S awareness (two yearly)	90%	95%	⇧
Moving & handling med/high risk (two yearly)	79%	86%	⇧

Strategic risk management (Two yearly)	Training is no Longer available	Training is no Longer available	

- **Local inductions for new starters and visitors on site:**

Within the Induction Policy there is a checklist for local induction. The Health and Safety section includes details of:

- Purpose and procedure for referrals to Workplace Health and Wellbeing Centre
- Procedure for evacuation
- Fire exits, fire equipment & assembly points
- Major Accident Policy
- COSHH
- RIDDOR Regulations
- Health & Safety Policy
- Areas Health and Safety procedures
- DSE assessment
- Moving & handling procedures:
- Medicines safety procedures:
- Incident reporting procedures:
- Infection Control Procedure
- Explanation of the key equipment used within the ward/department and training requirements.

Estates contractors are required to watch a site-specific induction video which comprehensively covers the Trust site and safety rules. To evidence that contractors have fully understood the information conveyed they are required to successfully pass a multiple-choice question paper. On successful completion of the test, the contractor is subsequently issued with a contractor induction pass. As part of the contractors' induction there is a site induction ten-point test that must be completed with the contractors' and made clear to the contractor, that they are responsible for ensuring their employees are able to demonstrate that they have received site induction information.

- **Combined Risk Audits**

The Combined Risk Audit was deferred due to staffing within the Non-Clinical team a proposal of taking the Combined Risk Audit forward was presented to the Health and Safety Committee. The decision was made at the Health and Safety Committee to use the opinion of specialist advisors to provide evidence of overall Trust compliance.

- **Internal audit**

An Internal audit for COSHH took place in 2023, the internal audit showed limited assurance. There were actions produced as part of the audit to help provide further assurance. These actions have been reviewed and completed throughout 2023-2024, internal audit felt that with the improvements made that there was now significant assurance with COSHH.

- **Risk assessments**

The Trust's Risk Management Strategy requires a formal risk assessment to be completed when a hazard is identified. The Trust has implemented a two-phase approach to health and safety risk assessments:

  - Phase one: Generic risk assessments are being undertaken for tasks which are common across the organisation (e.g. slips and trips, manual handling, stress). These are held centrally and made available to all areas. In some instances, these generic assessments will be sufficient, but in other areas they may need to be adapted to reflect local conditions.
  - Phase two: Additional risk assessments will also be identified and completed, which will be area-specific (e.g. clinical, admin, communal).

There is a structure in place which enables unresolved risk assessment to be escalated onto a particular level of risk register.

- **Workplace inspections**

Unfortunately, no joint workplace inspections were undertaken with the trade unions during 2023-24 due to staffing levels within the Non-Clinical Risk Team. There were several inspections that took place from the Non-Clinical Team, these were of wards, new building works, central corridors and the Community sites as well as car parks.

- **Health and Safety Climate Survey**

The prevailing health and safety culture within an organisation, i.e. the way it approaches and manages health and safety issues, is a major influence on the health and safety-related behaviour of people at work. The HSE advocate that developing a positive health and safety culture is important if high standards of health and safety are to be achieved and maintained. The Trust has developed a climate assessment tool in relation to Health and Safety that it rolled out 2022/23. This tool is planned to be used again within 2024/25.

3.2 Reactive Monitoring

The Trust monitors health and safety performance in a reactive way by ensuring that precursor incidents are identified, analysed and contextualised through its Quality Oversight System. Precursor incidents can be identified through incident reporting, complaints, staff and patient feedback, risk assessments, failures of business continuity plan etc. The Quality Oversight System enables the categorisation of precursor incidents, the agreement in relation to the level of investigation required and the identification of any learning.

3.2.1 Health and safety incidents

The Trust monitors all health and safety incidents with specific reference to the top five occurring incidents. The Trust has encouraged managers and their staff to report incidents throughout 2023/24. Table 2 provides as summary of the top five incidents by frequency

Table 2: The top five Health and Safety Reported Incidents

Incident category
Unsafe environment
Medical device
Verbal abuse
Physical assault
Threatening behaviour

The slips, trips and falls category only includes staff, visitors and contractors. The patient falls incidents do include incidents that should fall under health and safety as they are related to the fabric of the building or water and ice, these incidents are part of the review of health and safety incidents.

A separate Group are focusing on violence and aggression across the Trust, Violence prevention and reduction group. This group are focusing on what work is been undertaken Trust wide and it looks the incident data received from the incident management system as well as from alternative sources.

3.2.2 RIDDOR reportable incidents 2022/23

Twenty-one incidents were identified as meeting the criteria for reporting under RIDDOR during 2023/24. These are described in Table 3 with details of action and any learning that has been put in place. Wider organisational learning will be disseminated via the Care Groups Governance Structure.

There was a number of administration process failures associated with the management of RIDDOR in the Trust, as evidenced during the review of the RIDDOR incidents reported during 2023/24. These administration failures include:

- Not all finally approved RIDDOR reportable incidents have the incident management system section “actions taken to prevent recurrence” completed.
- 45% incidents were reported to the HSE within the required timescales.
- Not all of the incidents that are reported to the health and safety Executive have the RIDDOR forms attached to the incident management system.

RIDDOR reporting has significantly reduced during 2023/24.

It is essential to ensure that all incidents which are reportable under RIDDOR are firstly identified, and secondly reported to the HSE on time. In addition, copies of the RIDDOR report from the HSE should be attached to the incident management system. This is monitored via the Non-Clinical Risk team and is part of the key performance indicators for the Health and Safety Committee.

3.2.3 Incident investigation

All reported incidents should be investigated by the manager and assessed as to whether additional control measures are needed to prevent any re-occurrence. The Trust has a policy which describes its approach to incident investigation, which is compliant with national guidance.

All RIDDOR reportable incidents should have a robust investigation. The level of investigation will depend on the type of RIDDOR incident. A standard approach should be developed for RIDDOR investigations.

All RIDDORs are reported to Quality Oversight Committee as soon as they are reported to the HSE. Actions are produced a learning shared.

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Specified injuries	
Patient fall, slip or trip on same level Patient was trying to mobilise back to his bedspace and has tripped between bathroom door and bedroom.	**Action** • Immediately attended to the patient and used lifting equipment to safely move the patient. **Learning** • Picked up as part of the root cause analysis.
Patient fall, slip or trip on same level Patient was admitted to BRI from Westbourne Green on the 6th of March 2022 Patient had CT TAP on the 10th of March 2022 noted from the report to have an acute fracture of the right femur -. Noted in medical notes on the 10th of March that patient had fallen overnight at WBG on the 3rd of March 2022.	**Action** Clinical evaluation and discussion with orthopaedic surgery is advised Patient was treated for DKA **Learning** • Picked up as part of the root cause analysis.
Patient fall, slip or trip on same level Unwitnessed fall. Post fall examination identified right minimally displaced pubic rami fracture.	**Action** • Post fall examination • Review of patient notes. **Learning** Picked up as part of the root cause analysis.

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Patient fall, slip or trip on same level Patient fell during a period of confusion and agitation, became confused on the ward. Patient fell onto his bottom. This resulted in a fracture	**Action** • Checked over and assisted by other Staff members to sit in a chair. **Learning** • A falls review had not been completed to reflect the patients changing condition.
Patients fall from height Patient fell during the night after climbing out of bed over the bed rails. Subsequently tripped/slipped on their bilateral leg bandages.	**Action** • Patient reviewed by doctors already on the ward. • assisted back to bed with nursing staff. • Observations recorded. • Sent for x-rays – confirmed fracture right NOF, wrist, humerus. **Learning** • Bed railings assessment not completed • Nursing staff to reassess for falls on transfer to the ward. • If head injury, or banged head during fall, GCS to complete and document. • Documentation of discussion when escalating postural drop to the doctors and needing medical review

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Patient fall, slip or trip on same level Patient admitted with falls and found to have R acute subdural hematoma on CT head. Fell again and rescanned on 22/3 which showed increase to bleed. Patient had 1:1 care however, patient fell when nurse left patient unsupervised to go to sluice.	**Action** • Patient assisted back to bed, • Patient reviewed within 30 minutes, Nurse rounding completed, Bed side vision check completed • 1:1 with patient at all times. **Learning** • Lying and standing blood pressure was completed but this showed a significant postural drop, this was not rechecked, • Neurological observations are not documented in line with protocol, no 4AT assessment documented, Post falls assessment not completed, Daily staff briefings to commence • Ensure 1:1 at all times, 1:1 not to leave patient until another staff member takes over.
Patient fall, slip or trip on same level Patient had a bad dream woke up needing the toilet but when staff member came to help him, he thought staff member was carrying a knife, so he tried to punch her in the face, lost his balance and fell over causing acute/subacute nasal bone fracture.	**Actions** • Patient was assisted to stand up, face and hands cleaned when bleeding stopped. • NEWS checked, including neuro observations. **Immediate Learning** • Weekly falls assessment to be carried out • Red socks put in place • Discussed with patient to call for assistance when required

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Patient fall, slip or trip on same level Staff member heard a loud bang, found patient in semi sitting position on his right side, shouting out in pain holding his right groin. On examination the right hip was clearly shortened and externally rotated patient complaining of pain to right hip.	**Actions** • Assisted patient to lay flat on the floor and examined, pillow under head for comfort. Right hip clearly shortened and externally rotated patient complaining of pain to right hip. • NEWS taken, assisted up from floor and transferred into bed using EVAC jack and assistance of 5 staff members. Given analgesia Called YAS for transfer to BRI - suspected Fractured Neck of femur. • Neck of femur confirmed. **Immediate Learning** • Investigation and underway
Patient Moving and Handling Incident Patient came to colposcopy/Vulval clinic today by patient transport in her own wheelchair. Patient lives on her own and said she doesn't have any help or carers. Patient came without a sling or slide board. Nurses had to hoist patient using hospital sling from her wheelchair onto the gynaecology couch with stirrups and needed help to undress this took three staff members. After the examination The Dr and health care assistant were helping the patient to get dressed and her left leg fell from the stirrup causing the patient some pain. This then took four staff members to help her get dressed and hoisted back into her wheelchair. The patient was made comfortable, and advice was taken from the orthopaedic on call Dr who advised to take the patient to accident and emergency. Patient taken to accident and emergency to be checked over	**Action** • Datix reopened (03/10/2023) after letter of complaint from patient's family stating that patient had suffered a fractured hip. **Learning** • Ensure all staff are up to date with moving and handling competency. • Look into including a question regarding mobility on referral forms to ensure staff are prepared for any moving and handling or dressing needs. •

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Staff Moving and Handling Incident Staff member taking air mattress from a bed when the pump from the air mattress accidently fell from the bed onto her foot (Over 7 days injury)	**Actions** • Added ice pack to foot and attended Accident and Emergency **Immediate Learning** Ongoing Investigation
Patient fall, slip or trip on same level Patient witnessed getting up from the bed and began to walk, he fell forward landing on his face. No obstruction present and patient denied any loss of consciousness. Injury to member of public resulting in being taken to hospital.	**Actions** • CT head ordered. Shows nasal septum fracture. • Referred to ENT 4/12 at 0915. • Next Of Kin informed of fall and then again about fracture 3/12 at 1629hrs and 1726hrs. **Immediate Learning** • There were a number of gaps in the initial assessment such as: No lying standing blood pressure taken. Bed rails in place but no bed rails assessment completed. No assessment for delirium completed. • Investigation ongoing

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Patients fall from height Patient In Emergency Department patient climbed over trolley rails to reach a drink, fell and landed on the floor and banged his head and had a seizure. Patient was placed back on to trolley and moved to area where he could be seen more easily Patient fell off the trolley again. Got up and seemed fine with no obvious injuries from second fall	**Actions** • Patient Went for CT head which showed a subdural bleed and subarachnoid haemorrhage, Leeds neuro team contacted – advised to watch and rescan in 4 hours • Patient had another seizure during this time and 2nd CT showed worsening bleed • Further neurosurgical review from LTHT, no neurosurgery required. To monitor, re-scan and re-discuss if any neuro deterioration. Remains GCS14 on ICU **Immediate Learning** • Bed rails assessment was not completed on admission and while bed rails in use. Bed rails assessments are not completed on trolleys, due to the natural height of the ED trolley, making it too high risk to leave the bed rails down. He was moved to a bed post fall. He would be deemed a risk of falls due to alcohol dependence. Debrief completed. • Due to acuity, he needed to be in resus, however only Resus 4 was available, which is the least visible cubicle, and staffing meant there were not enough nurses for 1:1 care, staffing ratio was 1:3

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Staff, Moving and Handling Porter jarred his right arm and shoulder as he pushed a bed into a lift, the lift floor stopped slightly above where it should and when the Porter pushed the bed it hit the lip, and he jarred his shoulder.	**Actions** • Due to this investigation being looked at after the event, security was unable to get any additional information from the coordinator that had left the Trust and was unable to access any CCTV to view the incident. • Estates have confirmed that the lift maintenance was up to date, and they were not aware of any issue at the time. **Immediate Learning** • Estates team confirm that lifts are on a regular 'maintenance' programme • Staff given opportunities through Coordinators line management, through Porter Drop ins and visible Management to report any Health and Safety issues • Risk Assessment and SOP to be completed and rolled out on Porters using lifts when transporting patients and equipment.
Staff slip, trip and fall Staff member was walking down to the Ultrasound Services department and fell down the second flight of stairs. She was unsure how it happened. The staff member has sustained a fracture to her left wrist and is due to be reviewed 12/09/2023 to ascertain whether surgery will be required. The staff member was wearing flip flops at the time of the incident	**Actions** • Investigation Ongoing • Immediately assisted into wheelchair and taken to A & E Dept. **Immediate Learning** • Addressed staff and informed them suitable footwear must be worn at all times

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Staff stuck by something A fan built into an office window fell from height onto a member of staff's head when the window was being opened. The fan hit the staff member directly on the head causing them black out for a second whilst stood up and to bite their tongue and causing a lot of pain to the head.	**Actions** • Staff member ensured they were ok by sitting down so they didn't collapse. • Staff member attended Accident & Emergency when they got home • A job requested with estates to make the area safe as the resulting fan has now left a large open hole in the window. • Fan removed; window repaired **Immediate Learning**
Patient, Fall from height Emergency Department patient assessed and deemed fit to be discharged home, assessed by Occupational Therapy and was awaiting transport home. Patient turned around to look up and lost balance and fell out of the arm chair on to floor. Safely transferred her on to trauma board and Consultant assessed, for further investigations including neuro exam and CT neck / head. CT neck showed fractured C1 / C2 of which requires specialist opinion to decide if local admission or Neuro admission under Leeds General Infirmary	**Actions** • Fall reviewed. Noted injuries. • No omissions in care. • Fracture to C1 and C2 • Neuro advised treat with Aspen collar. Patient currently on ward 28 - has IV fluids and awaiting PT and further review **Immediate Learning** • Picked up as part of the Root Cause Analysis

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Staff Moving and Handling Staff member reported a five-month history of symptoms of tennis elbow, affecting the right non-dominant shoulder. She has noticed clear association with work, more specifically with holding and twisting the paddles while performing mammography. Her symptoms improved with rest and away from work. She is otherwise in good health with no underlying health conditions.	**Actions** • Discussed issue with Moving & Handling • Moving & Handling to do a risk assessment of the process Management to review mammogram process and identify any mitigation **Immediate Learning** • There is currently no ergonomic risk assessment of the process
Staff Crush Injury Staff member arrived on the ward and used the disabled toilet, the door closed on his right hand. Staff member noted swelling and attended Emergency Department	**Actions** • X Ray completed, staff member was informed he had a fracture to his right hand • Staff member was spoken to and stated he was aware the incident was his own fault and that he was not paying attention **Immediate Learning** Staff member briefed to be aware of his immediate surroundings at all times
Staff, slip, trip and fall Staff member heard a noise on the ward, jumped up and set off running onto the ward to see if a patient had fallen when she tripped and fell over and landed on the floor hurting her shoulder.	**Actions** • Staff member has no recollection of what caused the fall; floor was not wet or uneven. Personal error whilst rushing to a patient's aid. **Immediate Learning** Staff are reminded to take care when going to assist patients.

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Patient, slip, trip or fall Staff heard a bang and patient shouting, patient laid on the floor, he stated that he had banged his head. Assessed for injuries, assisted to his feet, floor very slippy. Helped back onto bed with 2x staff that also nearly slipped on floor This was initially categorised as no harm. Staff noted fluctuations in GCS on medical review, stated conversation with nurse. GCS 15 on all neurological observations post fall. CT head performed which shows Multiple pathological fractures as described with possible small extradural haematoma at the vertex.	**Actions** • Falls care plan assessed prior to fall, • Post falls care plan completed, • moving and handling assessment completed, • LSBP completed with no postural drop, • Preventative interventions documented on falls care plan. **Immediate Learning** • There is documented evidence about providing more suitable footwear. • There is a lack of nurse rounding prior to fall.

Table 3 RIDDOR incidents 2023-2024	
Incident details	Action and Learning
Patient, Fall from height Patient fell from the top of the steps to the bottom of the steps (eight in total) from Mobile Breast Screening Unit (Parked at Sainsbury's Car Park, Keighley) after having had her mammogram. She attended ED on the 25 August at 17:38 having fallen downstairs and sustaining significant facial bruising, a 4 cm laceration to her forehead and pain to her arm/shoulder. CT head and neck undertaken with nil findings.	**Actions** • 26 August seen by consultant who noted on examination that neck NAD, chest and abdo NAD, right upper limb bruising to the heel of the hand but no bony tenderness around the distal radius or carpus. No neurovascular deficit. • Pelvis pain free to springing and compression. Good straight leg raises and knee flexion on both sides. Some grazing to both knees. Left arm held at angle of 30 degrees, no neurovascular deficit in the arm. Sensation in the axillary nerve appears to be intact. CT head and neck shows no acute injury. • X-rays and CT scan show a 3-part fracture of the proximal humerus with an anterior dislocation. The plan was for a MUA of should and for follow-up with shoulder surgeons as likely to require further surgery to her shoulder. • The MUA undertaken on 26 August at 15:00. Unable to fully reduce due to fracture pattern. Final position confirmed with image intensifier and polysling applied with binder. For analgesia, Tinzaparin and for discussion with upper limb team as likely require reverse shoulder replacement on upper limb trauma list. • Also undertook X-ray left hand confirming thumb fracture – for future splint. **Immediate Learning** • Investigation currently taking place

3.2.4 Personal injury claims

Table 4 provides as summary of personal injury claims that have been submitted to the Trust and relate to claims which have occurred during this reporting period.

Table 4: Type of claim and description 2023/24

Claim Type	Incident type	Description
Employers Liability	Lifting/moving/handling	Exacerbated previous injury during manual handling.
Employers Liability	Slip/trip/fall	Slip/Trip/Fall: Allegations surround pain, swelling and bruising to the knee/leg.
Employers Liability	Equipment failure	Equipment failure - Employee was emptying a bucket of water that was placed under the air conditioning unit as it was dripping water due to its disrepair. Claimant attempted to move the bucket to empty the water into the sink. She later felt pain in her lower back, this has resulted in nerve damage to the lower back.
Employers Liability	Workplace Regulations	Workplace Regulations – member of staff exposed to chemical. (COSHH)
Employers Liability	Slip/trip/fall	Slip/Trip/Fall: member of staff slipped within the car park.
Employers Liability	Slip/trip/fall	Slip/Trip/Fall: member of staff slipped within the ward area on recently cleaned floor.
Employers Liability	Needlestick Injury	Needlestick injury- member of staff, allegedly suffered a needlestick injury from a cannula needle.
Employers Liability	Struck my moving object	Struck by moving object: Member of staff was walking towards main building; some builders were loading a small trolley with plasterboard the trolley gave way and some of the boards fell on the claimant trapping her beneath the trolley resulting in soft tissue injuries to wrist and thigh.
Employers Liability	Workplace Regulations	Workplace Regulations – member of staff exposed to chemical. (COSHH)

Employers Liability	Lifting/moving/handling	Member of staff injured themselves whilst moving furniture.
Employers Liability	Struck by moving object	Member of staff struck by a part of the building fabric.
Public Liability	Slip/trip/fall	Slip/Trip/Fall: A child injured themselves in an outpatient's clinic. Whilst in the play area the child stepped on a jigsaw foam mat that was on the floor but not secured and slipped.
Public Liability	Data breach	Allegations surround a Data Breach
Public Liability	Slip/trip/fall	Allegations surround member of the public slipping on black ice
Public Liability	Discrimination	Discrimination Claim- Claim withdrawn
Public Liability	Slip/trip/fall	Allegations that a member of the public's wheelchair got stuck in a pothole cause the member of the public to come out of the wheelchair.
Public Liability	Equipment failure	Allegations over a wheelchair that a patient was transferring from onto the bed.

3.2.5 Regulatory Visits and Inspections

The Trust, as described previously, welcomes external scrutiny of its health and safety performance, informal and formal, to ensure it is in the best position to identify opportunities for change and improvement.

There has been one formal inspection by the Health and Safety Executive to the Trust during 2023/24. This related to an incident where a member of staff's radiation monitor badge had fallen off within a radiology room resulting in arbitrary result of radiation exposure. Following reporting this incident to the HSE, and inspection or Radiology took place this resulted in the Trust receiving a Fee for Intervention Order due to due to contravention with Health and Safety legislation.

On the morning of January 9, 2023, while crossing the staff carpark at gate 1 entrance a member of BTHFT staff was struck by a patient transport vehicle, knocked to the ground requiring an ambulance and assessment at A&E. The Incident was RIDDOR reported, and the investigation

was later reported. Please note this investigation took a long time to produce. Following receipt of the Investigation report the HSE have Issued the Trust with a **Material Breaches, Notification of Contravention** concluding that the Trust is in breach of **The Health and Safety at Work etc Act 1974 section 2**

> *General duties of employers to their employees.*
> *(1) It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.*
> *2) Without prejudice to the generality of an employer's duty under the preceding subsection, the matters to which that duty extends include in particular*
> *(d) so far as is reasonably practicable as regards any place of work under the employer's control, the maintenance of it in a condition that is safe and without risks to health and the provision and maintenance of means of access to and egress from it that are safe and without such risks.*
> *(e) the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.*
>
> Recommendations
>
> Complete the actions submitted to the HSE following Notice of Contravention. Implement traffic/pedestrian management plan remedial works, submitted to the HSE.

The Trust had contact with the HSE following the submission of a RIDDOR related to potential exposure to an asbestos containing material. This was investigated as a Serious Incident with an action plan that was shared with the HSE. No further action was sorting following submission of the investigation.

Relationships with enforcement agencies and regional health and safety colleagues remain strong with regular communication ensuring that learning is shared.

4.1 Action taken in response to the top five reported health and safety incidents 2020/21

Verbal abuse and threatening behaviour

Despite a significant amount of work to reduce violence and aggression (V&A), inappropriate/threatening behaviour, and verbal abuse towards staff this behaviour remains an issue in all areas of the Trust and may indicate that staff are not always identifying inappropriate behaviour at the earliest opportunity to prevent escalation to more serious aggression.

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 violent situations. It was identified that the CRT provided to staff was non-compliant with the Health Skills Framework; this training has been reviewed and amended

The Education and Training department continue to deliver Conflict Resolution Training (CRT) in line with guidelines (refresher training is provided 3 yearly). Whilst the Trust Education Department delivers the national syllabus for CRT, there is a gap for staff to receive 'Breakaway training' in line with the Trust Physical Intervention Policy.

In January 2021 NHS England and Improvement published the new national violence prevention and reduction standard which compliments existing health and safety legislation. This standard takes the Plan, Do, Check and Act approach with a four-step management method to validate, control and achieve continuous improvement of processes. There are several indicators within each of the sections that need to be achieved to enable the organisation to be fully compliant against the standard.

NHS England make it clear that employers have a general duty of care to protect staff from threats of violence at work. 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. From 2022/23 all NHS organisations operating under the NHS Standard Contract must have regard to the violence prevention and reduction standard.

Following these standards a Trust has commissioned The Violence Prevention & Reduction (VPR) Steering group which is authorised by the Trust Board of Directors to maintain oversight and assurance against the NHS Violence Prevention Reduction Standard and associated or related work/initiatives across the Trust. This Steering Group will report directly into the Health and Safety Committee and then up to the People's Academy.

Physical Assault

There has been a decrease in the numbers of assaults reported within the reporting period, 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 significantly high. This demonstrates that our current prevention and management strategies are having a limited effect in reducing these types of assaults and the importance of the work being done to review both training and the collaborative measures required to improve the prevention and management of those patients who display clinically related challenging behaviour leading to physical assault.

Where assaults occurred not involving medical factors i.e. intentional assault, the Security Management

Team supported the Police in prosecuting offenders.

Each year the top five areas reporting violence and aggression are identified via incident management reports and a violence and aggression risk assessment is undertaken in those areas with a member of the non-clinical risk management team, Estates and the Local Security Management Specialist and sister/matron/manager of the area.

Security observations involve the interaction and monitoring of patients to prevent them from absconding and or causing harm to self or others whilst under a deprivation of liberties, mental health section or presenting with other clinically related challenging behaviours i.e. delirium, dementia, under the influence of drugs or alcohol etc.

The Security Management team and the dedicated Police Community Support Officers focus patrols in the top five reporting areas for violence and aggression to provide a visible deterrent, encourage better reporting from staff, as well as supporting staff in dealing consistently with challenging behaviour as well as the development of management plans for individual patients to support a reduction in levels of Violence and aggression.

The Security Management team works closely with specific wards those patients presenting with mental health issues and patients who display challenging behaviour (not clinically related). They continue to work closely with key staff, safeguarding teams and police.

The Trust trialled the use of body worn cameras for clinical staff on ICU, Accident and Emergency and ward 28, information provided on the feedback forms from staff in the trial areas felt that these were useful.

Medical Devices

Medical device incidents have increased in 2023/24 the Head of Clinical Engineering is the first point of contact for incidents or issues related to device safety. The Head of Clinical Engineering will decide if the adverse incidents need to be reported to the MHRA. All the incidents are reviewed by Clinical Engineering, and they are presented to the Medical Device safety Group who have their own committee risk register, and they look for themes and trends.

4.2 Learning from health and safety precursor incidents

There is learning from most health and safety precursor incidents. These precursor incidents can be identified from many sources including claims, complaints, serious incidents, patient and staff feedback etc. This learning can be organisation wide (and beyond) or related to individuals or individual sets of circumstances. The Trust has a Quality Oversight System, where any precursor incident is evaluated both in terms of the level of investigation required, this system is set up to ensure that knowledge about and learning from these precursor incidents is managed in a way that maximises its effectiveness and impact.

Examples of learning

RIDDOR reporting – how can this reporting procedure be improved?

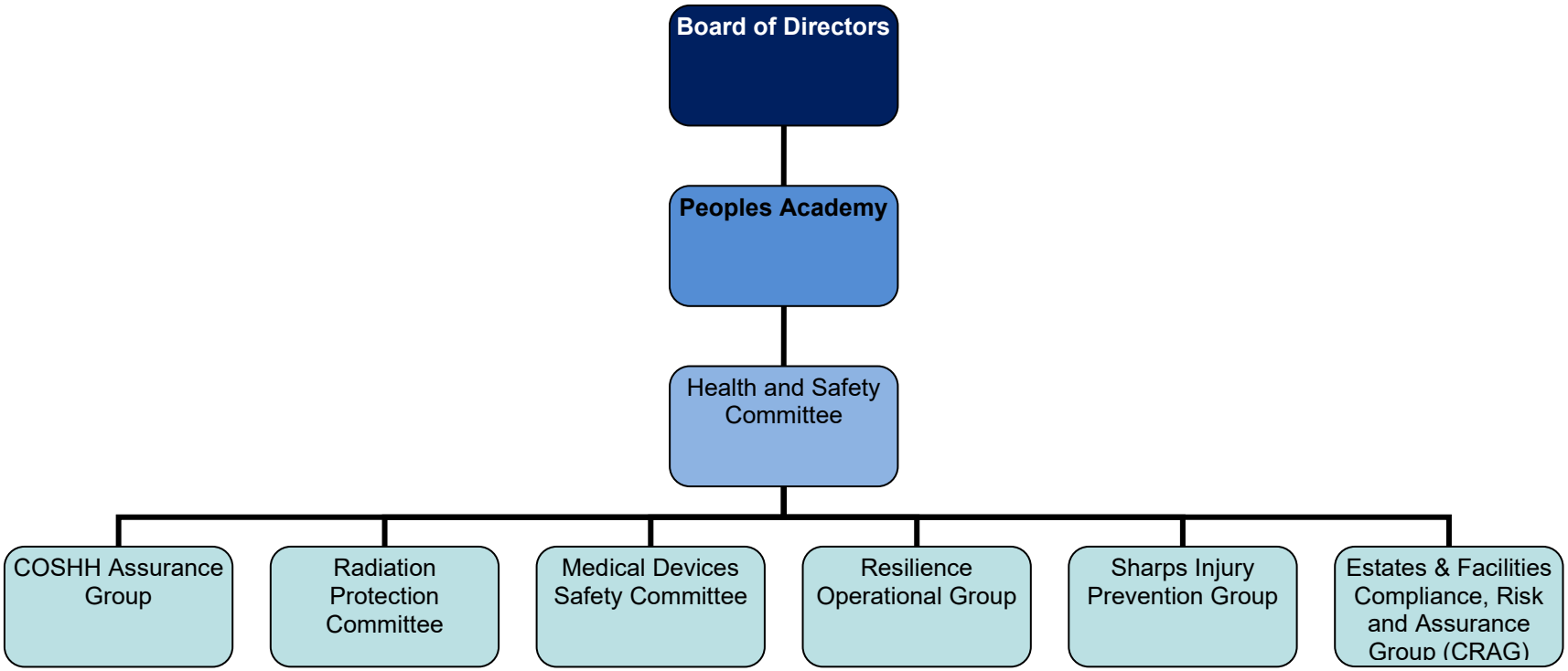
Changes have been made to the RIDDOR reporting procedure to remedy the situation, and an awareness campaign was developed and implemented using posters, conversations and screen savers. A RIDDOR reporting protocol has been developed that includes a proforma for investigating incidents. The screen savers continue to be used when there is a slot available.

Risk Assessments – when should they be undertaken?

Generic risk assessments are being explored. There will be generic risk assessments produced for moving and handling inanimate loads going forward and other area where this is felt appropriate.

How do we communicate basic messages-learning matters

Appendix 1: Governance for Health and Safety: Organogram (April 2023-onwards)



Appendix 2: Objectives and progress 2023/24

Objective	Progress/comments	Status	Recommendation
Implement a scheduled plan to roll out the replacement of the Autronica fire alarms subject to funding.	Ongoing capital investment via backlog maintenance to support high-risk items on a prioritised approach. Further investment required to support and address to ensure patient and public safety. Ongoing servicing and maintenance of fire and fire protection systems in line with statutory, mandatory and best practice requirements.	On Going	This is part of the action plan
The Trust to commission a marked up drawing highlighting lines showing the fire compartmentation in each building.	Drawings received and noted	Action Completed	
Estates and Facilities to produce an annual report for asbestos detailing the level of compliance against the Control of Asbestos Regulations 2012	An annual report has not been produced by the Specialist Advisor; however, a report has been produced by the appointed expert external to the Trust.	On Going	This is part of the action plan
Estates to continue to monitor the 15-year ventilation plan against the Trust's backlog profile – subject to funding availability.	A 15-year plan is in place for ventilation that is risk based. The ventilation plan is under review due to competing priorities associated with the Trust's backlog profile and aging estate.	Partially Completed and ongoing.	This is part of the action plan

Objective	Progress/comments	Status	Recommendation
A Task & Finish Group will be established to progress implementation of Sky Visitor – electronic contractor management system.	A task and finish Group has not been established. However, the Estates Department have introduced a new protocol (issued of specific high viz vests) to assist with identification of contractors. Estates and Facilities are progressing the implementation of (Sky Visitor) which is an electronic system used to help manage contractors while on site.	Partially Completed and ongoing.	This is part of the action plan
To review outstanding action from the internal audit, Manual Handling Team to support the mangers in developing departmental risk assessments.	The manual Handling department are focusing on risk assessments. The team have developed generic risk assessments that are available on the intranet.	Partially Completed and ongoing.	This is part of the action plan
Carparks should be reviewed to consider surface, signage and designated walkways – subject to funding availability.	Some drawings have been produced related to changes in carparks and roads at SLH. Some designated walkways have been put in place at BRI	On going.	This is part of the action plan
All flat roof areas at BRI and SLH are suitably surveyed, and current edge protection is inspected, and a remedial action plan is produced. Work is undertaken to ensure compliance.	All flat roof areas at BRI and SLH are suitably surveyed, and current edge protection is inspected, and a remedial action plan is produced. Work is undertaken to ensure compliance. This however will be very expensive and will require considerable planning and suitable funding, and remedial works should be risk assessed and work	Partially Completed and ongoing.	This is part of the action plan

Objective	Progress/comments	Status	Recommendation
	prioratised on a level of risk. Areas surveyed and found not to be safe should be closed to staff and contractors until mitigating controls are implemented to manage the risk.		

Appendix 3: Risk profiling 2023/24

The below risk profile is RAG rated in line with table 5

Risk	Controls	Compliance with legislation/guidance
Fire	There is an in-date Fire Safety Policy and Strategy Procedure that has been updated and is due to expire in March 2025. There is an annual statement of fire safety that was presented to the Board in May to provide assurance. **Training:** Training is, wherever possible, bespoke to the type of role that staff undertake, or the area in which they work. Training is aimed to be delivered by a mixture of lectures, walk through, tabletop exercises are used as well as interactive theoretical scenarios. The Trust has 88% of its employees trained in fire safety. Difficulties getting shift-working staff to scheduled training sessions have been addressed by the flexibility of the Fire Safety Trainer in delivering training programmes out of hours. **Fire risk assessments:** The Fire Team continued to conduct a system wide review of the Fire Risk Assessment process which included revisiting and refreshing all fire risk assessments throughout the Trust in line with current legislation. An analysis of all fire risk assessments and an updated fire risk assessment schedule has been developed. A full program of reviews is now in process and will continue annually. Recommended actions from the FRA's are dealt with either locally, where possible, through the Estates Maintenance Team or specialist contractor. If major actions are identified, these are brought to the Fire Systems Review Group; the Estates Health & Safety Group, and where necessary escalated to CRAC. Fire risk assessments stand at 100% complete across all areas of the Trust, these risk assessments identify a number of actions. However, actions from these risk assessments still need to be implemented. **Unwanted Fire Alarms (False Alarms)** Analysis of false alarms for 2022, compared with the previous year, is shown below, the number of false alarms has decreased overall:	RRFSO 2005 HTM 05-01

2022		
BRI	SLH	Total
117	10	127
2023		
BRI	SLH	Total
94	10	104

Underlying causes are attributed to fire alarms being triggered as a result of:

- Smoking.
- Staff cooking, namely toast.
- Patients activating manual call points (red boxes).
- Faulty detectors mainly due to the age of the device or water ingress.
- Contractors not asking for alarms to be isolated and dust setting them off.
- Unknown causes due to age of existing fire alarm systems.

Evacuation plans:
There are bespoke evacuation procedures for every area within the Trust, which are included in the local fire logbook. The fire plans within the logbooks are currently being reviewed and updated.
The Fire Safety team visit wards to audit the logbooks and to review local evacuation procedures with staff to ensure they understand the procedures of their area of responsibilities.

Evacuation drills:
Evacuation drills are performed where possible, and tabletop exercises are used to test the evacuation procedure.

Personnel Emergency Evacuation Plans (PEEPs):
PEEPs are explained at induction and mandatory training, and there are PEEP pro-formers included within the fire safety logbook.
Concerns have been raised that PEEPs are not being completed in all areas. It has not been agreed that PEEPs can be added onto EPR.

Fire Incidents:

In During 2023 there were five fires reported.

	In February there was an incident in A&E Male WC. The fire was started by a patient/visitor deliberately starting a fire in the WC. The fire was started by toilet roll being ignited. The fire and smoke were contained within the room and smoke detector activated alerting Switchboard, they bleeped the Fire Response Team who attended promptly and found that the fire had burnt out, silenced & reset the alarm and locked off the room to allow it to be refurbished the following day. No injuries occurred. In March there was an incident on Ward 7 on the Bradford Royal Infirmary (BRI) site. A patient lit a cigarette whilst on oxygen. Unfortunately, due to the saturated oxygen levels the patient received slight burns to face. The fire was extinguished by staff and the Fire Response Team were called and attended. The patient received superficial burns that were dealt with by staff on the Ward, all smoking materials were removed from room. In June a patient set fire to paper magazines at the side of her bed using a cigarette lighter, there was fire damage involving a drip stand, mobile phone and charging cables and light smoke pollution to the room and bedding. A member of staff smelt smoke as she was passing room. She entered the room to investigate the smell of smoke, at the same time the fire alarm sounded across the ward. No injuries were reported. In August a buffing machine battery charger was both left plugged into the mains power socket and turned on, although not connected into a machine. The actual charger was sat on the floor in a pool of water, which caused the charger to short out producing large volumes of smoke. The room filled with smoke which then leaked under the door to the catering area. Smoke was discovered in the area by a member of staff who activated the Manual Call Point to raise the alarm. After receiving a bleep call, the 'Fire Response Team' attended the incident and immediately raised the alarm to actual fire. The Fire Service was contacted, and 3 fire engines and a command car attended. The Fire service used positive pressure fans to blow the large amount of smoke out of the building via the catering gantry loading bay. No injuries reported during incident. In October a patient who was under 24/7 bed watch on Ward 27 started to become agitated, he held a lighter in his hand, was shouting and trying to get off the bed.	

	A security guard was positioned on the corridor at the door entrance. He noticed the patient was agitated and had a cigarette lighter, so immediately went to get assistance from ward staff. Upon returning to the room, they found the mattress and bedding on fire, ignited by the lighter. Both members of staff extinguished the fire. As 4 out of the 5 fires were smoking related. The Trust needs to ensure that it creates a safe environment that reduces the risk of staff patients and visitors smoking in illicit areas due to the no smoking arrangements **Areas of concern** The Trust has two fire alarm systems that unfortunately do not talk to each other. The Autronica system is obsolete, and the Trust is unable to now get hold of any spare parts if required. The Kentec system is also no longer supported and as such we can only use the spares that the Trust already has. There is a third new fire alarm system within the maternity block that will replace the Auronica system as part of the rolling replacement plan. Overarching fire protection risk to the Trust including: - Fire alarm systems - Fire stopping/compartmentation Recommendations: Implement a scheduled plan to roll out the replacement of the fire alarms subject to funding. (AP1) When the ward is vacated the necessary remedial work around the fire dampers will take place and the fire compartmentation walls be checked by a third-party accredited company. (AP2)	
Asbestos	There is an Asbestos policy and procedure in place There is a competent Asbestos Manager in post **The measures to control the risks of asbestos on Trust premises are as follows:** There is an asbestos register within MICAD which details the location and type of known asbestos on Trust premises.	Control of Asbestos Regulations 2012 The Construction (Design and Management)

	Asbestos information accessed via portal. Areas containing asbestos are graded black/red/amber/green. A programme of risk assessments is undertaken for all relevant areas. The Trust also commissions external UKAS accredited consultancy to undertake annual Re-inspections of all known asbestos across all site's and conduct annual Reassurance Air Testing within amber and red zones, **Annual Asbestos Awareness Training:** UKATA accredited asbestos awareness training delivered via online E-learning and face to face provided for all estates staff and managers who are likely to encounter asbestos or manage someone who could encounter asbestos, all external contractors working on site will have completed an accredited asbestos awareness course accredited by UKATA, ITAP or ROSPA within the last 12 months as part of the induction and contractor controls. **Audit process:** An internal audit of the Trust's management of asbestos was carried out in Jan 2021 by Audit Yorkshire; it concluded that the Trust has appropriate controls in place to manage asbestos risks, with no recommendations. There is not an annual report from this specialist Advisor like there is from others within Estates and Facilities, asbestos although a managed risk, is a risk that has to be considered with the volume of building work and age of the Estate. Recommendations: Estates and Facilities to consider producing an annual report for asbestos detailing the level of compliance against the Control of Asbestos Regulations 2012. (AP3)	Regulations 2015.
Legionella	There is a Water Safety Policy in place. The Trust has a management plan for water safety; it consists of: **A Water Safety Steering Group**, this group aims are to ensure the safety of all water used by patients / residents, staff and visitors, and to minimise the risk of infection associated with waterborne pathogens. This group and its purpose are under review. **A Water Safety Working Group,** this group meets on a monthly basis with the objective of providing assurance, monitoring for BTHFT risk systems along with completing the risk assessment review process and documenting this review. **The Water Safety Plan** This plan defines the operational procedures, routine maintenance, routine monitoring,	Control of Substances Hazardous to Health Regulations 2002 HTM 04-01 (safe water in healthcare premises)

	and emergencies for all BTHFT risk systems. **Audit process:** An annual water management audit is undertaken by the Authorising Engineer. The audit report includes recommendations for improvement and forms part of the water hygiene management system BTHFT are receiving updates from NHS Property Services for all the Community Hospital as their estate and have assurance their water systems are being managed effectively. These sites are not managed by BTHFT. There is regular legionella and Pseudomonas Aeruginosa routine sampling • Regular monthly sampling undertaken within augmented care areas • Consistent quantities of positive pseudomonas aeruginosa present in all augmented care areas • All contaminated outlets in clinical areas protected by point of use filter.	
Scalds from hot water	There is a Prevention of Full Immersion Scalding & Burns Injuries Policy in place. The policy contains the following information/guidance: • All patient baths, showers and bidets are fitted with a fail-safe thermostatic mixing valve • Hand wash basins considered to be in high-risk areas have also been fitted with a fail-safe thermostatic mixing valve • The temperature setting and fail-safe operation are routinely checked every six months for each mixing valve and records of the checks kept in a logbook. • Staff assisting patients in bathing, should ensure that water is at a suitable temperature before the patient tests the water themselves or proceeds to full/partial immersion.	HSE information sheet, HSIS6: Managing the risks from hot water and surfaces in health and social care
Burns from hot surfaces	There is a Prevention of Full Immersion Scalding & Burns Injuries Policy in place. All in patient areas have radiator guards installed, and high-risk pipework sections have been securely boxed in/or covered and insulated to prevent the risk of burn injury. Unauthorised access to kitchens is controlled with key coded entry systems, although some kitchen doors are wedged open. For this reporting period there haven't been any incidents reported involving a person being burned from a hot surface.	HSE information sheet, HSIS6: Managing the risks from hot water and surfaces in health and social care

Electrical safety	The Electrical Safety Policy sets out the requirements imposed on persons engaged to work on the electrical infrastructure including electrical design, installation, modification, repair, maintenance or inspection and testing ensuring acceptable methods of working. The policy is currently in date. The Electrical Safety Procedure provided guidance to BTHFT Responsible Persons responsible for implementing safe systems of working for persons operating and maintaining plant and equipment connected to (or intended to be connected to) a High, Low or extra-low voltage supply. All the Electrical sub stations at Bradford Royal Infirmary and St Lukes Hospital have been upgraded with the latest switch gear technology to minimise risk of failures In Operation and to detect early power failure to site. The Trust have new contractor BES Group who are carrying out fixed wiring testing and are on schedule for 2024 and they also have new contractor Ventro LTD who are carrying out Emergency Lighting testing who have just started and are working through both sites. • UPS/IPS maintained by Bender & Power Technique, maintenance & service up to date • Generators maintained by Vital power, maintenance & service up to date • HV Switchgear maintained by IUS, maintenance & service up to date • LV Switchgear maintained by IUS, maintenance & service up to date • PAT testing undertaken by JR PAT Testing. Clinical electrical risk assessments were developed looking at what additional work will be required to include additional uninterruptable power supplies (UPS) isolated power supplies (IPS) or tertiary supplies to maintain a resilient and safe electrical supply to critical areas in the event of a mains electrical failure. These assessments looked at what was required for each clinical area. Going forward it has identified that funding needs to be allocated for this work and operational disruption is to be expected to areas to enable resilience works to be undertaken.	The Electricity at Work Regulations 1989 Health technical memorandum 06-01: electrical services supply and distribution (HTM 06-02) Electrical safety guidance for low voltage systems
Falls from windows	There is a Prevention of falls from windows maintenance procedure in place. • All windows within the Trust are fitted with window restrictors. • Maintenance of windows within this Trust is carried out annually and recorded • Staff are encouraged to report any window restrictor that has been removed to the Estates Department. DH alert: EFA/2012/001: window restrictor issue Integral side-stay mechanism window restrictors fitted with plastic spacers and used in many window applications. Action: examine these window restrictors: this action has been completed.	Workplace (Health, Safety & Welfare) Regulations 1992 HSE information sheet: HSIS5 Falls from windows or balconies in health and social care

	Any window restrictors that are requested to be removed in non-clinical areas have to have risk assessments completed prior to the agreement to remove the restrictor. **There are several windows particularly at SLH that require replacing due to age and integrity of the windows. These are replaced on an ongoing basis when they are identified subject to funding.**	
A person accessing roofs/high points on Trust premises. Risk is falling/jumping	A risk assessment has been undertaken which has assessed the risk of a person accessing roofs or high points at Bradford Royal Infirmary and St Luke's Hospital. The assessment identified those areas which could be accessed and made recommendations to reduce this risk. The Trust has worked through the recommendations to ensure roof access is minimised.	Management of Health and Safety at Work Regulations 1999
Medical equipment	There is a Medical Equipment and Devices Policy in place which was ratified 2022 and is scheduled for review in 3 years. The Medical Device Safety Committee (MDSC) is responsible for setting the overall strategy and policy The Medical Devices Safety Officer is responsible for reporting adverse incidents to the MHRA and acting as a first point of contact for matters of device safety. The Medical Device Leads are based at ward level and work with the Head of Clinical Engineering to manage the equipment and devices in their area. The Clinical Engineering Department has responsibility for the maintenance and repair of equipment and medical devices within their remit. The department also maintains the e-Quip medical device inventory for the Trust. This system is web based which will support further development to include the Scan 4 Safety scheme. The Clinical Engineering department will not deploy items of equipment to wards and departments unless staff members in those wards and departments have had the appropriate training or during exceptional circumstances have completed a risk assessment to mitigate the risk. A monthly planned preventative maintenance (PPM) schedule has been developed and incorporated into the e-Quip system. This schedule will continue year on year and monthly dashboard Key Performance Indicators (KPI's) have been generated highlighting performance of High, Medium and Low Risk PPM's. Through the quality system, several Key Performance Indicators are established and monitored these KPI figures are	Provision and Use of Work Equipment Regulations 1998 MHRA Management of Medical Devices

	reported monthly at the Estates and Facilities (EFM) Board meeting. The MDSC monitors: Risks and incidents associated with the safe use and management of medical devices. Activity around MHRA, National Patient Safety Alerts and manufacturer Field Safety Notices. Completeness of training records as well as evidence that non-attendees are followed up. Competency assessment records and updates for staff who have been absent from the organisation or who work in area that has received new equipment. It is not currently possible to ascertain the numbers of staff who have completed medical equipment training. This has been recognised and added to the medical devices risk register. A business case was generated by Trust Chief Medical Officers Team with support from Clinical Engineering and Education Services to address this. Assurance: The Clinical Engineering Department undertakes an annual review which is forwarded to CRAG. Clinical Engineering had its ISO9001:2015 recertification audit. The Auditor acknowledged the challenges that the Trust had faced during the pandemic and was satisfied with the proposed and implemented Clinical Engineering recovery plan In addition, Audit Yorkshire were appointed by the Trust Execs to review Medical Device Management within the organisation. Clinical Engineering supported the audit and provided evidence as requested. The subsequent audit report highlighted significant assurance in December 2022. There are five open risks on the risk register: • **No refresher training being carried out on medical devices** A business case has been submitted from the chief medical officers' team with support from Clinical Engineering and Training & Development team. This has subsequently been approved and actions are being implemented. • **Historic underspend on capital medical equipment** ○ The budget for the replacement of capital medical equipment has been underfunded for many years. This means old and obsolete equipment will need to be kept in use for longer periods of time. This will	

	impact on areas if equipment fails during the year and there is no funding left for replacements. ○ Additional investment of circa 1.7 million has been approved and implemented by Clinical Engineering for financial year 2022/23 to support the rolling replacement of aged devices. CSU's have also received additional capital funds (on a case-by-case basis) during this financial to replace faulty, aged devices to maintain continued service provision. ○ With additional investment, ageing devices are still in use and the capital underspend on medical devices still stands. • **Inadequate management of maintenance contracts for medical Equipment** ○ The management of maintenance contracts for medical equipment is currently not controlled by a single department. The medical device policy states that the procurement department is responsible for the administration of manufacturers' maintenance contracts liaising with managers, users and Clinical Engineering as appropriate. Individual departments often do not take responsibility for their equipment, and it is being used clinically without adequate maintenance arrangements being in place. • **No revenue budget for the replacement of medical equipment** ○ At present no one is controlling revenue spend on medical equipment with departments only replacing as and when equipment fails. There is no longer term strategy which would help reduce overall costs by bulk buying. • **Use of Medical Devices outside of their annual service test date.** ○ This risk covers the potential use of Medical Devices that have not been serviced or tested within the required interval due to issues outside the Foundation Trusts control. ○ This could be due to a lack of contractor's availability, due to reduced staffing levels. ○ Limited parts availability due to reduced stock levels and international materials shortages. ○ A lack of replacement stock resilience to swap out devices requiring maintenance as loan devices used to support surge capacity. ○ Limited access to devices within high-risk areas. ○ Inability to effectively locate affected devices due to equipment redeployment and regular Ward / Dept. reconfigurations to meet clinical demand.	

	○ Surge in medical equipment purchases to support trust recovery plan.	
Noise and Vibration	Data gathered from noise surveys of plant rooms, machinery and equipment is used as part of the risk assessment process. The assessments can be accessed via the Estates intranet page. Noise measurement data is stored on the Casella Insight data base and is readily available for inspection.	Control of Vibration at Work Regulations 2005 The Control of Noise at Work regulations 2005
Ventilation	There is a Ventilation Systems Policy and respective Procedures which are in date. A Ventilation Safety Group (VSG) meets on a bi-monthly basis **LEV:** Local extract ventilation systems located in the Estates workshop areas are thoroughly examined and tested at least on a 14 monthly basis. Monthly checks are in place to ensure local exhaust ventilation (LEV) systems continue to operate satisfactorily in between the above statutory inspections. **General ventilation:** All specialist ventilation systems are verified annually in accordance with Health Technical Memorandum 03-01. All ventilation air handling units (AHU) plant/equipment are included within the PPM regime managed by Estates. All new or refurbished ventilation systems are validated in accordance with Health Technical Memorandum 03-01. **Training:** Personnel carrying out maintenance works to ventilation systems must receive suitable training, which includes information about any significant hazards arising due to their maintenance activities which may either affect them personally or any other person who may be affected by their actions or omissions. All training is in accordance with Health Technical Memorandum 03-01. **Monitoring:**	Workplace (Health, Safety & Welfare) Regulations 1992 Control of Substances Hazardous to Health Regulations 2002 HSG202 – General Ventilation in the Workplace HTM 03 01

	Compliance with the Ventilation Systems Policy will be monitored by the Head of Estates - Maintenance who reports quarterly to the Designated Person. Ventilation status reports are sent quarterly to the Infection Prevention and Control Committee. A 15-year lifecycle programme has been developed to improve ventilation compliance across the Trust in a proactive manner, which is to be delivered via the annual capital budget allocations. The prioritised programme is monitored and reviewed by the VSG and escalated through relevant assurance and working groups. External verifications are carried out which highlight many areas of Non-Compliances, the Major issues are captured on the 15-year lifecycle program which is running behind due to capital funding and operational disruptions to the respective services. The minor non-compliances will be generally due to air pressures and air change rates not fully meeting the recommended levels, these can be due of the changes within the revised HTM, and further details can be obtained at the Ventilation Safety Group meetings. Ward 1 Isolation rooms have been refurbished. Both Pathology and Renal ventilation is in need of replacement and with the Capital Project team. Other areas of Non-Compliance are related to the inability to decant clinical areas which is required to replace the old, expired ventilation which isn't fit for purpose and has been used beyond its normal life expectancy. As new projects come to fruition compliant ventilation requirement are sourced and fitted. Air Handling Units (AHUs) supplied and fitted through Capitol Projects works and installed by Tilbury Douglas on block 8, 9 and 14 have been designed and fitted without sufficient thought to future maintenance by the Operations Team. Currently these AHUs are not being maintained as they are unsafe to access. Works are now underway to remedy access issues to the above-mentioned AHUs and should be completed by autumn 2024 at allow safe access to undertake safe maintenance activities. Recommendations: Estates to continue to monitor the 15-year ventilation plan to ensure that it stays on target (AP4)	

Managing contractors	The Trust has no policy covering the management of contractors within BTHFT. There is a policy for the management of contractors within Estates but that does not cover other contractors commissioned by other departments that might impact on the safety of a building, infrastructure of personnel, for example IT or Suppliers commissioned by Procurement. The Estates & Facilities Policy sets out how they control the risks of contractors being on site. This involves the contractor providing the evidence to ensure they are competent and will control their own risks. In addition, the Estates Department provides information to the contractor about the potential risks to their workers whilst on site. Currently Estates Capital and Operations use a contractor form to gather information required prior to any contractor being commissioned. This is reviewed annually in line with Estates Contractor Management policy. On commissioning all contractors are issued with site safety rules, undertake a health and safety induction and test prior to starting any work on the Trust's estate. Managers are responsible for ensuring all contractors working on BTHFT property have been inducted and all relevant documentation have been provided and checked prior to any works activity. To improve management of contractors, Estates are implementing a contractor management software package (Sky Visitor) to improve management of contractors on site, ensuring the appropriate safeguard and documentation is in place before any work commences on site. The system will involve digital sign in/out, a contractor portal to store compliance/competency records, insurance certificates, risk assessments and method statements etc. Implementation has not commenced on the system. Estates have successfully rolled out an initiative to help identify and manage contractors (specific high visibility vests) over the last year to assist with management. It also allows the Trust to easily identify contractors and which company they belong to. **Training:** All Estates contractors attend a health and safety induction programme which includes a bespoke video on safety on the hospital grounds as well as a questionnaire to test learning Recommendations: A Task & Finish Group will be established to progress a Trust wide policy for the management of all contractors and suppliers. (AP5)	The Construction (Design and Management) Regulations 2015

Waste management	**Legislation and Guidance** The policy and standard operating procedures for the management of healthcare waste had a review date of January 2024. The purpose of this policy is to ensure waste is segregated, stored and disposed of correctly. A new Trust wide SOP for dealing with Sharps that have been found in bags has been agreed and signed off. **Training** Guidance setting out the requirements for the segregation of waste within the Trust is provided to new starters within the Trust as part of their induction pack. Waste guidance is also contained within the Infection Control section of the Trust Induction for new starters. Appropriate training is provided to all members of the waste team who are involved in the handling of waste. The workplace Health and Wellbeing Department contact waste staff regarding appropriate vaccinations. The Waste Management Team are proactive through Global communications in promoting new waste processes or addressing issues that have become apparent such as the “Sharps in Bags Protocol”. **Audit process** The policy requires annual waste audits to be undertaken to ensure compliance with legislation. Every ward and department that is operational will be undertaken annually on a rolling basis. **Concerns** Issues with waste management on Mortuary Hill, the manual transporting of bins down the hill is an often-dangerous task due to deliveries and contractors working and driving in the area. Consideration of a Winch system for the bins or re site the waste compound to an alternative location.	The Controlled Waste Regulations 2012 HTM 07-01
Moving and handling (patient & non-patient)	**Training** Practical face to face training continues to be delivered to staff in line with the updated risk assessment and standard operating procedures implemented to ensure the risk for delivering the training was mitigated to the lowest level practicable. Manual handling training currently being delivered: • All new starters complete the NHS Core Skills Framework Level 1 e-learning – 99% compliance. • All high/medium risk staff have an update every three years from the manual handling team – 86% compliance	Manual Handling Operations Regulations 1992 LOLER 1998

In addition to the core induction and update training the manual handling team have

- Undertaken a number of workplace competency assessments undertaken within specialist areas throughout the Trust. This eliminates the requirement to release staff for training and is an observation of competency of the core skills in the workplace which cannot be replicated within a training environment

- A suite of video clips on the core techniques is available on the Manual Handling webpage of the intranet for reference.

Risk assessment:
Inanimate Risk assessments
There are generic risk assessments for inanimate handling available on the Moving and Handling Intranet site as well as a blank risk assessment form for staff to complete for their specific inanimate load handling risks.

Patient Risk Assessments and Care plans
A review of patient care plans and their compliance is undertaken.

Equipment Audit

The Trust wide annual equipment audit was undertaken by the manual handling team. The equipment requirements were sent to the Care Groups who authorised their areas to be cross charged from the bulk purchases made by the Ergonomics Advisor. The manual handling team arranged the labelling and distribution of all the equipment to the appropriate areas.

Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) Inspections
The manual handling team have continued to undertake the quarterly documented inspections for all the hoist slings within the Trust. A database of all slings is held and checked to ensure the Trust is compliant with the legislated six-monthly inspections.

Recommended actions:
To review outstanding action from the internal audit
- Support the mangers in developing departmental risk assessments. (AP6)

Violence & aggression to staff	There are policies in place to support staff in managing violence and aggression, specifically: • Policy on the prevention and management of violence and aggression • Policy for withholding treatment from violent and abusive adult patients Both policy reviews have been granted extensions, due to the absence of the LSMS • The new Violence Prevention and Reduction Standard is under review and will be implemented through the Associate Director of Quality as a work stream as part of the Trusts wider response to the staff survey. The Local Security Management Specialist (LSMS) will be a member of the working group supporting the implementation of identified actions. The management of violence and aggression and physical assaults has remained a primary focus, in particular in clinical operational areas to support clinicians-staff and in working alongside our safeguarding team in dealing with challenging patients and visitors. There is a Violence Prevention reduction meeting which reports to the Board biannually. **Risk assessment:** Annually the top five areas reporting violence and aggression are identified and a violence and aggression risk assessment is undertaken in those areas with a member of the non-clinical risk management team, Estates and the Local Security Specialist and sister/matron/manager of the area. **Training:** Conflict Resolution is a mandatory training requirement for all staff with 3 yearly on-line refreshers. The Trust has an appointed Local Security Management Specialist (LSMS) in post, who will support staff in the prevention and management of violence and aggression. The security management team work alongside ward staff to support the development of patient behavioural management plans, behaviour agreements and withdrawal of treatment as a last resort. The identified challenges, and that are no surprise to both the security service team and the Trust is the	Management of Health and Safety at Work Regulations 1999

	number of assaults 'involving medical factors' - 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) and this remains a significant factor in this year's reporting on physical assaults.	
Lone working: Trust wide staff:	There is a Trust wide policy for the protection of lone workers to ensure that all staff are aware of their personal responsibilities and take suitable precautions in relation to lone working. This policy and guidance describe the management arrangements for ensuring so far as is reasonably practicable, the health, safety and welfare of all staff who work alone and reflects good practice. This policy applies to all BTHFT staff, including temporary and agency staff, volunteers, students and those on work experience and should be read in conjunction with the 'Trust Policy on the Prevention and Management of Violence and Aggression Managers are responsible for ensuring lone working staff are appropriately protected before entering a lone working situation, assessing the benefit of and where necessary providing security devices, including alarms that can be activated by members of staff working on or off Trust premises in areas where high risk lone worker activity regularly takes place. Local areas are to manage their own devices and training. Any issues with lone working should be reported to security.	HSE guide INDG73(rev3): Working alone Management of Health and Safety at Work Regulations 1999
Lone working: Estates staff:	The Estates Department have produced a Lone Working procedure for their own staff. The Estates Department has identified which of their staff could be lone working. Lone working areas have been identified There is system in place Estates Operations Maintenance Teams are now exclusively using two-way radios with man down facility in line with Estates Lone Worker Policy and Procedures	HSE guide INDG73(rev3): Working alone Management of Health and Safety at Work Regulations 1999

Driving at work	There is a procedure for driving at work. There are two main groups of drivers who drive in the course of their work, these are: • Those who drive in vehicles provided by the Trust to enable them to carry out their duties (e.g. staff visiting patients at home in their "virtual wards") • There is another group of drivers who use their own vehicle in the course of their work. These are often referred to as the grey fleet.	Management of Health and Safety at Work Regulations 1999 HSE guide INDG382(rev1): Driving at work
Vehicle/pedestrian segregation on Trust premises	There are designated pedestrian routes throughout the Bradford Royal Infirmary (BRI) site. Most car parks, on the BRI site, have designated pedestrians' routes marked out, however Temple bank car park, remains rough ground. St Luke Hospital there are still areas where pedestrians have to walk across vehicle routes. One of the main car parks has a temporary roll-crush surface which makes it difficult to mark out pedestrian routes. Although there are long barriers in this car park which guide pedestrians towards the main hospital building, rather than walking between parked cars but signage is lacking. The car parks are audited on an ad-hoc basis. The Risk assessments relating to the traffic management on site and pedestrian/vehicle interface has been updated. With a large amount of building work on site at both BRI and SLH it is important to look at how vehicle and pedestrian access is safely segregated. A review of the carparks at SLH has taken place and drawings have been produced. Once funding is in place work will start with the car parking near gate 1. **Recommended actions:** Carparks should be reviewed to consider how to mitigate slips, trips and falls and include protected designated walkways with appropriate signage. (AP7)	Workplace (Health, Safety & Welfare) Regulations 1992 HSG136

Workplace transport	There is a Trust procedural document ("Driving at Work Procedure") which covers the main areas of driving for the Trust. The three main factors to ensure workplace transport is safe are: **A safe site:** Both main hospital sites have defined pedestrian routes which are designed to ensure effective vehicle/pedestrian segregation. There is also a maximum speed limit of 5MPH on site. **A safe vehicle:** Workplace transport consists of a mix of staff using their own car for Trust purposes and number of commercial vehicles (including vans) which are used on Trust sites and on public roads. All Trust vehicles are maintained by the leasing company. In addition, the drivers of Trust vehicles should complete a pre-use check sheet. **A safe driver:** All drivers of Trust vehicles attend a driver training course to assess their driving competency The driver's licence is checked annually	Workplace (Health, Safety & Welfare) Regulations 1992 HSG136
Working at height	There is an Estates specific working at heights policy (June 2022) in place and not due for review until June 2025. There is a Trust wide procedure for working at height All work height other than work on low-level podiums and stepladders is covered under a permit-to-work system. Most flat roof areas have been fitted with edge protection. However, some have been in place for many years and vary in condition and compliance with current height requirements under Building Regulations and British standards. **Training:** Estates and Facilities staff receive the appropriate training, information and instruction to both satisfy legal requirements and to ensure competence Specific staff are trained to work at height using harness and lanyards, and with IPAF and PASMA access equipment. External training providers provide training for all access equipment which is used by Estates staff. All work at height tasks carried out by Estates staff have been risk assessed.	Work at Height Regulations 2005

	There is now a working at height procedure for the Trust for risk working at height such as climbing steps to clean or access storage. **Recommended actions:** All flat roof areas at BRI and SLH are suitably surveyed, and current edge protection is inspected, and a remedial action plan is produced. Work is undertaken to ensure compliance. (AP8)	
Bed rails	There is a Slips, trips & falls policy in place, which contains the Bedrails policy The procedure is that a bedrails assessment will be completed for all patients who are identified as a risk of falling. **Training:** Education on the use of bedrails is included in the Clinical moving & handling training. "Bedrails" have been added to the "contributory factors" section of the incident management system.	Management of Health and Safety at Work Regulations 1999 HSG220 MHRA device bulletin DB 2006(06)
Slips, trips and falls	There is Prevention of slips, trips and falls policy in place **External areas:** Slip/trip hazards A member of the Estates Department conducts a visual inspection of external areas at both hospital sites to ensure any slip/trip hazards are identified and dealt with **Snow/ice**: There is a gritting plan in place for the hospital sites which identifies when, and which areas need gritting **Internal areas:** There are agreed procedures for floor washing and dealing with spillages	Workplace (Health, Safety & Welfare) Regulations 1992 Management of Health and Safety at Work Regulations 1999

Patients falls	There is Prevention of slips, trips and falls policy in place currently under review There is an RCA Panel which reviews all patient falls investigations. There is a Falls Prevention and Improvement Group. The above groups feed into the Patient Safety Subgroup Upon admission all patients over the age of 65 and those that present a risk of falling are assessed for risk of falling. All patient falls, which result in harm should be investigated Following concerns being raised that patients falls assessments were not routinely being undertaken across the Trust work has been undertaken that demonstrates a significant increase in compliance. Focus will move to improving the compliance with the use of falls care plans.	Workplace (Health, Safety & Welfare) Regulations 1992 Management of Health and Safety at Work Regulations 1999
COSHH	There is a COSHH policy in place, the latex policy has now been incorporated into this document The Trust website contains a dedicated section on COSHH. This provides information for staff, including training resources, links to Sypol and other national guidance documents. A new 0.5 post was successfully recruited to. This post will assist with the management of Sypol and training of staff on the use of the Sypol system Sypol has been rolled out in a number of clinical areas. There over 100 trained COSHH assessors and the number of overdue COSHH assessments have reduced from over 6000 to 700. The COSHH Assurance Group has recently undergone a review of the membership, TOR and KPIs **Training:** The training scheme is currently under review. **Internal Audit** Internal audit reported significant assurance.	Control of Substances Hazardous to Health Regulations 2002
Cytotoxic drugs	There is a procedure in place for the Management of Cytotoxic chemotherapy spillages & contamination Cytotoxic spillage kits are available on wards and theatres which use cytotoxic drugs.	Control of Substances Hazardous to Health Regulations 2002

	Training: Training for cytotoxic spillages will be provided to all relevant staff This will be provided on commencement of employment and at two yearly intervals	
Stress at work	**Controls** – Management of Stress at Work Policy in place. The policy is currently being revised. The policy includes primary, secondary and tertiary prevention interventions. The policy will also include a modified work-related stress risk assessment tool and guidance for managers. The modified risk assessment tool enables direct questioning of individuals/teams regarding specific issues arising within the HSEs 6 principle causes of stress at work and should support employees and their managers to agree practical solutions and action plans. Staff well-being support is available via OH, EAP, Thrive, Psychology services, West Yorkshire Mental Health Hub, Access to Work and all the national provision.	Health and Safety at Work etc. Act (1974), The Management of Health and Safety at Work Regulations (1999), Management standards for work-related stress. Health and Safety Executive (2008a) Guidance on the prevention and management of stress at work
Ionising Radiation	The Trust has (ionising and non-ionising) radiation safety policies in place. The Trust has a Radiation Protection Committee (RPC) that monitors the use of all types of ionising radiation throughout the Trust. The Radiation Protection Adviser (RPA) advises Trust management on all matters of safety relating to the use and monitoring of ionising radiation within BTHFT. The Radioactive Waste Adviser (RWA) ensures that an appropriate EPR permit is maintained in relation to the holding and disposal of radioactive materials. The Medical Physics Experts (MPE) advises BTHFT on the requirements for the protection of patients and research volunteers undergoing medical exposures to include dose optimisation, patient dosimetry, quality assurance, development	The Ionising Radiation Regulations 2017

	Radiation Protection Supervisors (RPS) supervises the work with ionising radiation in the areas for which they have been appointed. **Training:** All managers must ensure that all members of staff who work with ionising radiation are appropriately trained and familiar with the local procedures and protocols for such work and include this as part of staff induction to a new work area and new practices. This means that staff who entre radiation-controlled areas must complete radiation safety training (available on ESR), and all staff who are operators of practitioners must complete annual update training (available on ESR) as well as having completed adequate training as defined in IR(ME)R initially. **Monitoring:** - RPS (for each radiation using area send quarterly reports to the RPC and appropriate general manager - Radiology has an internal programme of annual radiation safety audits and provides quarterly reports on this to the RPC. - The RPA monitors and reports on compliance with legislation via quarterly reports provided to the RPC. - The quarterly RPC monitors and provides assurance of compliance with a systematic agenda covering all uses of radiation at the Trust. - Internal Audit audits are carried out by Audit Yorkshire periodically. - External audit is carried out by the appropriate regulatory authority such as the Environment Agency, Health & Safety Executive and Care Quality Commission. **Visits and enforcement by External Agencies** There has been one enforcement by External Agencies The Nuclear Medicine Department is routinely visited by the Counter Terrorism Security Advisor (as at all other hospitals). The last visit did not raise any concerns.	
Infection, Prevention & Control - staff	There is an Infection Prevention Control Committee (IPCC) annual programme of work which is based on the 10 criteria within the "Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance". This includes prevention and control of infection pertinent to staff health. Progress on the annual work programme is provided quarterly to the Quality & Patient Safety Academy and IPCC; These quarterly reports form the annual report. IPC policies, protocols and guidance are developed, revised and updated as required by the referenced	Control of Substances Hazardous to Health Regulations 2002 (COSHH). The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS

	regulation and guidance – these are approved through the IPCC and signed off by the Executive Lead. An audit programme is developed for regular monitoring of compliance with these protocols. The IPCC reviews clinical incidents and supports clinical teams in the investigation of any incidents or occupational/ healthcare related infections. These investigations are completed in collaboration with Risk & Quality Team, IPC Team and Occupational health Team. The Occupational Health Teams are represented on the IPCC and are included in any relevant outbreak control meetings. The Occupational Health Team produces protocols and policies relating to staff health, screening and immunisation.	on the prevention and control of healthcare associated infections and related guidance. CQC Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. NICE QS61 Infection Prevention & Control HSE guidance, blood borne viruses INDG342 PHE guidance,
Sharps safety	There is a contamination incident policy The structure: **Sharps Injury Prevention Group** – reviews incident data **Workplace Health and Wellbeing Centre** - provide support, advice following a contamination incident There is a poster (which can be printed off from the Trust website) which describes what to do in the event of a sharp's injury. The Sharps Injury Prevention Group has agreed a protocol for dealing with sharps that are inappropriately disposed of within waste bags.	Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
Decontamination	There is a Decontamination of Medical Devices Policy in place Sterile Services Department (SSD), provided by B Braun, provide decontamination services to the Trust.	Provision and Use of Work Equipment Regulations 1998

	Decontamination of flexible endoscopes is undertaken on-site. A dedicated endoscope decontamination unit is used and is compliant with extent guidance: HTM01-06 and the Joint Advisory Group for Gastroenterology (JAG). Subject to annual external IHEEM (JAG) audit by appointed AED and periodic audit by JAG. The next IHEEM audit (for on-site endoscopy) successfully passed with no advisories. **Audit process** SSD is subject to external audit	
First aid	The first aid protocol has been reformatted by the Education Department and submitted to the Health and Safety Committee for ratification, this was not approved due to changes within Education and a lack of ownership. The protocol details which areas need to complete a first aid needs assessment. Without this protocol in place, it is unlikely that these assessments are being undertaken with any kind of regularity.	The Health and Safety (First Aid) Regulations 1981
New & expectant mothers	There is a New & expectant mothers' policy in place (it is contained within the Leave and Pay for New Parents Policy) The policy contains a link to the risk assessment process for new or expectant mothers. The risk assessment form has an escalation procedure to follow, to reflect differing levels of risk	Management of Health and Safety at Work Regulations 1999 HSE guide INDG373: New and expectant mothers who work
Young persons at work	There is a work experience policy in place Young persons on work experience will attend an induction on the first morning of placement. The policy includes a list of what activities work experience students can be involved with, and what areas they are not allowed to access.	HSE guide ING364(rev1) Young people and work experience

Using computers	There is a Display Screen Equipment (DSE) Policy in place, which is currently under review. There have been no changes in legislation covering DSE therefore, it is not anticipated the policy content will change. The policy includes training requirements, risk assessment process and eyesight testing arrangements. A DSE Information and Training e-learning course is available via ESR to all DSE users. Occupational Health are re-introducing classroom-based training for local DSE risk. Occupational Health referral is advised for staff with any DSE health concerns that cannot be solved by a local risk assessor. The Home Working Policy links to DSE policy. It contains ergonomic and well-being advice for remote worker and their workstations.	The Health and Safety (Display Screen Equipment) Regulations 1992. The Management of Health & Safety at Work Regulations 1999.
CAS alerts	There is a Central Alert System (CAS) policy in place The procedure is as follows: 1. All safety alerts come into the Quality Governance Department 2. Alerts are disseminated to relevant areas 3. Confirmation that alerts have been actioned comes back to this department. 4. Any areas that do not confirm alerts have been actioned, are followed up and escalated to the Department's Manager and if necessary to Senior Quality Governance Lead Additional assurance is sought as required.	
Environmental risks to staff working in non-Trust owned or controlled premises	There is a designated person in the Estates Department who oversees the management of the environmental risks in third party properties. There is a compliance matrix which clearly demonstrates how the various issues such as asbestos, water safety and electricity are being managed/controlled. There are regular meetings with the building owners.	Management of Health & Safety at Work Regulations 1999

Table 5: Assessment of compliance with legislation based on risk profiling

RED	Non-compliant with regulations: Many gaps/areas of concern **MAJOR** level of risk due to non-compliance for Trust (no actions identified or plan in place to manage) and/or unsafe for patients/staff - Enforcement action almost certain
AMBER	Non-compliant with regulations: some gaps/areas of concern **MODERATE** level of risk due to non-compliance for Trust (actions identified, plan in place and on target to complete) And/or unsafe for patients/staff - Enforcement action likely/possible
YELLOW	Non-compliant with regulations minimum gaps/areas of concern. **MINOR/INSIGNIFICANT** level of risk due to non-compliance for Trust (actions identified and plan in place and on target to complete). No risk to patients/staff– Enforcement action unlikely
GREEN	Fully compliant with regulations (i.e. Legislations, HTM's, Guidance and no areas of concern. (actions complete and monitored for maintenance of compliance) No risk to patients/staff -No enforcement action expected

Appendix 4 Recommendations and action points to be addressed during 2023/24

Ref no.	Action point	To be actioned by	By when
AP1	Implement a scheduled plan to roll out the replacement of the fire alarms subject to funding.	Fire Manager	31 March 2025
AP2	When the ward is vacated the necessary remedial work around the fire dampers will take place and the fire compartmentation walls be checked by a third-party accredited company.	Fire Manager	31 March 2025
AP3	Estates and Facilities to produce an annual report for asbestos detailing the level of compliance against the Control of Asbestos Regulations 2012	Deputy Director of Estates and Facilities	30 January 2025
AP4	Estates to continue to monitor the 15-year ventilation plan against the Trust's backlog profile – subject to funding availability.	Deputy Director of Estates and Facilities	31 March 2025
AP5	A Task & Finish Group will be established to progress implementation of Sky Visitor – electronic contractor management system.	Deputy Director of Estates and Facilities	31 March 2025
AP6	To review outstanding action from the internal audit, Manual Handling Team to support the mangers in developing departmental risk assessments.	Ergonomics Advisor	31 March 2025
AP7	Carparks should be reviewed to consider surface, signage and designated walkways – subject to funding availability.	Head of Estates Maintenance	31 March 2025
AP8	All flat roof areas at BRI and SLH are suitably surveyed, and current edge protection is inspected, and a remedial action plan is produced. Work is undertaken to ensure compliance.	Head of Estates Maintenance	31 March 2025

BO.11.24.26 - ANY OTHER BUSINESS

BO.11.24.27 - ISSUES TO REFER TO COMMITTEES OR ELSEWHERE

BO.11.24.28 - REVIEW OF MEETING

BO.11.24.29 - DATE AND TIME OF NEXT MEETING

BO.11.24.30 - BOARD OF DIRECTORS WORK PLAN

REFERENCES

Only PDFs are attached

Bo.11.24.30 - Board Open Work Plan 2024-26.pdf

BOARD OPEN 2024-26

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			x	*Deferred from September
Green Plan	Director of Estates & Facilities		x			x			x		
Communications - Annual Update	Chief People & Purpose Officer	x		x							
Digital Strategy	CDIO	x			x			x			
Improvement Strategy	Chief Medical Officer		x			x			x		
Engagement Strategy	Chief Nurse		x			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	x									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		x	
Staff Survey Results	Chief People & Purpose Officer			x						x	
Freedom to Speak Up	Chief Nurse	x			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	Quarterly
Healthcare Worker Flu Vaccination Best Practice Assurance	Chief People & Purpose Officer		x						x		
Apprenticeships	Chief Medical Officer			x						x	Presentation
Education Annual Report	Chief Medical Officer				x						
FINANCE & PERFORMANCE											
Finance Report	Chief Finance Officer	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 / Chief Finance Officer			x						x	
Financial Plan	Chief Finance Officer			x						x	
Capital Programme	Chief Finance Officer			x						x	
Budget setting process & timetable	Chief Finance Officer	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	

BOARD OPEN 2024-26

Item	Lead	Nov 24	Jan 25	Mar 25	May 25	Jul 25	Sep 25	Nov 25	Jan 26	Mar 26	Notes
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Chief Finance Officer		x						x		
PARTNERSHIPS											
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 Nurse	x	x	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief Finance Officer / CPPO	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 and Committees	Committee/Academy Chairs				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			
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						
Fit and Proper Person Test - annual review	Chief People & Purpose Officer				x						
Modern Slavery Statement	Chief People & Purpose Officer	x						x			
COG Engagement Policy	Chief People & Purpose Officer		x								
STANDING ITEMS											
Patient Story	Chief Nurse		x		x		x		x		
Getting to know the CSUs	Chief Operating Officer/Chief Medical Officer/Chief Nurse	x		x		x		x		x	
Chair's Report	Chair	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 Committees	Committee/Academy Chairs	x	x	x	x	x	x	x	x	x	
ITEMS FOR INFORMATION ONLY											
Confirmed Academy and Committee minutes	Committee/Academy 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.11.24.31 - CONFIRMED COMMITTEE/ACADEMY MINUTES

A. QUALITY COMMITTEE - 19 SEPTEMBER & 17 OCTOBER

REFERENCES

Only PDFs are attached

Bo.11.24.31a - Confirmed Quality Academy Minutes - 19 September 2024.pdf

Bo.11.24.31a - Confirmed Quality Committee Minutes - 17 October 2024.pdf

QUALITY ACADEMY (QA)
MINUTES

Date:	Thursday, 19 September 2024	**Time:**	11:00-13:30
Venue:	Microsoft Teams meeting	**Chair:**	Professor Louise Bryant (LB), Non-Executive Director/Co-Chair
Present:	- Professor Louise Bryant (LB), Non-Executive Director/Co-Chair - Ms Karen Walker (KW), Non-Executive Director - Ms Julie Lawreniuk (JL), Non-Executive Director - Professor Karen Dawber (KD), Chief Nurse (CN) in attendance from 11.30 am		
Attendees:	- Dr Paul Rice (PR), Chief Digital and Information Officer - Ms Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing, representing Karen Dawber up to 11.30 am - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director and representing Ray Smith - Ms Judith Connor (JC), Associate Director of Quality - Mrs Sara Hollins (SH), Director of Midwifery - Mrs Sarah Freeman (SF), Director of Nursing (Operations) - Ms Jacqui Maurice (JM), Head of Corporate Governance - Ms Faye Alexander (FA), Head of Education - Ms Jane Kingsley (JK), Lead Allied Health Professional - Ms Grainne Eloi (GE), Associate Director of Nursing and Quality, Bradford District and Craven Health and Care Partnership - Dr Michael McCooe (MM), Associate Medical Director, Learning from Deaths - Ms Denise Stewart (DS), Quality and Patient Safety Facilitator		
In Attendance	- Ms Louise Lacy (LL), General Manager, Children and Neonates, and Dr Rajib Lodh (RL), Consultant Paediatrician, for agenda item QA.9.24.7a - Mr Mark Hindmarsh (MH), Director of Strategy and Transformation, and Mr Naveed Saddique (NS), Service and Business Development Manager, for agenda item QA.9.24.8 - Mr Nick Rushton (NR), Patient Safety Manager, Learning from Deaths, for agenda item QA.9.24.11 - Ms Sonya Tetley (ST), Nursing and Midwifery Quality Lead - Ms Kay Pagan (KP), Assistant Chief Nurse, Informatics - Mr Sean Willis (SW), Associate Chief Nurse, Quality and Workforce - Ms J Kitching, EA to Chief Nurse		
Observers	- Ms Helen Wilson, Governor - Ms Karina Edwards, Internal Audit Manager, Audit Yorkshire - Dr Daniel Sapier, Junior Doctor/Education Fellow		

Agenda Ref	Agenda Item	Actions
QA.9.24.1	**Apologies for Absence**	
	- Dr Ray Smith (RS), Chief Medical Officer (CMO) represented by John Bolton, Deputy CMO - Mohammed Hussain (MHu), Non-Executive Director/Co-Chair - Sughra Nazir (SN), Non-Executive Director	
QA.9.24.2	**Declarations of Interest**	
	There were no declarations of interest.	
QA.9.24.3	**Minutes of the meeting held on 14 August 2024**	
	The minutes of the meeting held on 14 August 2024 were approved as a correct record. Verbal updates were given at the meeting on the outstanding actions and these were reflected in the action log. The following actions were closed: **QA24002** – QA.2.24.5 (28.02.24) – High Level Risks – Concerning the Trust's reliance in Pathology with Fordham and West Yorkshire Association of Acute Trusts (WYAAT) programme migrating to Clinisys Laboratory Information Management System, PR noted the Trust is now in a position to go-live with the Clinisys product on Tuesday, 1 October 2024. This has been confirmed by the Programme Board and the regional team and internal communications to this effect have commenced. Leeds are planning to go partially live towards the end of November 2024, with the expectation of being fully live in February 2025. Any further Leeds slippages will be reported by PR to the Academy. For assurance purposes this issue remains on the Risk Register. **QA24016** – QA.8.24.5 (14.08.24) – Review of Quality Academy Terms of Reference and Work Plan prior to submission to Board in September – JM confirmed the Terms of Reference and work plan have been updated and recirculated. It is envisaged the Academy will be changing to a Committee from the 25 September 2024.	
QA.9.24.4	**Matters Arising**	
	Items to escalate from the Chief Nurse/Chief Medical Officer: Representing KD, JH noted there was nothing to escalate as raised by the CN. JB also noted there were no items to escalate that would not be covered under other items on the agenda. **Quality Committee Terms of Reference**: JM referenced the work since the last meeting in terms of the Quality Committee Terms of Reference, focusing on the membership following consideration by KD, RS and JC. The Terms of Reference have subsequently been updated accordingly and there has been a review of the subgroups of the Quality Committee with a number being removed and others merged. Further changes may ensue over the coming months. This documentation will be submitted to the Operational, Governance and Assurance group followed by the Executive team meeting for final sign-off prior to submission to the Board of	

	Directors on 25 September 2024. Following that meeting it is envisaged the group will be known as the Quality Committee. The workplan has been streamlined and the updates were noted by the Academy.	
QA.9.24.5	**Quality Academy Dashboard**	
	LB noted the dashboard should provide a single view of the Academy indicators aligned to the Trust's Strategic Objectives. JB highlighted the following: • Summary Hospital-level Mortality Indicator (SHMI): This considers the statistical likelihood of patients seen in the Trust dying in the ensuing 30 days following discharge, based upon patients' characteristics. It gives an expected number of deaths and the actual number of deaths are measured against that number. This is not an indication of the quality of care provided, however, this number has increased and the Trust remains an outlier. Potential issues were discussed including Coding, these are actively being investigated/addressed particularly around the R69X code used to code patients who have no co-morbidities. Just over 6% of patients in WYAAT are allocated this code, Bradford has 38% of patients in total allocated this code. Solutions and explanations are sought. Once the error is fixed, it is expected Bradford Teaching Hospitals NHS Foundation Trust's (BTH) SHMI will significantly improve against the expectations, the expected number of deaths rising to match the actual number of deaths. These corrections are expected to result in a financial impact and demonstrate a number of positive effects on BTH's metrics. JB noted there are three potential known areas where this error could have resulted: (1) Clinical staff incompletely or incorrectly documenting comorbidity in patients' notes. (2) Whether the correct codes are being logged. Coders are unable to code against a query diagnosis. (3) Issues relating to an electronic mapping piece of software that links to a Healthcare Resource Group (HRG) code in another piece of software which indicates funding feeding into the statistical expectation of death. Crude mortality rates are reported to be reducing, therefore, JB, PR and the Director of Finance are meeting to address matters with urgency. LB highlighted available figures in April 2022 which appeared to be decreasing, figures having steadily shown an increase since May 2022. Reports to date for this situation are unsatisfactory with the Trust Governors now requesting a full and concise explanation. • Pressure ulcers – The increase in trend was noted in three ward areas (an increase in Grade 2 and a decrease in Grade 3 pressure ulcers), with additional support/learning being provided	

	in these areas. • Falls - The innovative work underway by the Falls' Lead was highlighted noting engagement with clinical teams and volunteers being recruited to assist with the Falls' Prevention Programme. Falls' Prevention week commenced in the Trust on 16 September 2024. • Medicine Management - JC noted the importance of the work underway with Business Intelligence and Pharmacy colleagues around this metric. LB queried whether issues/incidents of high importance would appear as metrics on the dashboard. JC noted further conversations would be required, for example around blood transfusion, an electronic bar-coding system would eliminate the low or no harm incidents. A proposal will follow to the Committee in due course. Data not appropriate for the dashboard would require regular reporting in order the Academy receive oversight, however, it was suggested that this may be reported through Patient Safety Incident Response Framework (PSIRF) on a quarterly basis. The financial risk around SHMI will be escalated to the Board of Directors at its meeting on 25 September 2024. Assurance was received following discussions.	QA24017 Associate Director of Quality (JC)
QA.9.24.6	**Quality Oversight and Assurance Profile and Patient Safety Incident Investigation (PSII) Report**	
	JC presented the Quality and Assurance Profile and the Patient Safety Incident Investigation report (PSII) report for August, compiling of data reported between 1 June and 31 August 2024. The following highlights during the reporting period were noted: • 41 safety incidents were escalated from the Clinical Service Units (CSU) and were discussed at the Safety Escalation Group (SEG). • 10 safety incidents discussed at SEG were escalated to the Quality of Care Panel (QuOC) meeting and as a result two PSIIs were declared under PSIRF. 2024/6343 concerned inequitable care leading to poor outcomes and experience for people with learning difficulties, particularly around reasonable adjustments, and 2024/6878 concerned jump risks in Trust public areas for which a management plan is now in place. The escalations to SEG and QuOC are currently being monitored within the relevant teams. • The externally reported incidents received at QuOC were noted with an increase in the number of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) reports identified. As a result Radiology are reviewing the incidents reported over the last twelve months and considering actions that have been put in place to establish if any commonalities or themes are emerging. • There were no monthly enquiries received in June, July or August 2024 from the Care Quality Commission (CQC). There is a new CQC relationship owner for BTH, this being the fourth appointed in a short period of time. No CQC Engagement meeting has been held for approximately nine months, due to the Inspection period remaining open. A total of 17 ad hoc enquiries had been received, these all now being closed as a	

	result of responses. The impact on workload was noted. • Two PSIIs were agreed for reporting, as noted above, and 2024/7388 a Maternity and Newborn Safety Incident (MNSI), Term baby transferred to the Neonatal Unit due to Oxygen requirement and therapeutic cooling. • Three MNSI investigations have been completed: 2023/20335 and 2024/4263 (Neonatal deaths) and 2023/22608 (Baby readmitted with hypoglycaemia). • 26 Central Alerting System alerts were highlighted to QuOC with two alerts requiring a response, for which the Trust is fully compliant. • A number of claims have been settled with none listed for trial. • Thirteen inquests were attended with a further 12 currently listed and 5 pre-inquest review hearings with a further two listed. Panel solicitors are supporting more frequently due to the current schedules. • Organisational learning noted included the sharing of learning with colleagues in WYAAT. • The Quality Oversight System continues to review all safety incidents and triangulates themes and any learning with other sources of intelligence/insight. • Duty of Candour requirements continue to be met with no breaches since August 2016. The Non-Executive Directors questioned the need for two separate reports noting the issues when comparing. From an assurance perspective the report notes incidents open beyond 30 days, however, the majority of incidents are closed within the 30 days with very few exceeding this target. The Academy agreed to a joint report being submitted to future meetings. The Academy noted the current position and was assured following the discussions that the Trust has processes in place to identify, investigate and learning from PSIIs, meeting national and local reporting requirements.	
QA.9.24.7	**High Level Risks**	
	JB presented the report noting the discussion of the high-level risks at the Executive team (ET) meetings held on 19 August and 9 September 2024 and the following were highlighted: • Risk 2605 – Currently rating 20 (previously 25) concerned delivery of chemotherapy at Eccleshill. Extra capacity has since been allocated to alleviate the situation however review is ongoing and expected to be informed by regional work underway in terms of alignment of Oncology services across Place and the wider Integrated Care Board (ICB). With regard this continuing risk, JL queried the effect on the situation following the introduction of increased capacity. JB believed the immediate risk was resolved, however, will seek further confirmation along with timescales. The Finance and Performance Committee on 19 September 2024 highlighted that it would be appropriate to have the chemotherapy risk aligned to the Finance and Performance Risk Register also, due to the 31 and 62 day targets and this has been actioned. **Post-meeting note:** *01.10.24: Patients are having*	

	chemotherapy at the required time. Capacity will increase and work is ongoing to ensure that the capacity will meet that demand. • Risk 2618 – Concerning recruitment of consultants into the stroke team. There is currently an establishment of three consultants on the stroke team, two of which are locum consultant posts and a vacancy has now arisen from the departure of the substantive consultant. Delivery of the service is currently not compromised and work to reappoint to the Consultant post is underway. Additional measures are being put in place to ensure supportive processes around the stroke service such as oversight, governance and risk being adequately managed, with input of consultant time from other allied departments, for example Neurology. JL highlighted the Urgent Care Improvement report discussed by the Stroke service at the Finance and Performance Committee on 19 September 2024, noting the great work, the improved performance and the impact of the loss of the substantive consultant. LB raised Risk 2566, concerning the timely discharge of patients due to a lack of space in social care. KD referenced a discussion of Risk 2566 at the Executive team meeting on 16 September 2024 whereby a pre-discussion of all risks is undertaken. A decision was reached at that meeting that the risks within the risk paper discussed, would be updated within the paper, prior to submission of the Risk paper to future Committees/Academies. KD highlighted the elevated SHMI score currently being investigated by Clinical Coding and Informatics. The crude death rate is decreasing if not remining static and a focus group is considering possible solutions including financial implications. LB suggested that Coding and SHMI should be added to the Risk Register. MM highlighted the recent discussions with the Care Quality Commission (CQC) Inspector around Learning from Deaths, with BTH's work having been described as most impressive. These issues are not representative of the clinical work underway, however, MM welcomed either/both headings being added to the Risk Register if this would raise the profile to resolve the issues as a matter of urgency. JB considered Coding should be added and KD reported that a full discussion was held at QuOC on 16 September 2024. KD agreed to discuss further with the Executive team on 23 September 2024, with Mel Pickup, Chief Executive Officer, and PR as portfolio lead recommending a high risk is added to the Risk Register to reflect these discussions. **Post-meeting note:** *Following discussion at the Executive Team meeting, PR will provide an update/review on clinical coding on the Risk Register.*	QA24018 Chief Nurse (KD) QA24019 Chief Digital and Information Officer (PR)
QA.9.24.7a	**Briefing on Risk 2509: Waiting Times for Autism and Attention Deficit Hyperactivity Disorder (ADHD) Assessment**	

	LL, General Manager, and RL, Clinical Director (also working in the Child Development Centre and community), were welcomed to the meeting to provide a summary of the current risk related to Autism, a lifelong developmental condition affecting social, communication and imagination skills, to enable oversight and assurance of the actions being taken by the CSU, following a request around the risk and how these are being mitigated being both a Trust and a system issue. This risk is one of the highest with a score of 16. Over 758 children are currently on the waiting list awaiting an autism assessment. The Trust's Autism Lead, Dr Indie Thopte, has undertaken a considerable amount of work with the pathways and pathway changes, however, further work is required. RL described this national issue and changes proposed to shorten the diagnostic pathway with the introduction of a one-stop clinic for diagnosis. Bradford has one of the most complex cohorts of children in terms of illnesses and disabilities in the entire country, therefore, children are being managed with increasing complexities adding to the challenge. Any changes have a knock-on effect on other groups of children's cases. Bradford District Care Trust are suggesting alternative pathway proposals and the Operational Development group, attended by LL, will consider these models from a finance perspective. LB and KD thanked LL and RL for the informative update demonstrating the importance, describing the challenges both to Bradford and nationally and the explanation behind the high-level risk. LB noted the recommendations and that this risk will remain on the High-Level Risk Register in relation to the Academy. As a member of the Operational Delivery group, LL will ensure the Trust is fully aligned to receive information. RL noted this service needs an entire system approach ensuring shorter waits, efficiency, support at an earlier stage rather than a focus on diagnosis and work at system level and this should improve the situation. The initial work is to limit the rate of the growth of the waiting list. GE offered her full support in pulling the data services together to ensure improved outcomes, noting the whole of West Yorkshire approach. GE was thanked for her support. Having reviewed, challenged and assessed the identification and management of risks within their remit on the high-level Risk Register, the Academy noted that all relevant key risks have been identified and are being managed appropriately and the potential financial risk around SHMI will be highlighted to the Board of Directors at its meeting on 25 September 2024.	

QA.9.24.8	**Health Inequalities (HI)**	
	MH introduced NS, as the Trust Lead for Health Inequalities, to provide an update on the current key highlights. NS provided an update against the NHS England HI framework noting self-assessment is being developed and is maturing across the four domains of leadership, capability, partnership and data and actions devised to improve Trust ratings to ultimately move to the rating of thriving, which is the highest level. An oversight group focusing on aligning the HI work across the Trust has been set up and an action plan compiled following self-assessment of a publication on HI from NHS Providers, 'What Good Looks Like', to help strengthen the inequalities programme and improve the Trust's ratings and these were discussed. A focused Board Development session is being held on 23 October 2024 to highlight the strategy and plans around HI enabling better connection with the work underway across the Health and Care Partnership, across Place, where there is a strong established team and work programme around reducing inequalities across Bradford. The session will be an opportunity to relaunch the HI programme as well as focus on BTH's role as service provider, a partner and an anchor organisation. The Reducing Inequalities Alliance (RIA) recently published a briefing on how the NHS and care organisations can reduce poverty. This will be further discussed at the Board session in order to strengthen relationships with RIA. NS discussed living well and the team's participation at events held in house to sign post assistance to those requiring support. NS referenced a number of staff who have enrolled in/completed the Improving Population Health Fellowship Programme in relation to the West Yorkshire Health and Care Partnership and is looking at improving the awareness of this programme with CSUs. LB thanked NS for the thought-provoking paper in this challenging area and the work around poverty associated with patients for example those who Do Not Attend, those on certain employment contracts and other multi-factorial aspects. KD questioned the Trust's achievements over the last few years and the ambition to train staff and the need to socialise this more within the organisation. The Race Inequalities and Equality, Diversity and Inclusion work is apparent in the fabric of the organisation and reducing inequalities work is apparent in Maternity and in other areas, however, KD questioned/challenged the Academy on the impact of this work across the Trust. NS replied topics are being driven forward, although progress had stalled recently the action plan devised with the Reducing Inequality Alliance will support progress. Further demonstration at the Board Development session via the action plan will be visible.	

	Future work with other Trusts and teams will be highlighted ensuring galvanisation of the whole project. Communication routes are in need of improvement as the Trust seeks a higher profile. NS agreed to contact KD to discuss further prior to the Board session. MM volunteered the services of the Bradford Institute for Health Research (BIHR) research team who have been running community health checks for example around diabetes and hypertension, and work with anchor institutions within the Bradford area of most deprivation, via the Improvement Academy. PR raised the Place-based activities around digital inclusion and the Virtual Royal Infirmary covering all opportunities. KW suggested designing a whole HI process into all Trust processes/services. The Academy noted the content and the intended actions and was assured following the discussions.	QA24020 Lead for Health Inequalities (NS)
QA.9.24.9	**Maternity and Neonatal Services Update**	
	SH presented the July and August 2024 Maternity and Neonatal Services Update report to the Academy and the following highlights were noted. **9.1 – July Report** • Previously discussed escalations of concerns from the Maternity and Neonatal Safety Incidents (MNSI) have now been closed completely following face to face meetings with MNSI and the information shared with them. An overarching action plan is now in place which will be signed off by the Board on 25 September 2024. • No stillbirths. • Two cases of reported Hypoxic-ischaemic encephalopathy (HIE) did not meet the MNSI criteria. • No neonatal deaths, three expected deaths of babies born in Bradford who died in Leeds due to requiring specialist services. • No maternal deaths. • Ongoing maternity investigations noted. No new neonatal Serious Incidents (SI) or ongoing SIs. No completed SI reports to share. There were two MNSI reportable cases. • An MNSI Escalation of Concerns letter was received by the service in July, in relation to consultant attendance as per Royal College of Obstetricians and Gynaecologist guidance. This has been responded to and closed with no further action. • There were two occasions in July where the unit was assessed as needing to divert women to other organisations. **9.2 – August Report** • There were no maternal deaths. • There was one case of HIE which did not meet the MNSI criteria. • Three stillbirths were reported and there were four neonatal deaths, two babies in addition died in the post-natal period these had not had any neonatal care but will be considered	

	through the Sudden Unexpected Death in Childhood (SUDIC). • The ongoing maternity investigations were noted, in addition there were two After Action Review cases noted as appendices and the learning was identified. • There were two completed investigation reports including learning and safety recommendations, PSII 2023/140163, term baby admitted to the Neonatal Unit (NNU) seizures noted at 12 hours of age and MI-036808, around ensuring the mother's perception of baby wellbeing is considered in the context of clinical assessment. The difficulties of this action were raised which may result in some challenge. SH described a situation where a training exercise was underway to which bleep-holders would normally respond. This Neonatal simulation exercise/training was taking place at the same time as the incident which caused some confusion. The learning was noted around improving staff awareness of communication tools and the sharing of information between teams and the multiple clinical areas to ensure robust processes are in place when in situ training drills are underway in order not to compromise any response to an actual emergency situation. The Methicillin-resistant Staphylococcus aureus (MRSA) colonisation cases in June and July were noted. At the time of writing the report 14 cases had been identified with no babies developing MRSA bacteraemia and all but one now discharged home. The immediate actions taken were noted by the Academy, noting the common source could be shared equipment or staff members. Actions continue including the monitoring of cases, bi-weekly meetings and the weekly screening of babies. However, since the writing of the report there has been a further increase of five MRSA cases, fortunately no cases of bacteraemia and immediate actions have been taken. These babies have not come to any harm as a result of the positive MRSA and the next steps are being considered including environmental sampling of all high touch surface areas across the NNU, labour ward and transitional care. There has been a robust focus on additional training of all staff members around infection, prevention and control. In addition enhanced cleaning and surveillance Multidisciplinary team meetings continue on a fortnightly basis and include members from the UK Hospital Corporation of America (HCA) and also from NHS England. MRSA cases in previous years had been reported as nil, noting this unfortunate issue. The sensitive issue of staff transmission was discussed. Following a planned approach a targeted decolonisation of staff members will be rolled out between the labour ward, obstetric theatres and the NNU, with the Trust considering offering body wash treatments to staff and/or swabbing in an attempt to identify any carriers. Robust communications are required describing the various options and will be carried out in an extensive sensitive and measured way. There is much work ongoing with support from both Infection, Prevention and Control (IPC) and Occupational Health (OH) colleagues in order conversations can be held with staff side and staff themselves. Side effects are very small and if staff refuse a	

	conversation will be held with the staff member around Code of Conduct. KD noted this is a complex issue whereby the Trust potentially is registering an outbreak situation, however, this is not blood stream infections of MRSA but MRSA which has been found on the skin of babies and could potentially be being transmitted via staff, equipment or families. To step down an outbreak takes time undertaking environmental checks and extra swabbing with the swabbing of babies increased too twice weekly. MRSA is not a condition that can be completely irradicated, however, only becomes a major concern if it enters the body. The Trust has increased screening and good practice IPC processes as standard. Staff on the unit are being more cautious and extra vigilant when carrying out their duties. To date the outbreak has not caused any harm, as it is colonised and has been picked up as part of routine screening, as a result of good practice. Bacteraemia rates on the NNU are slightly above for some bacteria but are charting around the middle of the chart. SH confirmed the actions will be undertaken in a very supportive and sensitive way in order staff are not made to feel responsible. Further steps were discussed following these additional processes should no source be identified. LB noted regular updates to the Academy will continue around this complicated issue. SH highlighted there is a moderate risk at present to being fully compliant to the Maternity Incentive Scheme (MIS) Year 6. This challenge is specifically in relation to the MIS and Practical Obstetric Multi-Professional Training (PROMPT). To receive the financial incentive the Trust is required to be fully compliant in all ten safety actions. This situation has, however, now been downgraded to a moderate risk due to ongoing work ensuring an increased number of anaesthetic and obstetric colleagues being booked on to the appropriate training days. A 90% level is required to pass this challenge and the Board will be informed of this situation due to the significant funding received for MIS on an annual basis. SH was thanked for her medical leadership in assisting in ensuring the appropriate staff attend the training days. SH was thanked for the suite of papers. The Academy noted the content of the report and was assured following the lengthy discussions. LB queried whether the monthly presentation going forward could display the metrics regarding for example births, neonates, HEI and maternal deaths on graphs in order data could be viewed over the months/years as a visual means of providing assurance. SH noted an annual summary is provided of stillbirths year on year which have been steadily decreasing demonstrating improvements particularly when data of babies born with congenital anomalies are	QA24021 Director of Midwifery

	removed. SH agreed to present the data in this visual format and PR offered his assistance. The Academy noted the content and was assured following the discussions.	(SH)
QA.9.24.10	**In-Patient (IP) Survey**	
	Following receipt of the Trust's results of the Adult IP survey from 2023, JH was notified by the national team identifying errors in the data presented and noting these errors were present in reports circulated nationally. The information, therefore, will not be shared in-house until the issue is rectified. These errors resulted in some of the benchmarking information provided being incorrect. Results will be brought to the Academy once the revised report is received. By way of assurance JH noted patient experience data is discussed regularly through the Patient Experience group, the Academy receiving the notes of the meetings. The corrected report is expected to be received by the Trust imminently.	
QA.9.24.11	**Learning from Deaths and Mortality Review Improvement**	
	MM noted the focus around SHMI alluding to earlier conversations during this Academy meeting. The SHMI data was presented between August 2023 to May 2024, demonstrating the ratio of the observed to expected deaths both in hospital and up to 30 days following discharge. SHMI is calculated by the number of observed deaths divided by the number of expected deaths multiplied by 100. The expected deaths are a construct based on the Trust's information submitted to NHS Digital. To note the figure does not indicate the level of the quality of care being delivered nor is an indication of avoidable deaths. A value greater than 100 (based on NHS England averages) meaning that the patient group being studied has a higher mortality level than expected. SHMI values across West Yorkshire have been raised previously, with only Airedale having a consistent value below the 100 target for SHMI. BTH throughout the period has had the highest SHMI in West Yorkshire by, on average, five points per month more than the next highest Trust which is Leeds. This is despite BTH having the lowest crude mortality rate in West Yorkshire and the second lowest number of expected deaths, just 300 more than Airedale, despite BTH seeing nearly double the amount of patients. BTH is recorded to have the second highest number of admissions (67,138) behind Leeds, between August 2023 and May 2024. Clinical coding determines and informs NHS England of the activity and the conditions for which patients are treated. Coding also informs NHS England of the background and co-morbidities of the Trust's population. If clinical coding is poor or not reflective of the condition of patients' treatment, then NHS England assumes the Trust has a healthier population and, therefore, a lower number of expected deaths. BTH currently has the fifth lowest depth of coding in England and one of the highest burdens of disease in the	

	country. The R69X (null) clinical code is applied by NHS England when a patient's data has errors and/or a symptom code as the primary diagnosis, creating a 'null' record with no data contained. This should be avoided. BTH has the fourth highest rate of R69X codes in the country at 46.5%, this demonstrating nearly 50% of records have had a null code applied by NHS England demonstrating they cannot count towards the Trust's indicators. Following discussion with the Finance Department, there are financial implications and incentives in getting codes correct, particularly with day-case and elective patients. BTH currently has the third highest number of null codes in the country for elective patients (almost 40%). Over the last few weeks more detailed coding has been developed with assistance from PR and the wider Business Intelligence team. MM noted support for clinical coding should be a key priority for the Trust. Key stakeholders need to process map the clinical coding journey with this situation being rectified in the next six months due to monthly resubmissions being suspended from April 2025 by NHS England, as the Trust will not be able to revise data on a monthly basis as currently able to undertake. Excellent mortality work is underway in the Trust as informed by the CQC Inspectors at their visit in April 2024. JL noted the huge importance of this work, however, questioned assurance that the Trust has the resources to complete this work within the timescale. The Trust is aware of what is involved as identified through previous research and with a new focus around organisational priorities it is hoped these deadlines will be met. KW referenced the patient outcome element whereby improving patient outcomes will improve funding and the Trust receiving monies due will increase capacity. PR confirmed the high priority of this organisational-wide piece of work and provided assurance to the Academy noting the recent backlog position with the team supporting an activity that has outsourced some of this work, following vacancies and sickness in the core coding team. Elective Recovery Funding (ERF) work is underway to drive the quality of captured data. The key issue is around the complex care delivered by the Trust on vulnerable patients in the community. LB noted this issue requires more complex investigation and regular updates would be received via the dashboard at the Academy meetings. LB queried whether any expertise from other NHS Healthcare providers could be accessed to assist. PR noted coders are a professional group and noted the possibility of a shared leadership resource from Airedale. The Academy noted the content, the challenges and work in	

	progress as described.	
QA.9.24.12	**Internal Audit Reports Relevant to the Academy**	
	• BH/43/2024 - Nursing Assessments and Care Plans – Limited Assurance. JH informed the Academy a number of key individuals were involved in the improvement plan linked to the audit report undertaken of a small sample size, noting two elements. - Gaps present around the recording of live data on the Electronic Patient Record (EPR). Work is now underway with clinical leaders to ensure improvements in specific areas. - Understanding reasons why documentation around clinical engagement is not being completed as set out in EPR. If a field is made mandatory this results in good compliance, however, this would not be appropriate for all sections in the EPR and nursing documentation. Detailed work with clinical colleagues is underway. In terms of patient safety there are various ways the Trust can understand patients are receiving good care and that assurance is evident, however, the completion of the documentation requires further improvement. - The improvement plan has been created embedding evidence around the different standards reported through nursing excellence meetings. Recommendations have been agreed and discussed at the Audit and Assurance Committee and these are being used to form the improvement working plan with colleagues. • BH/04/2025 – Freedom to Speak Up (FTSU) – Significant Assurance. • BH/05/2025 – Discharge Management – Significant Assurance. LB thanked JH for this insight noting the Academy will have continued oversight of the improvement plan for BH/43/2024.	
QA.9.24.13	**Any Other Business**	
	There was no other business to discuss.	
QA.9.24.14	**Matters to share with Other Academies**	
	• People Academy - Training compliance in Maternity regarding MIS Year 6.	
QA.9.24.15	**Matters to escalate to the Board of Directors**	
	• Training compliance in Maternity regarding MIS Year 6. • SHMI - Potential financial risk. • Maternity - MSRA cases.	
QA.9.24.16	**Date and Time of Next Meeting**	
	October 2024 – Date to be confirmed. **Post-meeting note:** *The next Academy meeting has been confirmed as Thursday, 17 Oct. 2024 to be held 9am to 11.30 am.*	
	Annexes for the Quality Academy **Annex 1 – Documents for Information**	
QA.9.24.17	**Bradford District and Craven Quality Committee (Highlight**	

	Report and Minutes)	
	Noted for information.	
QA.9.24.18	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QA.9.24.19	**Clinical Outcomes Group**	
	Noted for information.	
QA.9.24.20	**Patient Experience Group**	
	Noted for information.	
QA.9.24.21	**Patient Safety Group**	
	Noted for information.	
QA.9.24.22	**West Yorkshire Association of Acute Trusts Quality and Safety Meeting Update/Minutes**	
	Noted for information.	
QA.9.24.23	**Quality Academy Work Plan**	
	Noted for information.	

Bradford Teaching Hospitals
NHS Foundation Trust

ACTIONS FROM QUALITY ACADEMY – 19 SEPTEMBER 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24017	19.09.24	QA.9.24.5	**Quality Academy Dashboard** Medicine Management - JC noted the importance of the work underway with Business Intelligence and Pharmacy colleagues around this metric. LB queried whether issues/incidents of high importance would appear as metrics on the dashboard. JC noted further conversations would be required, for example around blood transfusion, an electronic bar-coding system would eliminate the low or no harm incidents. A proposal will follow to the Committee in due course.	Associate Director of Quality	October 2024	
QA24018	19.09.24	QA.9.24.7	**High Level Risks** KD agreed to discuss further with the Executive team on 23 September 2024, with Mel Pickup, Chief Executive Officer, and PR as portfolio lead recommending a high risk is added to the Risk Register to reflect these discussions.	Chief Nurse	October 2024	01.10.24: KD has discussed. Completed. **CLOSED.**
QA24019	19.09.24	QA.9.24.7	**High Level Risks** KD agreed to discuss further with the Executive team on 23 September 2024, with Mel Pickup, Chief Executive Officer, and PR as portfolio lead recommending a high risk is added to the Risk Register to reflect these discussions.	Chief Digital and Information Officer	October 2024	

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			Post-meeting note: *Following discussion at the Executive Team meeting, PR will provide an update/review on clinical coding on the Risk Register.*			
QA24020	19.09.24	QA.9.24.8	**Health Inequalities** KD questioned the Trust's achievements over the last few years and the ambition to train staff and the need to socialise this more within the organisation. NS agreed to contact KD to discuss further prior to the Board session.	Lead for Health Inequalities	October 2024	27.09.24: MH has discussed with KD. Completed. **CLOSED.**
QA24021	19.09.24	QA.9.24.9	**Maternity and Neonatal Services Update** LB queried whether the monthly presentation going forward could display the metrics regarding for example births, neonates, HEI and maternal deaths on graphs in order data could be viewed over the months/years as a visual means of providing assurance. SH noted an annual summary is provided of stillbirths year on year which have been steadily decreasing demonstrating improvements particularly when data of babies born with congenital anomalies are removed. SH agreed to present the data in this visual format and PR offered his assistance.	Director of Midwifery	October 2024	03.10.24: SH - The format requested will take time to devise, however, production is now being worked on and information will be presented in this format as soon as available, possibly by the New Year 2025. **CLOSED.**

QUALITY COMMITTEE
MINUTES

Date:	Thursday, 17th October 2024	**Time:**	09:00-11:30
Venue:	Microsoft Teams Meeting	**Chair:**	Julie Lawreniuk Non-Executive Director/Chair
Present:	- Julie Lawreniuk (JL), Non-Executive Director - Professor Karen Dawber (KD), Chief Nurse		
In Attendance	- Bryan Machin (BM), Non-Executive Director to ensure quoracy - Adam Griffin (AG), Deputy Chief Digital and Information Officer representing Paul Rice (part meeting) - Byron Johnson (BJ), Senior Quality Governance Lead representing Judith Connor - Faye Alexander (FA), Head of Education - Jacqui Maurice (JM), Head of Corporate Governance - John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Kay Pagan (KP), Assistant Chief Nurse for Informatics - Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary - Leah Richardson (LR), Patient Safety Specialist, in attendance for agenda item QC.10.24.8b - Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes, in attendance for agenda items QC.10.24.8 and QC.10.24.14 - Nicholas Rushton (NR), Patient Safety Manager, Learning from Deaths in attendance for agenda item QC.10.24.8 - Rupert Allen (RA), Quality Lead for Patient Experience, in attendance for agenda items QC.10.24.10 and QC.10.24.10a - Ruth Tolley (RT), Quality Lead for Patient Experience, in attendance for agenda items QC.10.24.12 and QC.10.24.12a - Sara Hollins (SH), Director of Midwifery - Sarah Smith (SS), Quality and Patient Safety Facilitator - Linda Preston, Executive Assistant, Minute Taker		
Observers	There were no observers.		

Agenda Ref	Agenda Item	Actions
QC.10.24.1	**Apologies for Absence**	
	- Professor Louise Bryant (LB), Non-Executive Director/Co-Chair - Karen Walker (KW), Non-Executive Director - Sughra Nazir (SN), Non-Executive Director - Dr Paul Rice (PR), Chief Digital and Information Officer - Dr Ray Smith (RS), Chief Medical Officer (CMO) - Joanne Hilton (JH), Deputy Chief Nurse/Director of Nursing - Judith Connor (JC), Associate Director of Quality - Kez Hayat (KH), Head of Equality, Diversity & Inclusion - Sarah Freeman (SF), Director of Nursing (Operations)	

QC.10.24.2	**Declarations of Interest**	
	There were no declarations of interest.	
QC.10.24.3	**Minutes of the Meeting Held on 19th September 2024**	
	The minutes of the meeting held on 19th September 2024 were approved as a correct record. An update was provided to the following action: QA24017 Quality Academy Dashboard: BJ advised that work continues on the dashboard with the Business Intelligence (BI) team. A paper will be presented to the Committee once it is confirmed when the work is likely to be completed. Action to remain open. The following actions were closed: • QA24018/19 High Level Risks: Following discussion at the Executive Team meeting. The Quality Committee noted the post meeting note whereby PR would provide an update/review on clinical coding on the Risk Register. • QA24020 Health Inequalities: KD held the required discussion with MH prior to the Board session on Health Inequalities on the Trust's achievements over the last few years, the ambition to train staff and the need to communicate on this more within the organisation. • QA24021 Maternity and Neonatal Services Update: Regarding the request from LB to include more detailed metrics (e.g) births, neonates, HEI and maternal deaths to enable data to be viewed over the months/years as a visual means of providing assurance. Work is underway to present the data more visually and this will be available to the Committee in the new year.	
QC.10.24.4	**Matters Arising**	
	Items to escalate from the Chief Nurse / Chief Medical Officer JB and KD confirmed there was nothing to report.	
QC.10.24.4a	**Escalation from Audit Committee: Nursing Care Plans** KD advised her team are working with the Informatics team to produce a risk assessment clearly articulating the risk around the interoperability of the systems, and how care plans are used, and details are recorded. The risk assessment will be provided to the November Quality Committee meeting to give assurance of actions being taken and necessary steps going forward. This will also satisfy the requirements of the Audit Committee.	QA24022 Chief Nurse (KD)

QC.10.24.4b	**Pharmacy Reporting** In RS' absence JM advised Pharmacy reporting needs to be added to the Quality Committee work plan and the frequency of this determined. As OC was not present at the meeting it was suggested RS discuss this with him and Sannah Khan, Medication Safety Officer outside of the meeting.	QA24023 Chief Medical Officer (RS)
QC.10.24.5	**Board Assurance Framework: Strategic Risks Relevant to the Committee Quarter 1 and Quarter 2**	
	LP advised the Board Assurance Framework review has been completed. The updated Assurance Framework, where the number of risks has reduced from 17 to 13 and is more in line with benchmarking across other Trusts, was approved by the Board of Directors in September 2024. As detailed in the circulated documentation there are four risks aligned to the Quality Committee. Discussion was held regarding the need for inclusion of a risk relating to patient safety/experience aligned to the Quality Committee, and it was agreed LP would discuss this further with KD and RS outside of the meeting. The risk will then be submitted to an Executive Team Meeting (ETM) and brought back to the Quality Committee, before being presented to the Board of Directors for approval. Following a query from JB in relation to the second strategic risk, LP confirmed the Board of Directors specifically requested a risk around the digital service is included on the assurance framework. In relation to the Risk Appetite Statement, following discussion it was agreed that this would be given further consideration at the next Quality Committee meeting, alongside the addition of a new risk relating to quality of care.	QA24024 Associate Director of Corporate Governance/ Board Secretary (LP)
QC.10.24.6	**High Level Risks**	
	Regarding the new risk in relation to violence and aggression in the Emergency Department (ED), KD advised the Executive team made the decision for a security presence to be in the ED at all times due to the increasing number of incidents, and staff now feel more secure. She added that a paper is to be presented to the ETM, Committees and Board of Directors proposing a two-year project around those areas which need to be transformed Trust-wide for emergency patients coming to the hospital. KD also stated that the score for the staffing risk has reduced to 12 and expressed her thanks to all those involved in the recruitment of nursing staff over the last two years. BM suggested the risk description should be changed as it currently refers to Covid and the target date also requires amendment. KD confirmed these changes have been made but not yet reflected in the documentation. Regarding new risk 56, JB advised one of the two Gamma cameras is no longer in operation and is to be replaced. The remaining camera is also approaching the end of its serviceable	

	life, and therefore capacity is reduced until the new camera has been commissioned and installed which will take approximately six weeks. Mitigations have been put in place for this period, however JB stated that the risk will be heightened for both the Trust and some of the surrounding hospitals should there be any issues with the one operational camera. Once the new camera is in place planning (including financial planning) will then need to commence for replacing the second camera. JB advised risk 2162 has been raised by the ED and relates to the way pathology and radiology results come back into the Trust following Airedale NHSFT's (ANHSFT) go live of their Electronic Patient Records (EPR) system, and our Laboratory Information Management System (LIMS) putting pathology results into our EPR system. This is being worked through but is a potential issue for all clinical services as the results will not go to the same places as they used to. In relation to the ED specifically, the issue arises for patients who have left the department as the request is generated by them due to their investigations being initiated there, however the patient has then moved on to other areas of the hospital and the responsibility for reviewing the results therefore passes to the receiving team. In this situation there is the possibility as part of the new pathways that the information flows through, the EPR changes could cause the results being sent to the ED who no longer have clinical responsibility for the patient. The Committee confirmed following the discussions that all relevant key risks have been identified, reported to the Committee, and are being managed appropriately.	
QC.10.24.7	**Quality Committee Dashboard**	
	JB stated that because of the clinical coding work being undertaken, the Trust's high level of confidence will affect the Summary Hospital Mortality-Level Index (SHMI) which will become more in line with expectations. He added the SHMI is undertaken on a 12-month rolling period and therefore changes are not always seen immediately, however updates will continue to be provided via the dashboard. JB also referred to the Artificial Intelligence (AI) processes being developed whereby patient records will be reviewed and the codes which should be attached will be actively located. This will result in an improved depth of coding and an increased number of co-morbidities being noted.	
QC.10.24.8	**Insights Report: Quarter 1 and Quarter 2**	
	NR discussed the Insights Report and highlighted that: • Compared to quarter 1 and quarter 2 of the last financial year there has been an increase in the number of reported incidents. Contributing factors are the transition to the Innovation, Research and Improvement System (IRIS) and the improved communications and reporting culture. KD commented that whilst taking this into consideration and that there are now more staff and patient safety personnel in	

	the Clinical Service Units (CSU), there is still a requirement to recognise where risk exists in an area. • Due to resource challenges within the Legal team, reporting in terms of litigation, claims and inquests is proving to be increasingly difficult. There has however been a significant increase in the number of inquests heard which is partly due to the Coroner's Office now being in new premises and three inquests being able to be held at any one time. JB noted this increase in cases can also affect the Trust's workload if staff are interested parties and may also be required to give evidence. • There has been a significant increase in complaints and concerns received by the Patient Advice and Liaison Service (PALS) over the previous year. JL asked if the resource is available to manage the increase in cases and complaints being received. NR advised the number of cases completed is very similar to the number of new cases received. KD added more resource is required in the Freedom to Speak Up (FTSU) team and a business case is to be submitted. LT and KD also explained how the data held within the Patient Safety Incident Response Framework (PSIRF) can be viewed in a more thematic manner, and used to understand patient safety incidents and emerging risks. JB discussed the changes at the Medical Examiner's Office where all deaths now must be reviewed by an independent Medical Examiner, and the family of the deceased must be contacted to check if they have any concerns. There is therefore the possibility of more coronial referrals being made. NR agreed; however, he added that this does not mean that there is necessarily a cause for concern in all the cases.	
QC.10.24.8a	**Quality Account Improvement Priorities Update: Quarters 1 and 2** LT highlighted the following: • The Trust is one of 142 organisations taking part in an NHS England national pilot around the implementation of Martha's rule, which is to ensure staff and patients have an opportunity to raise concerns and have access to a 24/7 rapid review critical care outreach team. • Of the four patients admitted to ICU after being seen by the Critical Care Outreach Team (CCORT), none had triggers of deterioration in their physiological markers, and therefore these signs were picked up more quickly. JB and LT will discuss the detail of these cases further outside of the meeting. • NHS England has provided the Trust with £40,000 for involvement in the pilot for implementation of Martha's rule. Some of this funding has been used for two clinical staff	

	secondments (one whole time equivalent) who support staff and patients on the wards.	
QC.10.24.8b	**Patient Safety Incident Response Framework (PSIRF) Oversight: Quarters 1 and 2** LR gave an overview of the circulated documentation. The Committee noted: • The improvement programmes are data driven, and there is a requirement to ensure the improvements which are being made are demonstrated within the data. • The strategy for the Patient Safety Partner programme is being developed to avoid repetition with other roles within the Trust such as the falls volunteers. BM queried if the medication safety and blood transfusion workstreams are behind plan. LR advised the incident data and what could be learnt from this is the driving force behind the plan. She confirmed those two workstreams are running a little behind schedule as there has been no Medication Safety Officer in the Trust, however the new Medical Safety Officer is now in post. LR advised that the transition to the Scan4Safety system for blood transfusions also had an impact and as that has not progressed as hoped, the observational work being undertaken by the Quality Improvement team will continue.	
QC.10.24.9	**Maternity and Neonatal Services Update**	
	SH presented the update relating to September 2024. The Committee noted the following key points. • In relation to MRSA SH stated that additional vigilance measures remain in place such as hand hygiene and environmental mitigations. The first positive MRSA environmental swab came from one of the computers used in the department which is on wheels, and this has therefore been thoroughly cleaned and staff have been reminded of hand hygiene protocols prior to using communal items of equipment. Work is also being undertaken in conjunction with the Infection, Prevention and Control team to determine if there is alternative equipment which can be used in the clinical environment. • MRSA decolonisation of Maternity and Neonatal Unit staff commenced in October with a positive response and uptake from staff. • Regarding the Perinatal Mortality Review Tool (PMRT), SH advised the Trust has not met one of the four standards, however there are no concerns regarding it being met before the submission date. SH added the attendance of the Maternity and Neonatal Voices Partnership (MNVP) Service User Lead at the PMRT meetings is very positive	

	as they bring another level of scrutiny particularly around social deprivation and inequalities and act as the voice of the service users. • In terms of learning, SH advised that from the results of the safeguarding audit it is recognised there is a need to identify additional opportunities to ask all women who use the service the routine domestic abuse question. SH discussed the ways being looked at to do this as it needs to be asked when the women are unaccompanied. • The Respiratory Syncytial Virus (RSV) vaccine is being given to pregnant women from 28 weeks onwards to prevent bronchiolitis and respiratory infections in babies under the age of one. This is a new initiative from Public Health England (PHE) which was required to be rolled out by 1st September 2024. The Committee was advised that the Trust was initially an outlier as the majority of our maternity services vaccinations take place in primary care, however our antenatal clinic staff and maternity assessment centre staff have now been trained to administer the vaccine. Following the commencement of the vaccination programme during the second week in October, the vaccine is now offered to all women who attend for routine and ad-hoc antenatal appointments, which is an improved position - as initial expectations of a full rollout was not until the beginning of November 2024. KD added further detail around the rollout plan for the vaccine which was agreed with PHE, and both SH and KD commented that evidence has shown that no other organisations met the rollout deadline of 1st September 2024. SH further advised that additional funding has been received from PHE to train community-based staff undertake rollout of the vaccine to lower risk women in the community who do not attend hospital on a routine basis. The Committee provided its approval of the PMRT quarterly report and noted the learning included therein.	
QC.10.24.10	**National Standards for Healthcare Food and Drink Annual Compliance Report 2024**	
	RA discussed the report provided and advised the only area of non-compliance with the food standards is in relation to the requirement to implement digital meal ordering for patients. The other two points noted in relation to suitable food and drink for staff are partially compliant. RA stated the hospital food and drink standards include a wide range of differing elements of food provision to patients, staff and visitors and, our sustainability. These are supported by the Trust's nutrition governance structure which comprises of an	

	overall Nutrition Steering Group with four sub-groups relating to different aspects of nutritional care: patient food, children's group, artificial nutrition support (nasogastric and parental feeding) and, sustainability (Estates & Facilities). There are also plans to form a sub-group looking at food provision to staff and visitors to improve the offerings currently available. The main barrier in the non-compliant area of digital meal ordering is around the financial implications and scoping work has commenced to look at the projected costs.	
QC.10.24.10a	**Food and Drink Strategy 2024-29** RA stated that the shared strategy provides on update and draws from the National Standards for Food and Drink. It provides detail of the Trust's previous achievements and the aim for the next five years to look at progressing the hospital food and drink standards. The strategy has been developed with nursing, dietetic, catering and service user input. Ratification of the strategy is sought to enable progression to a designed service user friendly document. JL asked if other Trusts already provide a digital food ordering service and noted that no timescales are currently shown with respect to achieving compliance. RA advised other Trusts are in a similar position to our Trust and face similar challenges. KD stated compliance has improved significantly over recent years especially with the funding of a Dietician, and will continue to improve as a result of the initiatives in the Closing the Gap Programme. KD also stated the staff rest areas have been improved following the pandemic with the inclusion of microwave facilities. BM asked if there was still room for improvement regarding patients requiring help with eating as indicated by the in-patient survey results, even though the Trust has given itself a favourable rating in this area. RA confirmed there is always room for improvement as this is a very individual area depending on a patient's particular circumstance and the staff involved in their care. He confirmed questions are included in the nutrition audits on patients being prepared for, and supported, with their meals when required, and these are frequently answered positively. RT added when ward accreditation is undertaken good, compassionate preparation of patients for mealtimes and meal service is observed, and the good data received from patients is not always replicated in the in-patient surveys. LR confirmed this is also seen in the Place level assessments she undertakes. KD added that carers are with patients full-time in some instances, however it is not always clear who has responsibility for different elements of the required care. There is therefore a need for understanding and clarity around expectations and with whom each responsibility lies, ie developing a 'contract'. The Committee provided its approval of the Food and Drink Strategy 2024-2029 for its next stage recognising it is a Trust rather than a patient document.	

QC.10.24.11	**Mental Health Strategy**	
	KD provided background to the development and refresh of the Mental Health, Learning Disability and Neurodiversity Strategy 2024/2028 which has been shared with the Committee. She discussed the improvements which have been made in recent years which have contributed to increased life expectancies for those with poor mental health, but noted that further work is still required on a national level for people with learning disabilities. The Committee provided its approval of the strategy.	
QC.10.24.12 and QC.10.24.12a	**Patient Experience – Six Monthly Update and National In-Patient Survey**	
	RT provided an overview of the shared Patient Experience Bi-annual Report and provided detail of the other initiatives and learning undertaken by the Patient Experience Team (PET) in addition to the in-patient survey. She also discussed with the Committee the improvements made and assurances provided by the PET to the Trust's various Committees and groups, outlined the next steps to be taken, and the results of the CQC adult in-patient survey. RT extended an invitation for any interested colleagues to participate in a PLACE assessment. JL queried if those who complete the in-patient surveys are truly representative of the patients within the Trust, and any steps which can be taken to improve in this area. RT alluded to the survey being a national undertaking and there is therefore a need for the CQC to improve their target audience. She continued the Trust performs better in the Family and Friends Test (FFT) survey; however, the demographics are not hugely dissimilar, and an opportunity may lie with volunteers helping to support the collection of data. KD noted the limitations of the survey in its current form; however, she commented that the improvements in areas such as resource shortages will hopefully correspond to improved survey results. RT confirmed there has been an improvement on the previous year's results with fewer items on the action plan, and some of these have constraints out of our immediate control eg concerns with privacy and dignity which directly relate to issues with the Trust's estate buildings. The Committee noted the report. RT left the meeting.	
QC.10.24.13	**Digital Bi-Annual Report**	
	AG presented the report, and the key highlights were noted by the Committee: • The refreshed Digital Transformation Strategy and Business Plan is due to be completed by the end of the year. • In addition to a new Head of Applications and Development, four Associate Chief Clinical Information Officers (CCIO) have	

	also been appointed. • Regarding EPR optimisation, the Theatres, Anaesthesia and Critical Care (TACC) module is due to go live in a staged manner in November 2024 • As part of the strategy redesign the Data and Business Intelligence team have been the subject of an external review by a trusted third party and areas for improvement were highlighted. An improvement programme to address these has been developed which includes the new dashboards now being produced and which can be adapted to support all areas of the Trust. The Committee confirmed it is satisfied the informatics function continues to strive to ensure the Trust is well led regarding digital matters. AG left the meeting.	
QC.10.24.14	**Internal Audit Reports relevant to the Committee**	
QC.10.24.14a	It was noted that no internal audit reports relevant to the Committee had been received since the previous meeting. **National Audit Outliers:** • <u>National Audit of Dementia Outlier Analysis Round 6:</u> Due to JCI's absence at the meeting, it was agreed to defer this item to the next meeting. • <u>Out of Hours Discharges:</u> LT advised that the Trust has not received official notification that we are an outlier for this national audit which was in relation to out of hours discharges from intensive care between the hours of 22:00 and 06:59, and therefore no action is required from the Committee.	
QC.10.24.15	**Any Other Business**	
	There was no other business to discuss.	
QC.10.24.16	**Matters to share with Other Academies/Committees**	
	There were no matters to share with the other Academies/Committees.	
QC.10.24.17	**Matters to Escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors. JL noted a Quality Committee Escalation and Assurance Report (AAA) will be submitted to the next Board of Directors meeting to assure/alert/advise as appropriate.	
QC.10.24.18	**Date and Time of Next Meeting**	
	The next meeting is scheduled for Thursday, 21st November 2024 at 09:00-11:30.	

	Annexes for the Quality Committee: Items for Information	
QC.10.24.19	**Freedom to Speak Up Quarterly Update**	
	Noted for information.	
QC.10.24.20	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	
QC.10.24.21	**Quality Committee Work Plan**	
	Noted for information.	
QC.10.24.22	**West Yorkshire Health and Care Partnership System Quality Group Minutes**	
	Noted for information.	

ACTIONS FROM QUALITY COMMITTEE – 17TH OCTOBER 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24017	19.09.24	QA.9.24.5	**Quality Academy Dashboard** Medicine Management – JC noted the importance of the work underway with Business Intelligence and Pharmacy colleagues around this metric. LB queried whether issues/incidents of high importance would appear as metrics on the dashboard. JC noted further conversations would be required, for example around blood transfusion, an electronic bar-coding system would eliminate the low or no harm incidents. A proposal will follow to the Committee in due course.	Associate Director of Quality	November 2024	17.10.24 – BJ advised work continues on the dashboard by the Business Intelligence (BI) team and a paper will be presented to the Quality Committee once it is known from JC when the work is likely to be complete. **05.11.24:** NR – An update on this will be received at the November Quality Committee as part of the Quality Committee Dashboard – colleagues in Pharmacy are preparing a paper that will come with the Dashboard outlining the next steps forward. CLOSED.
QA24022	17.10.24	QA.10.24.4a	**Escalation from Audit Committee: Nursing Care Plans** KD advised her team are working with the Informatics team to produce a risk assessment clearly articulating the risk around the interoperability of the systems and how care plans are used, and details are recorded. The risk assessment will be submitted to the November Quality Committee meeting.	Chief Nurse	November 2024	**05.11.24:** KD – Sent to JH, KP and Sean Willis, Associate Chief Nurse, Quality and Workforce. Item on the November agenda. CLOSED.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA24023	17.10.24	QA.10.24.4b	**Pharmacy Quarterly Reporting** In RS' absence JM advised Pharmacy reporting needs to be added to the Quality Committee work plan and the frequency of this determined. As OC was not present at the meeting it was suggested RS discuss this with him and Sannah Khan, Medication Safety Officer outside of the meeting.	Chief Medical Officer	November 2024	**05.11.24:** RS has emailed OC and Sannah Khan requesting a quarterly report to the Quality Committee. CLOSED.
QA24024	17.10.24	QA.10.24.5	**Board Assurance Framework (BAF)** Discussion was held regarding the need for inclusion of a risk relating to patient safety/experience aligned to the Quality Committee, and it was agreed LP would discuss this further with KD and RS outside of the meeting. The risk will then be submitted to an Executive Team Meeting (ETM) and brought back to the Quality Committee, before being presented to the Board of Directors for approval.	Associate Director of Corporate Governance/ Board Secretary	November 2024	**05.11.24:** To be presented at Quality Committee November meeting. BAF included on the November agenda. CLOSED.

B. PEOPLE ACADEMY - 19 SEPTEMBER & 24 OCTOBER

REFERENCES

Only PDFs are attached

Bo.11.24.31b - Confirmed People Academy minutes - 19.9.24.pdf

Bo.11.24.31b - Confirmed People Academy minutes - 24.10.24.pdf

PEOPLE ACADEMY MINUTES

Date:	Friday 19 September 2024	**Time:**	14:00 – 16:00
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)		
In Attendance:	- Catherine Shutt, Assistant Director of HR/ Head of OD (CS) - 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) - Rachel Pyrah, General Manager to CDIO Office (RP) - Jane Kingsley, Lead Allied Health Professional (JK) - Georgi Dyson, Assistant Director of HR (GD) - Joanne Hilton, Director of Nursing / Deputy Chief Nurse (JH) - John Bolton, Deputy Chief Medical Officer (JB) - Amanda Grice, Manager Workplace Health & Well-Being Centre (AG) - Sonia Sarah, Equality, Diversity and Inclusion Manager (SS) - Samia Hussain, Assistant Director of HR (SH)		
Observer	Karina Edwards, Internal Audit Manager, Internal Audit Yorkshire (KE) Farideh Javed (FJ) and Andy Waller (AW), Governors Dr Daniel Sapier, Junior Doctor, Future Leads Programme – Innovation in Digital/Virtual Education (DS) Amanda Nicholson, HR Business Partner (AN)		

Agenda Ref	Agenda Item	Actions
PA.9.24.1	**Apologies for Absence**	
	• Laura Parsons, Assistant Director of Corporate Governance / Board Secretary (represented by Jacqui Maurice, Head of Corporate Governance) • Ray Smith, Chief Medical Officer (RS) • Faeem Lal, Director of HR (FL)	
PA.9.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.9.24.3	**Minutes of the meeting held on 9 August 2024**	
	The minutes of the meeting held on 9 August 2024 were approved as an accurate record. The Academy noted the outcome regarding the following actions: • PA24008 – PA.2.23.13 – Gender Pay Gap – A workshop session has been held with the gender equality forum. Update from the session to be presented to this academy in November	

	2024. Action closed. • PA24022 – PA.8.24.17 –Any other business. AS has referred the safety concerns to KD. It was agreed for KD to confirm assurance and assess in October 2024.Action open. • PA24016 – PA.7(1).24.5 – Nursing and Midwifery staffing data publication report. Formal report not received yet, but conversations have taken place with RB & KH to discuss next steps and to feedback at this meeting in November. Action open.	
PA.9.24.4	**Matters arising**	
	There were no matters arising.	
Assurance		
PA.9.24.5	**Flu Vaccine**	
	AG provided some background and assurance, into the roll out of the flu and Covid vaccination programme. The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. This year the Trust is required to provide Flu vaccine to all patient facing roles and also consider setting up an occupational health vaccination programme for COVID19 booster, for front line health care workers or signpost to the National programme. Since pre pandemic, figures and demands within Occupational Health (OH) have increased significantly and this has impacted on Key Performance Indicators (KPIs) affecting recruitment and supporting return to work. The paper was previously presented to the Executive Team Meeting (ETM) where a number of options were discussed and ETM's preference was to deliver a similar campaign to last year, working with Rimmington's Pharmacy to deliver both Covid and Flu vaccination up until the end of December. The offer includes visits to all trust sites, weekend, out of hours drop-in clinics will be offered, the Covid and Flu vaccination will be available in one single appointment, there will be no additional cost to the trust and Rimmington's will use the Flu vaccine stock provided by the Trust. The campaign will commence w/c 7 October and this will be publicised in weekly bulletins, Let's Talk and Screen Savers. The Occupational Health team will be recording the uptake figures and will provide these weekly to the Trust and monthly to UKHSA. The Academy agreed for the recommendations set out in the paper and it was agreed for AG to provide uptake figures at a future meeting: **Action**: AG to provide vaccine update figures at the November meeting. The academy was assured by the paper.	(PA24022) Manager Workplace Health & Well-Being Centre
PA.9.24.6	**Nursing and Midwifery Staffing Data Publication Report**	
	SW referred to the report which was taken as read and highlighted the following:	

	• Fill rates remain above 90%. • Staffing risk has reduced from a score of 16 to 12. • Bank rates have not escalated since February 2024 • Band 5 positions remain at 10%.- this doesn't make sense? 10% vacancies? • The volume of Band 2 health care positions have not reduced and the Trust is currently reporting over 140 vacancies across all wards. Recruitment inventions are underway to reduce the vacancies, over 200 applications are currently being reviewed and the bootcamp is also underway supporting recruitment. • The aim to reduce the vacancy position to less 10% by April 2025 • Harms and risk reporting is within the expected variation and a lot of work is underway to reduce falls and pressure and progress has been seen on this. The academy was assured by the paper.	
PA.9.24.7	**People Academy Dashboard**	
	GD presented this item jointly with item PA.9.24.8 – Workforce Report and highlighted the following: • Staff in post continues to grow from 6801 to 7408 in the last 12 months, there is still a recruitment freeze on non clinal posts. The increase in number is largely due to Estates and Facilities staff, most of the staff members within this group were contracted through agency and bank staff, whereas some of the staff members within this group have now taken on substantive employment. • Recruited 90 newly qualified nurses and 20 HCA enrolled onto bootcamp every month. • Staff turnover remains the same which is currently at 8.99%. • There has been a slight improvement in absence which is currently at 5.73% but not on target, SH and her team are currently working with the CSUs to look at KPIs and areas to target and the top absence reason is relating to anxiety/stress and depression. • Brilliant Bradford Awards are taking place on 26 September, there were over 250 nominations for the awards and over 250 colleagues will be attending the event. • The Organisation Development team and Equality, Diversity and Inclusion team are working on a piece of work around progression mapping. • SH explained that during August/September the HR team have delivered briefing sessions to managers on sickness absence and organisation change, as part of 'Closing the Gap' programme, where over a hundred managers attended the sessions. • HR Business Partners are meeting with managers on a regular basis, analysing sickness data and looking at ways to support those managers. • The sickness absence policy is currently under review and	

	will be updated to make it more streamline and supportive both towards managers and staff. • Data is shared on a regular basis with managers. • Specific work is being undertaken with Nursing and Midwifery staff and bespoke training and the mangers responsibility around sickness absence and reporting. • Continuously advertising the support methods offered to staff to ensure staff are supported whilst off work and once they return to work. KW queried if the increase of absence and turnover was seasonal. GD confirmed that turnover is based on HIRE as the percentage increase with staff in post, this necessarily does not mean that staff are leaving, there has been a reduction in the number of staff leaving. SH explained that a report will be presented at October's meeting - a deep dive has been undertaken on sickness absence and the report will explain whether this is due to seasonal or other factors. AS stated, that the highest factor of sickness absence is stress, anxiety and depression, he queried whether there is a differentiation between what is work related or non-work related, is the information captured and are we assured that stress risk assessment are being carried out adequately. AS also queried the Equality Data, with regards to the under representation of BAME staff within bands 8A and above, BAME staff and the disproportion with women at higher bands, and asked whether there will be any targeted work to address the disparity. SH explained that, as part of the 'Closing the Gap' piece of work, a scheme scoping document has been developed which highlights all the absence and the sickness management support which will be provided, as well as some bespoke analysis in relation to equality. With regards to sickness absence relating to stress, SH mentioned that data is not captured whether an individual is off work due to work or non-work-related stress, but guidance is available for mangers to support staff once they return back to work. KD mentioned that her staff struggle with completing the paperwork and administration around sickness absence/return and monitoring and asked whether any support is offered to proactively manage sickness. SH mentioned that the HR team are looking at streamlining the process but emphasised that it is the managers responsibility to compete the paperwork and support individuals returning to work and recording the information in a timely manner. AG informed colleagues that the OH team record every single absence, whether this is work related or not, she also mentioned that she will share any data with this group, the OH team also offer support to managers around the completion of the stress risk assessment and getting to the root of the issue rather than referring the staff member onto additional support services. KW asked AG to provide data on sickness absence relating to stress/anxiety/depression, AG agreed to provide this in her report presented at the November meeting.	

	Action: AG to provide data on sickness absence relating to stress/anxiety/depression, AG agreed to provide this in her report presented at the November meeting. A conversation took place around what NHSE and other organisations are doing to reduce HCA sickness absence and best practice across the region and SW agreed to share further information once this was made available. The academy was assured by the paper.	(PA24023) Manager Workplace Health & Well-Being Centre
PA.9.24.8	**Workforce Report**	
	This item was covered under agenda item PA.9.24.7.	
PA.9.24.9	**High Level Operational Risks**	
	RB presented the hight level risk register and informed colleagues of following: • 9 risks on the register and there are no new risks for the academy • There are a number of mitigations which are due at the end of September and beginning of October. • The hight level risk register has been presented to the Executive Team meeting for approval. The academy was assured by the paper.	
PA.9.24.10	**Medical Appraisal and Revalidation Annual Statement of Compliance**	
	JB presented the annual statement of compliance where the report must be submitted annually to NHSE regarding our duties as a designated body, who has a responsible officer duty to their registered medical staff. JB informed members that RS presented the Medical Appraisal and Revalidation annual report a couple of months ago at this academy, the report circulated with the papers is a compliance report. 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. Our Trust is one of the highest performing trusts in medical appraisals and no appraisals were deferred. The statement of compliance collates the responses from the previous report and submission is made to NHSE, the information in the report covers everything the trust submitted previously and there are no changes to the report from the previous one which	

	was shared with this academy. AS queried whether the personal development plans are part of the appraisal process or whether that is separate process. JB confirmed that the personal development plan is part of the appraisal process and progress is measured against outcomes. The academy was assured by the paper.	
Learning and Improvement		
PA.9.24.11	**Staff Appraisal**	
	CS provided a brief overview of the work which is currently underway to launch this year's staff appraisal. CS shared feedback which has been received, where there is an expectation for managers and colleagues to have different conversations at different times throughout the year and the OD team will streamlining and aligning the process. The OD team are developing a paper called dynamic conversations which will allow the manager and staff member to bring all the different conversations in one place, whether that is 1:1, health and wellbeing conversation, talent, development etc. The conversation tool has four pillars around health and wellbeing, performance, prioritisation and finally aspirations and this has been underpinned by a new toolkit this includes a variety of resources i.e. signposting etc. A personal development plan will also be developed and this has come on the back of some of the work OD have undertaken. A progression map journey for each job family has been created and this sets out all the roles by service and band and at a glance, this gives the opportunity for staff to consider the progression opportunities available. The new process allows manages to carry out appraisals in a simpler, succinct, more cohesive and effective way, but providing an opportunity for staff to have regular conversation around what matters the most and ensuring staff are supported in a timely manner. The Academy noted the update. This will sit along the annual appraisal, but this will help support those regular conversations between the manager and staff member. A more detailed paper will be presented at a future academy which will explain the process in greater detail. **Action:** CS agreed to present a paper on Dynamic conversations at the November meeting. The academy noted the update.	(PA24024) Assistant Director of HR/ Head of OD
PA.9.24.12	**Staff Survey Engagement**	
	CS introduced the paper and gave members an overview of approach for this year's staff survey.	

	The staff survey will launch on 30th September (29th September midnight official launch). There will be a nine-week survey period running form 30 September to 9 November 2024, 7580 surveys will be sent to colleagues across the Trust and these will be sent to our bank staff as well as substantial staff. Paper copies will be issued to staff within E&F Directorate as well as staff on maternity leave, shared parental leave and staff who are on long term sick. Last year the response rate was 43%, this year a target has not been agreed, but the aim is to exceed last year's target. CW described the interventions that are going to be put in place to increase the response rate and these are screen savers, posters across sites, regular reporting and there will be designated service leads who will promote the survey and will encourage uptake. As in 2023 teams with more than 10 staff responders were able to receive their own results via heatmaps, this will also be available for this year's survey too. The results will be published in January 2025. Due to 'closing the gap' there will be no financial incentive for the team with the highest responds. AS queried whether paper copies of the survey will be available for staff who request these, CS confirmed that paper copies of the survey will not be able to staff if they have received an electronic survey via their email. The academy noted the update.	
PA.9.24.13	**Staffing Pay Offer**	
	SH advised that as reported in the paper, provided an update on the pay award for staff on Agenda for Change (AFC), Medical and Dental and Doctors in training terms and conditions. The 5.5% pay award has been agreed for each pay scale and there will be additional changes to the scale, such as new intermediate pointed for bands 8a, 8b, 8c, 8d and 9, all staff will receive their uplift in October's pay and this will be back paid from April 2024. For staff who are paid weekly, payment will be made to them on 18 October and for those staff who are paid monthly will be paid on 30 October. Staff on pay bands 8a to 9 the new intermediate pay point will be implemented in November 2024, for those staff who are eligible with back pay included. For medical and dental staff a 6% pay increase will be paid and again this will be back dated to 1st April 2024. For doctors and dentists in training it has been agreed for a 6% increase to their pay point, on average this will be an increase of 22.3%. Where some individuals have preferred to receive the back pay in multiple instalments (for instance, paid across several months),	

	rather than together in a single month, they will pay the same amount of tax and National insurance over the course of a financial year as they would if they received it as one payment. Colleagues have been advised to consider the potential impacts of spreading the payments out across multiple months. For example, if an individual is claiming Universal Credit, any lump sum or backdated earnings may affect how much Universal Credit received in the month they are paid. The academy noted the update.	
PA.8 24.14	**Any other Business**	
	• **Training & Education self-assessment report.** FA introduced the report, she informed colleagues that the annual self-assessment return must be completed for NHSE, where the trust self-assesses on the education quality standards. Engagement has taken place with various stakeholders across the trust where the Education Manager for Professional Education led the self-assessment, to assess if standards were being met. FA provided an overview of the top three successes and the three top challenges, in relation to education provision and these were highlighted in the paper. AS asked whether steps have been taken to improve the culture of welcoming students. FA explained that when conversations take place with employees, they are made aware to make the environment welcoming for students, when this happens it is due to workload pressure, another factor to consider is when the nursing and midwifery standard of supervision changed, students did not have a dedicated mentor assigned to them and students do not have a direct person to go to when support is required, the trust is trying to implement the student environment charter to improve the students experience. LS asked whether we receive any analysis on the NETS survey by any protected characteristics.? FA stated that we don't receive any data from NHSE and they were unable to collect the data. The Academy was assured by the paper and approved the recommendations in the paper. FA referred to a BMA article, which relates to 'doctors who formerly were known as "junior" doctors' mark their official transition to the title "resident" doctors. FA explained that this has not been confirmed by NHSE whether employees will be adopting to the alternation. FA has received some queries from some staff members and there is no update about this from the trust.	
PA.8.24.15	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.8.24.16	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	

PA.8 24.17	**Date and time of next meeting**	
	24 October 2024, 13:00 to 15:00	

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 –19 September 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	24.10.2024	AS has referred the safety concerns to KD. It was agreed for KD to confirm assurance and assess in October 2024. Completed. 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	24.10.2024	
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	24.10.2024	Completed. Action closed
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	24.10.2024	On the agenda. Action closed
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	24.10.2024	
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	13.11.2024	

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	13.11.2024	Formal report not received yet, but conversations have taken place with RB & KH to discuss next steps and to feedback at this meeting in November. Action open.
PA24022	19.09.2024	PA.9.24.5	**Flu Vaccine:** AG to provide vaccine update figures at the November meeting	Manager, Workplace Health & Well-being centre	13.11.2024	
PA24022	19.09.2024	PA.9.24.7	**People Academy Dashboard:** AG to provide data on sickness absence relating to stress/anxiety/depression, AG agreed to provide this in her report presented at the November meeting.	Manager, Workplace Health & Well-being centre	13.11.2024	
PA24024	19.09.2024	PA.9.24.11	**Staff Appraisal:** CS agreed to present a paper on Dynamic conversations at the November meeting.	Assistant Director of HR/ Head of OD	13.11.2024	

PEOPLE ACADEMY MINUTES

Date:	Thursday 24 October 2024	**Time:**	13:00 – 15:00
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) - Ray Smith, Chief Medical Officer - Karen Dawber, Chief Nurse (KD)		
In Attendance:	- Faye Alexander, Head of Education (FA) - Jacqui Maurice, Head of Corporate Governance (JM) - Amanda Limbert, Head of Service for workforce information and flexible workforce (AL) - Rachel Pyrah, General Manager to CDIO Office (RP) - Georgi Dyson, Assistant Director of HR (GD) - Joanne Hilton, Director of Nursing / Deputy Chief Nurse (JH) - David Robinson, Consultant in Emergency Medicine (DR) - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) - Ellie MacIver, Deputy Director of Operations (EM) - Kez Hayat, Head of Equality, Diversity and Inclusion (KH) - Amanda Limbert, Head of Service for Workforce Information and Flexible Workforce (AL) - Samia Hussain, Associate Director of HR (SH) - Ruth Haigh, Equality, Diversity and Inclusion Manager (RH) - Sarah Freeman, Director of Nursing (SF) - Sean Willis, Associate Chief Nurse (SW) - Sonia Sarah, Co-Chair Enable staff network (SS) - Raquel Licas, Chair of RESIN (RL)		
Observer	- Amanda Nicholson, HR Business Partner - Justine Carroll, HR Business Partner		

Agenda Ref	Agenda Item	Actions
PA.10.24.1	**Apologies for Absence**	
	- Faeem Lal, Director of HR - Amandeep Singh, Partnership Lead - Altaf Sadique, Non-Executive Director - Catherine Shutt, Assistant Director of HR/ Head of OD - Osman Chohan, Director of Pharmacy - Jane Kingsley, Lead Allied Health Professional - Abbie Wild, Chair of LGBT staff network - Susan Parker, Co-Chair Enable staff network	
PA.10.24.2	**Declarations of Interest**	
	No interests were declared.	
PA.10.24.3	**Minutes of the meeting held on 19 September 2024**	
	The minutes of the meeting held on 19 September 2024 were approved as an accurate record.	

	The Academy noted the outcome regarding the following actions: • PA24022 –PA.8.24.17–Any other business: AS has referred safety concerns to KD. KD has assessed in October and confirmed assurance. Action completed and closed. • PA24019 – PA.8.24.8 - FTSU Quarterly Report: FTSU e-learning training for Non-Executive Directors and Executive Directors as well as staff at Band 8A and above has been mandated. Action closed. • PA24020 – PA.8.24.12: People Academy Dashboard. Update on sickness absence is on the agenda at this meeting. Action closed. • PA24018 – PA.8.24.6 - Workforce Growth and Transformation: An item on progression mapping will be presented at the next meeting. Action closed. • PA24021 - PA.8.24.13 – People Academy ToRs and Work plan: A regular item on 'totality on workforce plan/growth and transformation' to be added to the workplan. Action closed. **Action**: LP to add an item to the workplan titled 'workforce of the future,' this item will be presented twice a year with KD and RB identified as the joint executive leads. The initial report would come to the Academy in January 2025.	(PA24026) Associate Director of Corporate Governance / Board Secretary
PA.10.24.4	**Matters arising**	
	There were no matters arising.	
Assurance		
PA.10.24.5	**Sickness absence deep dive**	
	SH informed members that a comprehensive analysis of sickness absence for the period September 2022 to September 2024 was undertaken. SH provided a detailed overview of the data, which was included in the report and outlined all the work carried out to reduce sickness absence. HR briefing sessions have been introduced which support the 'closing the gap programme,' sessions were held in July to support managers with the policy implementation of sickness absence and organisational change, 70 managers attended the session and positive feedback was received. Further briefing session are planned to take place, and these will be about performance improvements and probationary periods. Bespoke work is underway with the Deputy Director of Nursing, where sickness data is being analysed and plans are in place to deliver some bespoke training, so that a proactive approach can be taken when managing sickness absence. The health and wellbeing policy is currently under review and will be presented at the next Joint Negotiating Consultative Committee (JNCC). The ongoing support from the HR Business Partners, in terms of supporting managers with sickness absence and day to day operational support continues. HR will continue to manage and maintain the overall reduction in sickness absence and data will be available to support managers. Other support which has contributed to reducing sickness absence	

	has been from the Occupational Health team. SH pointed out, that there could be a possibility that sickness absence could increase due to some changes, these are new ways of working and in particular, the improvements made to e-rostering and the recording of absence for medical staff, the impact of the non-clinical recruitment freeze, reduction in the use of bank and agency staff, as well as 'closing the gap' programme and the winter period will also impact on this. KW challenged this stating that any risks on sickness absence such as the recruitment freeze and the CTG programme should be identified and mitigated. KD asked how can we support staff with reasonable adjudgments once a staff member has returned to work after a period of sickness absence? SH stated that the trust has a responsibility to offer reasonable adjustments for staff members who require this, and we must explore other options in the trust, to ensure staff are given the support for any reasonable adjustments and these must be reviewed regularly. A lengthy conversation took place, and suggestions were made to help reduce sickness absence i.e. targeted data, return to work interviews and capturing of data, drop-in clinics, easier and simpler processes to support and maintain absence reporting. The academy approved the recommendations outlined in the paper.	
PA.10.24.6	**Approval of action plans for WRES and WDES**	
	KH presented the refreshed 2024/23 action plans for Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). KH explained that both standards are part of the NHS contract, as a Trust NHS England requires us to review our refreshed data in terms of WDES and WRES for our workforce. KH referred to the paper and informed members that feedback received from last year's action plans, stated the plans were very detailed which can lose focus and to concentrate on where the indicators require improvement with focussed actions. As a result of this, the team have worked closely with the staff equality networks and developed the action plans, from the feedback received, ensuring these are aligned to where the indicators require improvement. The action plan has been co-developed with staff from across the trust and targeted engagement has also taken place, with the staff equality networks, as well as staff from the wider 'People' directorate to look at improving and advancing workforce practices. Once the action plans have been approved, they will be published on our website and will also be shared with NHS England. A six-monthly update will be presented at this academy in terms of progress and areas of focus. A lengthy conversation took place around the recruitment process	

	and suggestions were made to review and change the recruitment process for some bands, to make the process simpler for candidates to apply for posts. GD is currently reviewing the recruitment process, and it was suggested to arrange an extraordinary meeting to review recruitment in totality and retention. **Action**: It was suggested that an extraordinary meeting is held in December or January, to discuss recruitment in totality and retention. KW will give this some thought. The academy approved the recommendations outlined in the paper.	(PA24027) Chair
PA.10.24.7	**New Education Strategy 2025-2030**	
	FA presented the new education strategy which will be launched in January 2025. It covers a five-year period. The plan has been in development since April 2024, and this follows on from the previous five-year strategy. It has been refreshed and refocused. FA highlighted the six objectives which are: 1. Develop a competent, capable, compassionate, and sustainable workforce. 2. Lead innovation and research in healthcare education. 3. Influence healthcare education and system-wide partnerships. 4. Provide high-quality, inclusive learning environments that foster a culture of lifelong learning. 5. Support and empower educators, trainers, supervisors, and assessors. 6. Optimise resources and funding to ensure sustainable, high-quality education and training. A series of engagement sessions have taken place with the education team, learners, volunteer patients, as well as internal and external stakeholders and they all have contributed to the new strategy. The strategy is very broad, but a detailed implementation plan will be designed which will pick out, how the team will achieve some of the objectives and specific scheme of works will be introduced with neighbouring universities, which will form part of the implementation plan. The plan will also update on the progress of the new strategy, as part of the annual education report. DR stated that the new strategy builds on the existing five-year plan, and it was the first education plan for the trust, which was focused on building structures within the service to deliver high quality education. The aim for the next five years is to be more outward looking, sharing knowledge and to influence the systems and lead the way for research and innovation. RP suggested that the digital strategy is included in the strategy, which FA agreed to include.	

	The academy approved the recommendations outlined in the paper.	
PA.10.24.8	**People Academy Dashboard**	
	GD introduced the dashboard and highlighted the following: • There has been in an increase with staff in post. • There has been an increase with turnover from 8.97% to 10.17%, with the biggest impact in Nursing. • Absence has increased slightly, with the highest absence reasons relating to anxiety, stress and depression. the Estates and Facilities team have the highest level of sickness absence and HR are working with the team to minimise sickness absence. • 34 newly qualified midwives have been appointed, 19 of these have been inducted and commenced in post this week. There has been delays with Leeds Exam board which affects the remaining new appointees, and they will not be in post until November/December. • The HCA bootcamp is being rolled out monthly. • The proportion of Ethnic Minority employees is continuously rising and is currently at 41.3% from 40.2% and we are continuing to exceed our target. • There has been a slight increase in the disability declaration rate which is currently at 4.9%. • Temporary staffing is continuously seeing a decrease in the usage of agency and bank staff and overtime, particularly in areas as AHP's, Medical and Dental, Nursing and Midwifery and Estates and Facilities. JH mentioned that she would welcome a conversation with GD around the nurse leavers and how the Business Partners can support this piece of work. **Action**: JH and GD to discuss the nurse leavers and the support available from the HR Business Partners, to effectively manage the data. The academy was assured by the paper.	(PA24029) Director of Nursing / Deputy Chief Nurse
PA.10.24.9	**High Level Operational Risks**	
	LP presented the high-level risk register and informed colleagues of following: • There are two new risks on the high-level risk register which align to this academy, and they are: • Risk no. 2629 which relates to Violence and Aggression in Emergency Department, which is scored at 15. • Ris no. 2612 which relates to Emergency Department (ED) Consultant review of pathology and radiology resulting to increase of results, which is also scored at 15. • Risk no 184 has changed in score from 16 to 12, which relates to safe staffing risk, this has been removed from the high-level risk register. The mitigation date will need to be extended beyond its date, as the target score is 8.	

	The Academy was assured that all relevant key risks have been identified, reported to the Academy and are being managed appropriately.	
PA.10.24.10	**BAF – Strategic risks relevant to the academy**	
	LP informed members that a full review has been undertaken of the board assurance framework over the last couple of months and the risks associated to this academy, were included in the suite of papers. There is a risk relating to the wellbeing of our workforce and EDI, where we may fail to provide an appropriate learning experience for trainees, all these risks are currently scored at 9. The risk appetite statement needs to be agreed for this year and was included with the circulated papers, LP asked members to consider whether any changes need to be made to the paper and if the current position was correct. Members were asked to review the guidance document and to feed back any changes to LP, the revised BAF will be presented at the next academy meeting and will also be presented to the Board of Directors. **Action:** LP to present an updated version of the BAF report at the next meeting. The academy was assured by the paper.	(PA24029) Associate Director of Corporate Governance/Board Secretary
PA.10.24.11	**Nursing and midwifery staffing data publication report**	
	SW highlighted the following key points from the report: • Fill rates remain above 90% and have been in this position for several months. • Vacancy rate is at 7%. • HCA vacancies are improving but there the trust is still reporting over 183 vacancies across the wards. • SW noted that there was an error on the report, but there have been no pressure ulcers reported at Westwood Park in the last 12 months. The Tissue viability team will be working with Westwood Park to understand what is working well and share good practice across the trust. • There was one IRIS related to staffing, which caused a delay to the administration of IV medication but no patient harm. • The current staffing risk score is (ID 3732) 12 and this is being closely monitored. • There has been a slight reduction in Red Flag which are reported via SafeCare. The academy was assured by the paper.	
PA.10.24.12	**Establishment Growth**	
	The Trust submitted its workforce plan in April 2024 for the subsequent 12 months. At the time of the submission January's	

	data was submitted. The current trajectory against the workforce plan for September is above plan for Estates, Facilities, Admin and Nursing. There has been significant investment in reducing nursing bank and agency usage. The overall reduction in agency WTE from April to date is 37.6 WTE and the nursing workforce target for September was 9.31 and the trust achieved 3.84, so we are significantly under target for our agency use. The Nursing directorate has put a lot of effort into reducing bank usage. There has been no HCA agency usage since September 2023. Agency nursing usage has only been used in September in Renal for two shifts and the other usage is for Theatres, which has seen significant savings. Significant investment has been put into reducing overtime across the Trust. In almost all staff groups, the use of overtime has been withdrawn and replaced by bank usage to ensure safe staffing levels. Work continues with specific areas where short term approval has been given to continue to offer overtime, this is expected to also disappear by the end of the financial year. There has been an increase in bank of 110.78 WTE against the target of 133.15 WTE, however the Trust has been able to replace some overtime specifically in Facilities and Admin with less expensive bank usage. Further exploration is required around splitting Estates, Facilities and the Admin workforce plan to identify which areas the over establishment is in. The academy was assured by the paper.	
PA.10 24.13	**FTSU Q2 quarterly update**	
	This item was deferred to November's meeting.	
PA.10 24.14	**GMC survey feedback**	
	DR provided an update on the GMC annual survey for post graduate doctors in training. The survey measures the quality of experience for trainees in postgraduate medical training. The most recent survey was conducted during March-May this year and the results were shared in July. Since the publishing of the report the team has been analysing, sharing and receiving feedback and developing actions. DR pulled the headlines from the report, and these were all included in the circulated paper. DR discussed areas where we are presenting well and areas which require improvements. The next steps for development will be: • Engage with College Tutors/CSUs, sharing detailed feedback. • Oversee actions via education steering groups (Postgraduate Medical Education Foundation) • Triangulate with NETS, exception reporting, resident doctor forum and other surveys.	

	• NHSE, the next Senior Leadership Education meeting is due to take place in July 2024 where conversations will take place about the survey, benchmarking and actions. LB asked what the mitigation plans are in relation to workload - that will make us feel assured that there will be improvements over time. DR stated that he is unable to provide assurance as most of the assurance is operational, but the department will look at increasing trainee numbers and any other opportunities that will become available to expand on core training posts going forward. KW asked how much work we do, with doctors in training, about expectation management. DR stated that expectation management is very important, and it is covered during the induction programme. RS confirmed that a lot of work has gone into supporting junior doctors, improvements have been made to rotas, the environment including the Doctors mess. Junior Doctors are also well represented at the Local Negotiating Committee (LNC), Junior Doctors Forum and undergo induction. Where the organisation is an outliner, a lot of input has gone into those areas which have been identified to improve, with clear action plans which provides assurance. Some specific work has gone into initiatives such as, the hospital at night, ensuring there is more support for those staff who work out of hours, night and weekends. Clinical support workers who work during the night offer support to junior doctors and they have taken away a lot of the tasks from junior doctors, to help support workload pressure. Medical student assistants will join the trust in November who will work during the weekends, they will have similar roles as the clinical support workers and will support the junior doctors. RS also mentioned that the Trust is under-represented with junior doctors, the Trust cannot request additional junior doctors, as the Deanery allocates the placements, but the Trust will be submitting a bid for additional junior doctors once the application window opens. KH asked if the survey can be broken down to capture equality related data. DR stated that the equality data information is not available, but DR mentioned he will investigate this and will meet up with KH outside of the meeting to review and discuss the data. FA mentioned that she did approach NHSE to request the data for the NETS, but NHSE was unable to provide the data, and she was not sure whether the same would apply to the GMC survey. The academy was assured by the paper.	
PA.10 24.15	**Any other business**	
	KD mentioned that the Trust was approached via the FTSU Guardian at Leeds University, to support a medical student who was due to commence their studies. The individual wears a face veil and there was a lot of push back from organisations, who could	

	have potentially offered the student a placement. Organisations were refusing the student a placement, based on not being able to practice in a clinical area. A lot of background work took place in our Trust with the Equality, Diversity and Inclusion team (EDI) and the Spiritual, Pastoral and Religious Care team, (SPaRC). As a result of this the Trust has updated its personal dress appearance policy for all roles and supports individuals who choose to wear a face veil.	
PA.10.24.16	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
PA.10.24.17	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
PA.10 24.18	**Date and time of next meeting**	
	13 November 2024, 13:30 to 12:30	

Items for Information		
PA.10.24.21	**Report/minutes from Health and Safety Committee**	
	This item was shared for information only.	
PA.10.24.22	**Nursing and midwifery staffing data publication report**	
	This item was shared for information only.	
PA.10.24.23	**Internal audit reports relevant to the Academy**	
	This item was shared for information only.	

ACTIONS FROM PEOPLE ACADEMY held 24 October 2024

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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	13.11.2024	
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	13.11.2024	Formal report not received yet, but conversations have taken place between RB & KH to discuss next steps. An update will be provided at the November meeting.
PA24023	19.09.2024	PA.9.24.5	**Flu Vaccine:** AG to provide vaccine update figures at the November meeting	Manager, Workplace Health & Well-being centre	13.11.2024	AG to provide a verbal update at the November meeting.
PA24022	19.09.2024	PA.9.24.7	**People Academy Dashboard:** AG to provide data on sickness absence relating to stress/anxiety/depression, AG agreed to provide this in her report presented at the November meeting.	Manager, Workplace Health & Well-being centre	13.11.2024	SH presented an update on sickness absence at the meeting on 24 October. Academy to confirm if they wish to receive a specific update re: stress / anxiety / depression from Occupational Health.
PA24024	19.09.2024	PA.9.24.11	**Staff Appraisal:** CS agreed to present a paper on Dynamic conversations at the November meeting.	Assistant Director of HR/ Head of OD	13.11.2024	
PA24027	24.10.2024	PA.10.24.10	**Approval of action plans for WRES and WDES**: It was suggested that an extraordinary meeting is held in December or January, to discuss recruitment in totality and retention. KW will give this some thought.	Chair	13.11.2024	
PA24028	24.10.2024	PA.10.24.8	**People Academy Dashboard:** JH and GD to discuss the nurse leavers and the support available from the HR Business Partners, to effectively manage the data.	Director of Nursing / Deputy Chief Nurse & Assistant Director of HR	13.11.2024	
PA24029	24.10.2024	PA.10.24.10	**BAF – Strategic risks relevant to the academy:** LP to present an updated version of the BAF report at the next meeting.	Associate Director of Corporate Governance/Board Secretary	13.11.2024	This item is included on the agenda. Action closed.

PA24026	24.10.2024	PA.10.24.3	**People Academy ToRs and Work Plan:** LP to add an item to the workplan titled 'workforce of the future,' this item will be presented twice a year with KD and RB identified as the joint executive leads. The initial report would come to the Academy in January 2025.	Associate Director of Corporate Governance / Board Secretary	15.01.2024	Item has been added to the workplan for January and June.

C. FINANCE & PERFORMANCE COMMITTEE - 19 SEPTEMBER & 16 OCTOBER

REFERENCES

Only PDFs are attached

Bo.11.24.31c - Confirmed F&P Committee Minutes - 16.10.24.pdf

Bo.11.24.31c - Confirmed F&P Committee Minutes - 19.9.24.pdf

FINANCE AND PERFORMANCE COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date	16 October 2024	**Time:**	09:00-11:00
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director
Members Present:	- Julie Lawreniuk, Non-Executive Director (JL) - Zafir Ali, Non-Executive Director (ZA) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - David Moss, Director of Estates and Facilities (DM) - Ben Roberts, Chief Financial Officer (BR) - Mark Hindmarsh, Director of Strategy & Transformation (MH)		
In Attendance:	- 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) - Ellie MacIver, Deputy Director of Operations for Cancer & Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations, Unplanned Care (SM) - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) - Michael Quinlan, Deputy Director of Finance (MQ) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt) - James Taylor, Deputy Chief Operating Officer (JT) - Rachel Waddington, Deputy Director of Operations Planned Care (RW) - Jacqui Maurice, Head of Corporate Governance (JM) - Duncan Cooper, Act as One Programme Director (DC) for agenda item FC.10.24.8 - Steven Amos, Emergency Planning Manager (SAm) for agenda item FC.10.24.18		
Observing:	- Zainab Rasheed, Graduate Management Trainee (shadowing MH)		

No.		**Action**
FC.10.24.1	**Apologies for Absence**	
	The following apologies were noted: - Sughra Nazir, Non-Executive Director - Terri Saunderson, Director of Operations (TS)	
FC.10.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FC.10.24.3	**Unconfirmed Minutes of the Meeting held 19 September 2024**	
	The minutes of the meeting held on the 19 September 2024 were approved as an accurate record.	
FC.10.24.4	**Matters Arising**	
	The Committee reviewed the action log, and the following actions were updated: - FA24016 **Revised F&P Committee Work Plan:** It was agreed to add Treasury Management as a monthly update to the workplan. Workplan updated as required. Action closed. - FA24017 **High Level Risks Relevant to the Committee:** The risk register to be reviewed to ensure all risks are captured, in particular risk 2605 (Chemotherapy) which should be in included on the F&P Academy register. Risk register reviewed. Risk 2605 was aligned to the Quality	

No.		Action
	Committee only. Has now also been aligned to F&P Academy to ensure 'oversight due to the impact on cancer waiting times (31 day and 62 days targets)'. Action closed. - FA24018 **Monthly Finance Report:** If the Trust moves off forecast, then there are further consequences to consider such as control measures and approvals that will be expected. This will be articulated in more detail in a separate paper to the next meeting of the Committee. Item added to the October meeting agenda. Action closed.	
	Governance, Board Assurance Framework (BAF) and Risk	
FC.10.24.5	**Board Assurance Framework – Strategic Risks Relevant to the Committee**	
	LP explained this was the refreshed BAF which has now been signed off by the Board. LP reported there are four risks which are aligned to the Finance & Performance (F&P) Committee as detailed within Appendix 1. LP advised that the Board reviews its risk appetite statement on an annual basis. The risk appetite statement for the previous year (2023/24) is attached at Appendix 2. LP asked the Committee to review the statement for the sections relevant to the F&P Committee and consider whether the current appetite levels are appropriate, or whether any changes are required. LP explained that the Committee's views will be presented at the next Board meeting in November 2024, where the Board will be asked to approve its risk appetite statement for 2024/25. JL referred to the statements and was content with the narrative provided for each, in particular "to deliver our financial plan" which states that the Trust will not risk patient safety in order to deliver the Financial Plan and will strive to meet regulatory requirements. MH agreed and reiterated that it has been consistently highlighted that patient safety will not be comprised throughout the delivery of the Closing the Gap Programme (CTG) and the programme has been built with this fully in mind. The Committee was assured by the update and agreed with the risk appetite levels and the appetite statement for 2024/25 for presentation to the Board of Directors.	
FC.10.24.6	**High Level Risks Relevant to the Committee**	
	JL reminded colleagues of the Committees responsibility to review, challenge and assess the risks presented to ensure systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. In line with the agreed risk escalation process, any operational risks with a current score of 15 or above ('high level risks') are escalated to Executive Team Meeting (ETM) via the monthly reporting cycle, and then to Academies/Committees and the Board. Operational risks scoring over 12 are reviewed at the Executive to CSU meetings to enable monthly ETM discussion to focus on the most serious risks, with additional focus at the Executive to CSU meetings.	

No.		Action
	The Committee noted the matters raised at ETM on 14 October 2024 in relation to high level risks. JL noted that since the last report no risks have been closed or changed in score aligned to this Committee. One new risk has been added to the high-level risk register which is in relation to the nuclear medicine capability and BR provided some background information in relation to this risk and explained that the Medical Physics department have two gamma cameras supplied by an external provider who has declared one of the cameras as end of life. One camera is currently being replaced which means that up to January the risk is that if the second camera is out of action for any reason then there is no capacity to provide the required service. Mitigation includes support from other partners who also have gamma cameras. BR asked the Committee to note that the second gamma camera that is in use is the more reliable out of the two but this will also reach end of life by July 2027 therefore will be included within the capital plan in good time. The score for this risk is currently 15 with this mitigation in place, however, this will be increased to 20 if the mitigation is no longer deliverable. BR will keep a close eye on this to ensure the new machine installation remains on track. DS referred to the risk in relation to the Trust estate and advised that this risk will remain ongoing due to the age of the estate. This risk is being partly mitigated with the work that is underway as new estate is being built through the Trust capital programmes. The backlog maintenance work is also ongoing and this is carefully planned to ensure that the resource is targeted in the right areas. The Committee was assured by the update.	
FC.10.24.7	**Finance & Performance Committee Dashboard**	
	JL reminded colleagues that the dashboard provides a single view of the F&P Committee indicators aligned to the Trust's Strategic Objectives. Throughout the meeting members of the Committee have the opportunity to review and challenge the elements of the dashboard presented relevant to the Committee Terms of Reference. BR, DM and SA confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting.	
	Finance and, Strategy and Transformation	
FC.10.24.8	**WYAAT / ICS Update / Act as One Update**	
	JL welcomed Duncan Cooper, Act as One Programme Director (DC) to the meeting to present an update on the inequalities workstream. DC referred colleagues to the presentation and explained that the Reducing Inequalities Alliance is one of the enabler programmes within the Integrated Care Board (ICB) at Place in Bradford District and Craven. The structure focuses on influencing action through the core team which delivers key pieces of work and coordinates alliance activity. The alliance, which consists of partner representation from approximately 50 organisations meets every six weeks and works across the system on the	

No.		Action
	learning network and oversees programmes and deep dives. The workforce consists of approximately 30,000+ employees from various partner organisations across the district. DC talked through the objectives and vision of the alliance as detailed within the presentation and the Trust's role in reducing inequalities as a system partner, a social anchor and service provider. ZA was pleased to hear about all the work that is being undertaken and asked how the benefits of the work is measured and when the outputs will be publicised at a local level. DC explained that the Bradford Institute of Health Research (BIHR) undertook some deep evaluation on some of the schemes which showed positive outputs. One example is reduced admissions for patients with multiple morbidity from deprived areas of Bradford by 30% which is equivalent to £1.5m per year over five years. The Committee noted the update.	
FC.10.24.9	**Monthly Finance Report**	
	CSm presented the report and highlighted key points for the Committee to note. The Trust has reported a deficit of £12m which is on plan. £0.5m of NHS England (NHSE) funding for industrial action costs has now been received in line with NHSE instructions. A risk that has emerged in Month 6 is the cost pressure between the increase in funding and the increase in costs of pay awards which is approximately £2m however the Trust is not alone in this with other WYAAT Trusts also highlighting the same pressure. The underlying position in Month 6 was an improvement on previous months, now at a £2m underlying position which cannot be guaranteed as a sustained reduction but certainly a positive position to be in. CSm talked through the forecast position for the CTG Programme and the various improvement and efficiency targets to help deliver the savings. In terms of forecast scenarios the mid case out turn is £23.5m deficit which is an improvement on the previous month forecast, the best case is £14m deficit and the worst case is £32.1m deficit. CSm referred to Table 4b explaining the run rate required to move from mid to best case scenario. JL asked when the Committee will be sighted on the numbers for the next financial year as it was important to understand this now in order to start to plan and deliver as soon as possible. MH agreed and reminded the Committee that the CTG Programme is a rolling programme in order to deliver efficiencies every year and not just for this year. There are over 300 schemes identified on the tracker for the CTG Programme and the current work that is underway includes refining these schemes and identifying when savings will be made. Plans are already being developed to progress the schemes which are relevant to the next financial year. JL said it would be useful to see the data against this in future updates. BR said that a medium term plan is being developed with the ICB and this will be presented to the Committee at a future meeting. The Trust is working closely with system partners to check and challenge each others plans and to take learning from that.	

No.		Action
	ZA referred to the £5m positive swing in the deficit this month and asked if there is a risk of this going in the opposite direction. CSm said there are three areas of assurance for this. The first is that the balance sheet flex has improved by £3.3m compared to the previous month following an in-depth review of what is on the balance sheet and there is high confidence of this being achieved. The second is the ERF which is a £3.5m improvement compared to the previous month which has mainly arisen from an in-depth review by operational, performance and finance colleagues in relation to activity that should be legitimately counted that has not been included previously therefore a genuine opportunity that exists but a lot of work is required to deliver this in partnership with various departments including informatics and clinical colleagues. The third is the pay controls and the £2m assumption in relation to this. The work for this is developing and some decisions taken at executive level has contributed to this and although there are risks to this it presents a genuine opportunity. JL was encouraged to note the improvement on the financial position and the CTG figures noting that the risk on the forecast remains high. JL expressed that it was disappointing that no funding has been granted to Trusts to pay for the national pay award that has been agreed nationally. The Committee was assured by the update.	
FC.10.24.10	**Closing the Gap Update**	
	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 £33.2m and is equivalent to 85.3% of the target. Each individual scheme within the forecast delivery figure has been risk rated for how deliverable it is believed to be. 75% of schemes have been rated as low risk (compared to 64% in September), 17% as medium risk and 8% as high risk. MH reminded the Committee of the programme governance that has been implemented as detailed within the presentation. MH explained that the workstream charter has been slightly changed in order to provide a single route of approval for all vacancies and variable pay requests. It is proposed that the meeting will be held weekly and chaired by the Director of Human Resources. MH provided feedback following the CTG week that took place during September and was pleased to say that the week was positively received by colleagues across the Trust. MH reported that following the PwC audit which was commissioned to undertake a full West Yorkshire wide review the Trust has resubmitted it's progress to date against the PwC recommendations and provided the updated forecast position. Work has also commenced on a two to three week audit process for an internal audit report with Audit Yorkshire and the final report is expected at the end of November. In terms of next steps, focus will continue on delivery of the identified schemes, a launch of the new workforce workstream process and engagement with the external and internal audit process.	

No.		Action
	ZA asked if the actuals against target can also be included in future presentations alongside with the forecast. JL referred to the workforce workstream and asked if a more detailed insight can be provided in relation to this at a future meeting. MH confirmed both of these will be included in the next report. The Committee noted the update.	FC24019 Director of Strategy & Integration
FC.10.24.11	**Capital Update**	
	MQ provided a summary of the presentation and reported that the Trust has a budget of £42.8m and is forecasting to spend £40.3m. The main reason for the underspend is the slippage on the Endoscopy Programme which is an externally funded scheme. This will be an overall underspend of £2.5m. As this is under a "use it or lose it" regime opportunities are being explored to invest in additional capital schemes. The reserve list and risk register will be reviewed to see where additional investments can be made this financial year to the value of £2.5m. ZA emphasised the importance of ensuring this funding is not lost and is allocated accordingly. BR provided some assurance in relation to this and said that a framework has been agreed by ETM on how to prioritise schemes from the reserve list which can be approved through the Capital Operational Group without going through time consuming governance routes whilst ensuring that the principles set by ETM are fully adhered to. MQ highlighted that the capital plan is at risk mainly due to two reasons. The first is that the SLH Day Case Unit (DCU) is currently slipping and there is also some uncertainty in terms of the cost. The second is the Endoscopy Programme which has just started and although there is a cashflow forecast from the contractor this could change. Both of these programmes are being monitored closely and are reported to the Capital Strategy Group. JL referred to the SLH DCU Programme and asked where the slippage of this is being monitored. SA explained that he Chairs the SLH DCU Programme Board which reports into the Capital Strategy Group. The main issue is in relation to cladding and the contractor has advised that handover will take place on 29 November 2024. The Committee was assured by the update.	
FC.10.24.12	**Contract Update**	
	BR provided a summary of the paper and explained that the paper is presented to the Committee to provide an update on the current position with regard to the Trust's healthcare contracts. BR highlighted the following for the attention of the Committee: - There are challenges in terms of the Renal contract due to risk and capacity issues and this is being escalated. - In terms of local partnerships, BR is working closely with his counterpart at Airedale Trust in relation to receiving their final schedule of bills so this can be finalised.	

No.		Action
	- There is ongoing work underway relating to the metabolic service contract and this is progressing with oversight from BR and MH. The Committee was assured by the update.	
FC.10.24.13	**Treasury Management Update**	
	MQ presented the item and explained that the purpose of the paper is to provide the Committee with an update on the current cash position and forecast outturn for the end of the year. The paper also highlights if the Trust will have sufficient cash headroom to pay for both its revenue and capital activities. At the end of Month 6 the Trust held £28.6m cash in the bank which is £1.2m more than the planned £27.4m. In terms of the end of year position the forecast cash position is expected to be a positive £0.5m which means that there is a medium risk that the Trust will require revenue cash support during 2024/25. At the moment there are £9m cash releasing benefits from the CTG Programme. In the most likely scenario to deliver the £0.5m closing cash balance, £31.4m needs to be delivered by the end of the year in cash releasing benefits which is 71% in the next six months and is a significant challenge therefore posing a medium risk that the Trust will require revenue cash support during 2024/25. ZA emphasised the importance of monitoring all aspects of finances as one has an impact on another i.e. the impact of not achieving the CTG target and capital programme on the cash position. The Committee was assured by the update and noted the cash flow risks and that the Trust may require revenue cash support during Quarter 4.	
FC.10.24.14	**Finance Forecast Protocol**	
	BR presented the item and explained that the Trust's financial position is on plan at Month 6, but the underlying position remains challenging. The financial plan assumes a significant improvement in the monthly position from Month 7 with the best case forecast position is achievement of the £14m deficit plan, with a likely forecast of £26.5m (as at Month 5) deficit which is £12.5m worse than plan. NHSE introduced a new process for organisations and systems to follow when declaring non-achievement of their financial plans in November 2022. Is it important to note that the statutory requirement is that systems, and by default providers, must deliver financial balance. The oversight for the protocol for both individual organisations and systems is as follows:	

Scenario	Provider	System (WY ICS)	Oversight
1	Balance	Balance	N/A
2	Deficit	Balance	System
3	Deficit and/or Balance	Deficit	NHS England Region

In response to protocol the West Yorkshire Integrated Care System (ICS)

No.		Action
	Financial Framework was updated to put in a system escalation process as follows: - Discussion with Place Chief Financial Officers (CFO)/Directors of Finance (DoF) - ICS DoF review, with oversight from the ICS System Oversight and Assurance Group - Formal paper submitted to the ICS Finance Forum and ICS System Oversight and Assurance Group - Improvement support and exit criteria agreed. The process above is to be followed by organisations for both scenario 2 and 3 described above. The next stage of the process is to follow the NHSE 'Protocol for changes to in-year revenue financial forecast'. The protocol requires a set process as follows: - Evidence of the pre-conditions to invoking the protocol - Completion conditions on individual providers including evidence of sign-off by the whole executive team, review by a neighbouring Trust/Place - Sign-off of the Board Assurance Statement by the Chair, CEO, CFO and Chair of the Finance Committee - Financial recovery plan to submitted to agreed timescales. The Committee noted the report and it's responsibilities if the Trust were to formally change its forecast to being 'off-plan'	
	Performance	
FC.10.24.15	**Operational Performance Highlight Report**	
	CSt presented the report and referred colleagues to the presentation. CSt made reference to a number of points from the presentation including ambulance handover where performance is relatively stable, Emergency Care Performance (ECS) which continues to benchmark strongly nationally, the H-FAST pathway which has increased to four discharges per day and the Length of Stay (LoS) for pathway 1 which is reducing because of this but pressure within LoS is expected in the coming winter months. In terms of inpatient activity this delivered below plan in September and is projected to remain below plan in October. This is due to the delay in the opening of the SLH DCU which is now expected to receive its first patient in January 2025. Mitigation is being considered for this including weekend lists. Outpatient activity remains stable and on plan. The Referral to Treatment (RTT) waiting list size remained above plan but reduced in September 2024 and is expected to continue to do so in October 2024. The number of patients waiting over 52 weeks is projected to increase slightly in the same period. The number of patients waiting over 65 weeks increased in September 2024 despite ongoing efforts between Trauma & Orthopaedics (T&O), theatres and supporting staff to tackle issues regarding theatre capacity. It is expected to remain stable in October 2024 with 71 patients waiting 65 week waits of which 4 patients were greater than 78 week waits. SA explained that the main pressure is within T&O and	

No.		Action
	this is being addressed with the service and options being explored to reduce this including mutual aid which has been offered and patients are being contacted and asked if they are happy to transfer. CSt reported that confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.27% in September 2024. Targeted validation of incomplete pathways is sustaining the high confidence level. Diagnostic Waiting Times DM01 performance for September is projected at 80.25% remaining behind target of the expected improvement trajectory but is improving month on month. Cancer performance has had positive movement for the faster diagnostic standard and there has been good performance for two months for both this standard and the two week wait standard. Histopathology delays are reducing and administrative processes have also been strengthened. In terms of cancer treatment, performance continues to improve and work is ongoing to improve this further. ZA was pleased to see how well the Trust benchmarks both locally and nationally, particularly against the backdrop of the financial pressures and expressed his appreciation to colleagues for the positive performance. The Committee was assured by the update.	
FC.10.24.16	**Winter Response Plan**	
	SM presented the item and explained that the winter response plan which is a working document has had input from colleagues across the Trust and has also been presented to ETM and will be presented to the Hospital Management Team. SM talked through the demand assumptions and explained that actual demand is currently tracking just below the predicted demand. It is predicted that the first rise in demand will be in early November, the second is predicted in December when there is a six surge bed increase also in place and the third predicted rise is expected post-Christmas along with a further 12 surge bed increase. Demand is expected to fall from early March along with the closure of the surge beds. SM talked through the phases in relation to the opening and closing of winter beds and the cost of this. SM referred to the infection prevention control (IPC) measures and actions that will be taken in relation to testing, isolation and treatment along with the cost of this. BR asked how the winter plan is financed and SM said there is the winter resilience funding, the run rate assumptions throughout the year and also the scheme for the opening of surge beds. The Committee approved the plan.	
FC.10.24.17	**Operational Improvement Plan – Referral to Treatment**	
	RW presented the report and reminded the Committee that the Referral to Treatment (RTT) workstreams are divided up into three areas:	

No.		Action
	Transformation, Proactive Performance and Business as Usual. Work continues across all metrics with particular focus on productivity and CTG schemes as detailed on slide three of the presentation. RW talked through each of the elements and described the work being undertaken for each one including OPPROC, increase of outpatient clinics, DNA reduction, outpatient transformation to reduce follow up, day case unit efficiency, theatre productivity and increasing theatre lists. RW referred to RTT performance and wished to highlight those services that are doing really well to reduce waits as demonstrated in slide 11. In terms of the services facing challenges to achieve RTT performance, RW explained that 70 patients are expected to breach 65 weeks at the end of the month but the trajectory shows this reducing in late January and the current RTT performance is at 62%. The Trust waiting list size in comparison to other Acute Trusts across WYAAT is fourth out of seven. The Trust does not have long wait 65 week breach problems in all WYAAT high volume specialities – just in T&O and ENT. JL referred to the 70 patients that are expected to breach the 65 week wait and asked what the longest wait is. RW said there are four patients that are waiting over 78 weeks with 80 weeks as the longest but they all have planned dates and are being kept informed. CSt explained that the DNA work is not just focussing on reducing DNAs to increase activity but is also built around the health inequalities work which had significance variance and this gap is also reducing. The Committee was assured by the update.	
FC.10.24.18	**EPRR / NHSE Core Standards Compliance**	
	JL welcomed SAm to present the item. SAm explained that the paper updates the group on the current position of the NHSE core standards submission, which was returned to WYICB on 27/09/2024, before a final submission is made to NHSE by 31/10/2024. The following items were presented by SAm: - Appendix 1 Core Standard 10 Incident Response Plan that requires approval. The plan has undertaken its planned annual review with internal and external stakeholders and updated to reflect new guidance and is presented for approval by the group. This plan now includes an Incident Communications plan, which will allow for another core standard to become compliant. The Committee approved the plan. - Appendix 2 Core Standard 13 which is the New and Emerging Pandemics Standard. This relates to the Trusts Pandemic Influenza and Novel Viruses Policy, which was previously classed as partially compliant by NHSE. The changes are minor, and the Policy is currently out for comment with members of the IPC Committee. The Committee noted the update. - Appendix 3 Core Standard 55-66 Chemical, Biological, Radiological and Nuclear Plan which requires approval. SAm explained than the plan spans across the CBRN core standards domain, and has been shared internally and externally and updated following comments	

No.		Action
	received, actions from the YAS CBRN audit and new guidance. The Committee approved the plan. - Appendix 4 YAS CBRN/HazMat Audit Appendix 4 for the Committee to note. A recent audit has been carried out by YAS on the Trusts compliance with the 12 CBRN core standards (55-66). This has now been received back with nine being fully compliant (six last year), and three partially compliant (six last year). Work has already started with emergency department colleagues on the actions that need to be undertaken to get the three partial standards fully compliant. The Committee noted the update. - Appendix 5 NHSE Core Standards Submission – to note the current position. Currently the Trust is reporting 48 core standards as fully compliant and 14 partially compliant, up from 20 fully compliant and 42 partially compliant last year. This year the submission has reverted back to a self-assessment, with WYICB holding a peer review session for West Yorkshire Acute Trusts. It is not expected that NHSE will look into individual Trust returns but focus on the ICB's process for undertaking the self-assessment and peer review process this year. As the final submission is not until 31 October, work is progressing to become fully compliant with several more core standards. The submission will be signed off by SA in his role as Accountable Emergency Officer. SAm will provide a further update at the November Committee on the Trusts compliance with the core standards with an action plan provided for the standards that are partially compliant. The Committee noted/approved the documents as detailed above.	
	Estates and Facilities	
FC.10.24.19	**Premises Assurance Model (PAM)**	
	Item deferred to next month.	
FC.10.24.20	**Any Other Business**	
	<u>Healthroster (Allocate Optima Renewal) Tender</u> BR presented the item and explained that the Trust is currently using the Optima product via Allocate (RLDatix) for its Healthroster. The contract for this service requires renewal, and the options presented to the Trust is to either renew the system or review the market to find a new solution. There are two contract options on offer from RLDatix. A three-year term (two years with the option for one further twelve-month period) which comes with a 7% yearly uplift, and a five-year term (two years with the option for three further twelve-month extensions) which comes with a 5% yearly uplift. It is recommended that a contract be awarded to RLDatix for a five-year term to take advantage of the more economical uplift option while still allowing the Trust to go to market in relation to medic rostering. BR advised that in future tenders for contracts coming up to expiry will be presented in good time to the Committee for approval to present at Board for the final decision.	

No.		Action
FC.10.24.21	**Matters to Share with Other Academies/Committees**	
	There were no items to share with other Academies/Committees.	
FC.10.24.22	**Matters to Escalate to Board**	
	JL advised that any relevant matters would be escalated to Board via the formal F&P Committee Chair report including the positions of the CTG Programme, finance, cash, performance and RTT.	
FC.10.24.23	**Date and Time of the Next Meeting**	
	20 November 2024 – 09:00-11:00	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE COMMITTEE – 16 OCTOBER 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FC24019	16/10/24	FC.10.24.10	**Closing the Gap Update:** ZA asked if the actuals against target can also be included in future presentations alongside with the forecast. JL referred to the workforce workstream and asked if a more detailed insight can be provided in relation to this at a future meeting. MH confirmed both of these will be included in the next report.	Director of Strategy & Transformation	20/11/24	Included in the presentation at agenda item FC.11.24.12 Closing the Gap Update. Action closed.
FC24020						

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	19 September 2024	**Time:**	08:30-10:30
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director
Members Present:	- Julie Lawreniuk, Non-Executive Director (JL) - Zafir Ali, Non-Executive Director (ZA) up to 9.30am - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) up to 10am - Ben Roberts, Chief Financial Officer (BR) - Mark Hindmarsh, Director of Strategy & Transformation (MH)		
In Attendance:	- John Bolton, Deputy Chief Medical Officer & Medical Director - Ops (JB) - Sarah Freeman, Director of Nursing, Operations (SF) - Ellie MacIver, Deputy Director of Operations for Cancer & Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations, Unplanned Care (SM) up to 10am - Michael Quinlan, Deputy Director of Finance (MQ) - Terri Saunderson, Director of Operations (TS) up to 9.15am - 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) up to 9am - Jacqui Maurice, Head of Corporate Governance (JM) (representing Laura Parsons, Associate Director of Corporate Governance/Board Secretary) - Steven Amos, Emergency Planning Manager (SAm) for agenda items FA.9.24.11, FA.9.24.12 and FA.9.24.13		
Observing:	- Karina Edwards, Internal Audit Manager, Audit Yorkshire		

No.		**Action**
FC.9.24.1	**Apologies for Absence**	
	The following apologies were noted: - Sughra Nazir, Non-Executive Director - David Moss, Director of Estates and Facilities - Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
FC.9.24.2	**Declarations of Interest**	
	No declarations of interest were made.	
FC.9.24.3	**Unconfirmed Minutes of the Meeting held 4 July 2024**	
	The minutes of the meeting held on the 24 July 2024 were approved as an accurate record.	
FC.9.24.4	**Matters Arising**	
	The Academy reviewed the action log, and the following actions were updated: - FA24014: – **High Level Risks Relevant to the Academy:** *Circulation of excel version of appendix actioned. Inclusion of excel version of the risk register in meeting papers going forward.* Action closed. - FA24015: – **Treasury Management Update:** MQ, CSm and JM to consider if an extraordinary meeting required in August to agree the governance framework in case a request needs to be made to NHSE to	

No.		Action
	ensure Board sighted on required information to make the decision. *At time of the last report the Trust was making quarterly revenue cash submissions however this has now moved to monthly therefore there is more flexibility. Discussions will take place monthly at the F&P Committee therefore extraordinary meeting was not required*. 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. *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. Action to be discussed at FC.9.24.18.* Action closed.	
	Assurance	
FC.9.24.5	**Finance & Performance Academy Dashboard**	
	JL reminded colleagues that the dashboard provides a single view of the F&P Committee 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 BR confirmed that the details within the dashboard would be discussed under the relevant agenda items throughout the meeting.	
FC.9.24.6	**Revised F&P Academy Work Plan**	
	JM reminded the Academy that at the meeting held on 24 July 2024 it approved the proposed amendments to its Terms of Reference and the work plan prior to submission to the Board of Directors in September 2024 for approval. It was thought appropriate to re-present the work plan to this Academy to ensure it was sighted on the planned reporting from the Director of Estates and Facilities. The items added which are listed in the paper will be reported either bi-annually or annually and have been spread as evenly as possible across the work plan. JM asked the Academy to note in particular: - Two of the items listed on the workplan - the National Cleaning Standards and the National Catering Standards - will be removed from the work plan as it is now confirmed that they will be approved via a different governance route. - The 'Green Plan' item which will include the 'environmental sustainability' element. Reporting regularity in relation to the Green Plan is currently being finalised. - The frequency of reporting for several items that were outstanding have now been confirmed. - A note has also been added to the work plan regarding the 'Pathology Joint Venture' (scheduled to be presented at the Committee in November 2024) whereby the Committee will be asked to confirm which Committee/Academy this item will report into.	FC24016 Head of

No.		Action
	Action: To add Treasury Management update (monthly) to the workplan. The Committee noted the updated work plan.	Corporate Governance
FC.9.24.7	**High Level Risks Relevant to the Committee**	
	JL reminded colleagues of the Committees responsibility to review, challenge and assess the risks presented to ensure systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. In line with the agreed risk escalation process, any operational risks with a current score of 15 or above ('high level risks') are escalated to Executive Team Meeting (ETM) via the monthly reporting cycle, and then to Academies/Committees and the Board. Operational risks scoring over 12 are reviewed at the Executive to CSU meetings to enable monthly ETM discussion to focus on the most serious risks, with additional focus at the Executive to CSU meetings. The Committee noted the matters raised at ETM on 19 August 2024 and 9 September 2024 in relation to high level risks. JL noted that since the last report no risks have been closed or changed in score aligned to this Committee. One new risk has been added to the high-level risk register which is in relation to the Accident and Emergency Department (AED), and this will be discussed further at agenda item FC.9.24.9. SA advised that the Winter Plan is currently being finalised and this will be presented at the October F&P Committee ahead of being presented to Board. The Winter Plan will address the controls and mitigation plans for the risk. SA added that approval has been given at a recent ETM to expand the consultant workforce to support overnight consultant presence within AED as this provides a positive impact in terms of the number of patients waiting to be seen in the department the following morning. ZA asked if the finance risks are also listed within the high-level risk register and BR confirmed they are. CSm confirmed that the Cash, Capital and Income and Expenditure (I&E) risks are amalgamated into one and do feature on the risk register. EM referenced risk 2605 (chemotherapy) which she believed was 'missing' from the risk register for this Academy. EM stated (within the chat function) that she believed it should be aligned to F&P due to the impact on cancer waiting times - 31 day and 62 days targets. It was agreed that the risk register would be reviewed to ensure all appropriate risks are captured. The Committee was assured by the update.	FC24017 Head of Corporate Governance
	Learning & Improvement	
FC.9.24.8	**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 £28.6m and is equivalent to 73.5% of the target. Each individual scheme within the forecast delivery figure has been risk rated for how deliverable it	

No.		Action
	is believed to be. 64% of the schemes have been rated as low risk (compared to 53% in July), 26% as medium risk and 20% as high risk. MH reminded the Committee of the programme governance that has been implemented as detailed within the presentation. The workstream charters have been approved at the CTG Board and formal meetings have commenced to start to focus on these areas. The Executive to CSU meetings have been embedded and these provide oversight of CTG plans for each of the CSUs and provides an opportunity to escalate any issues that require executive support as well as to provide accountability. In terms of engagement MH reported that since the launch of the dedicated intranet page there have been over 3000 unique views. The first CTG bulletin was published in August with the second one due for release imminently. "Closing the Gap Week" is being planned for the week of the 23 September and aims to give CSUs time back to update the current year plans and forecasts and ensure key people are available to support them. During the week a series of webinars will also be launched to support the development of further plans for this and next year. JL asked when the forecast for the next financial year will be available in terms of savings as it would be good to see this a few months ahead of the start of the next financial year and also asked about the confidence level of the £28.6m being recurrent cash releasing schemes. MH said over 50% of this is recurrent and this is better than it has been in previous years but is still a challenge for the next financial year. MH said the CTG programme is now looking for schemes that are able to deliver in the current financial year and planning and execution of delivery of schemes for the next financial year has already started too. CSm agreed that a lot is recurrent, but some is also budget adjustments which does not help the run rate. Next months update will provide more detail as to what this means for the next financial year. One example of an uncertainty for next year of the £28.6m is that £4m of it is for ERF performance and we will not know what the ERF regime will be for next year until later in the year. BR added that a conversation has started with Executive Director colleagues in terms of the accountability framework and planning for the next year and agreed it is important to share the targets as soon as possible. The Committee noted the update.	
FC.9.24.9	**Operational Improvement Plan – Urgent & Emergency Care**	
	JL welcomed SM to present the update on the operational improvement plan in relation to urgent and emergency care. SM referred to the risk alluded to earlier in the meeting at agenda item FC.9.24.7 and explained that the new risk in relation to AED is a refresh of an existing risk that was previously on the risk register post pandemic. The risk was added in 2021 in relation to the operational pressures post pandemic and the challenges faced with overcrowding in AED. Following several actions the risk has been subsequently changed to cover just overcrowding. SM referred colleagues to the presentation and highlighted the following	

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	key areas which have progressed since the last update: - The Urgent Treatment Centre (UTC) received approval in June 2024. The second phase requires capital investment in estate so that a discrete footprint for UTC and AECU can be created. - The Consultant business case has been approved and processes will be developed as recruitment progresses. This will ensure that a Rapid Assessment and Treatment (RAT) model can be developed to ensure the sickest patients are seen at the front door by a consultant in AED. - Ward 8 was reopened in July 2024 as a medical day case unit to avoid admissions and support earlier discharge for patients requiring hot clinic follow-up, e.g. chest pain, respiratory and seizure pathways. Additional activity now includes gastro and respiratory patients. Further work is required to maximise ward 8-day case potential. - Data analysis, pathway mapping and time and motion studies have been completed in relation to ambulance handover to support improvement to prevent delays over 30 minutes during periods of high demand. New processes have been established and review of data remains ongoing. - There has been a transformation of key elements of the stroke pathway including further pathway work with Airedale Trust. The stroke improvement plan is now well underway in collaboration with the Act as One Programme. In terms of the SSNAP performance there is a high level of confidence that the improvement work undertaken will improve KPIs 1 and 2 over the coming 3-6 months. - The Trust is in the process of preparing to launch the “Outstanding Emergency Services Programme” to address the issue of overcrowding and to improve patient and staff experience. - Metrics from the junior doctors industrial action period demonstrates improved performance due to more senior decision makers providing cover further opportunities to strengthen the position will be picked up as part of the Outstanding Emergency Services Programme. - 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 have seen a marginal reduction, 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 the Trust continues to track below the regional average. - Emergency Care Standard (ECS) performance remains in the upper decile of Acute Trusts in England with average daily attendances coming down in August. - Hospital admission measures, conversion rates and long length of stays in hospital, the Trust compares well nationally. The Trust was previously visited by NHS England (NHSE) as being in the top 11 best hospitals for patient flow and just this week Stephen Kinnock, the Minister for Health and Care visited the Trust to see the command centre model and the H-Fast discharge process. JL thanked SM for the presentation and was pleased to note the improved stroke performance. SA asked the Committee to note a risk in relation to stroke which is in relation to the provision of consistent stroke services. A	

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	substantive consultant is due to leave the Trust which will leave two locum consultants for the stroke service. MH asked if there was a different way of quantifying and defining overcrowding across the Trust rather than just within Majors of AED. SM said there is no other definition provided. ZA queried the stroke response hours of 8am to midnight and asked if data analysis has been undertaken to determine this time period. SM explained that the number of patient presentations outside of these hours does not justify the additional investment but patients during this time are treated in AED. The Committee was assured by the update.	
	Performance	
FC.9.24.10	**Operational Performance Highlight Report**	
	CSt presented the report and referred colleagues to the presentation and highlighted the following: - Inpatient activity was one the biggest challenges last year, but theatre lists and overall activity performance have improved from last years position. There is ongoing work with closing the gap in relation to theatre productivity and in session productivity and this is predominantly observations and working with the teams to help identify where improvements can be made. 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. 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 and therefore risks the delivery of plan if further delays are incurred. - Referral to Treatment (RTT) performance is projected to remain stable in August 2024 at 63.16%. 52-week performance has dropped behind plan. 55 patients breached 65 weeks at the end of August 2024 and the challenge is 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. - In terms of waiting list management and validation, 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 data quality metrics on the RTT waiting list. Validation is now better coordinated between teams and the themes from corrections are fed into preventative work which supports ongoing improvements. - .	

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	- Diagnostics performance is improving in line with peer average and back towards plan which is positive. There have been improvements in most modalities where it was expected. CSm and EM will be reviewing the DM01 data for August in detail as the data provided in the report is a forecast due to timing of the report. - The fast-track element for cancer diagnostics and first appointment have both improved in recent months. The latest reported position on the Faster Diagnostic Standard (FDS) shows this has been achieved with the next two months also forecast to meet the standards. Two week wait (2WW) performance is tracking slightly below target due to high demand in some tumour groups, but this is not 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 business as usual. The SLIC impact can be seen with performance remaining over 97% throughout the seasonal referral peak. 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. 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. CSt was pleased to report that a lot of effort is being made to provide a focus on learning and improvement within the Cancer Board to help drive forward performance across individual tumour groups. SA provided an update in relation to patients who have been waiting over 65 and 78 weeks. The national ask was for all Trust's to have zero patients waiting over 65 weeks by the end of September. As at the current week there are 71 patients who have been waiting above 65 weeks at the Trust. As detailed within the report presented by CSt the pressure point is within T&O and this is due to not being able to attract consultants to pick up additional lists to address the long waits as this is extra contractual activity. Some of the more recent changes where other organisations have moved to an LLP model has resulted in consultants being less willing to undertake additional work. SA reported that patients have been contacted to see if they are willing to move to alternative providers as mutual aid support has been requested from other Trusts and the Yorkshire Clinic. A significant number of the patients have opted to remain on the Trust waiting list and not be transferred. There are four patients who have very complex health needs requiring specialist provision whereby two surgeons are needed to operate. In summary, of the 71 patients, 54 are capacity related, two (both at 65 weeks) are awaiting a corneal tissue which is provided through NHSE allocation. SA provided assurance that work is ongoing to reduce the waiting list, and a paper is due to ETM the following Monday which will describe the short-term options in terms of mutual aid and the long term action required to ensure sustainability and minimise patients waiting beyond 65 weeks in T&O.	

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	The Committee was assured by the update.	
FC.9.24.11	**Core Standards and EPRR Update**	
	JL welcomed SAm to present the item. SAm explained that the paper is to update the Committee on the key points of the NHSE core standards submission. A draft is to be returned to West Yorkshire ICB by 27 September 2024 and a final submission to NHSE by 31 October 2024. NHSE requirements for policies are that they are current, in line with current national guidance, in line with risk assessment, tested regularly, signed off by the appropriate mechanism, shared appropriately with those required to use them and outline any equipment requirements and any staff training required. Core standard two (EPRR Policy Appendix 1) was marked as partially compliant last year. The policy has undertaken its planned review, updated to reflect new guidance and shared with internal and external stakeholders and is presented for approval by the group. Core standard five (EPRR Resource) was marked as partially compliant last year. The feedback from NHSE stated "that there is a national requirement for the Board to be satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties. No evidence has been provided that the resources available to the Trust have been assessed by the organisation as sufficient - capacity versus demand." SAm referred colleagues to Appendix 2 which outlines the Trust's EPRR staffing resource and a Board Statement of Compliance. The document details the resource available and the key work that the team covers. SAm explained that the Trust's dedicated staffing resource to EPRR consists of a Band 8a Emergency Planning Manager and a Band 5 Emergency Planning Officer. These individuals are supported through the rest of the organisation through a system of departmental Business Continuity leads, so at this current time, the resource is appropriate for the Trust. Other similar sized organisations have supplemented their EPPR teams with dedicated administrative support however, given the current financial climate, the Trust will continue to monitor it's position and put forward a business case in the new financial year, should it be required. Core standard eight (Duty to Assess Risks) required additional governance on EPRR risks, currently there are 13 EPRR risks and six have recently been reviewed and shared with the Trust Resilience group and Health & Safety Committee and approval given. These risk assessments align to the North East & Yorkshire and National Risk Register (NRR) and are reviewed, as a minimum, annually in two batches. Several risks have now been updated as detailed within Appendix 3 (items one to six). The Committee approved the documents but due to the Committee no longer being quorate as ZA had to depart the meeting early it was agreed that ZA's approvals/comments will be sought virtually. *Post meeting note:* ZA supported the decision of the Committee.	

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FC.9.24.12	**Lockdown Policy**	
	SAm presented the item and explained that as described in the preceding item NHSE requirements are for policies to be current, in line with current national guidance, in line with risk assessment, tested regularly, signed off by the appropriate mechanism, shared appropriately with those required to use them and outline equipment requirements and staff training required. The Lockdown policy has undertaken its planned review and has been updated to reflect new guidance. Guidance was received from NHSE which was shared with internal and external stakeholders and is now presented for approval by the Committee. SAm asked the Committee to note this policy was classed as partially compliant in last year's core standards submission. Following feedback from NHSE, work has taken place to incorporate their feedback into the updated version and a clear governance route identified to sign off the Policy. The Committee approved the policy but due to the Committee no longer being quorate as ZA had to depart the meeting early it was agreed that ZA's approvals/comments will be sought virtually. *Post meeting note:* ZA supported the decision of the Committee.	
FC.9.24.13	**Generic Internal Mass Vaccination Plan**	
	SAm presented the item and explained that the paper provides an update to the Committee on the new Trust Mass Vaccination process. Following guidance received from NHSE, it was noted that it is a requirement for the Trust to have an internal mass vaccination plan similar to when antivirals/vaccines have been provided to Trust staff for swine flu and Covid. Previously the Trust relied on the regional plan as evidence of having a plan in place, but NHSE has stated the Trust must have it's own plan. The plan has followed the principles that were followed when the Trust set up the Covid-19 Mass vaccination plan for the Bradford area. As the next mass vaccination type is unknown, the plan has been written to allow flexibility in how to deliver this process for Trust staff. There are many variables such as type/frequency of vaccination, and any cold chain requirements that cannot be fully decided until the vaccine is agreed. If activated, the plan would be re-reviewed to incorporate all relevant elements of the vaccination process. The plan has been shared with all internal stakeholders who contributed to the original plan so that current information could be included to make it specific to the Trust. JB sought clarification regarding the use of the designation 'Medical Director' and if this should be 'Chief Medical Officer' or 'Medical Director for Operations'. SAm agreed to clarify this and make the appropriate change within the plan. The Committee approved the plan but due to the Committee no longer being quorate as ZA had to depart the meeting early it was agreed that ZA's approvals/comments will be sought virtually. *Post meeting note:* ZA supported the decision of the Committee.	

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	Finance	
FC.9.24.14	**Monthly Finance Report**	
	CSm presented the item and highlighted the following: - 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 year-to-date plan is approximately an £11m deficit and the annual plan is a £14 million deficit therefore the plan does get much more challenging as the year progresses. - CSm asked the Committee to note the reported Month 5 position assumes recovery of 100% of the Elective Recovery Fund (ERF) 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 over-performance 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 five, which presents a risk to the reported position. The ERF position will be reported from Month 6 onwards. - The in-month August underlying deficit of £2.7m represents a deterioration on Months 3 and 4. This deterioration is chiefly explained by updates to income assumptions relating to the Community Diagnostic Centre (CDC) and the Lung Health Check programme totalling £0.8m in month. Both services are now funded on a variable basis and are delivering significantly less activity than planned. Updated activity levels for both income streams show a hit of approximately £0.8m as activity is much lower than planned. It is expected that there are plans in place for both services to increase their incoming in the coming months. - As demonstrated in Chart 1 £0.5m of non recurrent flexibility was required to report an on line plan, however, the position underlying position deteriorated at Month 5. It was important to note that unlike previous years there are not a vast amount of options available on the balance sheet to support the underlying run rate. The coming months will need to provide absolute cost reduction opportunities and income increases to deliver the financial plan each month. - 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 final column of Table 2c shows the impact of in-month movements on the forecast compared to the previous month's forecast. The £0.75m Month 5 in-month deterioration in these metrics results in a £3.7m deterioration in the base case year end extrapolation. - 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 CTG target £3.6m behind plan at Month 5. The shortfall has been offset by increased income, expenditure controls not recorded as efficiencies under the CTG programme and the deployment of £2m of non-recurrent flexibilities. The risk adjusted forecast is delivery of £28.3m of efficiencies, which would result in a £10.6m shortfall against	

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	the required £38.9m of financial improvements. This projected CTG shortfall is the key driver of the mid-case forecast £12.5m adverse variance to the planned £14m income and expenditure deficit. The risk adjusted Month 5 CTG forecast is a £0.8m improvement on the £27.5m forecast provided at Month 4. It is important that progress accelerates in Months 6 and 7 if the annual financial plan is to be delivered. This progress is reliant on the conversion of the opportunities identified in each CSU into concrete plans for delivery and rapid implementation. - 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 is therefore unrealistic even in the medium term. The part year opportunity in 2024/25 of these opportunities is £40.2m. This indicates that the Trust's budget holders and the CTG workstreams have the opportunity to bridge the forecast £10.5m 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. - In terms of the forecast, three scenarios have been modelled for the remainder of the financial year as detailed on page 8 of the report. It is believed that the mid case forecast of a £26.5m deficit, falling behind plan at Month 8 as the best estimate is the most likely scenario. Month 8 does coincide with the phasing of the £5m stretch target that was added into the final financial plan and the target for Month 8 is a deficit of £0.1m or £0.2m compared to over £2m in Quarter 1 and £1.2m in Month 5. If the forecast does come to pass, then it is likely that external cash support will be required in Quarter 4. - A number of adjustments are made for non-recurrent issues in the baseline period and known changes to run rate, improving the forecast by a combined £2m. Urgent investments to address safety or compliance issues approved by the Executive Team in-year will increase the expenditure run rate by £0.8m and business cases approved in 2023/24 and included in the annual plan add a further £0.8m of costs in Quarters 3 and 4. The most significant cost pressures relate to the recruitment of 120 newly qualified midwives and adult / paediatric nurses who will commence employment in Months 6-8. This adds an estimated £2.8m to the expenditure run rate in Months 6-12, with limited offset from Bank staff recognised in the forecast. JL referred to a question from ZA which he raised before leaving the meeting asking if scenario planning has been undertaken, particularly in the case that by March if the CTG target has not been achieved and the discussion with the Integrated Care Board (ICB). BR explained that if the mid case forecast is accepted then the financial framework will need to be followed and one of the expectations from NHSE will be for the Trust to describe what the outturn exit run rate is which is the underlying position of £30m deficit. If we are to move off forecast, then this will require approval through the Board as per the new framework. It is important that we are very clear as to when we may be formally declaring to be off forecast. It was also important to note that if the Trust moves off forecast, then there are further consequences to consider such as control measures and approvals that will be expected. This will be articulated in more detail in a	FC24018 Chief Finance

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	separate paper to the next meeting of the Committee. The Committee was assured by the update.	Officer
FC.9.24.15	**Treasury Management Update**	
	MQ presented the item and explained that the purpose of the paper is to provide the Committee with an update on the current cash position and forecast outturn for the end of the year. The paper also highlights if the Trust will have sufficient cash headroom to pay for both its revenue and capital activities. In terms of the Year-to-Date Position, as at the end of Month 5 the Trust held a closing cash balance of £31m. On the 1 April the Trust had an opening cash balance of £54.2m. This means £33.2m has been spent by the closing position at Month 5. Approximately £20m of this is cash expenditure for the previous year's capital programme therefore such a rapid reduction in cash will not be seen again for the remainder of the year and MQ highlighted the Trust had a significant capital accrual the previous year which must be spent in the current year. In terms of forecasting the cash position to NHSE the Trust will be reporting a deficit position of £14m and full delivery of the CTG programme. This will mean forecasting a closing cash position of £11.6m. The planned closing cash position was forecast as £17m and the reason why £11.6m is being forecast is due to Income and Expenditure (I&E) working capital and balance sheet flexibility that has been used to release into I&E. In terms of capital, it is expected that capital expenditure and capital payable will be broadly in line with the plan with very small movement. MQ highlighted the importance of distinguishing between the I&E cash forecast and capital cash forecast because if revenue support is requested then this is only available for revenue and not capital. The best-case scenario is that the Trust delivers the planned deficit of £14.0m and £38.9m CTG target and reports a closing cash balance of £10.7m. The most likely scenario is that the Trust will report a deficit of £26.5m meaning that the closing cash balance may be a negative £1.7m. It is more than likely that the Trust will require revenue support during Quarter4. The worst-case scenario assumes a deficit of £34.3m and a closing cash balance of a negative £9.6m. MQ reported that during October the Trust is expecting to pay approximately £13.2m pay awards and receive funding for the pay awards in November. Currently the Trust is expecting to have sufficient cash in the bank to manage this cash flow but engagement with NHSE is ongoing should the position change and interim cash support is required. MQ shared that he was aware other Trusts that have requested cash support have not received the full amount requested. It was important to recognise that if the Trust did enter into a negative cash position, then thought will need to be given to how supplier payments or the capital programme are managed going forward to ensure there is sufficient cash in the bank. JL expressed her concern at the worrying financial outlook and reiterated the importance of the Board understanding the implications fully. BR agreed and provided some insight in relation to expectations from NHSE	

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	when requesting cash support based on the experience of other Trusts and said there are some real consequences that the Board needs to be aware of. It may be that the capital programme needs to be reduced to support the cash position as has been the case with some other Trusts. BR agreed to have a discussion at ETM in relation to whether treasury management and cash position needs to be added to the operational risk register and the BAF. The Committee was assured by the update and noted the concerning cash flow risks and that the Trust may require revenue cash support during Quarter 4.	
FC.9.24.16	**Capital Update**	
	MQ provided a summary of the presentation and reported that £10.9m has been spent of the £15.1m year to date budget leaving the Trust £4.2m behind plan. The main reason for that is delays in some schemes in the capital programme, in particular the new Day Case Unit (DCU) and the Endoscopy Unit. Both are expecting recovery throughout the year. At the end of the year the Trust is forecasting a spend of £41.4m against the CDEL allocation of £42.8m therefore reporting a forecast underspend of £1.4m. MQ explained that NHSE will be informed that the full allocation will be spent and the £1.4m underspend is for internal reporting as the contingency fund remains low at £1m and could increase to £1.5m once the Trust receives a £0.5m donation for the Da Vinci Robot. The Capital Strategy Group is reviewing the reserve list to consider where the £1.4m can be sent in the current financial year. MQ referred to vesting certificates and advised that following the completion of the 2024/25 Statutory Accounts the Trusts external auditors recommended that the Trust considers the implications and requirements of management of public money guidelines. The Trust will work with the auditors to review the process for vesting for equipment going forward to ensure we meet the required recommendations. MQ raised this at ICS level and was advised that auditors at other Trusts were not raising this as a concern therefore the National Audit Office may send some communication in relation to this to provide a consistent message. MQ said that if the Trust is unable to use vesting certificates going forward then this will reduce the flexibility of being able to account for items which puts the forecast at risk. Further discussion in relation to this will take place at the Audit Committee. The Committee was assured by the update.	
FC.9.24.17	**Procurement Update**	
	BR provided a summary of the paper and explained that the government has overhauled the European Union procurement rules and there are several new principles to be considered when undertaking procurement. Further updates will be provided to the Committee as the Trust works through and understands the impact of the principles.	

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	The Committee was assured by the update.	
FC.9.24.18	**Trust Action Plan following PwC Review of Closing the Gap**	
	BR introduced the item and explained that PwC was commissioned by WYAAT to undertake a four-week rapid review of the arrangements in place to ensure delivery of financial plans at each of its Trusts. This work is now complete, and WYAAT is in receipt of a report, which consists of specific sections for each Trust. Each section contains recommendations designed to provide each Trust with an objective assessment of its capacity, capability, and financial controls in place, as well as areas for potential in-year financial improvement both internally and WYAAT-wide. MH added that none of the recommendations put forward for the Trust are out of step with those made to other Trusts or are outside expectations. Indeed, many actions were already underway or planned. In response to the report, a proposed action plan has been developed which the Committee is asked to review to ensure that the actions are commensurate to the risk and that the Executive lead for each one is appropriate. JL asked if timescales will be added against each action and MH confirmed an updated version has timescales included and this is the version that will be presented to the Closed Board of Directors meeting the following week. The Committee approved the action plan.	
FC.9.24.19	**Any Other Business**	
	There were no further items of business to discuss.	
FC.9.24.20	**Matters to Share with Other Academies/Committees**	
	There were no items to share with other Academies/Committees.	
FC.9.24.21	**Matters to Escalate to Board**	
	JL advised that any relevant matters would be escalated to Board via the formal Finance & Performance Committee Chair report including the CTG, financial position and cash position.	
FC.9.24.22	**Date and Time of the Next Meeting**	
	16 October 2024 – 09:00-11:00	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE COMMITTEE – 19 September 2024

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FC24016	19/09/24	FC.9.24.6	**Revised F&P Committee Work Plan:** It was agreed to add Treasury Management as a monthly update to the workplan.	Head of Corporate Governance	16/10/24	Workplan updated as required. Action closed.
FC24017	19/09/24	FC.9.24.7	**High Level Risks Relevant to the Committee:** the risk register to be reviewed to ensure all risks are captured, in particular risk 2605 (Chemotherapy) which should be in included on the F&P Academy register.	Head of Corporate Governance	16/10/24	Risk register reviewed. Risk 2605 was aligned to the Quality Committee only. Has now also been aligned to F&P Academy to ensure 'oversight due to the impact on cancer waiting times (31 day and 62 days targets)'. Action closed.
FC24018	19/09/24	FC.9.24.14	**Monthly Finance Report: I**f the Trust moves off forecast, then there are further consequences to consider such as control measures and approvals that will be expected. This will be articulated in more detail in a separate paper to the next meeting of the Committee.	Chief Finance Officer	16/10/24	Item added to the October meeting agenda. Action closed.
FC24019						

D. AUDIT COMMITTEE - 10 SEPTEMBER

REFERENCES

Only PDFs are attached

Bo.11.24.31d - Confirmed AC mins -10.9.24.pdf

Bradford Teaching Hospitals
NHS Foundation Trust

CONFIRMED AUDIT COMMITTEE MEETING MINUTES

Date	Tuesday, 10 September 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 Audit Chair • Zafir Ali (ZA), Non-Executive Director
In Attendance	• Ben Roberts (BR), Chief Finance Officer • Michael Quinlan (MQ), Deputy Director of Finance • Paul Hewitson (PH), External Audit, Deloitte • Karina Edwards (KE), Internal Audit, Audit Yorkshire • Chris Boyne (CB), Internal Audit, Audit Yorkshire • Richard Maw (RM), Counter Fraud, Audit Yorkshire • Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary • Katie Shepherd (KS), Corporate Governance Manager • David Moss (DM), Director of Estates & Facilities – ED in attendance • Adam Griffin (AG)- Deputy Chief Digital & Information Officer/Chief Technology Officer – A.9.24.18 & A.9.24.19 only • Neil Scott (NS)- Head of Business Intelligence - A.9.24.18 only • Rachel Pyrah (RP)- General Manager to CDIO Office - A.9.24.19 only • Jacqui Griffin (JG) – Assistant Director of Finance – A.9.24.20 only • Julie Ward (JW), Senior Healthcare Contracts & Senior Overseas Manager – A.9.24.20 only • Judith Connor (JC), Associate Director of Quality – A.9.24.21 & A.9.24.22 only • Jo Hilton (JH), Director of Nursing/Deputy Chief Nurse – A.9.24.11 only

No.	Agenda Item	Action
-	**Private meeting with Audit Committee members, Internal and External Audit**	
A.9.24.1	**Apologies for absence** • Mohammed Hussain (MH), Non-Executive Director (authorised absence)	
A.9.24.2	**Declarations of interest** No interests were declared.	
A.9.24.3	**Minutes of the meeting held 21 May, 30 June & 22 August 2024** The minutes of the meetings held on 21 May, 30 June and 22 August 2024 were approved as a correct record.	
A.9.24.4	**Matters arising** The following actions were confirmed as closed as indicated on the action log. Actions closed - 21 May 2024 • A24033 – Annual review of AC • A24032 – Audit Committee annual self-assessment • A24031 – Audit Committee Annual Report 2023/24	

	• A24029 – Counter Fraud annual report 2023/24 • A24027 – Limited assurance internal audit report • A24026 – Internal audit progress report • A24008 – External audit annual plan 2023/24 • A24018 – Schedule of losses and special payments • A24024 – Any other business - BR confirmed that the Trust did not post a deficit plan therefore a template was not required for review Actions closed – 20 June 2024 • A24033 – External audit position statement Actions closed – 22 August 2024 • A24034 – ISA 260 – Foundation Trust **Updates were provided with regard to the remaining actions as follows:** • A23025 – Partnership arrangements – new standard due to be issued January 2025 – item to remain open • A24030 – Cyber security - September 2024 – ZA felt that the narrative provided did not address his issue raised. He expected the Trust to map the new cyber assessment framework against the 10 steps to ensure no items are missed in terms of cyber security. CB noted that the NHSE cyber team have been mapping former DSPT assessments to the new UCAF and the new guidance has been published recently. The auditor guidance has not yet been published but it is expected that work is undertaken to map across from the old system to the new one. All organisations will be required to make an interim return on the new standards in December 2024 with the full assessment due at the end of June 2025. It was agreed that a verbal update on progress, in relation to mapping work and where the Trust is in terms of anticipating the submission in December, will be provided at the November meeting. item to remain open	
A.9.24.5	**Auditor's Annual Report** PH confirmed that the updates discussed at the last Audit Committee had been included in the final report presented and he drew attention to the recommendations made. He confirmed that for the purpose of the 24/25 audit he will review the findings that may be made by the CQC when they report the results of their review. Other than the specific issues reported on, leading to recommendations, there were many positives to be taken from the auditors' report. The Committee noted the report and the assurance provided.	
A.9.24.6	**External Audit update** There was nothing to report on this item as work on the 2024/25 audit has not yet commenced. The 'wash up' meeting with External Audit, the Finance Team and BM and ZA has yet to take place and BR agreed to progress this.	Chief Finance Officer A24035
A.9.24.7	**Use of External Audit to Provide Non-Audit Services (standing item)** There was nothing to report on this item.	
A.9.24.8	**Internal Audit progress report** KE provided an overview of the paper which detailed the progress made towards the delivery of the 2024/25 Internal Audit Plan.	

	Six finalised reports have been issued since the last meeting: one high assurance report, three significant assurance reports and two where an opinion has not been provided. KE drew attention to the following key points within the report: • BH/03/2025 – Charitable Funds/Bradford Charity audit which highlights the current position and shows slight progress made. • There were three-management requests for changes to the 2024/25 audit plan. BM and ZA requested that BR and the Executive Team consider the implications when moving audits to Q3/Q4 as this has an impact, at year end, on the ability of the auditor and the Audit Committee to review the reports in time. BR confirmed that discussions have taken place with Internal Audit to draft a local action plan to minimise management requests for changes to the Audit Plan. The Committee approved the three management changes. • The new KPIs contained within the progress report acknowledge the timescales for reporting to the Audit Committee and any deviations from those dates will be reported for visibility purposes. Performance to date is 100%. • Independent validation on completed recommendations is provided throughout the year. A sample test on 20 closed recommendations was undertaken with only one having insufficient evidence and it was recommended that management consider re-opening the recommendation, with a new revised date for completion, to address the gaps identified. The Committee agreed that the internal audit BH/02/2024 Payroll should be re-opened. • Two training events are planned for September and December and places can be booked directly with Internal Audit. • Target dates for reporting to the Audit Committee have been set for the summary of performance against the 2024/25 internal audit plan report. • KE gave an overview of the audit summaries in detail. It was noted that the process, in terms of follow up of limited assurance, has changed and the reporting, going forward, will have a different format. • KE referred to the separate report on benchmarking for the BAF and risk management. Bradford benchmarks well against its peers. • Recommendation tracking and reporting has now transferred to the Trust from Internal Audit. The timetable for reporting has been reviewed to allow management sufficient opportunity to make updates to the system. ZA felt it was important to refer to the 'revised date' recommendations within the report as 'overdue' recommendations as in essence they are actually overdue. He referred to the 'aged' overdue recommendations within the report and was concerned that the majority of them fell within the 90 – 120 days overdue bracket. He suggested a more robust response from management is provided to the Audit Committee on actions to reduce these. BR agreed to progress this with management to reduce the 19 oldest outstanding recommendations. KE noted that Executive Assistants will provide colleagues across their business areas with the overdue internal audit recommendations and request timely updates and it was anticipated that the position will start to improve.	Chief Finance Officer A24036 Chief Finance Officer A24037

	The Committee noted the report and the assurance provided. The three management changes were approved, and it was agreed to re-open the internal audit recommendation BH/02/2024 Payroll.	
A.9.24.9	**Follow up of Internal Audit recommendations** As discussed at A.9.24.8	
A.9.24.10	**Annual Internal Audit performance review** From a recent survey sent to all Audit Committee members and attendees, BR reported that he had received 9 responses, with 4 responses received from the Executive team. Overall positive responses had been received from Audit Committee members and the Executive team. One 'don't know' response related to the Internal Audit Charter review which is now attached to the annual plan for approval. This was previously a separate agenda item. BR noted that for future surveys a response from all of the Executive team is required to provide a more detailed overview. BM asked KE to feedback the response to her colleagues. The Committee noted the verbal update.	
A.9.24.11	**Limited assurance internal audit reports** **a. BH432024 – Nursing Assessment & Care plans – limited assurance** JH joined the meeting to provide an update on progress. Nine recommendations were reported in the internal audit report and an improvement plan was developed along with setting up two working groups to review the recommendations. Work is ongoing in relation to the live reporting and making it more user friendly to ensure the completion of documentation. Changes have been made to the EPR system care plans and assessment section in July 2023, but it was felt that this hasn't made enough of a difference to the evidence reviewed as part of this audit. Work continues on the improvement plan and the implementation of any recommendations to the EPR system. Several additional audits have taken place internally to highlight any clinical risks or concerns and ward accreditation continues to take place. ZA asked how the Trust is going to address the significant risk to patient harm if we are not recording key details in EPR and if checks aren't taking place on a routine basis. He felt that the limited assurance score was generous, even though the sample size was small, but expressed concerned that certain important sections of the care plans are being omitted. JH stated that resource from the Digital Matron and the Digital Nurse will be available to support the work to address these issues and the implementation of a ward insights report would aid this improvement work. The improvement plan will be fed into the Quality Committee meetings and will be discussed at the meeting on the 19th September. JH felt that there has been no impact on delivery of care but agreed that the documentation needs updating with the input from clinical teams. BM felt that the culture needs to be improved about the importance of completing these documents to ensure the individual care that a patient receives is communicated to all staff involved in that care. JH noted that the work of the digital teams alongside clinical staff will	

	help in implementing a culture shift. It was agreed that a note would be drafted on behalf of the Audit Committee to the Quality Committee requesting that full consideration of the issues raised in the audit report would be given at a forthcoming meeting (see Matters to share with other committees/academies). **b. BH482024 – Estates procurement** DM confirmed that all outstanding actions have now been closed with evidence provided, on the K10 system, to support this. The Committee noted the reports, and the assurance provided.	
A.9.24.12	**Counter Fraud progress report** RM provided an update on the position to date and gave an overview of the current and concluded investigations. • There is one investigation ongoing • Prevent and deter work is ongoing and an update section will be provided at alternate Audit Committee meetings which will include a round-up of previous cases. ZA and BM queried the next steps in relation to INV/23/01825 timesheet fraud investigation and the suggestion of an initial move towards internal pursuance which they didn't feel was strong enough having read the details of the case. RMN felt that the case wasn't strong enough to report to the Police or specifically the Crown Prosecution Service for a decision on charge as there would be an enormous amount of evidence to gather before reaching that stage, as noted within the interim report. There were no guarantees of a charge, and the Trust could find itself in a position of investing huge amounts of money on an investigation only to be able to recoup an element of the money owed. BR felt that, on review of the report, there are three issues, namely fraud, overpayment and clinical issues. The overpayment and clinical issues are being reviewed by appropriate colleagues within the Trust. In relation to the fraud issue, he felt it was unlikely the case would progress to prosecution. RM agreed to provide an update on the overpayment and clinical issues for case INV/23/01825 within his next counter fraud report to the November Audit Committee. DM queried how the overpayment monies can be recouped and RM noted that the double payments are a payroll issue, and the monies can be taken back. An invoice would be raised to the ex-employee for the monies owed. In relation to overpaid or wrongly paid monies civil litigation could be an option as proving this, on the balance of probabilities, is a lot stronger than beyond all reasonable doubt. ZA referred to INC/24/01934 – on page 6 and the naming of the BTHFT staff member who reported the allegation. He felt that from a GDPR perspective it was not good practice to name the individual within the report. ZA referred to INT/24/01692 & INC/24/01853 – Anonymous allegation referenced on page 5 of the report. As the finding was that there was no substance to a fraud allegation, ZA felt that this item should not have been	Counter Fraud (RM) A24038

	included in the report. RM confirmed that it had been included, as agreed by senior management, to provide total transparency. ZA also felt it wasn't appropriate to add speculative comments to this section of the report. The Committee concluded that the allegation did not meet the threshold for reporting to the Audit Committee. The Committee noted the report, and the assurance provided.	
A.9.24.13	**Exception reports: Schedules of losses & special payments and appropriateness of single source tenders** MQ noted that there had been some payments in Q1 related to payment via the NHS Litigation Authority for losses and special payments as show in the report. Work is ongoing with Procurement and Estates to ensure that all waivers are reconciled on the Estates system and that checks and balances take place as recommended within the recent audit. BM noted that he may revisit the rationale of the time delay in implementing the waivers. BR confirmed that he has met with the Procurement team to discuss timeframes. The Committee noted the report and the assurance provided.	
A.9.24.14	**Trust compliance with Standing Orders, Standing Financial Instructions/Scheme of Delegation (standing item)** There was nothing to report on this item.	
A.9.24.15	**Suspension of Standing Orders/Standing Financial Instructions (standing item)** There was nothing to report on this item.	
A.9.24.16	**Other assurance functions (standing item)** There was nothing to report on this item.	
A.9.24.17	**Partnership arrangements: implications for the Audit Committee** LP advised that there were no updates to report.	
A.9.24.18	**IA report BH382024 Medical Records (limited assurance) - 3 monthly update** RP joined the meeting to provide an update on progress on the seven recommendations which are being reviewed by a newly formed task and finish group who had their first meeting on the 20th August 2024. The group agreed the Terms of Reference, added a risk to the risk register and work continues at monthly meetings to complete the recommendations by the deadline of December 2024. ZA queried recommendations 6 & 7 with a current status of green on the report but were actually overdue if they are measured against their original date as opposed to their extended date. RP agreed to update the report. BM felt that until each of the recommendations have been completed and reviewed at the Digital Data & Technology Committee, the Audit Committee would still expect further updates. KE said that the recommendations had a	General Manager to CDIO Office (RP) A24039

	target date of December 2024, Internal Audit had another review in this area in the 2024/25 plan, which should be commencing shortly. The Committee noted the report, and the assurance provided.	
A.9.24.19	**Data Quality 6 monthly update** AG joined the meeting to provide an overview of the policies and procedures for ensuring acceptable data quality. Data quality within the Trust is evidenced by the standard measurement tool DQMI which scores the Trust high with most scores being in the 90% bracket. There are workplans in place to address the two areas that are scoring below 90%. Work continues to find ways to improve data quality with improved engagement with the CSUs and clinical colleagues as well as the expansion within the informatics team. BM queried why Bradford seemed to benchmark well against other Trusts and NS confirmed that the key to success, at the Trust, is in part to engagement and collaborative work undertaken throughout the Trust. BM queried who the Information Sub Committee Group reported to within the governance of the organisation and LP confirmed that this reports via the Digital & Data Transformation Committee and then to the Quality Committee. The Committee noted the report and the assurance provided.	
A.9.24.20	**Overseas visitors' presentation** An action was raised at a previous Audit Committee in relation to the proportionately high number of write offs, £108,000 for 2023/24, from overseas visitors as noted in the schedule of losses and special payments report. JW and JG joined the meeting to provide an overview of the systems and processes undertaken in relation to overseas visitors' income recovery. She referred to the recent overseas service audit that had taken place which had received significant assurance and provided some background on the objectives, scope and opinion of the audit. She made reference to the work undertaken with the build of the Electronical Patient Record (EPR) system to ensure overseas patients are recorded, checked and tracked using the red, amber and green banners. The overseas team has worked closely with the Education Department training all frontline administration staff on EPR red, amber and green banners at registration. The Trust was one of the first in West Yorkshire Association of Acute Trusts (WYAAT) to implement the Message Exchange for the Social care and Health (MESH) automated system which provides data on every patient that has attended the hospital. This ensures that the overseas team can track patients to either exempt or charge them for services provided. The overseas team continue to work closely with various teams across the Trust to ensure checks are undertaken and the overseas patient is identified on the EPR system, and all information is recorded prior to an appointment being offered. Evidence of applicable exemptions for overseas patients are recorded in the overseas central database, EPR system and the finance system Oracle. All	

	patients who are identified as a chargeable patient are asked to pay for the full patient pathway treatment up front and in full as per the regulations. If the patient can't pay or won't pay, and the treatment is urgent, the clinician in charge has to sign a clinical decision form which is then escalated to the clinical lead and finance manager for review. JW provided an overview of the costings in relation to recording of relevant treatment costs which include recording the trust market force factor and the 50% uplift that is applied for all overseas patients. Once the treatment has been coded an invoice is raised and any upfront payments received would be applied to the invoice via the financial accounts team. Shared Business Services (SBS) arrange re-payments plans and continue to chase payment until the debt is settled. After 60 days all overdue invoices, over £500, are referred to our external debt recovery company, CCI. At day 90 the Trust is required by law to refer the debt to the Home Office and the patients' details remain on the national database of debt, so alerts are able to be issued to Trust's to check the debt is still outstanding. ZA asked what assurances are in place to minimise fraud, at the point of service, with patients impersonating someone else to try and bypass the system. JW confirmed that thorough checks of identify documents are undertaken and the team work closely with our local partnership office at the Home Office and other hospitals both locally and nationally. ZA asked what percentage of bad debt is written off at the end of the year in terms of the total recouped. JW noted that the Trust recovers around 27% of income which is above the national average. It was noted that 60% of debt is in maternity with 40% in cardiology, stroke and trauma and orthopaedics. Last year 262 new overseas patients were 'cost avoided' which is a low figure compared to the overall number of patients that come through our Trust, but its 262 patient slots that were freed up for patients that are entitled to free NHS care, this further supports cost avoidance and debt. MQ confirmed that around £500,000 per annum is received from overseas patients with around 35-40% written off. He confirmed that work continues to recover the monies on all written off debts until it is no longer economically viable to do so. Once a debt is written off, and the patient is picked up through the Home Office/UKBA the Trust would still request the monies that have been written off. The Committee noted the presentation, and the assurance provided.	
A.9.24.21	**Assurance regarding compliance with Risk Management Strategy** JC joined the meeting and together with LP provided an overview of their roles relating to risk management within the Trust. • LP noted that the high-level risk register continues to be reported on a monthly cycle. The BAF is currently being reviewed by the Board and a list of risk topics has been agreed which will be included in the BAF with the Executive Team and their staff developing the risks associated with those topics. The paper will be presented to Board in September for approval with reporting continuing through the Committees/Academies. Reporting, in future, will be on a quarterly basis rather than bi-monthly	

	with risks being streamlined to around 13 on the BAF to bring this more in line with the benchmarking. • JC stated that it was her responsibility to ensure that the Quality Governance Framework is discharged appropriately within the Clinical Service Units (CSU) triumvirates. Each CSU is assigned a Quality & Patient Safety Facilitator and Quality & Patient Safety Officer. Frequency of meetings largely depends on the size of the CSU and work on an annual plan is undertaken by each CSU to ensure all elements are covered. • The Moving to Outstanding meeting has now moved to an Operational Governance and Assurance meeting. The terms of reference have been overhauled and a different focus on that meeting with the CSUs is in place. • Results of an audit undertaken in 2024 highlighted three recommendations with two completed and closed. The third relates to risk management training at induction. Discussion is taking place to update this recommendation as the focus on induction training has changed. • In terms of assurance, JC noted that the Trust has an electronic Health & Safety e-learning package which covers all elements of risk management and is also included in our new trust induction handbook. Although there isn't a slot on the induction programme, availability of information and support for staff has been improved. BM queried if JC was content with the package of changes made and she confirmed that there are still different levels of maturity within the CSUs, and she welcomed the new audit which she hoped would tease out where extra support is needed. She felt that changes to the sub committees of the Board will help to focus on the assurance elements and move forward improvements. ZA asked about the Trust's maturity in relation to the quality of information in regard to risk of mitigating actions. JC confirmed that the Trust has moved from the Datix risk management system to InPhase (IRIS). The first iteration of the dashboard has been produced which will aid the CSUs to pull their information from the system and she felt that this was a big step forward in aiding the CSUs to utilise the data. Work will continue to develop the reporting system to ensure data is pulled through in a timely manner. The Quality Dashboard will then be reported through to the Quality Committee along with reports from the Operational Governance Assurance Group. The Committee noted the paper, and the assurance provided.	
A.9.24.22	**Review of external regulatory visits register** There was nothing to report on this item but once the CQC report is received an update will be provided as part of the standard agenda item.	
A.9.24.23	**Conflicts of Interest Annual report** LP provided an overview of the paper which provided the Audit Committee with assurance regarding the arrangements in place to manage conflicts of interest. Between April 2023 – March 2024 the Trust achieved a	

	compliance rate of 99% in relation to decision making staff which provides good assurance. One key area for improvement is the timeliness of declarations for decision makers within the 28-day period as this score has dipped slightly compared to the previous year. Benchmarking information indicates that the Trust has the highest rate of compliance compared to its peers in WYAAT. The Committee noted the paper, and the assurance provided	
A.9.24.24	**Any other business** There were no matters raised.	
A.9.24.25	**Matters to share with other committees/academies** It was agreed that a note would be drafted on behalf of the Audit Committee to the Quality Committee requesting that full consideration of the issues raised in the audit report would be given at a forthcoming meeting. LP agreed to ensure that BH432024 – Nursing Assessment & Care plans – limited assurance is included on the Quality Committee for discussion.	Board Secretary A24040 Board Secretary A24041
A.9.24.26	**Matters to escalate to the Risk Register** Discussion took place around the benefits of limited assurance internal audit reports being added to the high-level risk register. After discussion it was agreed that as these action plans and recommendations are being picked up through other channels there was no requirement to add them to the risk register.	
A.9.24.27	**Matters to escalate to the Board of Directors** The External Auditors Report will be circulated, via email, to the Board.	Board Secretary A24042
A.9.24.28	**Items deferred to subsequent meetings** There were no items deferred.	
A.9.24.29	**Attendees for subsequent audit committee meeting** The AC would continue with the practice of Executive attendance on a rotational basis.	
A.9.24.30	**Review of meeting** Consideration to be given to the timings of speakers invited to the meeting to minimise disruption to the flow of the agenda. This will be reviewed at future agenda setting meetings going forward.	Board Secretary A24043
A.9.24.31	**Date and time of next virtual meeting:** • 19 November 2024 14:10-17:00	

Action log from the Audit Committee Meeting held 10 September 2024

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		Next number in sequence	*A24044*		
10.9.24	A.9.24.6	**External audit update** The 'wash up' meeting with External Audit, the Finance Team and BM and ZA has yet to take place and BR agreed to progress this	**Chief Finance Officer A24035**	November 2024	Updated provided at A.11.24.6 on the November agenda. Action closed
10.9.24	A.9.24.8	**Internal audit progress report** The Committee agreed that the internal audit BH/02/2024 Payroll should be re-opened.	**Chief Finance Officer A24036**	November 2024	Progress made and update to be provided at the November meeting. Action to remain open
10.9.24	A.9.24.8	**Internal audit progress report** ZA felt it was important to refer to the 'revised date' recommendations within the report as 'overdue' recommendations as in essence they are all overdue recommendations. He referred to the 'aged' overdue recommendations within the report and was concerned that the majority of them fell within the 90 – 120 days overdue bracket. He suggested a more robust response from management is provided to the Audit Committee on actions to reduce these. BR agreed to progress this with management to reduce the 19 oldest outstanding recommendations.	**Chief Finance Officer A24037**	November 2024	Verbal update to be provided at the November meeting.
10.9.24	A.9.24.12	**Counter fraud progress report** RM agreed to provide an update on the overpayment and clinical issues for case INV/23/01825 within his next counter fraud report to the November Audit Committee	**Counter Fraud (RM) A24038**	November 2024	Update included within the November progress report under the prevent and deter section. Action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
10.9.24	A.9.24.18	**IA report BH382024 Medical Records (limited assurance) - 3 monthly update** ZA queried recommendations 6 & 7 with a current status of green on the report but were actually overdue if they are measured against their original date as opposed to their extended date. RP agreed to update the report.	**General manager to CDIO office (RP)** **A24039**	November 2024	
10.9.24	A.9.24.25	**Matters to share with other committees/academies (nursing assessment and care plans)** It was agreed that a note would be drafted on behalf of the Audit Committee to the Quality Committee requesting that full consideration of the issues raised in the audit report would be given at a forthcoming meeting.	**Board Secretary** **A24040**	November 2024	Communication from the audit committee shared with the Chair and Lead Executives of the Quality Committee. Action closed.
10.9.24	A.9.24.25	**Matters to share with other committees/academies** LP agreed to ensure that BH432024 – Nursing Assessment & Care plans – limited assurance is included on the Quality Committee for discussion.	**Board Secretary** **A24041**	November 2024	Agenda item/document included at Quality Committee held in October 2024. Action closed.
10.9.24	A.9.24.27	**Matters to escalate to the Board of Directors** The External Auditors Report will be circulated, via email, to the Board.	**Board Secretary** **A24042**	November 2024	Report circulated. Action closed.
10.9.24	A.9.24.27	**Review of meeting** Consideration to be given to the timings of speakers invited to the meeting to minimise disruption to the flow of the agenda. This will be reviewed at future agenda setting meetings going forward.	**Board Secretary** **A24043**	November 2024	Taken account of when setting the agenda. Action closed.
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**	November 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

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
					September. Agenda item added to the September agenda.
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**	November 2024	ZA felt that the narrative provided did not address his issue raised. He expected the Trust to map the new cyber assessment framework against the 10 steps to ensure no items are missed in terms of cyber security. CB noted that the NHSE cyber team have been mapping former DSPT assessments to the new UCAF and the new guidance has been published recently. The auditor guidance has not yet been published but it is expected that work is undertaken to map across from the old system to the new one. All organisations will be required to make an interim return on the new standards in December 2024 with the full assessment due at the end of June 2025. It was agreed that a verbal update on progress, in relation to mapping work and where the Trust is in terms of anticipating the submission in December, will be provided at the November meeting. item to remain open 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.
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**	January 2025	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.

E. CHARITABLE FUNDS COMMITTEE - 22 JULY 2024

REFERENCES

Only PDFs are attached

Bo.11.24.31e - Confirmed Charitable Funds Minutes - 22.7.24.pdf

Bradford Hospitals Charity

CONFIRMED MINUTES - CHARITABLE FUNDS COMMITTEE

Date:	Monday 22 July 2024	**Time:**	15:30-17:00
Venue:	Via Microsoft Teams	**Chair:**	Altaf Sadique, Non-Executive Director
Present:	**Non-Executive Directors:** • Altaf Sadique, Non-Executive Director (AS) **Executive Directors:** • Sajid Azeb, Chief Operating Officer (SA) • Chris Smith, Interim Director of Finance (CS) • Mel Pickup, Chief Executive (MP)		
In Attendance:	• Michael Quinlan, Deputy Director of Finance (MQ) • Jacqui Maurice, Head of Corporate Governance (JM)		
Minutes:	• Mel Lomas, Executive Assistant		

No.	Agenda Item	Action
C.7.24.1	**Apologies for Absence** • Bryan Machin, Non-Executive Director • Laura Parsons, Associate Director of Corporate Governance/Board Secretary (represented by the Head of Corporate Governance)	
C.7.24.2	**Declarations of Interest** No declarations of interest were made.	
C.7.24.3	**Minutes of the Meeting Held on the 30th of April 2024** The minutes were accepted as an accurate record of the meeting. The action log was reviewed and updated as below. **C23007 - Investment Report** AM (Rathbones) to switch the Moet Hennessey stocks to a non-alcohol product. MQ confirmed on the 17th of June that the Moet Hennessey stocks have been sold. Action closed. **C23008 - Investment Report** AM (Rathbones) to share the risk questionnaire with the Committee. Item incorporating the link to the risk questionnaire added to the agenda at C.7.24.9. Action closed. **C23009 - Five Year Plan (2024/25-2029/30)** BM to review the case for independence with MH and MQ. Meeting scheduled for the 26th of June 2024. Action closed. **C23010 - Committee Effectiveness Review – Feedback and Review of Terms of Reference** Charity Team to invite Committee members to events and activities. The Head of Fundraising has confirmed that invitations to events will be extended to Committee members. Action closed. **C23011 - Charitable Funds Committee Workplan** JM to amend the due date of the ISA 260 item from July to November. Workplan updated as	

	required. ISA 260 funds scheduled for receipt in November 2024. Action closed.	
C.7.24.4	**Matters Arising** There were no matters arising.	
C.7.24.5	**Finance Report** MQ highlighted the following key points within the slide presentation. • In April 2024, the Charity Committee agreed a new 5-year plan, which includes investment into and raising funds for the Neonatal Unit. This also includes the establishment of an independent charity with expansion of the fundraising team to generate further income. • At Month 2, the total value of the fund is reporting at £118,000 more than plan, largely due to a reduction in expenditure within the charity in the absence of a Charity Director and a reduction of investment in equipment and services. • By the end of the year, the fund is forecast to almost be back in-line with plan, with a slight underspend in pay costs - again due to the recruitment of a new Charity Director. • The aim is for a 25% rate of return. The current rate is 45% and by the end of the year is expected to be around 30%. MQ pointed out that being behind plan will potentially have an impact on donations. The Committee noted the update.	
C.7.24.6	**Internal Investment Funds** MQ requested Committee approval for two proposals: • **Drawdown** Certain Rathbones funds at a cost of slightly less than £300,000 may need to be liquidated this year due to the level of costs incurred. In addition, the charity owes the Foundation Trust £500,000 for the Da Vinci robot. • **The Elsie Sykes Trust** Around £250,000 was invested with the Elsie Sykes Trust in 2019, a donation which is owned by the charity. This was a temporary arrangement to loan the fund to Elsie Sykes to invest on the Foundation Trust's behalf. The proposal is to now invest these funds with Rathbones as the market indices indicate that Rathbones is currently performing slightly better than Elsie Sykes. The Committee approved the two proposals.	
C.7.24.7	**£500k Donation for the Da Vinci Robot** MQ advised that the charity received £500,000 in 2023 to donate towards the new robot. Approval is now required to transfer these funds back to the FT.	

	The committee approved the proposal.	
o	**External Investment Report** MQ summarised the main points from the report. The committee was asked to note: • The value of the fund was £1.3 million as of the 30th of June. An appreciation of its value is expected this year of around £27,000, with an estimated annual income in the form of dividends of around £21,000, a yield of 2.5% (slightly less than the 3% target). This will be discussed with Rathbones when they attend the next meeting. • The 3-month yield is 1.7%, which is lower than the target, but higher than the benchmark and the cash investment that could potentially be made is slightly less than the Consumer Price Index (CPI) plus 2% return. CS queried why the stock market, with a longer-term timeframe, was being used when there are potentially higher interest rates with a fixed-term product. MQ stated that a score of 3 in terms of risk appetite was previously noted and the organisation didn't choose to maximise capital growth or income, instead choosing a balanced approach. The yield mentioned above relates to income growth, with capital growth not considered. MQ pointed out that the capital growth and revenue figures are higher than they would be from a purely cash basis. The Committee noted the report.	
C.7.24.9	**Completion of Rathbones ERQ (Entity Risk Questionnaire)** MQ advised that once this questionnaire has been completed, Rathbones will pull together a risk portfolio for review and discussion. The Committee reviewed the questions and agreed on the following answers: **Q1: It would be preferable for the organisation to accept the risk of short-term losses to get better potential long-term gains?** The Committee answered strongly agree. **Q2: Which portfolio from the graph shown would the organisation prefer to invest in?** CS stated that he would err on side of caution with a product that generated moderate returns with minimal risk. AS remarked that the organisation has chosen lower risk options historically and given the costs of using an investment management company better returns are required. The Committee agreed on option 4. **Q3: The organisation would accept fluctuations in the value of its investments to get better returns in the longer term?** The Committee agreed with this question.	

	Q4: Your organisation is considering a single long-term investment in isolation, which you can purchase in units costing £10,000 each. Select one investment from the 6 possibilities shown. The Committee agreed on option D. **Q5: What sort of spread of investments would be suitable for your organisation? All high risk/high return, low risk/low return or somewhere in between?** The Committee agreed on option 3. **Q6: Imagine that your organisation is making an investment for the medium term (5-10 years). How would you rate the degree of risk that you should be taking?** The Committee agreed that this should be a moderate degree of risk. **Q7: Your organisation would prefer to seek large potential returns from its investments, knowing that it is taking a commensurately large amount of risk?** The Committee neither agreed nor disagreed with this question. **Q8: On the scale presented, please indicate where you would prefer the organisation to be positioned in respect of a balance between maintaining the purchasing power of its wealth in the long-term, or avoiding a decrease in the capital value of its wealth in the short-term.** The Committee agreed on Option 4, to favour protecting purchase power over protecting capital value. **Q9: What is the organisation's investment time horizon before any anticipated material withdrawals?** MQ advised that there is currently £200,000 in the fund against an investment of £1 million. SA pointed out the future large expenditure on the new Neonatal Unit and that if the fundraising doesn't go to plan a withdrawal may be required. MQ stated that a material withdrawal usually consists of 15-20% or more. The Committee agreed to two years or less. **Q10: Does the organisation have any significant debt that it may not be able to meet in the normal course of its business?** The Committee agreed to answer no. **Q11: Does the organisation have any requirement for cash withdrawals from this investment and if so, how much?** The Committee chose option 3, we are looking to make withdrawals, but would only need to cover our unforeseen expenses. **Q12: What proportion of the organisation's total investable assets are you investing with Rathbones?**	

	The Committee answered more than 75%. **Q13: What proportion of the organisation's investment would you be able to lose without it significantly affecting the achievement of your objectives?** The Committee answered between 10 and 25%. **Q14: How many months/years of the organisation's current rate of expenditure could be covered with your remaining cash reserves?** The Committee answered between 6 months and a year. **Q15: In the event of any emergency, would the organisation need to access this investment?** The Committee answered that this was highly probable. **Q16: Over the next 2 years, how would you expect the organisation's income and expenditure to change?** The Committee answered that income will increase relative to expenditure. **Q17: Confirm the approximate average length of time the relevant representatives of your organisation have been investors in the financial markets.** The Committee answered 5 years or less. **Q18: Please select the investment types the relevant representatives of your organisation understand sufficiently to explain to someone who is not an investment expert.** The Committee answered cash, government bonds, index-linked government bonds, corporate bonds, high yield corporate bonds, UK equities, international developed and developing markets, commodities, property funds, infrastructure funds and private equity. **Q19: Which of the following investment types have the relevant representatives of your organisation held at any time?** The Committee answered cash, government and index-linked bonds. **Q20: Which of the following investment types do the relevant representatives of your organisation currently hold?** The Committee answered cash, government and index-linked bonds. **Q21: Please indicate if the relevant representatives of your organisation have experience of financial matters through their formal education, professional work or self-study.** The Committee answered affirmative to all the options, apart from through work in the finance industry.	

	Q22: Which of the following types of professional services have the relevant representatives of your organisation used in the past? The Committee answered having your investment managed for you by a professional on a discretionary basis.	
C.7.24.10	**Rathbones Contract** MQ presented this paper for approval and explained that the organisation entered into a contract with Rathbones in 2019 initially for 3 years with an option to extend for 2 years. The contract is due to end in August 2024. Due to the move to independence, a full tender exercise isn't being recommended. It is advised to stay with Rathbones, extending the contract for 12 months, until which time the new independent charity trustees can decide on the next steps. The Committee approved the recommendation.	
C.7.24.11	**Bradford Hospitals' Charity Treasury Management & Investment Policy** MQ presented this policy for approval. The latest Charity Commission guidelines have been reflected within the document and paragraph 6.2 has been updated to highlight the areas of risk which should be considered. The Committee approved the policy	
C.7.24.12	**Bradford Hospitals' Charity Reserves Policy** MQ also presented this policy for approval which the Charity Committee approved.	
C.7.24.13	**Charity Independence – Progress Against Plan** SA provided an update on the charity case for independence. The 12-month plan to progress to independence was approved by the Foundation Trust Board in March. 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 5 for approximately 5 weeks. The Committee noted the update and agreed with the plan.	
C.7.24.14	**Internal Audit Report – Bradford Hospitals Charity Movement to Independence Update** SA presented the report for information. In summary he advised that; a controls improvement review was carried out by Audit Yorkshire in November 2023, which highlighted a few areas that could be strengthened. Recommendations relate to the creation of new policies and procedures for an independent charity and, donor management which should be	

	strengthened if the charity wasn't to become independent. The recommendations will be actioned as the case progresses. AS queried the potential information governance/data protection implications of moving contact details across to a new legal entity. SA drew attention to the action whereby, "BTHFT should strengthen their procedures in relation to interacting with existing and potential donors, including around planned fundraising activities" and highlighted another around considering donors' backgrounds and the potential conflicts of interest in accepting donations. SA stated that once the plan has been developed legal advice will be sought on GDPR. MQ pointed out that the fundraising regulation standards need to be followed, as well as the Charity Commission guidelines and accounting standards. The Committee noted the report.	
C.7.24.15	**Operational Committee Report** SA praised the work of Lisa Williams, Head of Fundraising, who authored this 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. • A Corporate Fundraiser role is also in the pipeline, but there have been challenges with recruitment. This will be discussed with the recruitment agency used to find a Charity Director. • Eden Brown is the recruitment agency appointed to support the recruitment of the new Charity Director. The advert is now live, and interviews have been scheduled for 5th of August. • 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. • The profile of the charity internally is improved, with colleagues acknowledging the connection between the charity and the wider organisation and the Charity Team have been supportive of the various initiatives. AS queried the100 Club membership renewal date. SA stated that some members have been unable to renew, and numbers haven't been able to be increased this year in the same way as following the Aagrah event last year. AS suggested a 100 Club member thank you event to outline the charity's future plans. It was agreed that this would be combined with the commencement of the new Charity Director and launch of the new Neonatal Unit later in the year. The Committee noted the report.	

C.7.24.16	**Charitable Funds Committee Workplan** JM highlighted some temporary changes concerning the annual report and accounts and ISA 260, which are now included on the November agenda. There is also a query in relation to the Charity Strategy and it was agreed that this would be confirmed on the workplan for discussion once the new Charity Director is in post. The Committee noted the update.	Head of Corporate Governance C23012
C.7.24.17	**Any Other Business** No other business was discussed.	
C.7.24.18	**Date and Time of the Next Meeting - 3.30-5pm** • 5 November 2024.	

Bradford Hospitals Charity

Actions From the BTHFT Charitable Funds Committee 22nd July 2024

Action ID	Date	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
C23012	22.7.24	C.7.24.16	**Charitable Funds Committee Workplan** The Charity Strategy would be confirmed on the workplan for discussion once the new Charity Director is in post.	Head of Corporate Governance	November 2024	