NHS

Bradford Teaching Hospitals

NHS Foundation Trust

Annual Report & Accounts

2018/19

Together, putting patients first

Bradford Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts
2018/19

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

ANNUAL REPORT CONTENTS

QUALITY REPORT CONTENTS

WE ARE BRADFORD

Bradford Teaching Hospitals NHS Foundation Trust (the Trust) was created on 1 April 2004. It serves a local population of around 530,000 and employs over 5,800 people working across six sites. Each year we deliver around 6,000 babies, perform over 300,000 operations and see around 500,000 patients in outpatient clinics.

Our mission at Bradford Teaching Hospitals NHS Foundation Trust is "to provide the highest quality healthcare at all times".

We are one of an elite group of hospitals around the country which delivers care, teaching and research. To do well in any one of these domains is an achievement. It is an even greater challenge to excel in all three, but that is our ambition.

We strive for excellence and are committed to learning from and leading best practice to make sure we are delivering quality care. We aim to have a workforce representative of the communities we serve so we're the best place for our patients and our people. To this end, we have a vision for the Trust that describes our ambition and where we want to be as an organisation.

Our vision is "to be an outstanding provider of healthcare, research and education, and a great place to work."

Our values sum up who we are as an organisation. They are:

- *We care*
- *We value people*
- *We are one team*

We all work together to bring these values to life in our everyday work – whether we are working with patients or each other, We are Bradford.

2.1 OVERVIEW OF PERFORMANCE

2.1.1

STATEMENT FROM CHIEF EXECUTIVE ON PERFORMANCE

Over the last two years we have laid the foundations to address the challenges we face. As a result, 2019 is a year of huge opportunity for our Trust, and we aim to make a difference for Bradford and for all our service users.

One of our priorities has been to make our infrastructure and Information Technology fit for the 21st century – something we are well on the way to achieving through the opening of the new hospital wing at Bradford Royal Infirmary (BRI) and implementing a comprehensive electronic patient record (EPR).

2018 was a year of consolidation: beginning to realise the clinical benefits of the electronic patient record, and resolving long-standing questions like the future of vascular surgery in West Yorkshire; strengthening our consultant workforce, and winning national recognition for the innovative work we are doing in our acute hospitals and the community.

With our local partners, we have made great progress to keep people "happy, healthy and at home". This is more than just a sound bite – it is exactly the sort of care we would want for our own family members, and it is the reason why we come to work in the NHS.

Our range of established services designed to improve patient flow and treat people out of hospital, including the multi-agency integrated discharge team (MAIDT) and the Virtual Ward, have been bolstered by the addition of the award-winning children's Ambulatory Care Experience (ACE) service and a team of occupational therapists in Accident and Emergency (A&E).

The ACE service, which is a new way of working with General Practitioners (GPs) and other partners to improve health outcomes for children and their families, won the Health Service Journal (HSJ) Improvement in Emergency and Urgent Care Award in November 2018. We are leading the way in transforming how we work, as we become the first healthcare organisation in Europe to implement a Command Centre powered by artificial intelligence (AI).

The Command Centre goes live in 2019 and will help us deal with increasing attendances, create bed capacity and manage flow better.

Other key achievements over the past year include our dedicated Neonatal team becoming the first intensive care unit (Level 3) in the UK to achieve the Baby Friendly accreditation from UNICEF and the World Health Organisation.

We started building work on a new £3m flagship research centre – the Wolfson Centre for Applied Health Research – on the BRI site, which will spearhead improvements in the health and wellbeing of children and elderly people.

We completed a £1.8m transformation of our Women's and Newborn Unit to make it more comfortable and welcoming for our patients, staff and visitors – with a raft of energy-efficient measures included too.

While recruitment remains challenging for the whole of the NHS, we continue to attract high calibre staff to our Trust and develop innovative schemes to support retention, such as our in-house transfer process which supports clinical staff to move to a different specialty without having to leave the Trust to seek a new role.

And following a successful recruitment campaign, we welcomed no fewer than 22 newly-qualified midwives to our busy maternity unit. They joined us at the same time as 12 newly-qualified paediatric staff nurses were also appointed.

We also launched our Education Plan 2019-2024, to support our vision to become an outstanding provider of training and education.

The Plan sets out our ambition to support healthcare professionals in training, ensuring a high quality workforce for the future in the ever-changing NHS, which will maintain our hard-earned reputation as a provider of high quality education and training across all groups of healthcare professionals.

CHAPTER 2

PERFORMANCE REPORT

Our latest Care Quality Commission (CQC) report published in June 2018, highlighted 'positive improvement' and 'well-led' services at Bradford hospitals.

The CQC told us we are a 'well-led' organisation and that care at our hospitals was 'patient centred and compassionate' and highlighted many areas of 'outstanding practice'. In particular, it awarded BRI's urgent and emergency services, which were inspected during winter, one of the busiest and most challenging times of the year, a rating of 'Good' – an improvement on the previous inspection.

Surgery was also rated as 'Good' with medicine and maternity rated as 'Requires Improvement'. Not all our services were inspected during the visit and the partial inspection meant that the Trust was unable to raise its overall rating from 'Requires Improvement.'

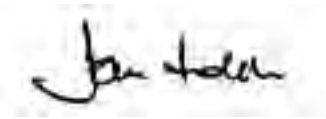
We have worked hard to improve our performance over the past year and have seen an exceptional turnaround in the Referral To Treatment (RTT) (18 weeks) standard, so we can relieve the anxiety of long waits for patients and increase their chance of a better outcome. Our Board of Directors (Board) has agreed a significant programme of investment – over £2m per annum so that we achieve a similar improvement in our urgent care, as measured by the four hour "Emergency Care Standard".

Our Bradford Improvement Programme continues to drive improvements that are owned and operated by frontline staff who are supported to identify and deliver the changes they want to see. Working with other acute trusts in the West Yorkshire Association of Acute Trusts (WYAAT) partnership, we will continue to collaborate to get best value from the goods and services we use, manage the risk of vulnerable services and make best use of the skills and staff we all rely on.

With our colleagues at Airedale NHS Foundation Trust we have started a programme of work to make every single service as good as it can be for the population we serve, looking for opportunities to collaborate and redesign care around the patient, avoid unnecessary duplication or variation, pool our strengths and make the best use of our combined assets.

We are dedicated to continual improvement, and providing patients with a high quality, comprehensive and joined-up service. Our focus will always be on improving patient safety, their clinical outcomes, and their experience of spending time in Bradford Teaching Hospitals, as we strive to be an outstanding provider of care.

Signed:



John Holden

Acting Chief Executive

24 May 2019

2.1.2

PURPOSE OF SECTION

This section aims to provide sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

2.1.3

PURPOSE AND ACTIVITIES OF THE FOUNDATION TRUST

All Foundation Trusts are required to have a constitution, containing detailed information about how that Foundation Trust will operate. The purpose of Bradford Teaching Hospitals NHS Foundation Trust (the Trust) is set out in its Constitution as follows:

"The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

The Foundation Trust may provide goods and services for any purposes related to:

- *the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and*
- *the promotion and protection of public health."*

In short, the purpose of the Trust can be summarised in its mission statement which is "to provide the highest quality healthcare at all times" and to do this in a way that is consistent with our values.

We also have a number of strategic objectives at the Trust to provide a link between our mission and vision statements, and the actions that we need to deliver them. We have developed five key objectives for the Trust, reflecting our mission and our values, they are to:

1. provide outstanding care for patients
2. deliver our financial plan and key performance targets
3. be in the top 20% of NHS employers
4. be a continually learning organisation
5. work effectively with local and regional partners

These objectives frame the practical steps we will take to help deliver our mission and vision statements and implement our Clinical Service Strategy.

"A commitment to our patients: our Clinical Service Strategy 2017-2022" sets out how we will improve the services that we offer and describes the type of Trust that we intend to be over the next five years.

The Clinical Service Strategy was published in September 2017 and sets out how we will develop our clinical services to meet the health needs of the people of Bradford and West Yorkshire. It outlines how we will work with partners to provide new, flexible models of care, tailored to meet the needs of patients and their families. It draws on discussions with our clinicians and staff, Commissioners, Healthwatch, our Trust Governors and other local stakeholders and was written following service user feedback.

As is the case with the rest of the NHS, the Trust faces many challenges due to a combination of a difficult financial climate, ageing population, rising public expectations, medical cost inflation, regulatory requirements and the competing demands for a specialist workforce.

In addition, Bradford and its surrounding district have a set of circumstances leading to significant growth in demand for health and care services, over and above the projections seen elsewhere. Population growth at each end of the age spectrum is significant, and when coupled with other factors such as pockets of deprivation, diet and housing, creates a challenging set of issues.

We have recognised that the way in which we operate has to be dynamic and open to change, both in terms of the treatments we offer, and the way we offer them. Quality must be at the heart of everything we do. It is

imperative that we embed a culture of safety into all of our processes; that we learn through our experience, and strive for ongoing improvement in patient outcomes. This makes it vital that we get the correct care models in place for future service provision, and with this in mind we have shaped the Clinical Service Strategy around four themes, each comprising specific actions:

1. **High quality care**

   We will

   - provide high quality healthcare, 24 hours a day, 7 days a week
   - take pride in being professional, compassionate and always putting safety first.

2. **Research-led care and learning**

   We will

   - capitalise on our outstanding research capacity, to make the Trust a national exemplar for applying research findings to clinical practice and in improving the health of our population
   - develop the Trust further as a centre of learning excellence and professional development.

3. **Collaborative hospital care**

   We will

   - develop the Trust as the hub for a range of specialised services in the west of West Yorkshire
   - work with other providers of acute hospital care, to best meet the needs of our shared patient populations.

4. **Connected local care**

   We will

   - support people to stay out of hospital where appropriate or be safely discharged as soon as they are ready, so that the defining feature of our approach is that we are "short stay by design"
   - work with local partners and contribute to the formal establishment of a responsive integrated care system
   - ensure the Trust remains closely connected to the community that it serves and becomes a "health-promoting hospital".

During 2018/19 the Trust managed care provision through three Clinical Divisions:	
Division of Medicine and Integrated Care	Emergency department, Acute Medicine, Renal, Diabetology/ Endocrinology, Infectious Diseases, HIV, Cardiology/Cardiorespiratory, Respiratory Medicine, Neurology/Neurophysiology, Dermatology, Rheumatology, Clinical Haematology, Oncology, Palliative Care, Stroke, Community Hospitals, Acute Elderly Wards, Virtual Ward, Dietetics/ Nutrition, Physiotherapy/Occupational Therapy, Clinical Psychology.
Division of Anaesthesia, Diagnostics and Surgery	Theatres, Anaesthesia, Day Case Procedures/Pre-assessment, Pain and Sleep, Intensive Care Unit, Trauma and Orthopaedics, Plastics, Breast, York Suite, Oral and Maxillofacial Surgery, Ophthalmology, Orthodontics, Ear Nose and Throat, Gastroenterology, General Surgery, Vascular, Urology, Radiology/Imaging/Clinical Physics, Radiation Physics, Pathology, Medical Illustration, Interpreting Services.
Division of Services for Women and Children	Services for Children, Maternity Services, Obstetrics and Gynaecology, Neonatal Services.
During 2017/18, one of the key steps towards implementing the Clinical Service Strategy has been for each of these clinical divisions to develop divisional plans each containing key priorities aimed at developing the services that we provide, in line within our mission and vision statements, so that we continue to meet the health care needs of our local population.	

In line with our mission and vision statements, so that we continue to meet the health care needs of our local population, during 2018/19, each of these clinical divisions has been actively implementing divisional plans which are aligned to the Clinical Service Strategy. These plans contain key priorities aimed at developing the services that we provide.

During 2018/19 the Trust has also worked towards implementing a new organisational structure for clinical operations. Clinical Business Units (CBUs) replaced the previous divisional structure. The new structure became operational from 1 April 2019.

2.1.4

HISTORY OF THE FOUNDATION TRUST AND STATUTORY BACKGROUND

Bradford Teaching Hospitals NHS Foundation Trust 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.

On 1 April 2004, Bradford Teaching Hospitals NHS Trust 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.

In addition to Bradford Royal Infirmary, the Trust has further sites at St Luke's Hospital, Westbourne Green, Westwood Park, Shipley, and Eccleshill Community Hospitals (currently not in use) and serves a population of around 530,000 people from Bradford and the surrounding area. We have approximately 900 acute beds, employ around 5,800 members of staff, and have more than 500 volunteers supporting our services. In year, our services deliver around 6,000 babies, perform over 300,000 operations and handle in the region of 500,000 outpatient appointments.

2.1.5

KEY ISSUES AND RISKS AFFECTING THE FOUNDATION TRUST

Directors have identified the principal risks that could impact the effective delivery of the Trust's objectives. These principal risks are as follows:

- failure to maintain the quality of patient services
- failure to recruit and retain an effective and engaged workforce
- failure to maintain operational performance
- failure to maintain financial stability
- failure to deliver the required transformation of services
- failure to achieve sustainable contracts with Commissioners
- failure to deliver the benefits of strategic partnerships
- failure to maintain a safe environment for staff, patients and visitors
- failure to meet regulatory expectations and comply with laws, regulations and standards
- failure to demonstrate that the organisation is continually learning and improving the quality of care for its patients

These principal risks are managed actively through a strategic risk register and are used to contextualise assurance within the Board Assurance Framework. The Integrated Governance and Risk Committee reviews all strategic risks (which are presented in a principal risk structure) each month, ensuring appropriate mitigation is in place and assuring its effectiveness. The Board Committees review the elements of the Board Assurance Framework and the strategic risk register for which they have a defined assuring role at each meeting, prior to its use at each meeting of the Board of Directors. This is to define the level of assurance associated with the delivery of the Foundation Trust's strategic objectives.

2.1.6

GOING CONCERN DISCLOSURE

After consideration of the contract position with commissioners, the control total offered by NHSI and forecast cash balances for 2019/20, the Directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

2.1.7

SUMMARY OF PERFORMANCE

The Trust has made improvements in how patients receive timely access to services. Performance against Cancer Standards and Referral to Treatment waiting times has significantly improved. Whilst performance against the Emergency Care Standard has been a challenge, this is against a background of increasing demand. There is a robust improvement programme in place and we are working closely with health and social care system partners to develop alternative pathways of care for patients in order to reduce demand on the Emergency Department. We also announced the launch our very own Command Centre which will be the first AI-powered hospital command centre; using digital innovation and proven best practices to deliver sustainable improvements in how we manage our patient flow and enable real-time co-ordination of care for each and every patient.

Infection control performance remains strong and whilst our overall CQC rating is 'Requires Improvement' progress towards 'Good' continues with the caring and well-led domains rated 'Good' at the last inspection.

Our staff continues to work hard to provide high quality, safe and timely care to our patients and this report details the achievements and challenges during 2018/19.

2.2 PERFORMANCE ANALYSIS

2.2.1

MEASUREMENT OF PERFORMANCE

The main regulatory body responsible for overseeing Foundation Trust performance is NHS Improvement (NHSI). The Trust has made monthly submissions to NHS Improvement throughout the financial year 2018/19.

The Trust continually measures its performance against a wide variety of key measures, including but not exclusive to:

- NHSI Single Oversight Framework
- National contract quality measures
- Local quality measures agreed with local Commissioners
- Internally agreed performance measures

As part of the NHSI Single Oversight Framework the Trust reports against a number of operational performance metrics:

- the Emergency Care Standard: A&E maximum waiting time of 4 hours from arrival to admission/ transfer / discharge
- maximum time of 18 weeks from point of referral to treatment (RTT) – patients on an incomplete pathway
- all cancers – maximum 62-day wait for first treatment from:
  - Urgent GP referral for suspected cancer
  - NHS cancer screening service referral
- maximum 6-week wait for diagnostic procedures

The Trust has submitted trajectories to NHSI against these metrics and is measured against these on a monthly, quarterly and yearly basis.

For relevant indicators the Trust uses the nationally-mandated definitions as provided by:

- National Contract Guidance
- NHSI Single Oversight Framework
- NHS Data Dictionary Definitions
- NHS Contract Technical Guidance

The Trust has a regular cycle of performance monitoring which incorporates:

- daily reporting against key indicators incorporating dashboard presentations
- weekly performance meetings with Clinical Divisions
- bi-monthly Clinical Division performance reviews conducted by Executive Directors
- monthly reporting to the Trust's Finance and Performance Committee

The Trust uses a variety of information resources to support analysis of performance using electronic data captured across a number of hospital systems.

Performance information is presented in a variety of ways incorporating:

- trend analysis
- red, amber, green ratings (RAG)
- dashboard presentations
- comparative analysis
- predictive trend analysis
- statistical Process Control charts

2.2.2

ANALYSIS OF PERFORMANCE

In what has been a difficult year for NHS access targets nationally, the Trust has struggled to achieve NHS Improvement Single Oversight Framework operational performance targets for the financial year 2018/19.

Levels of emergency demand via A&E and for emergency beds remained high throughout the year, continuing the trend of recent years, whilst elective access targets were also affected by continued demand for services.

The Trust did not achieve the monthly trajectories in 2018/19 for the Emergency Care Standard, RTT Incomplete threshold and 62-day wait for first treatment from urgent GP referral for suspected cancer.

In addition, the Trust did not achieve a number of monthly trajectories for the maximum 6 week wait for a Diagnostic procedure. Since the implementation of Electronic Patient Records (EPR) in September 2017, the Trust has been working to fully report all diagnostic tests relevant to the indicator.

NHS Improvement Single Oversight Framework – Operational performance metrics 2018/19 monthly performance.

Figure 1: NHSI Single Oversight Framework – operation performance metrics 2018/19 (monthly) shows the monthly performance against the Single Oversight operational metrics and underlines the challenges the Trust faces in financial year 2018/19 to recover the position.

Figure 1: NHSI Single Oversight Framework – operation performance metrics 2018/19 (monthly)

Metric	Threshold	Apr %	May %	Jun %	Jul %	Aug %	Sep %	Oct %	Nov %	Dec %	Jan %	Feb %	Mar %
RTT 18 weeks incomplete	≥92%	73.8	74.6	73.9	74.2	74.4	75.1	77.0	79.0	79.5	81.5	62.6	85.0
Emergency Care Standard	≥90%*	83.7	86.6	85.0	83.1	86.2	81.3	80.7	75.2	78.1	76.0	73.8	71.4
Cancer 62 day FT urgent GP referral	≥85%	73.5	68.7	60.2	70.2	62.5	68.3	62.3	61.7	70.3	73.2	63.9	71.7
Cancer 62 day FT following screening	≥90%	76.5	93.1	90.9	90.6	95.3	93.9	83.9	80.0	97.4	82.5	95.8	100.0
Maximum 6-week wait for diagnostic procedure**	≥99%	99.8	99.9	99.6	99.4	99.3	99.2	89.3	89.1	91.8	92.6	93.9	95.4

* Increased to 95% in October 2018 **Endoscopy reported from October 2018

Access key performance indicators

The Trust has experienced continued pressures against both elective and non-elective access targets, with continued demand via A&E and for emergency beds throughout the year.

The Emergency Care Standard was not achieved for the full financial year, with performance reported as 80.07%. The Trust did not achieve the threshold of 95% in any month of the financial year. For the full financial year attendances were 139,096 which represents an increase of 3.2% compared to 2017/18.

This volume represents the highest volume of attendances in the last nine years.

The A&E Department averaged 381 daily attendances in 2018/19 compared to 369 in 2017/18.

This position is reflected nationally, as most Trusts have experienced difficulties in achieving the threshold.

The RTT Incomplete threshold was not achieved in any month in 2018/19, however performance increased steadily throughout the year, reaching 85.0% in March 2019.

The NHSI Cancer threshold for Cancer 62 day first treatment was not achieved for the financial year 2018/19, with performance reported as 67.1%. The downturn in performance was due to a number of factors with clinical capacity remaining a constant challenge. The Trust continued to see large numbers of patients choosing to delay their treatment and is continually providing information to support patients to receive the best care available.

The NHSI Cancer threshold for Cancer 62 day screening was not achieved for the financial year 2018/19 with performance reported as 89.6% against the threshold of 90%.

Infection control key performance indicators

The Trust has reported continued excellent performance in the area of infection control.

The Trust performed better than the threshold applied to Clostridium difficile (a maximum of 51 cases) and will report 22 Clostridium difficile cases for the financial year 2018/19. This compares to 18 cases reported in the financial year 2017/18.

The Trust reported one Methicillin Resistant Staphylococcus Aureus (MRSA) case, attributed to the Trust, for the financial year 2018/19. This compares to 4 cases reported in the financial year 2017/18.

Commissioning for Quality and Innovation (CQUIN) 2018/19 performance

The Trust has delivered full achievement against a number of CQUINs however there are also a number of CQUINs where only partial achievement has been achieved. Full reconciliation of year end CQUIN achievement will take place in May 2019.

It is anticipated that the Trust will fully achieve the following CQUIN schemes:

- Activation System for Patients with Long Term Conditions
- Improving Haemoglobinopathy Pathways through Operational Delivery Networks (ODN)
- Quality, Innovation, Productivity and Prevention (QIPP) Incentivisation
- Offering advice and guidance
- Consistent coding for Oral Surgery and Oral Maxillofacial Surgery procedures

It is anticipated that the Trust will partially achieve the following CQUIN schemes:

- Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)
- Improving Staff Health and Wellbeing
- Improving Services for People with Mental Health needs who present to A&E
- Preventing Ill Health by Risky Behaviours - Alcohol and Tobacco

In 2018/19 there remained challenges in terms of achieving the national sepsis screening and antibiotic delivery targets however data collection has been significantly improved since the implementation of the EPR. A Sepsis nurse was appointed during the year to support improvements in sepsis screening and timely treatment beyond the scope of the CQUIN.

The Improving Staff Health and Wellbeing CQUIN was based on improving the results of three questions contained within the annual staff survey. This year the Trust did not improve in any of the three questions.

The Improving services for people with mental health needs who present to A&E CQUIN required the Trust to reduce the number of A&E attendances for a cohort of patients identified as patients who would benefit from mental health interventions. Despite strong collaboration with local agencies, including monthly multi-professional meetings, the Trust did not achieve the level of reduction necessary to fully achieve the CQUIN.

Financial Overview

Overview of Financial Performance for 2018/19

The Trust's financial plan for 2018/19, which was submitted to NHSI in April 2018, included a control total deficit excluding Provider Sustainability Funding (PSF) of £7.5m. Available PSF was £10.3m and the planned (control total) surplus including PSF was £2.8m.

The plan included a Cost Improvement Programme (CIP) savings target of £26.6m. The actual CIP savings for the year were £32.5m however this delivery was supported by non-recurrent financial efficiencies.

The reported pre-PSF deficit for the year was £26.6m. However, this includes a £19m impairment to the value of land and buildings asset and an adjustment

for depreciation on donated assets and donations for capital purchases. NHSI excludes these adjustments from its assessment of a Trust's operating results, and when these are removed the relevant pre-PSF deficit for the year is £7.5m, which is in line with the plan.

Actual full year PSF recovery notified by NHSI was £13.9m, which includes £7.2m of core PSF, £0.5m of Incentive PSF and £1.5m of Bonus PSF and a general distribution of PSF of £4.7m. Excluding the impact of the impairment, this results in a full year post-PSF surplus of £6.4m which is £3.6m ahead of plan.

Figure 2: Including Impairment and Figure 3: Excluding Impairment summarises how the position changed between 2017/18 and 2018/19:

Figure 2 - Including Impairment (£ million)

Details	17/18 Outturn	18/19 Plan	18/19 Actual	18/19 Variance	Change vs 17/18
Income excluding PSF	387.9	399.8	397.2	-2.6	9.3
Operating expenditure	-378.1	-387.9	-396.2	-8.3	-18.1
EBITDA	**9.9**	**11.9**	**1.0**	**-10.9**	**-8.8**
Non-operating expenditure	-16.3	-19.7	-8.6	11.1	7.7
Impairment	-14.6	0	-19.0	-19.0	-4.4
Pre-PSF margin	**-21.1**	**-7.8**	**-26.6**	**-18.8**	**-5.5**
PSF	13.5	10.3	13.9	3.6	0.4
Post-STF margin (with impairment)	**-7.6**	**2.5**	**-12.7**	**-15.2**	**-5.1**

Figure 3 - Excluding Impairment (£ million)

Details	17/18 Outturn	18/19 Plan	18/19 Actual	18/19 Variance	Change vs 17/18
Pre-PSF margin	-21.1	-7.8	-26.6	-18.8	-5.5
Adjust for Impairment	14.6	0	19.0	19.0	4.4
Adjust for depreciation on donated assets and donations for capital purchases	-0.6	0.3	0.1	-0.2	0.7
Adjusted Pre-PSF margin	**-7.1**	**-7.5**	**-7.5**	**0.0**	**-0.4**
PSF	13.5	10.3	13.9	3.6	0.4
Post-PSF margin (without impairment)	**6.4**	**2.8**	**6.4**	**3.6**	**0.0**

In 2018/19, the Trust invested £8.325m in capital expenditure and ends the year with a relatively strong liquidity position throughout the year resulting in an end of year cash balance of £21.2m.

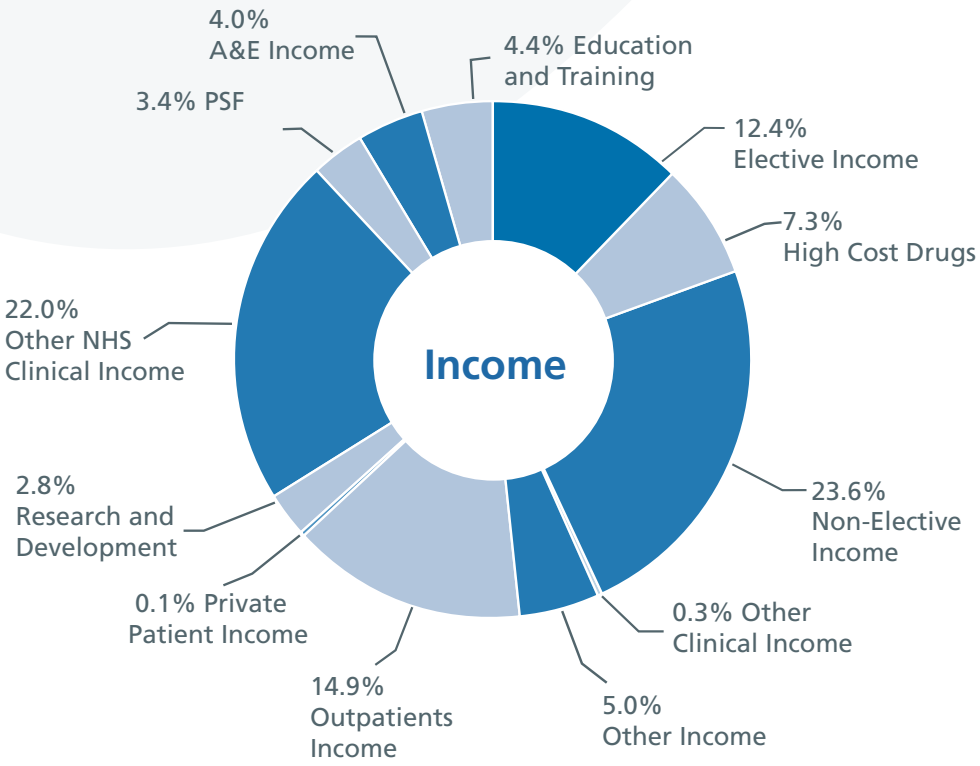
Income

The total income, including PSF, reported for the 2018/19 financial year was £411.1m, which is split as follows:

- clinical Income - £346.7m
- other Operating Income - £50.5m
- PSF - £13.9m

A more detailed breakdown of income in 2018/19 is provided in Figure 4: breakdown of income in 2018/19.

Figure 4: Breakdown of income in 2018/19.



NHS clinical income is primarily income from Clinical Commissioning Groups (CCGs) and NHS England in relation to the provision of patient treatment services under contractual and commissioning arrangements. Other income is primarily non-patient related income and includes income for education and training, research activities, catering, car parking and other services.

NHS Clinical income was (£13.8m) adverse to plan. This reflects lower than expected income for elective activity (£6.1m), non-tariff drugs (£4.9m) and other clinical income (£4.2m). This is partially offset by increased outpatient income £1.2m and A&E income £0.2m.

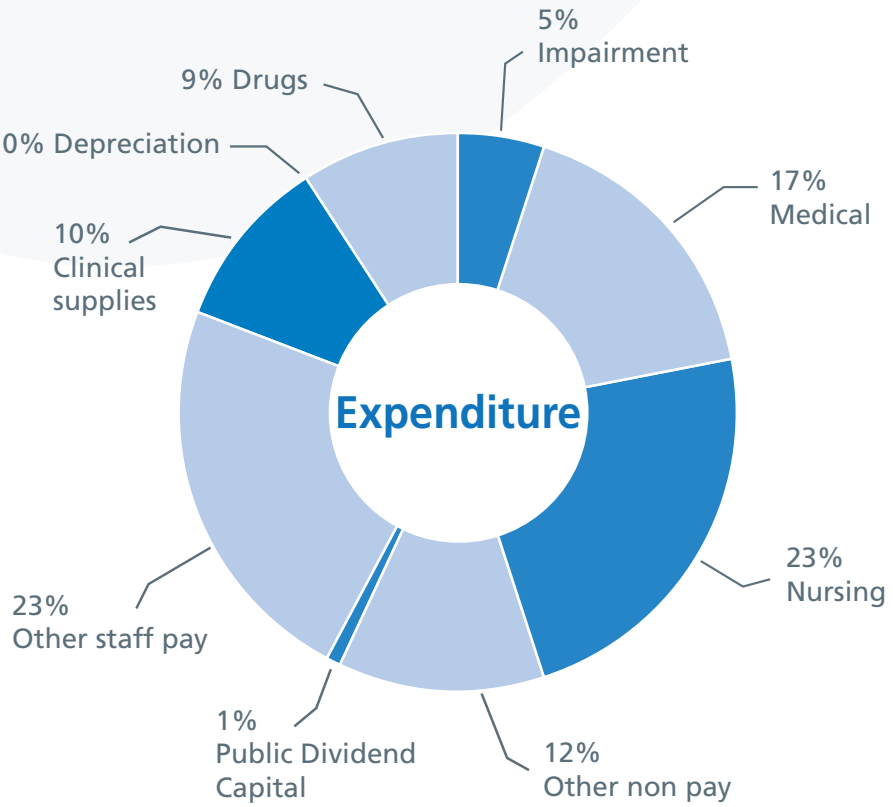
Expenditure

Including the impairment, the total expenditure reported for 2018/19 was £418.6m, which is split as follows:

- payroll bill for employed and agency staff: £263.1m
- non-pay costs including drug costs: £127.9m
- financing costs including depreciation and Public Dividend Capital: £8.6m
- impairment (nil cash impact): £19.0m

A more detailed breakdown of expenditure in 2018/19 is provided in Figure 5: Expenditure breakdown 2018/19.

Figure 5: Expenditure breakdown 2018/19



Excluding the impairment, the Trust incurred overspends in the following areas against the annual plan:

Pay cost overspends associated with

- additional nursing costs for 1:1 patient care and
- premium rate payments for waiting list initiatives

Non-pay overspends associated with:

- sub-contracting elective and outpatient work to independent sector providers to meet waiting time targets
- the prescribing of tariff drug and blood products

However, these were offset by non-recurrent financial benefits.

Efficiency Requirements

The annual financial plan determined that delivering the control total surplus of £2.8m required the Foundation Trust to secure efficiencies of £26.6m mainly through the delivery of CIPs that deliver real cash-releasing savings. Income and Expenditure pressures emerging within the financial year meant total efficiencies of £32.5m were ultimately required to meet the financial control total.

The efficiency plans have been delivered through a cost improvement programme carried out across the clinical divisions and support service departments. In addition, a number of trust-wide schemes have been commissioned to support the delivery of CIPs. CIP delivery was £32.5m, which was higher than planned, however much of this improvement is recognised as non-recurrent, and therefore must be found again next financial year in addition to the 2019/20 target.

Looking Forward to 2019/20

The financial outlook for the forthcoming and future years continues to pose a significant financial challenge which will need to be delivered through an extensive efficiency programme at a time of ever

increasing expectations for improving the quality and safety of healthcare and increasing demand. To both maintain and improve the quality and safety of services provided, all efficiency initiatives will undergo a robust Quality Impact Assessment (QIA) and will not be progressed unless the QIA is approved.

For the forthcoming years, the Trust will continue to link the delivery of efficiency gains with service improvement and transformation through the Bradford Improvement Programme. Improving the quality of care by removing waste and inefficient processes will in turn lead to a better patient experience.

The pre-PSF control total for 2019/20 is a deficit of £12.5m. Available PSF and Financial Recovery Fund (FRF) is £12.5m, which if recovered would allow the Trust to meet the breakeven post-PSF control total for 2019/20.

The cash and liquidity position is forecast to become increasingly challenging in 2019/20 and delivery of the required financial efficiencies will be crucial to supporting these metrics.

Key Financial Risks

The Trust started 2018/19 with a number of significant financial risks, which have been partially managed through the delivery of the financial position highlighted above.

The main financial risks for 2019/20 are as follows:

- managing within budgetary control targets and delivering the efficiency targets against a backdrop of inflationary cost pressures, service developments, demand increases and quality improvement initiatives
- delivery of a cost improvement target of £16.2m required to meet the breakeven control target surplus set by NHSI. £3m of the £16.2m efficiency target is to be addressed jointly with the Bradford and Airedale system as a shared system wide efficiency target
- delivering the contracted activity levels and ensuring robust, timely counting and charging processes are in place to facilitate monthly reporting; and
- maintain liquidity and delivery of the capital programme

In addition to maintaining strong financial management arrangements, the main contingencies identified to mitigate against the above risks should they materialise are to:

- identify further productivity and efficiency initiatives both at a Clinical Business Unit (CBU) level and centrally-driven
- identify non-recurrent measures that will release savings in-year
- closely monitor progress on access targets using the capacity review provisions within the contract to mitigate the potential loss of STF income
- the Trust has agreed a new contract form with the Bradford and Airedale CCGs which guarantees a fixed income level for the Trust in 2019/20 and is not variable based on Payments by Results (PbR). This fixed income level provides stability for both the Trust and its Commissioners and allows the system to focus on transformational change and cost reductions to jointly manage a shared financial position. Contracts with the Trust's other Commissioners remain variable on a PbR basis
- implement detailed monitoring and management of performance against contractual indicators, with rigorous internal mechanisms for targeting both delivery and improvement
- generate additional income contribution through increased market share of elective and outpatient activity.

Bradford Improvement Programme

The Trust will continue to implement the approach to financial and performance improvement in 2019/20, known as the Bradford Improvement Programme. This is overseen by the Bradford Improvement Programme Board, which has a robust project management approach and individual programmes led by Executive Directors, clinicians and transformation leads with the onus on delivery at the front line by clinicians and Clinical Business Units (CBUs) teams which replaced the organisations divisional structure from 1April 2019. Quality Improvement is integral to the programmes and each efficiency plan must follow the defined process. Each programme has a series of milestones to facilitate timely delivery, as well as key metrics against which performance can be demonstrated and judged.

The Bradford Improvement Programme Board has identified, and is pursuing, a number of both transformational and operational programmes that will drive delivery of the improvement agenda to enable the continuous journey to being a high quality organisation that puts patients first. The main transformational improvement programmes are as follows:

- Elective Care Improvement
- Outpatient Improvement
- Workforce Improvement

The main operational improvement programmes are as follows:

- Model Hospital
- Going Digital
- Procurement and Medicines Spend

The Trust continues to pursue improvements in value for money for the services it provides, together with the drive for improvements in the qualitative aspects of care. This has been demonstrated through the continued investment in the infrastructure and estate to provide modern, fit for purpose facilities and meet nationally prescribed standards.

The CBU annual plans and the capital programme also identify a number of schemes and service developments that will:

- enhance service delivery
- align capacity to ensure services are provided from the optimum location; and
- deliver real qualitative improvements to the services provided

The Trust's Programme Management Office and Transformation team are working closely with the CBUs to secure sustainable and tangible change throughout the organisation. The remit of the teams, working in partnership with clinicians and CBU managers is to:

- facilitate change and innovation
- maximise efficiency and productivity
- instil a culture of continuous improvement
- train staff in improvement tools and techniques; and
- co-ordinate programmes of improvement work

Through working with services and clinical teams to challenge existing processes, the significant outcomes will be clinician-led redesign of services and processes together with measurable efficiency, productivity and financial gains.

Cash and Statement of Financial Position

The cash position has decreased to £21.2m (2017/18 £25.6m) which is largely due to an in-year deficit in operating costs and capital investment.

Long Term Borrowing

The Trust secured a loan of £10m over 10 years from the Department of Health and Social Care (DHSC) (formerly the Independent Trust Finance Facility). The final loan has now been fully repaid with the final principal repayment made in January 2019. This loan was used to fund a modular ward block at the BRI site. Further loans from the DHSC have been taken to finance the capital investment strategy:

- a loan of £20m was secured over 20 years to fund the New Hospital Wing. A total of £20m has been drawn down and repayments totalling £3.156m have been made, with the final principal repayment due in February 2035.
- a loan of £16m was secured over 8 years to finance the investment in the Electronic Patient Record. A total of £16m has been drawn down and repayments totalling £4m have been made, with the final principal repayment due in November 2024.

The date each loan was secured and first repayment dates are shown in Figure 6 and the balances outstanding on each of these loans is shown in Figure 7.

Figure 6: Loan dates

Loan	Date Secured	First Repayment Date
Loans from DHSC – Ward Block 1	21 January 2009	27 July 2009
Loans from DHSC – New Hospital Wing	12 March 2015	18 August 2015
Loans from DHSC – Electronic Patient Record	13 April 2015	18 May 2017

Figure 7: Loan balances

	31 Mar 19 £000	31 Mar 18 £000
Current		
Loans from DHSC – Ward Block 1	0	1,000
Loans from DHSC – New Hospital Wing	1,052	1,052
Loans from DHSC – Electronic Patient Record	2,000	2,000
Salix Loans	0	38
Total	**3,052**	**3,090**

	31 Mar 19 £000	31 Mar 18 £000
Non-Current		
Loans from DHSC – Ward Block 1	0	1,000
Loans from DHSC – New Hospital Wing	15,792	16,844
Loans from DHSC – Electronic Patient Record	10,000	12,000
Total	**25,792**	**28,844**

Investments

The Trust does not have any investments in subsidiaries. However, during 2016/17 the Trust entered into two joint venture limited liability partnerships (LLPs), each with 50% equity investment, with Airedale NHS Foundation Trust, with losses limited to £1 each. The joint ventures, Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP, have been established to deliver and develop laboratory based pathology services.

The Trust invests any short term cash surpluses in the Government Banking Service and the National Loans Fund Temporary Deposit facility in line with the approved policy.

Capital Programme

Capital investment totalling £8.3m was made during the year. The main elements of the capital programme are shown in Figure 8.

Figure 8: Capital Investment

Scheme	£ million
Information Technology Schemes	3.6
Medical Equipment	0.9
Buildings and Engineering Maintenance and Upgrade	1.2
New Building Schemes & Other Strategic Investments	2.7
Total	**8.3**

2.2.3

ENVIRONMENT AND SUSTAINABILITY

The Trust is committed to the UK's Climate Change Act 2008, which has legally binding targets of reducing carbon emissions by 28% by 2020 and 80% by 2050, measured against a 2013 baseline. As a healthcare provider, employer and purchaser of goods and services, the Trust recognises that it has a significant impact on the environment and acknowledges its role in promoting sustainability and improving environmental performance.

The Trust aims to be in the top 20% of NHS employers and to provide the best possible work environment for its staff and recognises the impact that the environment in which people live has on their health. Therefore, by becoming more sustainable, and through caring for the environment, the Trust can help improve the lives of the people in its care.

The Trust has a continuing strong commitment to reduce the level of energy and resource consumption and to correspondingly reduce the cost of service delivery. The Trust seeks to eliminate wasteful practices leading to an overall reduction in energy waste and cost and also seeks to collaborate effectively with local and regional partners in doing so.

The Trust has to demonstrate its continual environmental performance by presenting, in the publicly accessed areas, a Display Energy Certificate (DEC). A DEC shows the 'operational rating' of the building, based on its actual carbon emissions compared to what would be considered typical for the type of building, where zero is the best rating and a rating over 150 is the worst. This is then benchmarked on an A-G scale, where A is the best. It should be noted that a rating of 100 is a typical hospital building. The ratings equate to Bradford Royal Infirmary being categorised as D on the A-G scale, and the Horton Wing at St Luke's Hospital being categorised as B.

Additionally, performance was affected by significant periods of adverse weather over winter 2018 (for example 'Beast from the East'). While the design and construction of the new hospital wing at Bradford Royal Infirmary embraces energy efficiency building standards, the increase in floor areas has had an impact on the operational rating.

Figure 9: Display Energy Certificate Performance for the main building at Bradford Royal Infirmary (Please note typical hospital operational rating equals 100 with 0 being the best rating).

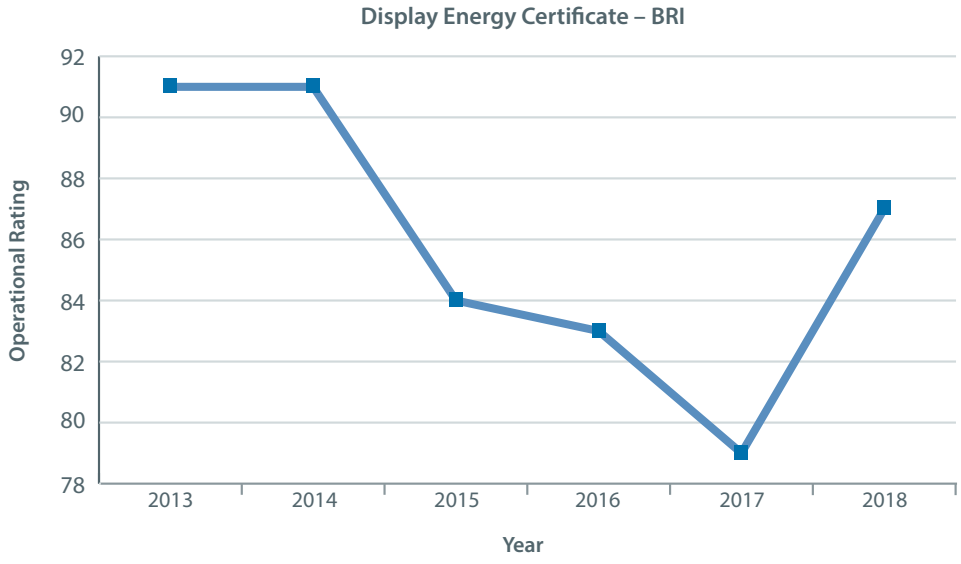


Figure 10: Display Energy Certificate Performance for Horton Wing Building at St Luke's Hospital (Please note typical hospital operational rating equals 100 with 0 being the best rating)..

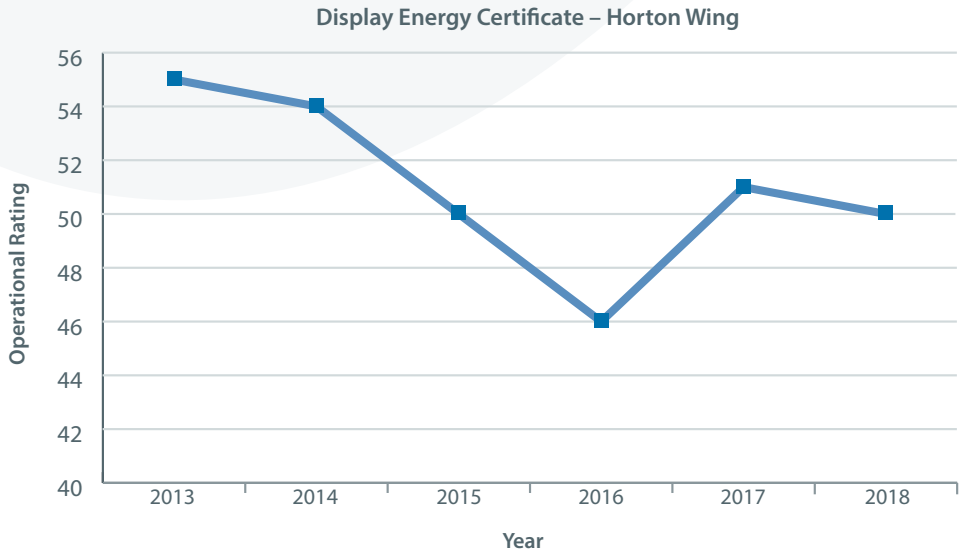
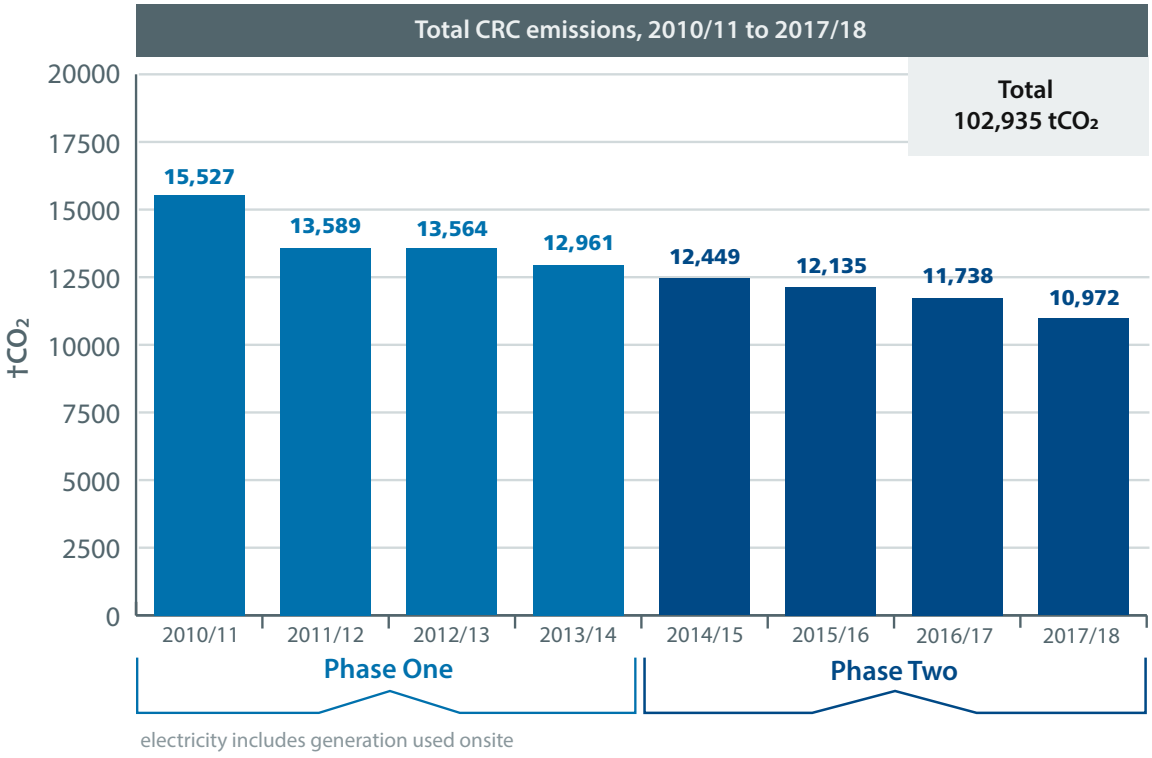


Figure 11 shows that the Trust has reduced its building operational carbon emissions by 29.3% in the past eight financial years. In terms of the Climate Change Act 2008 target of 28% reduction by 2020 against a 2012/13 baseline, we are currently achieving a 19.1% reduction on our externally verified gas and electricity consumption.

Figure 11: Bradford Teaching Hospitals NHS Foundation Trust - Carbon Reduction Commitment (CRC) energy efficiency scheme performance 2010 - 2018.



electricity includes generation used onsite

The Trust Utilities Consumption Group is continually investigating ways to operate the hospital more sustainably, for example, by assessing further investment opportunities in energy efficient technologies and introducing energy saving initiatives. Therefore, the Trust continues to strive to reduce its impact on the environment.

The Trust has also been awarded £82,000 by NHS Improvement to upgrade the lighting in patient occupied areas throughout the Bradford Royal Infirmary site which complements the LED lighting project carried out in the 2017/18 financial year.

The Trust submits data for the Estates Returns Information Collection (ERIC), which is a mandatory collection for all NHS trusts. This includes information relating to the costs of providing, maintaining and servicing the NHS estate, including energy use; we expect data for 2018/19 to be published on the gov.uk website in October. Figure 12: Bradford Teaching Hospitals NHS Foundation ERIC Return 2017/18 comparing NHS Acute Teaching Hospitals energy consumed per patient occupied floor area and Figure 13: Bradford Teaching Hospitals NHS Foundation ERIC Return 2017/18 comparing NHS Acute Teaching Hospitals Carbon emissions per occupied floor area shows the 2017/18 ERIC return for Carbon Emissions and Energy consumed per square metre. As can see the Trust performs strongly in comparison to its ERIC peer group.

Figure 12: Bradford Teaching Hospitals NHS Foundation ERIC Return 2017/18 comparing NHS Acute Teaching Hospitals energy consumed per patient occupied floor area

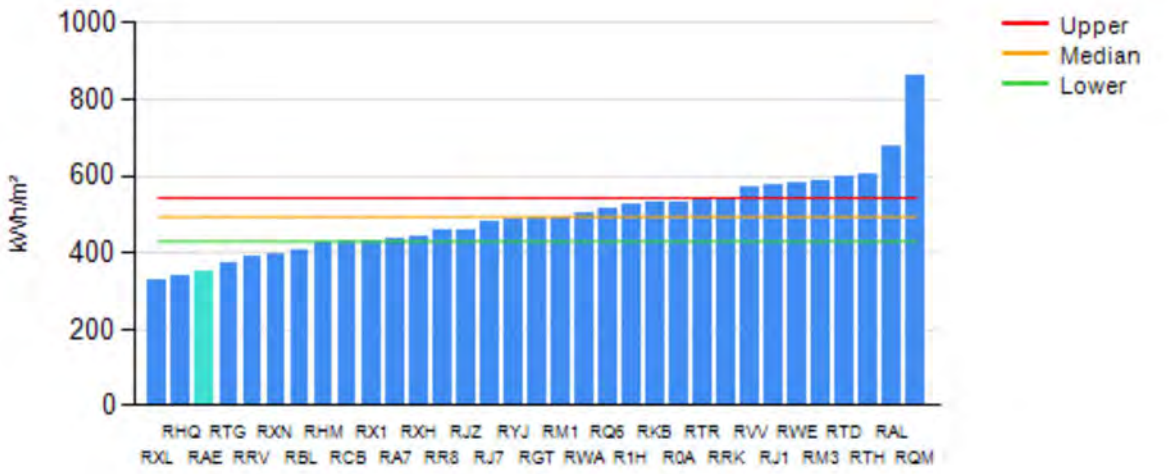
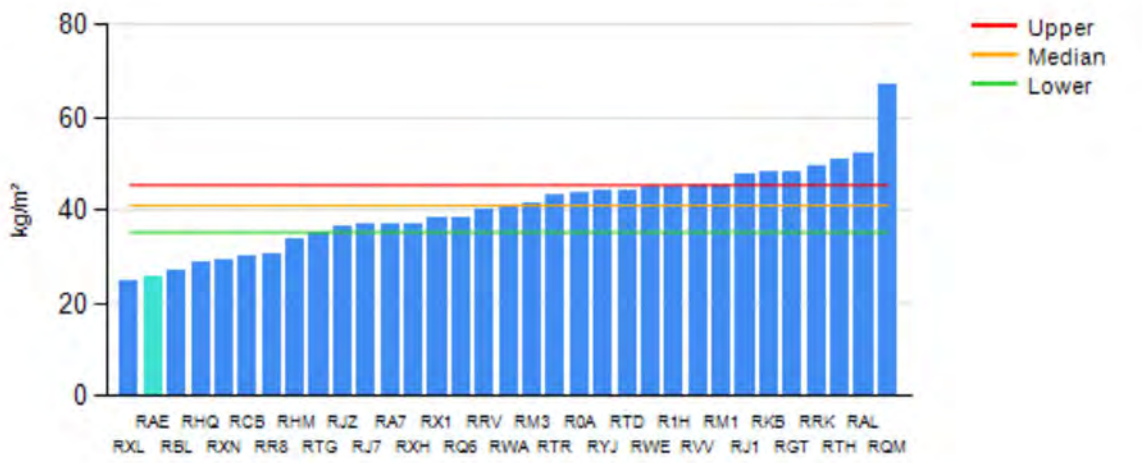


Figure 13: Bradford Teaching Hospitals NHS Foundation ERIC Return 2017/18 comparing NHS Acute Teaching Hospitals Carbon emissions per occupied floor area.



Bradford Teaching Hospitals NHS Foundation Trust – Second position = 25.85 kg/ m2

2.2.4

SOCIAL, COMMUNITY, ANTI-BRIBERY AND HUMAN RIGHTS: ISSUES AND POLICIES

The Trust has forged strong links with the local communities it serves. We work in partnership with other local health economy partners on shared equality objectives and consult with the local community on our progress. These issues are very important to this Trust so we have opted to include a full Equality Report in section 3.4. This covers employment, training and hate crime reporting.

Information about the Trust's anti-fraud, bribery and corruption policy can be found in section 3.3.2 on Staff Policies and Actions.

2.2.5

OVERSEAS OPERATIONS

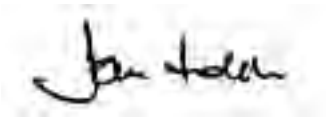
The Foundation Trust has no overseas operations.

2.2.6

EVENTS SINCE YEAR END

No significant events occurred between the end of the 2018/19 financial year and submission of this report to NHS Improvement.

Signed



John Holden

Acting Chief Executive

24 May 2019

3.1 DIRECTORS' REPORT

3.1.1

THE BOARD OF DIRECTORS

Our Board of Directors is responsible for all aspects of the operation and performance of the Trust, and for its effective governance. This includes setting the corporate strategy and organisational culture, taking those decisions reserved for the Board, and being accountable to stakeholders for those decisions.

The Board of Directors is a unitary Board. This means that within the Board of Directors, the Non-Executive Directors and Executive Directors make decisions as a single group and share the same responsibility and liability. All Directors, Executive and Non-Executive, have responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

The Board of Directors also has a framework of local accountability through members and a Council of Governors. The Council of Governors is responsible as a Council for holding the Non-Executive Directors, individually and collectively, responsible for the performance of the Board. In turn, our Governors are accountable to our Trust Members and key partners who elect or appoint them. Governors must represent their interests and those of the public.

The Council of Governors has established a Policy for Engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the provider licence or other matters related to the general wellbeing of the Trust.

The statutory duties and responsibilities of the Council of Governors are presented in section 3.5.2.

The Board reviewed the Reservation of Powers to the Board and Scheme of Delegation in November 2017. Matters reserved to the Board include:

- defining the strategic aims and objectives of the Trust
- annual approval of revenue and capital budgets
- approval of organisational structures to facilitate the discharge of business by the Trust

The Scheme of Delegation sets out the detailed arrangements for the delegation of budgetary control and financial procedures to the Executive Directors and is available in full on the Trust's website along with the Board of Directors Standing Orders which includes the terms of reference for all Board Committees.

The Board of Directors is responsible for the preparation of the Annual Report and Accounts. The Board considers whether the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

The tenure of Dr Tanya Claridge concluded in year. There are no other Executive Directors who have resigned or whose tenure was either terminated or concluded in-year. Professor Clive Kay's resignation as Chief Executive was effective on 31 March 2019.

Figure14: Composition of the Board of Directors – Executive Directors

Executive Directors			
Name	Role	Current Appointment	
		From	To
Professor Clive Kay	Medical Director Interim Chief Executive Chief Executive	1 November 2006 1 September 2014 11 December 2014	31 August 2014 10 December 2014 31 March 19
Ms Pat Campbell*	Director of Human Resources	1 December 2008	Present
Dr Tanya Claridge*	Director of Governance and Corporate Affairs	1 April 2018	30 September 2018
Ms Karen Dawber	Chief Nurse	29 August 2016	Present
Ms Cindy Fedell*	Director of Informatics	13 September 2013	Present
Dr Bryan Gill	Medical Director	5 May 2015	Present
Mr John Holden*	Director of Strategy and Integration Director of Strategy and Integration / Deputy Chief Executive	22 August 2016 1 May 2018	1 May 2018 Present
Mr Matthew Horner	Acting Director of Finance Director of Finance	1 November 2011 1 August 2012	31 July 2012 Present
Sandra Shannon*	Acting Chief Operating Officer Chief Operating Officer Chief Operating Officer / Deputy Chief Executive	8 January 2018 1 April 2018 1 May 2018	31 March 2018 1 May 2018 Present
* Non-voting Executive Director			

Figure 15: Composition of the Board of Directors - Non-Executive Directors

Non-Executive Directors			
Name	Role	Current Appointment	
		From	To
Ms Trudy Feaster-Gee	Non-Executive Director	1 January 2018	31 December 2021
Dr Trevor Higgins	Non-Executive Director Deputy Chair Acting Chair BTHFT Deputy Chair Acting Chair BTHFT	21 May 2012 1 November 2013 1 June 2016 1 November 2016 1 February 2019	20 May 2018 31 May 2016 31 October 2016 31 January 2019 20 May2019
Mr Amjad Pervez	Non-Executive Director Non-Executive Director	1 February 2015 1 February 2018	31 January 2018 31 January 2021
Mr Jon Prashar	Non-Executive Director	1 February 2018	31 January 2021
Mr Barrie Senior	Non-Executive Director	1 December 2017	30 November 2020
Professor Laura Stroud	Non-Executive Director	23 October 2017	22 October 2020
Mrs Selina Ullah	Non-Executive Director Senior Independent Director Acting Deputy Chair	1 September 2015 1 November 2018 1 February 2019	31 August 2018 31 August 2020 20 May 2019

Figure 16 lists the Non-Executive Directors who are considered to be independent, in line with the requirements included within the Foundation Trust Code of Governance.

Figure 16: Independent Non-Executive Directors

Independent Non-Executive Directors
Ms Trudy Feaster-Gee
Dr Trevor Higgins
Mr Amjad Pervez
Mr Jon Prashar
Mr Barrie Senior
Mrs Selina Ullah

Figure 17: Former Non-Executive Directors

Former Non-Executive Directors (Directors who resigned or whose term of office ended during the year)			
Name	Role	Appointment Dates	
		From	To
Professor Bill McCarthy	Non-Executive Director Chair Chair of both Nominations and Remuneration Committees	1 November 2015 1 November 2016 1 November 2016	31 October 2016 31 January 2019 31 January 2019
Mrs Pauline Vickers	Non-Executive Director Senior Independent Director	1 November 2013 1 December 2016	31 November 2018 31 November 2018

The Trust's Constitution sets out the circumstances that would disqualify an individual from holding a directorship and should any of those circumstances become applicable to a Non-Executive Director, their appointment would be terminated. Other circumstances that would result in termination of a Non-Executive Directors appointment are laid out in the Terms and Conditions agreed with the Non-Executive Director at appointment.

If the Council of Governors is of the opinion that it is no longer in the interests of the National Health Service that the individual continues to hold office then, subject to the provisions of the Constitution, an appointment may be terminated with immediate effect. The Council of Governors will consider each case on its merits, taking account of all relevant factors. These include;

if a Non-Executive Director fails to meet the requirements of the Fit and Proper Persons Test as set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended or supplemented from time to time)

- if an annual appraisal or sequence of appraisals is unsatisfactory
- if the Non-Executive Director fails to deliver work against pre-agreed targets incorporated within their annual objectives
- if there is a terminal breakdown in essential relationships, for example, between a Non-Executive Director and the Board of Directors
- non-compliance with the requirements of the Standing Orders of the Trust with regard to pecuniary interests in matters under discussion at meetings of the Trust (e.g. a failure to disclose such an interest)
- non-attendance at a meeting of the Trust for a period of three months unless the Council of Governors is satisfied that the absence was due to a reasonable cause and the Non-Executive is able to attend within such time as is considered reasonable
- the Non-Executive ceases to be independent within the meaning of the NHS Foundation Trust Code of Governance

The appraisal processes for the Chair and Non-Executive Directors were reviewed and approved by the Council of Governors in April 2018. All appraisals have been carried out in line with the processes agreed. The positive reports from the Chairman on the Non-Executive Director appraisals and from the Senior Independent Director on the Chair's appraisal were received by the Council of Governors in October 2018 and in January 2019 respectively.

Performance evaluation and reviews of the Board, its Committees and its Directors have taken place in year. Further details are included within section 3.1.3.

Register of Interests

The Board of Directors undertakes an annual review of the Register of Declared Interests. At each meeting of the Board of Directors and the Council of Governors, there is a standing agenda item that also requires Board members and members of the Council of Governors to make known any interest in relation to the agenda, and any changes to their declared interests.

The Register of Declared Interests for the Board of Directors and Council of Governors is maintained by the Foundation Trust Secretary. The registers are available to the public online at the following web address:

https://www.bradfordhospitals.nhs.uk/our-trust/lists-and-registers/ and are also available by request from The Foundation Trust Secretary, using the details below:

Trust Secretary
Trust Headquarters
Bradford Royal Infirmary
Bradford, BD9 6RJ

Telephone: 01274 36 4790

3.1.2

BETTER PAYMENT PRACTICE CODE

The Better Payment Practice Code requires organisations to aim to pay all valid undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. As an NHS Foundation Trust, the Trust is not bound by this code, but seeks to abide by it as it represents best practice.

The Trust aims to improve transactional processing to pay creditors within this target whilst maintaining a balance on appropriate authorisation and validation of invoices. Adherence to the code has improved for payments to both NHS and non NHS organisations with performance improving by number and value.

Figure 18: Better Payment Practice Code

	2018/19		2017/18	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	55,793	200,734	66,915	206,060
Total Non-NHS trade invoices paid within target	45,743	172,610	50,612	168,453
Percentage of Non-NHS trade invoices paid within target	83%	86%	76%	82%
Total NHS trade invoices paid in the year	3,268	14,699	3,139	18,144
Total NHS trade invoices paid within target	2,367	10,948	2,200	13,100
Percentage of NHS trade invoices paid within target	73%	75%	70%	72%

3.1.3

ENHANCED QUALITY GOVERNANCE REPORTING

The Trust's approach to Quality and Quality Governance is presented in detail section 3.8 Annual Governance Statement section of the Annual Report and 3.4.4 Quality Management System section of the Quality Report.

REVIEW OF GOVERNANCE AGAINST THE WELL-LED FRAMEWORK

The Trust was inspected by the CQC in February 2018 (the report being published on the 15 June 2018). The Trust's rating for the well-led domain improved. It was rated as good because:

- although there were some areas identified for improvement in leadership, management and culture within some of the services inspected, the CQC were sufficiently assured of the Trust's overall leadership, management and culture following their trust-wide well-led inspection
- three of the four core services inspected by the CQC in the unannounced inspection in January 2018 were rated as good for the well led domain and one as requiring improvement
- the CQC concluded that the Trust's vision and values had been shared and were understood by staff and that there was effective local leadership; staff were motivated and focused on team work
- the CQC also concluded that there was routine engagement with patients, staff, the public and local organisations to plan and manage services. They described a culture of continual improvement and research and innovation to improve the quality of the Trust's services
- The CQC also confirmed that services had systems for identifying and mitigating risks and that departmental risk registers were used effectively to manage local risks.

During 2018/19 the Trust continued its implementation of a Well-led action plan which had been developed following a review of the Well–Led Domain by Deloitte in 2017, which addressed opportunities for change and improvement identified in the CQC report. The Trust continued to test the effectiveness of the action plan through established assurance mechanisms, including internal audit.

PARTNERSHIPS

Health and social care organisations are working ever more closely together to meet the needs of their local population. Partnership working enables more joined up care to be offered to patients and helps ensure they are treated in the way most suitable to their needs. Many of the challenges facing the NHS can only be addressed through collaborative working. This collaborative working includes working with other NHS organisations, social care and the voluntary and community sectors.

Therefore the Trust has put considerable emphasis on the need to form effective partnerships in its clinical strategy. Two of the Trust's four themes in its clinical strategy are directly related to partnerships, these are: Collaborative Hospital Care and Connected Local Care.

Collaborative Hospital Care

During 2018/19, the Trust has worked closely with its partner acute Trusts across West Yorkshire including:

- Establishing a wide ranging programme of collaboration, that will cover all secondary care services, with our near neighbour, Airedale NHS Foundation Trust. This work will help ensure that services for our shared patient population remain robust and sustainable into the future. Recently aprogramme management office and programme governance was set up to oversee the programme for the next 2 years. A joint programme manager was also appointed between the two Trusts to help them develop a single service model for stroke services; this work has resulted in a significant improvement in the external rating of the service at both Trusts.
- Working closely with our partners through the West Yorkshire Association of Acute Trusts[1] (WYAAT) to improve care for patients and deliver efficiencies through a number of joint projects. A specific example is the work WYAAT is undertaking to establish a single West Yorkshire Vascular Service, which will have two arterial surgical centres, one of which will be located at Bradford Royal Infirmary. The WYAAT Trusts are also working together to use their collective purchasing power to reduce the cost of procurement, as well as creating technology solutions that allow Trusts to more easily share results of diagnostic imaging.
- Consolidating the progress made in the established joint venture (Integrated Pathology Solutions LLP) between Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust to deliver pathology services. This continues to deliver benefits including economies of scale, shared expertise and delivering high quality diagnostic services to other primary and secondary care providers.

[1] WYAAT is an innovative collaboration which brings together the NHS Trusts who deliver acute hospital services across West Yorkshire and Harrogate. WYAAT comprises Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and The Mid Yorkshire Hospitals NHS Trust.

Connected Local Care

During 2018/19 the Trust has worked closely with its partner organisations to develop connected local care, both across West Yorkshire and Harrogate and with partners in Bradford District and Craven. It has done this by:

- Being an active and committed member of the West Yorkshire and Harrogate Health and Care Partnership. The Partnership consists of organisations from across health and social care and the voluntary and community sector. The Trust agreed to sign up to the Partnership's Memorandum of Understanding (MoU) at its board meeting in September 2018. The Partnership is designed to enable its partners to work more closely together to improve health and social care services across West Yorkshire and Harrogate. Members of the Trust board play an active role in a number of the different programmes established by the Partnership. For example, Cindy Fedell, the Trust's Chief Digital and Information Officer, was recently appointed as the Senior Responsible Officer for the Partnership's Digital and Interoperability programme.

- Being an equally active and committed participant in partnership work across Bradford District and Craven. The Trust is a signed up member of the Bradford Provider Alliance and, as part of the Bradford Health and Care Partnership Board and the district-wide Integration and Change Board, is working to deliver the Happy, Healthy at Home vision for the future of health and care in Bradford District and Craven;

At the March 2019 Board meeting, the Trust agreed to sign a Strategic Partnering Agreement between the health and social care partners in Bradford District and Craven. This sets out how collaboration and decision making will take place in the future;

- Working with local partners to implement a new model of care for people with diabetes in Bradford and to improve the provision of Out of Hospital Care
- Representation on Bradford's ten Community Partnerships, which aim to provide services based on the needs of a population of 30,000 - 60,000 people
- Continuing to be the host organisation for the Well Bradford programme. Well Bradford works with local partners to deliver projects in the community with the aim of improving the overall health outcomes and wellbeing of three areas – Keighley, Holme Wood and Girlington. All areas share three objectives which are to provide green spaces and healthy places, to create social mobility for individuals and families and strengthen the existing communities. Over the last 12 months, progress has been made across all areas. A highlight of the past year has been the progression of the Green Mile project in Girlington. The Green Mile project has progressed to the implementation phase and the route is aiming to go live in the first quarter of 2019/20 – this is a much anticipated event with local schools intending to utilise the route for their students.

3.1.4

INFORMATION ON FEES AND CHARGES (INCOME GENERATION)

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. None of these schemes exceed £1 million nor are they sufficiently material to warrant separate disclosure. The revenues and expenditure relating to these schemes are included in the annual accounts.

3.1.5

INCOME DISCLOSURES

As required under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Trust confirms that the income it received from provision of goods and services for the purposes of the health service in England is greater than the income it received from the provision of goods and services for any other purpose. Furthermore, the generation of "non-NHS related income" does not impact adversely on the quality of healthcare services delivered by the Trust.

3.1.6

AUDIT DISCLOSURES

For each individual who is a Director at the time that this report was approved:

- so far as the Director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and
- the Director has taken all reasonable steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information, and to establish that the NHS Foundation Trust's auditors are aware of this information.

A Director is regarded as having taken all the steps that they ought to have taken as a Director in order to do the things mentioned above and:

- made such enquiries of his/her fellow Directors and the Foundation Trust's auditors for that purpose; and
- taken such steps (if any) for that purpose, as are required by his/her duty as a Director of the NHS Foundation Trust to exercise reasonable care, skill and diligence.

3.2 REMUNERATION REPORT

3.2.1

ANNUAL STATEMENT ON REMUNERATION

Annual statement from the Chair of Bradford Teaching Hospitals NHS Foundation Trust Nominations and Remuneration Committee.

I am pleased to present the Directors' Remuneration report for the financial year 2018/19. The Nominations and Remuneration Committee is established by the Board of Directors, with primary regard to Executive Directors' remuneration and terms and conditions of service.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS Improvement, the report is divided into the following parts:

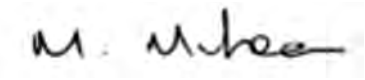
- Senior Managers' Remuneration Policy
- Annual Report on Remuneration. This includes details about Directors' service contracts, and sets out governance matters such as Committee membership, attendance and the business undertaken by the Committee.

Major decisions on remuneration

The Committee considered and agreed the annual pay increase for Executive Directors following recommendations received from NHSI in December 2018. With Professor Clive Kay resigning from the post of Chief Executive interim arrangements were agreed which resulted in the appointment of Mr John Holden as Acting Chief Executive with effect from 1 April 2019. The Committee agreed the level of remuneration on the basis of the 'established' pay rates issued by NHSI for Trusts of our size and turnover. The Committee has now commenced the search for the substantive Chief Executive role.

During 2018/19, the Committee considered a request from the Local Negotiation Committee to adopt a pension contribution alternative award policy and agreed that a proposal should be further explored and resubmitted within the next 12 months.

Signature



Dr Maxwell Mclean

Foundation Trust Chair and Chair of the Nominations and Remuneration Committee

3.2.2

SENIOR MANAGERS' REMUNERATION POLICY

Figure 19: Executive Directors' Remuneration Policy

Element of Policy	Purpose and link to Strategy	How operated in practice	Maximum opportunity	Changes to Remuneration Policy from previous year
Base Salary	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced Executive Directors.	As determined by salary band. Normally appointed on a 3 point salary band. If a Director is not appointed to the maximum point on their salary scale any incremental increase in pay is based on them displaying exceptional performance which is tied in with the Trust meeting its regulatory and corporate objectives. Progression is annually earned. In determining the appropriate salary band the committee considers : • Guidance on pay for very senior managers in NHS trusts and foundation trusts – NHSI 2018. • Salary levels for similar positions through the Foundation Trust and Association of UK University Hospitals (AUKUH) networks. • Individual skills and experience. • 'Established' pay ranges in acute NHS Trusts and Foundation Trusts published by NHSI. • Cost of living increases awarded in line with any pay award made to senior staff on agenda for change terms of conditions. No annual bonuses are paid. These factors are taken into account when setting and reviewing the salaries of staff who earn over £150,000. .	Increments if awarded are set at £5000. The committee on occasion will also recognise changes in the role, and/or duties of a Director and salary progression for newly appointed Directors.	No change awaiting publication of the VSM Framework on pay before reviewing policy.
Benefits (taxable)	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced Executive Directors..	Pension related benefits only.	As per NHS Pension Scheme regulations.	No change.
Pension	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced Executive Directors.	The standard NHS Pension Scheme is operated.	As per NHS Pension Scheme regulations.	No change.

Figure 20: Non-Executive Directors

Position	Remuneration	Policy
Chairperson Remuneration From 1 November 2017	£51,835	The remuneration for all Non-Executive Directors and the Chairperson is reviewed annually by the Governors' Nominations and Remuneration Committee. At the Governors Nominations and Remuneration Committee meeting held on 15 June 2018 remuneration was discussed in detail with reference to the current benchmarking information available from NHS Providers for the period 2017/18. The Council of Governors, following the receipt of a recommendation from the Governors' Nominations and Remuneration Committee, confirmed at their meeting on 19 July 2018 that at the present time, there would be no change to the remuneration of the Chair and Non-Executive Directors for 2018/19 and the rate would remain the same as that agreed for the previous year 2017/18. In July 2018 the Council of Governors considered a recommendation from the Governors' Nominations and Remuneration Committee to appoint an Associate Non-Executive Director for a period of one year. The Council of Governors approved the remuneration for the role at £5,000 per annum. There are no additional fees payable for other duties and no other items that are considered to be remuneration in nature. Non-executive Directors do not receive pensionable remuneration.
Non-Executive Director	£13,785	
Associate Non-Executive Director From 24 September 2018	£5,000	

Policy on payment for loss of office

In relation to loss of office, if this is on the grounds of redundancy then this would be calculated in line with agenda for change terms and conditions. Loss of office on the grounds of gross misconduct would result in a dismissal without payment of notice.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust has not consulted with employees when determining its Remuneration Policy for Executive Directors. Given the number of new Executive Director appointments in the last few years we take into account available benchmarking data and the guidance on pay for very senior managers published by NHSI to enable us to recruit and retain the best people.

3.2.3

ANNUAL REPORT ON REMUNERATION

Service Contracts

As described in the senior managers' remuneration policy section at 3.2.2 Figure 19, all senior manager contracts contain a notice period of 3 months and permanent contracts are issued. Service contracts are dated with the first day of appointment, the dates of which are as set out in the Board of Directors section of the Directors' report, at 3.1.1 Figures 14 and 15.

Nominations and Remuneration Committee for Directors

The Board of Directors has established a Nominations and Remuneration Committee. Its responsibilities include consideration of matters relevant to the appointment, remuneration and associated terms of service for Executive Directors. The Committee is also responsible for making any recommendations with regard to any local pay arrangements not covered by national terms and would be responsible for approving the running of any mutually agreed resignation scheme (MARS) or Voluntary Redundancy Scheme.

The Committee comprises the Chair and all Non-Executive Directors. The Chief Executive is in attendance and will discuss Board composition, succession planning, remuneration and performance of Executive Directors. The Chief Executive is not present during discussions relating to his own performance or remuneration. The Director of Human Resources (HR) is in attendance and will provide employment advice and guidance as necessary. She withdraws from the meeting when any discussions are held with regard to her performance or remuneration. The Director of HR also acts as Committee Secretary.

The Committee met four times during the year and has made a number of decisions during this time.

It agreed to a proposal by the Chief Executive that the post of Director of Governance and Corporate Affairs ceases to be a Board level post and that the Board Secretary role is incorporated into the post's remit for a trial period in the first instance.

In respect of remuneration decisions the Committee agreed to the Chief Nurse receiving a performance related pay increase in line with her contract. The Committee agreed to a proposal re the 2018/19 pay award for very senior managers following a letter received from NHSI in December 2018. The Committee agreed to award the flat rate uplift of £2075 per annum back dated to the 1 April 2018 which was the award applied to agenda for change staff on the top of pay bands 8c, 8d and 9. Whilst the Chief Nurse received a performance related pay increase, the Committee agreed not to withhold this award from her as her salary would then drop back in relative terms against her peer group. All Executive Directors were asked if they would agree to the deferment of the pay award to April 2019.

The Committee discussed a proposal to adopt a pension contribution alternative award policy in the light of changes to personal taxation with respect to contributions to the NHS pension scheme and changes to the standard annual allowance. The Committee agreed that a proposal should be explored further and resubmitted with the next 12 months.

With the resignation of the Chief Executive the Committee considered and agreed a proposal to appoint Mr John Holden, Director of Strategy and Integration to the acting role pending a substantive appointment being made. A panel consisting of the Acting Chair and two Non-Executive Directors conducted an interview and recommended his appointment to the full Committee which was supported. In respect of remuneration the Committee considered the NHSI established pay rates for Trusts

of our size and agreed to a salary of £190,000. The opinion of NHSI and the agreement of the Minister of State for Health has been sought and was obtained.

The Committee considered a request for Professor Clive Kay not to serve his full contractual notice period and to leave on the 31 March 2019. The Committee needed to satisfy itself that there was no risk to the Trust in terms of him leaving early. They considered the matter was considered fully and the Committee agreed the proposed leaving date.

The Committee has now commenced the recruitment to the substantive Chief Executive role.

Attendance during 2018/2019 is shown in Figure 21: Nomination and Remuneration Committee attendance and membership during 2018/19.

Figure 21: Attendance and membership during 2018/19

Member	13 September 2018	10 January 2019	30 January 2019	7 March 2019
Bill McCarthy (chair)	✔	✔	✘	✘
Trevor Higgins	✔	✔	✔	✔
Pauline Vickers	✔	✘	✘	✘
Amjad Pervez	✔	✔	✔	✘
Selina Ullah	✔	✔	✔	✔
Laura Stroud	✔	✔	✔	✘
Barrie Senior	✔	✔	✔	✔
Jon Prashar	✘	✔	✔	✔
Trudy Feaster-Gee	✔	✔	✔	✔
Clive Kay (in attendance)	✔	✔	✔	✔
Pat Campbell (in attendance)	✔	✔	✔	✔
Denotes period when not a member of the Committee				
✔ = attended ✘ = apologies sent				

Governors' Nominations and Remuneration Committee for Non-Executive Directors (NRC).

The Governors NRC met six times during 2018/19:

- 8 June 2018
- 14 September 2018
- 7 December 2018
- 26 February 2018
- 15 March 2019

NRC membership and attendance at meetings during 2018/19 is shown in Figure 22: NRC membership and attendance at meetings during 2018/19.

Figure 22: NRC membership and attendance at meetings during 2017/18

Name	09/06/17	15/09/17	29/09/17	08/12/17	16/03/18	Total
Professor Bill McCarthy, Chair	✔	✔	✔			3 of 3
Professor Marina Bloj, Partner Governor	✔	✔	✔	✔	✔	5 of 5
Mr Alan English, Public Governor	✔	✘	✔	✘	✔	3 of 5
Ms Wendy McQuillan, Public Governor	✔	✘	✔	✔	✔	4 of 5
Ms Hardev Sohal, Patient Governor	✔	✘	✔	✘	✔	3 of 5
Dr David Walker, Public Governor	✔	✔				2 of 2
Mr David Wilmshurst, Public Governor			✔	✔	✔	3 of 3
Ms Ruth Wood, Staff Governor	✔	✔	✘	✘	✔	3 of 5
Denotes period not a member						

✔ = attended ✘ = apologies sent

Associate Non-Executive Director

In July 2018 the Council of Governors approved the recommendation from the NRC to commence an appointment process for an 'Associate Non-Executive Director' with financial expertise to provide advice and scrutiny to support the work of the Finance and Performance Committee. The NRC confirmed the job description, person specification, the specific terms and conditions and, the contract for services with the Trust including the remuneration. The NRC worked with the support of the Chair to source candidates with the specific skill set required. Following interview, the NRC presented a recommendation to the Council of Governors to appoint an Associate NED subject to the completion of the Fit and Proper Person's requirements. The Appointment was approved. Mr Andrew McConnell took up his post on 24 September 2018.

Chairperson

Following the resignation of Professor Bill McCarthy, Chairman, in December 2018; the NRC has undertaken a Chair appointment process and has;

- appointed Harvey Nash, Executive Search, to assist the Committee with the Chairperson Appointment Process.
- agreed the full job description and person specification along with a schedule for the appointment process.
- confirmed the membership of the interview panel which comprised three Governors, the Chief Executive and an External Assessor.

On 15 March 2019 the Council of Governors approved the recommendation to appoint a Chairperson subject to the satisfactory completion of the Fit and Proper Person Requirements. Dr Maxwell Mclean took up his post on 1 May 2019.

Non-Executive Directors

Following the resignation of Mrs Pauline Vickers at the end of November 2018 and consideration of the term end of Dr Trevor Higgins (May 2019) the NRC agreed with the Council of Governors in October 2018 to undertake a search for the appointment of two new Non-Executive Directors. The process is scheduled to be completed in May 2019. As such a report on the full appointment process will be included in the Annual Report for 2019/20.

Expenses claimed by Directors

The total number of Directors holding office during 2018/19 was 20 (the number in 2017/18 was 21). The number of Directors receiving expenses during 2018/19 was 12 (the number in 2017/18 was 11). The aggregate sum of expenses paid to Directors in 2018/19 was £5,051 (in 2017/18 this was £6,162).

Expenses claimed by Governors

The total number of Governors holding office during 2018/19 was 19 (the number in 2017/18 was 20). The number of Governors receiving expenses during 2018/19 was 7 (the number in 2017/18 was 7). The aggregate sum of expenses paid to Governors in 2018/19 was £780.20 (in 2017/18 it was £1,036).

Fair Pay Multiple (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director in the Trust in the financial year 2018/19, £250,000 - £255,000 (2017/18 was £250,000 - £255,000). This was 9.4 times (2017/18, 9.5 times) the median remuneration of the workforce, which was £26,963 (2017/18, £26,565).

The median salary calculation is based on the spine point of individuals employed by the Trust on the last day of the financial year. Each staff member's spine point was taken and the median calculated from this population. Agency costs were not included as it was considered impracticable to evaluate the individual cost of vacant posts covered by temporary workers and deemed that such calculation would not materially alter the calculation of the median.

In 2018/19, and 2017/18, no employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Figure 23: Remuneration of Senior Managers (subject to audit)

Note: It is the view of the Board that the authority and responsibility for controlling major activities is retained by the Board and is not exercised below this level.

Name and Title 2018/19	Salary and fees (Bands of £5,000) £000s	All taxable benefits (to the nearest £100) £00s	Annual performance related bonuses (Bands of £5,000) £000	Long term performance related bonuses (Bands of £5,000) £000	All pension related benefits (Bands of £2,500) £000	Total (Bands of £5,000) £000
Bill McCarthy (Chairman)[1]	45 – 50	-	-	-	-	45 - 50
Trevor Higgins (Non-Executive Director / Acting Chaiman)[2]	20 - 25	-	-	-	-	20 - 25
Clive Kay (Chief Executive)[3]	250 - 255	-	-	-	-	250 - 255
John Holden (Director of Strategy and Integration / Deputy Chief Executive)	140 - 145	-	-	-	5.0 - 7.5	145 - 150
Sandra Shannon (Chief Operating Officer / Deputy Chief Executive)	125 - 130				52.5 - 55.0	180- 185
Karen Dawber (Chief Nurse)	125 - 130	-	-	-	40.0 - 42.5	170 - 175
Bryan Gill (Medical Director)	230 - 235	-	-	-	-	230 - 235
Matthew Horner (Director of Finance)	140 - 145	-	-	-	12.5 - 15.0	155 - 160
Patricia Campbell (Director of Human Resources)	110 - 115	-	-	-	-	110 - 115
Cindy Fedell (Director of Informatics)	115 - 120	-	-	-	30.0 - 32.5	145 - 150
Tanya Claridge (Director of Governance and Corporate Affairs)[4]	95 - 100	-	-	-	180.0 - 182.5	275 - 280
Pauline Vickers (Non-Executive Director)[5]	10 – 15	-	-	-	-	10 - 15
Amjad Pervez (Non-Executive Director)	10 – 15	-	-	-	-	10 - 15
Selina Ullah (Non-Executive Director)	10 – 15	-	-	-	-	10 - 15
Laura Stroud (Non-Executive Director)	-	-	-	-	-	-
Barrie Senior (Non-Executive Director)	10 – 15	-	-	-	-	10 – 15
Trudy Feaster-Gee (Non-Executive Director)	-	-	-	-	-	-
Jon Prashar (Non-Executive Director)	10 – 15					10 – 15
Andrew McConnell (Non-Executive Director)[6]	0 - 5					0 - 5

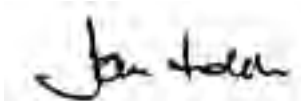
[1]Bill McCarthy (Chairman) left 31 January 2019, [2]Trevor Higgins (Non-Executive Director) Acting Chairman from 01 February 2019, [3]Clive Kay (Chief Executive) left 31 March 2019, [4]Tanya Claridge (Director of Governance and Corporate Affairs) Executive Director until 30 September 2018, [5]Pauline Vickers (Non-Executive Director) left 03 November 2018, [6]Andrew McConnell (Associate Non-Executive Director) started 24 September 2018.

Figure 24: Pension entitlements of senior managers (subject to audit)

2017/18 Name and Title	Real increase in pension at pension age (Bands of £2,500) £ 000s	Real increase in pension lump sum at pension age (Bands of £2,500) £ 000s	Total accrued pension at pension age at 31st March 2019 (Bands of £5,000) £ 000s	Lump sum at pension age related to accrued pension at 31st March 2019 (Bands of £2,500) £ 000s	CETV at 1st April 2018 (Bands of £1,000) £ 000s	Real increase / (decrease) in CETV (Bands of £1,000) £ 000s	CETV at 31st March 2019 (Bands of £1,000) £ 000s
John Holden (Director of Strategy and Integration / Deputy Chief Executive)	0 - 2.5	(2.5 - 5.0)	55 - 60	135 - 140	963 -964	126 - 127	1,118 - 1,119
Sandra Shannon (Chief Operating Officer / Deputy Chief Executive)	2.5 - 5.0	7.5 - 10.0	50 - 55	155 - 160	1,054 - 1,055	176 - 177	1,262 - 1,263
Karen Dawber (Chief Nurse)	2.5 - 5.0	0 - 2.5	35 - 40	90 - 95	545 - 546	119 - 120	681 - 682
Matthew Horner (Director of Finance)	0 - 2.5	(2.5 - 5.0)	50 - 55	120 - 125	765 - 766	121 - 122	910 - 911
Patricia Campbell (Director of Human Resources)	0 - 2.5	(2.5 - 5.0)	45 - 50	130 - 135	864 - 865	95 - 96	986 - 987
Cindy Fedell (Director of Informatics)	0 - 2.5	0	10 - 15	0	97 - 98	44 - 45	144 - 145
Tanya Claridge (Director of Governance and Corporate Affairs)[1]	7.5 - 10.0	20.0 - 22.5	20 - 25	55 - 60	215 - 216	178 - 179	399 - 400

- As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.[1]Tanya Claridge (Director of Governance and Corporate Affairs) Executive Director until 30 September 2018
- NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Signed



John Holden

Acting Chief Executive

24 May 2019

3.3 STAFF REPORT

3.3.1

STAFF NUMBERS AND COSTS

Figure 25: Staff Costs 2018/19

Staff Costs	Permanently employed total	Other total	Total staff costs
Salaries and wages	191,330	1,721	193,051
Social security costs	19,205	0	19,205
Apprenticeship Levy (pay element)	1,020	0	1,020
Pension cost - defined contribution plans	641		0
employer's contributions to NHS pensions	23,529	0	23,529
Pension cost – other	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Temporary staff - external bank	-	15,824	15,824
Temporary staff - agency/contract staff	-	10,360	10,360
NHS charitable funds staff	0	0	0
Total gross staff costs	**235,148**	**27,905**	**263,053**

Figure 26: Staff Numbers 2018/19

Note 4.2 Average number of employees (WTE basis)	2018/19 Total Number	2018/19 Permanent Number	2018/19 Other Number
Medical and dental	717	702	15
Ambulance staff	0		
Administration and estates	1,837	1,752	85
Healthcare assistants and other support staff	704	671	33
Nursing, midwifery and health visiting staff	1,947	1,548	399
Nursing, midwifery and health visiting learners	0		
Scientific, therapeutic and technical staff	669	650	19
Healthcare science staff	0		
Social care staff	0		
Agency and contract staff	0		0
Bank staff	0		0
Other	3	3	0
Total average numbers	**5,877**	**5,326**	**551**
Of which			
Number of employees (WTE) engaged on capital projects	8	8	0

Figure 27: Staff Numbers 2017/18

Note 4.2 Average number of employees (WTE basis)	2017/18 Total Number	2017/18 Permanent Number	2017/18 Other Number
Medical and dental	696	696	0
Ambulance staff	0		
Administration and estates	1,774	1,724	50
Healthcare assistants and other support staff	634	634	0
Nursing, midwifery and health visiting staff	1,822	1,558	264
Nursing, midwifery and health visiting learners	0		
Scientific, therapeutic and technical staff	629	629	0
Healthcare science staff	0		
Social care staff	0		
Agency and contract staff	0		
Bank staff	0		
Other	3	3	0
Total average numbers	**5,558**	**5,244**	**314**
Of which			
Number of employees (WTE) engaged on capital projects	8	8	0

Figure 28: Analysis of Staff Numbers

At 31 March 2019 – headcount figures, excluding agency and contract and bank staff			
Group	**Female**	**Male**	**Total**
Directors	8	10	18
Senior Managers	244	146	390
Other Employees	4,526	1,243	5,769
Total	**4,778**	**1,399**	**6,177**

At 31 March 2018 – headcount figures, excluding agency and contract and bank staff			
Group	**Female**	**Male**	**Total**
Directors	9	11	20
Senior Managers	238	140	378
Other Employees	4,345	1,175	5,520
Total	**4,592**	**1,326**	**5,918**

Sickness Absence

hese figures are from the NHS Digital Sickness Absence Publication, based on data from the Electronic Staff Record (ESR) Data Warehouse. Please note these figures are based on the calendar year.

Figure 29: Staff Sickness Absence

Staff sickness absence	2018	2017
Total days lost to sickness	56,321	52,726
Total staff years available*	5,285	5,175
Average working days lost per full-time equivalent member of staff	10.66	10.2

*Total staff years available – A full time employee working all year, is equivalent to 1 staff year. For part-time workers, the ratio of their contracted hours to those of a full-time employee are used to pro-rate their available time. E.g. a part time worker working 2.5 days a week will represent 0.5 staff years.

Expenditure on Consultancy

In 2018/19 the Trust spent £1,744,051 on consultancy (2017/18 £967,000).

Off-Payroll Engagements

Figures 30 to 32 demonstrate the Trust's compliance with HM Treasury guidelines on "off-payroll engagements".

Figure 30: Details of all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

Category	Number
No. of existing engagements as of 31 March 2017	3
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	3
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

All existing off-payroll engagements, outlined in Figure 30, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Figure 31: Details all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Category	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	32
Of which...	
No. assessed as caught by IR35	34
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	25
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Figure 32: Details of any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Category	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	18

Staff Exit Packages

Figure 33: All exit packages 2018/19

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0
£10,000 – £25,000	0	0	0
£25,001 – £50,000	0	0	0
£50,001 – £100,000	1	0	1
£100,000 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	1	0	1
Total resource cost	**£55,077**	**0**	**£55,077**

Figure 34: All exit packages 2017/18

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	7	1	8
£10,000 – £25,000	2		2
£25,001 – £50,000			
£50,001 – £100,000			
£100,000 – £150,000			
£150,001 – £200,000			
Total number of exit packages by type	9	1	10
Total resource cost	**£66,000**	**£5,000**	**£71,000**

Figure 35: Exit Packages – non-compulsory departure

	2017/18 Agreements Number	2017/18 Total Value of Agreements £000	2016/17 Agreements Number	2016/17 Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	1	5
Non-contractual payments requiring HMT approval	1	15	0	0
Total	**1**	**15**	**1**	**5**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	**0**	**0**	**0**	**0**

Trade Union Facility Time

Figure 36: The total number of employees who were relevant union officials during 2018/19

	Number
Number of employees who were relevant union officials during the relevant period	65
Full-time equivalent employee number	59

Figure 37: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	36
1-50%	28
51%-99%	0
100%	1

Figure 38: Percentage of pay bill spent on facility time

Total cost of facility time	£27,763.74
Total pay bill	£263,399,805
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

3.3.2

STAFF POLICIES AND ACTIONS

Staff Involvement and Consultation

'We are Bradford' which launched last year, is a way to help staff think about their contribution and how they work together. The work during 2018 focused on bringing our values to life as teams, through workshops delivered to teams across the Trust. In May 2018 our first 'Work as One' week took place, to bring our values to life as a whole Trust. The aim was to empower and engage staff through focusing on an operational priority. It encouraged staff to think differently, to be innovative and make changes that will improve the quality of patient care and patient experience.

The first event focused on improving the flow of patients through our hospitals. As a result of the success of the first 'Work as One' week, we held five further events throughout the year, including a 'system wide' week in January 2019.

Staff and volunteers from across the Trust take part in the events. During 'Work as One' events, Senior Leaders get 'out and about' talking to staff and encouraging staff to try out new ideas and ways of working.

Staff stories are shared through our weekly 'Let's Talk' newsletter which also provides information on Trust developments and celebrates achievements.

Our 'Let's Talk Live' regular listening events give staff the opportunity to meet the Chief Executive and members of the Executive Team to ask questions and raise concerns. We have also introduced a series of listening events in specific areas of the Trust in response to staff feedback. The Executive and Non-Executive Director walk-rounds of wards and departments continue, to talk to staff and find out more about issues that affect them.

Our 'Brilliant Bradford' Team and Employee of the month awards and annual staff recognition award ceremony are popular with staff. They have the opportunity to nominate colleagues who embrace our values and celebrate their achievements. In 2018/19, for the first time, staff were given the chance to have their say through deciding the shortlist for the Team and Employee of the Year, by voting on line - nearly 1000 staff took part in the voting.

Our regular Core Brief delivered in face-to-face meetings keeps staff informed of key strategic and operational issues affecting our Trust. We have a monthly Senior Leaders forum and quarterly 'Let's Talk together' events for Clinical and Senior Leaders to keep them informed of important issues and involve them in developing and shaping our strategies and services, including our new Patient Experience Strategy and the design of the new Command Centre.

Our Let's Talk hub on our intranet keeps staff informed of all our engagement activities including staff surveys and the Work as One initiatives. We are developing a new intranet for the Trust and engaging staff in this process. We are continuing to develop our use of social media, including Blogs, Facebook and Twitter.

Our quarterly Staff Friends and Family Test and annual NHS Staff Survey are open to all staff, giving everyone the opportunity to have their say about their experience of working in our Trust and make suggestions for improvements.

From the national NHS staff survey, in 2018, we found that the group of staff who reported the poorest experience were those with long term health conditions or disability. We carried out an additional electronic survey with this group. Over 130 staff responded making over 600 comments. As a result, we set up a group to develop a Disability Policy and consider actions required to address issues raised through the Workforce Disability Equality Standard. The new policy is anticipated to be launched in the summer 2019. The second poorest experience was reported by those who identify as lesbian, gay or bisexual. We also carried out an additional electronic survey with this staff group. Unfortunately, there were insufficient responses to enable us to consider any further action.

We have formal consultation and negotiation committees which meet regularly and we have a strong commitment to partnership working with our Trade Unions. Our Organisational Change Management Policy, agreed with our Trade Unions, is used for service changes. A number of formal consultations have taken place within the last year which has been managed under this Framework.

Policies Relating to Disabled Employees

The Trust's Recruitment and Selection Policy ensures full and fair consideration is given to applications for employment made by disabled persons by guaranteeing interviews for those who meet the essential criteria on a person specification. Graduates from the Trust's Project Search scheme, which offers work experience to students with learning disabilities, are guaranteed an interview prior to advertising agreed posts more widely.

The Policy on Managing Attendance details the arrangements for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period. We updated the policy in 2018 and gave more prominence to the disability sections, along with incorporating the reasonable adjustments template for managers. "Enable", the Disabled Staff Network, has worked with us on the guidance we provide to support staff and invited their input into the management training programme. The policy embeds the importance of employee health and wellbeing for all those working for the Trust.

The Staff Development Policy covers the arrangements for the training and development of all employees.

Health and Safety

The Trust has a Health & Safety Committee, which is chaired by the Director of Governance & Corporate Affairs and whose membership includes staff representatives, managers representing the Divisions and Corporate Departments. A Non-Executive Director has a specific role in relation to Health and Safety within their portfolio. The Health & Safety Committee reports to the Board of Directors. The Director of Strategy and Integration is the nominated Executive Lead for Health and Safety.

The Trust continues to work to improve its governance and practice in respect of its health and safety responsibilities, through the specialist support function and through the practice of all staff in the Trust. A key focus during 2018/19 has been on continuing to improve the identification, reporting and management of incidents requiring external reporting to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and also generating an assurance portfolio relating to the Trust's compliance with key health and safety legislation. The Trust has worked hard during the latter part of 2018/19 to ensure that its arrangements for the management of clinical waste, during a period of contingency arrangements were complaint with legislation.

The Trust reported 3,722 health and safety risk incidents in 2018/19, 966 of these incidents related to staff. The following areas continue to be our highest reported health and safety incidents affecting staff:

- verbal abuse against staff (152 incidents)
- contamination injuries (152 incidents)
- threatening behaviour against staff (136 incidents)
- physical assault against staff (118 incidents)
- staff slips, trips, falls (60 incidents)

Included in the health and safety risk incidents, are 31 incidents reported to the HSE under RIDDOR, all but five of these incidents related to staff, the others related to a member of the public, patient or contractor.

There have been no visits undertaken by the HSE in the last 12 months and no formal enforcement action has been taken against the Trust.

Countering Fraud and Corruption

The Trust complied with the 2018/19 anti-fraud, bribery and corruption standards as set by the NHS Counter Fraud Authority (NHSCFA).

As a special health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care.

A programme of proactive work has been carried out during the year by the Trust's Local Anti-Fraud Specialist and this has linked closely with the Trust's communications plans.

The Trust's Anti-fraud, Bribery and Corruption Policy and a range of related materials are available on the intranet for staff and work has continued to raise the profile of the Local Anti-Fraud Specialist through a range of initiatives.

3.3.3

STAFF SURVEY

Introduction

The annual NHS Staff Survey helps us to review and improve staff experience. It measures staff engagement and well-being and this year it also provides us with information about staff morale, which will help us to shape our cultural and organisational development work going forward. We use the results to monitor progress against our strategic objective to be in the top 20% of NHS employers.

Staff engagement

Our People Strategy: Our People, Our Future: Together Putting Patients First brings together our organisational, cultural and leadership work, providing direction for our activities, making sure we are all working towards being in the top 20% of NHS employers and a great place to work.

Our engagement programme, 'Let's Talk', which aims to develop our culture and improve engagement and communications continued throughout 2018/19. It included Let's Talk Live events, an opportunity for staff to spend time with our Chief Executive; engaging staff in developing strategies; Brilliant Bradford staff awards; sharing staff stories through our Let's Talk newsletter and the Executive Team 'walking the floor'.

We have continued to develop our managers and leaders, as we recognise that leadership plays a crucial role in shaping our culture. We encourage effective conversations with a focus on making sure everyone has an effective appraisal.

Our work to bring our values to life continued last year with We are Bradford sessions across the Trust,

exploring how the values come to life within teams and the Work as One events focusing on teamwork. All these activities are about getting our staff involved and working together; empowering them to make decisions and test new ideas; and encouraging them to be innovative and creative. Most importantly they are opportunities for our Senior Leaders and our managers to talk to and listen to our staff, a chance for them to have their say and their voices heard.

NHS staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 35% (2017: 35%); over 2000 staff took part. Scores for each indicator together with that of the survey benchmarking group of other Acute Trusts are presented in Figure 39.

Figure 39: NHS Staff Survey - Comparison of other Acute Trusts Benchmarking Group

	2018/19		2017/18		2016/17	
	Trust	Benchmarking group average	Trust	Benchmarking group average	Trust	Benchmarking group average
Equality, diversity and inclusion	9.0	9.1	9.0	9.1	8.9	9.2
Health and wellbeing	6.0	5.9	6.1	6.0	6.1	6.1
Immediate managers	6.9	6.7	6.7	6.7	6.5	6.7
Morale	6.3	6.1	New indicator, no comparative results for previous years			
Quality of appraisals	5.6	5.4	5.3	5.3	5.2	5.3
Quality of care	7.5	7.4	7.5	7.5	7.4	7.6
Safe environment – bullying and harassment	8.1	7.9	8.0	8.0	7.9	8.0
Safe environment – violence	9.6	9.4	9.4	9.4	9.4	9.4
Safety culture	6.7	6.6	6.6	6.6	6.6	6.6
Staff engagement	7.2	7.0	7.0	7.0	6.9	7.0

Overall the results of the survey are positive. Staff feel satisfied with the quality of care they give, feel their role makes a difference, and they are able to do the job to a standard they are pleased with. They feel supported by managers and colleagues; they're clear on responsibilities and feel trusted to do their job. This is the very essence of We are Bradford and shows how important it is to make sure we continue our work to bring our values to life.

More staff are saying they have opportunities to show initiative in their role; they feel able to make suggestions for improvements; are involved in decisions about changes that affect their work. More are saying their team has a shared set of objectives and meets regularly to discuss how they are doing – things which are demonstrated by effective teams. There is a significant positive shift in the number of staff satisfied with recognition of good work and feeling that the organisation values their work.

We are above average in nine out of ten indicator scores, compared to other Acute Trusts. We match the 'best' benchmark for the theme Safe environment – Violence; we are below average for Equality, Diversity and Inclusion;

Figure 40: NHS Staff Survey – Theme Results Overview

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.0	6.0	6.9	6.3	5.6	7.5	8.1	9.6	6.7	7.2
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	2,028	2,045	2,055	2,013	1,756	1,708	2,032	2,028	2,015	2,072

Figure 41: NHS Staff Survey – Significance testing theme scores

Survey Coordination Centre

2018 NHS Staff Survey Results > Appendices > Significance testing – 2017 v 2018 theme results

NHS England

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2018 score is significantly higher than last year's, whereas ↓ indicates that the 2018 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.0**	1972	**9.0**	2028	Not significant
Health & wellbeing	**6.1**	1991	**6.0**	2045	Not significant
Immediate managers	**6.7**	1996	**6.9**	2055	↑
Morale		0	**6.3**	2013	N/A
Quality of appraisals	**5.3**	1689	**5.6**	1756	↑
Quality of care	**7.5**	1668	**7.5**	1708	Not significant
Safe environment - Bullying & harassment	**8.0**	1960	**8.1**	2032	Not significant
Safe environment - Violence	**9.4**	1967	**9.6**	2028	↑
Safety culture	**6.6**	1981	**6.7**	2015	↑
Staff engagement	**7.0**	2016	**7.2**	2072	↑

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

We have made significant increases in scores for the questions in five of the ten indicator scores, including Quality of Appraisals, Safety Culture, Engagement, Immediate Managers and Safe Environment – Violence. Our score for Safe Environment – Violence matches the 'best' benchmark score. We have made no significant change in four of the themed areas – Equality, Diversity and Inclusion; Health and wellbeing; Quality of Care and Safe Environment – Bullying and Harassment. Our work during 2019/20 will focus on these areas.

Priorities and performance against targets for 2018/19

There are improvements across the majority of the areas in last year's Staff Survey action plan. Staff engagement, our top priority, significantly increased again this year, from 7.0 to 7.2, showing an upwards trend since 2016 when our Let's Talk programme of engagement work began, which is really positive.

There were significant positive shifts in the scores for communications between senior management and staff, up from 37.8% to 42.1% and support from immediate managers up from 66.2% to 69.8%. This shows not only that we are listening to our staff, we are working with them to make improvements and making a difference to their experience and how they feel about working here.

More staff are reporting good communications between senior management and staff, up from 37.8% to 42.1%; more staff are getting support from their managers, scores show an increase from 6.7 to 6.9.

The reporting of errors and incidents is up significantly from 92.9% to 96.0%. There has been a comprehensive piece of work here for example; improving timeliness, quality and meaning of feedback when an incident is reported so that staffs recognise the important contribution they are making to the safety of patients and staff through reporting incidents.

The percentage of staff experiencing violence, harassment and bullying from staff is down significantly, from 2.4% to 1.5% which is positive. There has been no change to the number reporting most recent incident of harassment, bullying or abuse; it is expected that as the role of Staff Advocate embeds, this will improve this year. The results show that the number of staff experiencing harassment, bullying or abuse from managers and colleagues has reduced.

Our focus on patient care and experience was to improve the effectiveness of the use of patient and service user feedback; although there was an increase here, it was not significant. Benchmarking has taken place and a local working group is being set up to look at the effective use of feedback and uptake for future improvement.

Priorities 2019/20

It is important that we continue to build on the progress we have made during 2018/19 and increasing staff engagement remains our top priority – getting this right should have a positive impact on other areas including patient experience and outcomes; staff motivation; morale and wellbeing.

Although we have made significant improvements in many of the themed areas compared to last year, there is more work to do to improve Equality, Diversity and Inclusion, Quality of Care, Quality of Appraisals, Safe Environment – Bullying and Harassment and Health and Wellbeing and Safety Culture to match the best benchmark scores. We will be focusing on these areas during 2019/20. We will also be addressing the areas where we are either below average or our scores have decreased since last year. This includes reporting of physical violence and areas around use of patient and service user feedback.

These priorities will be addressed through our Trust Staff Survey action plan and our People Strategy annual plans, with progress monitored throughout the year by the Workforce Committee, Executive Management Team and Board of Directors.

3.4 EQUALITY REPORT

3.4.1

INTRODUCTION

The Trust aims to ensure that the services we deliver and our employment practices do not discriminate against any individual or groups. The Director of Human Resources oversees the equality agenda and chairs the Diversity Work Stream. The Head of Equality and Diversity leads on the equality agenda in terms of service provision and employment. Mrs Selina Ullah is the Non-Executive Equality and Diversity champion on the Board of Directors.

3.4.2

ACHIEVEMENTS IN 2018/19

Project SEARCH Bradford

Project SEARCH began in Cincinnati Children's Hospital in 1996 and is now an internationally renowned programme which provides real employment opportunities to young people with learning difficulties who are aged between 18 and 25 years.

Project SEARCH works by providing three work rotations to the young people (Interns), immersing them into the culture of work with five hours on the job experience and two hours tuition and reflection each day. It is based on a programme of systematic instruction – beginning with a small number of tasks, adding on additional tasks when the Intern is ready. The programme increases the employment potential for people with learning difficulties from a national average of less than 6%. Since Bradford Project SEARCH started, 42 of our interns have graduated. Of these, 33 have gained employment, a success rate of 79%.

The key partners in Bradford Project SEARCH are:

- Southfield School, who are the franchise holder, provide a full time tutor, project assistant and resources for the project;
- Hft, which is a national charity providing supported employment for people with learning difficulties who provide the full time job coach;
- Bradford Travel Training Unit, who provide one to one support to all Interns to overcome the major barrier of independent travel to work;
- Bradford Council, who provide the funding for the Job Coach and have a key strategic objective to increase employment rates for vulnerable adults; and
- University of Bradford, who are a key employment partner for Project SEARCH. They provide third term placement opportunities and have provided employment to some Interns.

We are now in our sixth year of Project SEARCH Bradford. We provide:

- a base room (where the Interns, Tutor, Coach and Project Assistant are based)
- internship opportunities and mentor
- business liaison (the Head of Equality and Diversity)

Nine young people started Project SEARCH Bradford in September 2018, with eight still on the programme. They are receiving varied work experience in jobs such as administration, ward hospitality, cleaning and catering. It is hoped that the year spent in the Trust will provide the Interns with the experience, confidence and ability to compete for jobs both inside the Trust and among local employers. We had significant achievements with Project SEARCH in 2018/19 which included:

- winning the national HPMA University of Bradford Award for Cross-Sector Working
- a "follow along" coach is now employed three days per week to support the 12 graduates of the programme who work in BTHFT
- 88% of the Project SEARCH Interns who graduated in July 2018 have gone on to paid employment
- the Trust achieved its commitment to employ at least one third of the Interns who graduate, with three 2018 graduates gaining employment in the Trust
- in January 2019, we hosted the first Network meeting for Project SEARCH sites in the North of England.

In November 2014 the Trust set up a Business Advisory Committee (BAC) to develop links with the local business community in Bradford. We have refreshed

the membership of the BAC and held our first meeting in March 2019. We are very pleased to announce that 23 individuals attended including those representing nine businesses. Those businesses were:

- Puddle Digital
- Bradford District Care NHS Foundation Trust
- Tesco
- Barclays Bank
- Compass
- Bradford Metropolitan District Council
- Victorguard Care
- Nuffield Health
- University of Bradford

The BAC is chaired by our Chief Executive. The membership also includes the Director of Human Resources and the Head of Equality and Diversity.

Interpreting Services (Spoken Languages)

The demand for interpreting services is continuing to increase. The range of languages in which interpreting services are provided is also increasing, and we have now provided interpreting services in over 50 different languages, including Braille and British Sign Language.

3.4.3

STAFF EQUALITY

BLACK ASIAN AND MINORITY ETHNIC (BAME) EMPLOYMENT TARGETS

Figure 42: Top 10 languages requested (April 2017 – February 2018)

Language	No. of Sessions
Urdu/Punjabi	18,425
Czech/Slovak	5,901
Polish	3,239
Arabic	2,425
Bengali	1,894
Hungarian	1,297
Romanian	719
BSL	716
Pushto	606
Russian	495

In February 2015, the Board of Directors set itself a target date of 2025 to achieve a workforce reflective of the local BAME working age population of 35%. This is a challenging but achievable target which would require a year on year increase of 1% BAME staff to reach the target. Our data for the first three years looks promising in some areas, with more work to be done in others. Our overall percentage of BAME staff has risen from 24.7% in March 2015 to 30.16% in March 2019. Based on this we are on track to exceed our target of having an overall workforce that reflects the local population by September 2025 by around 3.5%.

The data for senior managers (from band 8 upwards) is less encouraging. From a starting point in March 2015 of 7.59%, the percentage of BAME staff at this level has risen to 15.33%. Whilst this demonstrates a year on year increase, the trajectory of the latest figures indicates that by 2025, only 25.5% of our senior managers will be from BAME backgrounds. This is a concern in our ambition to have a workforce reflective of the local population. We are hoping to escalate the progress. From November 2018, a senior BAME member of staff is now fully involved in the recruitment process for all appointments at Bands 8 and 9. We will be evaluating their experience of this process and refining our recruitment practices where necessary.

WORKFORCE RACE EQUALITY STANDARD (WRES)

NHS England has agreed a set of Standards against which we have to submit our data in order to comply with the NHS standard contract. The WRES forms the first stage in a process of addressing workforce equality issues. Our WRES data helps form part of the data we scrutinise as part of our Corporate Objective to be in the top 20% of NHS employers.

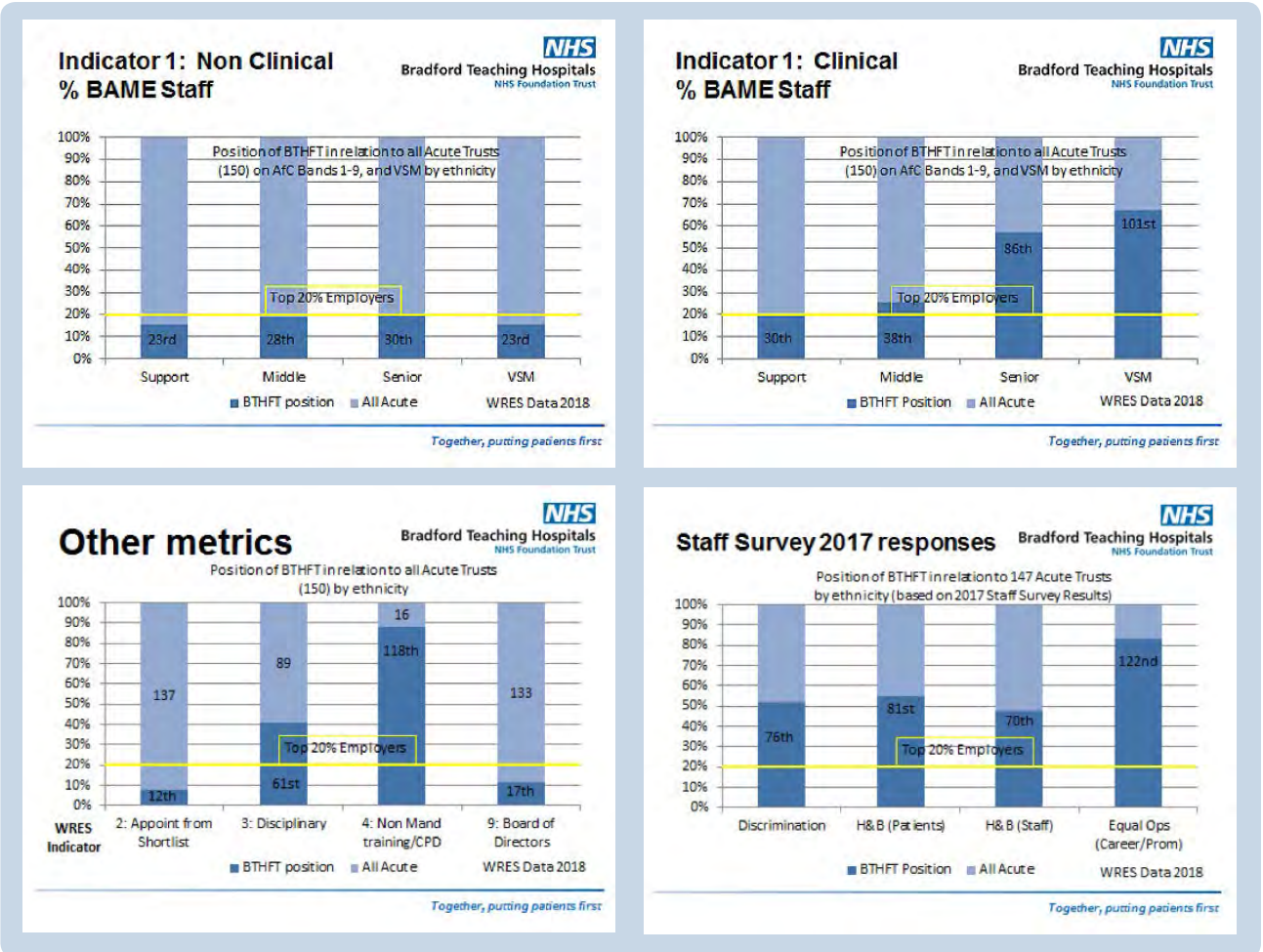
The nine WRES indicators are:

1. percentage of staff in each of the aggregate AfC Bands 1-9, and VSM by ethnicity (broken down Non Clinical and Clinical)
2. relative likelihood of staff being appointed from shortlisting across all posts
3. relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. relative likelihood of staff accessing non-mandatory training and CPD

5. percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. percentage believing that trust provides equal opportunities for career progression or promotion
8. in the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
9. percentage of Board representation by ethnicity and Executive/Non Executive Membership

The 2017annual Staff Survey had four indicators that contribute to our WRES data which we submit annually in July. Our overall WRES response is shown in Figure 43.

Figure 43: Equality And Diversity Training



EQUALITY AND DIVERSITY TRAINING

Training for Senior Managers – 91.7% of staff in senior management positions have received training on their responsibility to improve performance in the number and positions of staff from all sections of the community in employment and providing tools to reduce bias and in exercising management responsibilities. This training is mandatory for all senior Managers.

E-Learning for all staff – 99.7% of all staff have undertaken a mandatory 20 minute e-learning package. It includes an introduction to bias, equality legislation and highlights the rights and responsibilities that all staff have in relation to equality and diversity both as employees and as service providers.

STAFF ADVOCATES

Our Staff Survey results showed that, for some staff, there is real disparity in their perception of fairness in for example, equal opportunities for career progression, promotion and harassment and bullying.

For a number of years, we have had advisors who support staff who are experiencing harassment and bullying. However, compared to the proportions of our staff who tell us they are being harassed or bullied, only a very small number of our staff used the service.

We worked with the Royal College of Nursing to provide training to the first cohort of Staff Advocates. These Advocates have been trained to support staff with issues that can make working life hard, such as: discrimination, barriers to career development, unhealthy work culture, unfair recruitment practices as well as harassment and bullying.

The thirteen Advocates can be approached by individual staff that have concerns. They provide confidential help to identify solutions to the issues staff have. Crucially though, we intend for the Advocate to become our 'eyes and ears' and help us build a picture of areas of the Trust that have particular issues. We can then provide support to those areas to ensure they are living the Trust's values. Whilst each discussion will remain confidential, we want to build a picture of any 'hotspot' areas that we need work with to improve the working lives of our staff.

STAFF NETWORKS

Staff networks for BAME staff, staff with long term health conditions or disability and LGBT staff operate within the Trust. All the networks are confidential, self-governing groups which provide support and help in raising awareness of issues affecting these staff groups and wherever possible, staff are given approval to attend meetings during work time.

The Head of Equality and Diversity is working with the Chair of Enable, the network for staff with long term health conditions or disability, on an action plan to address the concerns raised through the electronic survey. These actions include developing a standalone disability policy and highlighting the need for managers to make reasonable adjustments for disabled staff.

3.4.4

EQUALITY ANALYSIS

The Head of Equality and Diversity meets with the authors of all policy documentation to complete an equality analysis of new and revised policies. The Equality Impact Assessment includes analysis of all nine protected groups and also considers the human rights FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy). Changes are made or action taken to mitigate against disadvantage where there is evidence that protected groups might be affected by the policy.

3.4.5

EQUALITY OBJECTIVES

In April 2016, the Trust published equality objectives for 2016-20, seven of which we share with other local health economy partners. In summary these are:

- carry out a Gender Pay Gap Audit using a recognised audit framework
- implement the Accessible Information Standard (AIS)
- improve BAME service users access and experience of services
- increase awareness of mental health issues and to improve access and experience of mental health service users across the health economy;
- prepare for the implementation of the Workforce Disability Equality Standard by preparing data and developing and delivering plans to tackle the issues identified
- implement the Workforce Race Equality Standard
- implement the recommendations in the Healthy Attitudes Stonewall Study and Equity partnership, lesbian, gay, bisexual, and transgender Local Health Needs Assessment; and
- commit to employing at least a third of Project SEARCH Interns who have graduated from the programme

We work in partnership with other local health economy partners and consult with the local community on our progress. We are proposing a

series of community consultation events using existing forums to report on our progress and seek views on the development of our new set of objectives which will be put in place in April 2020.

Our Equality Objectives identify the challenges that we face in providing services and employment opportunities for people from the protected groups. Making progress against these is challenging but we have put in place realistic targets for achieving the objectives. The Trust's Workforce Committee and Board of Directors receive a six-monthly equality update report, which enables them to track progress against the equality objectives.

3.4.6

HATE CRIME REPORTING

We have been working with Bradford Hate Crime Alliance over the past 18 months with the aim of setting up a Hate Crime Reporting Centre. The Alliance provided training to volunteers and staff in the voluntary services team. Unfortunately due to a number of circumstances beyond our control, we are no longer able to develop a reporting centre. However, the initiative came out of joint work with our Black, Asian and Minority Ethnic (BAME) staff network on their experience of violence and aggression in the workplace. Therefore, in June 2019, Bradford Hate Crime Alliance will train our Staff Advocates to support our staff who experience Hate Crime, through our internal risk management system. We will therefore be able to provide our staff with support when they experience Hate Crime and we will be able to report when this happens in the Trust. This initiative demonstrates that we are listening to, and taking action when our staff face hate related crime.

3.4.7

STAFF SURVEY (WHOLE)

This year all staff have been invited to take part in our quarterly Staff Friends and Family Test (instead of a smaller sample) and our annual NHS Staff Survey was carried out for all staff again. This enables us to have more confidence that the experience of our staff is based on a more representative group.

3.4.8

DOMESTIC VIOLENCE

We continue to work with local partners to ensure that we are responding to issues of domestic violence.

3.5 NHS Foundation Trust Code of Governance

3.5.1

STATEMENT ON COMPLIANCE WITH THE CODE OF GOVERNANCE

Bradford Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

A review of the Trust's compliance with the Code of Governance was carried out by the Integrated Governance and Risk Committee in April 2019 and reported to the Board of Directors in May 2019.

The review concluded that, with regard to the provisions within the Foundation Trust Code of Governance to which "comply or explain" is applicable; the Trust is compliant with all those provisions.

3.5.2

COUNCIL OF GOVERNORS

Statutory duties

The Council of Governors hold a number of statutory duties. These are to:

- appoint and remove the Chair and Non-Executive Directors
- set the terms and conditions and remuneration of the Chair and Non-Executive Directors
- approve the appointment of the Chief Executive
- appoint the External Auditor
- receive the Annual Accounts, Auditor's Report and Annual Report
- convene the Annual Members Meeting
- be consulted on the forward plan (annual plan) of the organisation
- approve any proposed increases in private patient income of 5% or more in any financial year
- represent the interests of the Members of the Trust as a whole and the interests of the public
- require one or more of the Directors to attend a Governors' meeting to obtain information about the Trust's performance of its functions or the Director's performance of their duties (and for deciding whether to propose a vote on the Trust's or Director's performance)
- approve significant transactions
- approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- approve amendments to the Trust's Constitution

With regard to their statutory roles and responsibilities the Governors have, during 2018/19:

- approved the Appraisal Processes for the Chairman and the Non-Executive Directors
- considered and approved the agenda for the Annual General Meeting / Annual Members' Meeting 2017/18
- received the Annual Accounts, Auditor's Report and the Annual Report 2017/18
- received the Audit Report from the Auditor on the Quality Report and the Annual Report 2017/18
- received a response from the Trust in relation to the External Auditor's recommendations arising from the external audit on the Quality Report 2017/18 indicators with regard to; Referral to Treatment (RTT) and Ambulance Handovers.
- re-appointed Ms Selina Ullah, Non-Executive Director, for a second three-year term to September 2021
- appointed Mr Andrew McConnell as Associate Non-Executive Director (and non-voting member of the Board of Directors), as a member of the Board of Director's Finance and Performance Committee, for a period of one year from 24 September 2019
- received the report from the Chairperson on the outcome of the Appraisal process on the Non-Executive Directors

- received the Report from the Senior Independent Director on the outcome of the Appraisal process of the Chairperson
- received regular reports from the Governors Nominations and Remuneration Committee on the business conducted by the Committee to inform the recommendations presented to Council for approval with regard to the Non-Executive Directors (including the Chairperson)
- following consultation with the Board of Directors confirmed the Council of Governors support for the appointment of Ms Selina Ullah as Senior Independent Director following the resignation of Ms Pauline Vickers, Non-Executive Director in November 2019
- following the resignation of Professor Bill McCarthy, BTHFT Chairperson; confirmed the appointment of Dr Trevor Higgins, Acting Chairperson from 1 February 2019, until the appointment of a substantive BTHFT Chairperson or, to May 22 2019 (the term end of Dr Trevor Higgins)
- received and noted the appointment by the Board of Directors of Ms Selina Ullah, Senior Independent Director, as Acting Deputy Chairperson until the appointment of a substantive chair or, to May 22 2019
- approved the appointment of the Trusts' Chairperson on 15 March 2019, subject to the completion of the Fit and Proper Persons Requirements (FPPR) in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5
- together, with the Board of Directors, held discussions with regard to annual planning, strategic development, performance and regulatory compliance

The Council of Governors has also reviewed and approved the:

- Council of Governors Standing Orders
- Council of Governors Engagement Policy (with the Board of Directors).
- Terms of Reference for the Council of Governors
- Terms of Reference for the Governors Nominations and Remuneration Committee
- Non-Executive Director and Chairperson Appraisal Process 2018
- appointment of Mr David Wilmshurst as a member of the Governors Nominations and Remuneration Committee
- re-appointment of Professor Marina Bloj as the Lead Governor
- appointment of Mr David Wilmshurst as the Lead Governor
- remuneration of the Chair and Non-Executive Directors
- appointment process for the Non-Executive Directors (including the Chairperson appointment process)
- terms and conditions for Non-Executive Director appointments made in year
- the locally selected indicator for external audit in 2018/19, in line with NHSI reporting requirements. The indicator selected is the Standardised Hospital Mortality Index (SHMI).

COMPOSITION OF THE COUNCIL OF GOVERNORS

Figure 44: Council of Governors from 1 April 2017 to 31 March 2018

Public Governors (elected)		Term end date
Ms Stella Hall	Public Bradford East (first term)	March 2019
Mr Michael Parry	Public Bradford East (first term)	May 2019
Ms Hilary Meeghan	Public Bradford South (second term)	December 2020
Mr Alan English	Public Bradford South (first term)	May 2019
Ms Ruby Hussain	Public Bradford West (first term)	November 2018
Ms Jenny Scott	Public Bradford West (first term)	December 2019
Mr Alan Edmonds	Public Bradford West (first term)	December 2021
Mr David Walker	Public Shipley (first term)	November 2018
Mr David Wilmshurst	Public Shipley (second term)	December 2019
Ms Wendy McQuillan	Public Keighley (first term)	March 2019
Ms Marian Olonade-Taiwo	Public Keighley (second term)	December 2019
Ms Marian Olonade-Taiwo	Public Keighley	December 2019
Patient Governors (elected)		
Ms Hardev Sohal	Patient (Out of Bradford) (second term)	March 2019
Staff Governors (elected)		
Ms Ruth Wood	Staff: All Other Staff groups (second term)	December 2019
Ms Katherine Wright	Staff: Allied Health Professionals and Scientists (first term)	May 2019
Ms Pauline Garnett	Staff: Nursing and Midwifery (first term)	March 2019
Dr Sulleman Moreea	Staff: Medical and Dental (first term)	December 2019
Partner Governors (appointed)		
Cllr Tariq Hussain	Partner Governor Bradford Metropolitan District Council	May 2019
Dr Andrew Clegg	Partner Governor University of Leeds	December 2018
Professor Marina Bloj	Partner Governor University of Bradford	March 2019

There are two vacancies on the Council of Governors; one for a Public Governor (Rest of England) and one for a Patient Governor.

Vice-Chair and Lead Governor		
Mr David Walker	Vice-Chair of the Council of Governors	April 2018
Dr Andrew Clegg	Partner Governor University of Leeds	December 2019
Professor Marina Bloj	Lead Governor	December 2019

The appointments by the Council of Governors are made for a maximum term length of two years for each position or, to the end of their term as a Governor whichever is sooner.

ELECTIONS TO THE COUNCIL OF GOVERNORS

An election has been held in the Bradford West membership constituency. Mr Alan Edmonds, as the highest polling candidate, was elected as the Bradford West Public Governor.

Nomination packs with information about how to stand for election to all available positons have been made available from the Returning Officer at Electoral Reform Services Ltd.

ATTENDANCE AT MEETINGS OF THE COUNCIL OF GOVERNORS IN 2018/19

The Council of Governors met formally six times in 2018/19:

Figure 45: Attendance at Meetings of the Council of Governors 2018/19

Name		19.4.18	5.5.18 (AGM/AMM)	20.7.17	16.11.17	18.1.18	15.3.19	TOTAL
Professor Bill McCarthy	Chairperson, BTHFT	✔	✔	✔	✔	✔		5 of 5
Professor Marina Bloj	Partner Governor University of Bradford	✔	✔	✘	✔	✔	✔	5 of 6
Dr Andrew Clegg	Partner Governor University of Leeds	✘	✔	✔	✔	✔	✘	4 of 6
Mr Alan Edmonds	Public Governor Bradford West					✔	✔	2 of 2
Mr Alan English	Public Governor Bradford South	✔	✘	✔	✔	✔	✔	5 of 6
Ms Pauline Garnett	Staff: Nursing and Midwifery	✔	✔	✔	✔	✔	✔	6 of 6
Cllr Tariq Hussain	Partner Governor BMDC	✔	✔	✔	✘	✔	✘	4 of 6
Ms Stella Hall	Public Governor Bradford East	✔	✘	✔	✔	✔	✘	4 of 6
Ms Wendy McQuillan	Public Governor Keighley	✔	✘	✔	✔	✔	✔	5 of 6
Ms Hilary Meeghan	Public Governor Bradford South	✘	✔	✔	✔	✔	✔	5 of 6
Dr Sulleman Moreea	Staff: Medical and Dental	✔	✔	✔	✘	✔	✔	5 of 6
Ms Marian Olonade-Taiwo	Public Governor Keighley	✔	✔	✔	✔	✔	✘	5 of 6
Mr Michael Parry	Public Governor Bradford East	✘	✔	✔	✔	✘	✘	3 of 6
Ms Jenny Scott	Public Governor Bradford West	✔	✔	✔	✔	✔	✔	6 of 6
Ms Hardev Sohal	Patient Governor (Out of Bradford)	✔	✘	✔	✔	✔	✔	5 of 6
Mr David Walker	Public Governor Shipley	✔	✔	✔	✔			4 of 4
Mr David Wilmshurst	Public Governor Shipley	✔	✔	✔	✔	✘	✔	5 of 6
Ms Ruth Wood	Staff Governor: All Other Staff groups	✔	✔	✔	✘	✔	✘	4 of 6
Ms Katherine Wright	Staff Governor: Allied Health Professionals and Scientists	✔	✘	✔	✔	✘	✘	3 of 6
Ms Ruby Hussain	Public Governor Bradford West	✔	✔	✔	✔			4 of 4

The Trust confirms that all elections to the Council of Governors have been, and are being, held in accordance with the election rules as stated in the Constitution.

Process undertaken for the appointment of the external auditor

This is reported on page 49 of the Annual Report.

Governors' effectiveness

In addition to the delivery of their statutory duties and responsibilities, in March 2017 the Council of Governors undertook a review with the Chairman which covered the effectiveness of the Council of Governors. The key area marked for particular focus was the development of stronger relationships between the Non-Executive Directors and the Governors. In 2018/19 the Governors' work programme has included and been informed by the following.

Governor engagement with the Board of Directors

The members of the Board of Directors, in particular the Non-Executive Directors, regularly engage with the Council of Governors to develop an understanding of the views of Governors about the Trust. The Board and Governors have continued to cement and develop a range of engagement models during 2018/19 – all of which have been supported by the Chairperson. These activities have also supported the delivery of responsive learning and development opportunities for Governors (both individually and collectively).

Council of Governors Meetings: During 2018/19 the Council of Governors' meetings routinely include the delivery of key presentations, supporting challenge and discussion between Directors and Governors on matters of key material interest for the Foundation Trust. In year sessions have covered:

- Five Year Capital Investment Programme
- Divisional Strategic Plans 2018/19
- NHS Provider Licence Self Certification
- development of the Foundation Trust's Quality Plan
- outcomes and forward planning from the 'Work as One Week'
- the Alternative Delivery Model (Wholly Owned Subsidiary)
- the NHS 10 Year Long Term Plan
- the Trust Operational Plan for 2019/20
- the Patient Experience Strategy
- highlight reports and Committee minutes from the Board of Director Committee Chairs regarding Audit and Assurance, Quality, Finance and Performance, Workforce, Major Projects and Partnerships
- 'assurance the way forward: future reporting (to the Council of Governors from the Board Committees

Governors have also been consulted on the content of the Quality Report 2018/19.

Meetings with the Chair: Professor Bill McCarthy, Chairperson and subsequently, Dr Trevor Higgins, Acting Chairperson, held regular quarterly meetings with the Vice-Chair of the Council of Governors and the Lead Governors. The Deputy Chairperson and subsequently, the Acting Deputy Chairperson of the Board of Directors has been in attendance and an open invitation has also routinely been extended to all Governors to attend these sessions.

Joint meetings between the Non-Executive Directors and Governors: Quarterly informal sessions between Governors and Non-Executive Directors have supported the focus on matters discussed at meetings of the Board of Directors and, how Non-Executive Directors are holding the Executive Directors to account. These sessions have proved beneficial in support of Non-Executive Directors and Governors developing their relationships.

Governors' Business Review: The Council of Governors undertook a comprehensive review of their effectiveness on 24 January 2019. The review covered:

- size and composition of the Council of Governors
- operational planning / strategy
- management of the Council of Governors Meeting
- Council of Governors Effectiveness
- the role of the Chair
- overall Council of Governors Performance

Following confirmation of the appointment of a new Chair in May 2019 the outcomes will be reviewed with the new Chair and the Council of Governors and actions in response to the review agreed.

Communications with Governors: In year, Chair bulletins, Chair Board Reports, Minutes from the Board Meetings and Agendas for Board meetings have been provided to Governors. Governors have received:

- news items and briefings from a range of statutory and non-statutory organisations which has included CQC, NHSI, NHS Providers and the King's Fund
- promotion of in-house and external learning and development opportunities including those offered by GovernWell
- signposting to the work of the Bradford Metropolitan District Council Health and Social Care Overview and Scrutiny Committee
- other items of note shared by Governors

All Governors are in receipt of the weekly staff magazine 'Let's Talk' which keeps them abreast of operational initiatives, priorities, developments and good news stories.

In 2018/19 the Governors have not exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Trust's performance or its functions or the Directors' performance of their duties. The Non-Executive and Executive Directors regularly attend the Council of Governors meetings.

Governor engagement with Patients, Visitors and Staff

During 2018/19 Governors have had opportunity to visit a range of clinical and non-clinical operational areas through participation in a number of programmes and initiatives taking place at the Trust. In year involvement has included:

- mock CQC programme
- team of the year judging
- BRI/SLH Site visits

Governors have also taken part in a wide range of other activities which have also supported them in the delivery of their duties, roles and responsibilities. These have included the following:

- participation in the Trust's improvement programme ProgRESS (Programmed Reviews of Effectiveness, Safety and Sensitivity)
- two Governors, Ms Marion Olonade-Taiwo and Ms Hilary Meeghan continue to attend the panel of the Bradford Innovation Group (BIG) which supports the development of ideas and innovations amongst staff teams to support improvements in the patients' experience and contribute to the safety and quality of care provided in our Trust.
- Governors have routinely taken part in the Patient-Led Assessment of the Care Environment (PLACE) visits programme.

External engagement

Governors are active within a range of third sector and statutory organisations that form part of the local health economy and these relationships inform engagement with the Board of Directors. The Trust has also worked to support and facilitate the development of networks between the Council of Governors and statutory and third sector organisations that are part of the local health economy. In year Governors have attended:

- the National Governors' Conference, FOCUS, delivered by NHS Providers
- BMDC Health and Social Care Overview and Scrutiny Committee
- West Yorkshire and Harrogate Health and Care Partnership Patient Experience event
- Shaping the Future event delivered by local health partners.

Learning and development

Formal and informal learning and development opportunities have continued to be made available to the Council of Governors. As well as areas identified in relation to their engagement with the Board of Directors;

- a number of Governors have attended sessions delivered by GovernWell (NHS Providers) - part of the national training programme for Governors.
- Governors took part in a special Training and Development session related to 'recruitment and appointments' and equality and diversity to support Governors in relation to the Non-Executive Director and the Chair recruitment process.
- Governors met with the External Auditor, Deloitte LLP, to understand more about the scope of their role and, to gain further insights into their work in relation to the audit of the Trust's Quality Report.

3.5.3

BOARD OF DIRECTORS

Introduction

The Board of Directors is responsible for the day-to-day management of the Trust and the operational delivery of its services, targets and performance.

Our Directors

Professor Clive Kay,
Chief Executive

Clive was appointed as Chief Executive Officer January 2015.

Clive was appointed a Consultant Radiologist in Bradford in 1998. He became Clinical Director of Radiology (2001-06), subsequently Medical Director (2006-14), Deputy Chief Executive in 2013, and Interim Chief Executive in September 2014, at Bradford Teaching Hospitals NHS Foundation Trust. Prior to working in Bradford, he spent three years at the Medical University of South Carolina as Visiting Associate Professor of Radiology. His previous external roles include Chair of the Royal College of Radiologist's Scientific Programme Committee, Member of Council of the Royal College of Radiologists, and a Member of the Editorial Board of Clinical Radiology. He is a past Chair of the British Society of Gastrointestinal and Abdominal Radiology. He is a Fellow of the Royal College of Radiologists and a Fellow of the Royal College of Physicians of Edinburgh. He is an Honorary Visiting Professor at the University of Bradford, and a Lay Member of Council of the University of Bradford.

Mrs Sandra Shannon,
Acting Chief Operating Officer

Sandra was appointed as Chief Operating Officer on 1 April 2018 and Deputy Chief Executive from June 2018. Sandra has over 18 years' experience in senior operational management roles including Deputy Chief Operating Officer, Hospital Director, Programme Director and Cost Improvement Programme Management Office Director as well as leading turnaround and performance improvement in a number of NHS organisations. She also worked as part of the National Intensive Support Team at the Business Services Authority supporting NHS Trusts to reduce healthcare associated infections and improve hospital cleanliness. Sandra started her career as a nurse and a midwife and held a number of professional roles including Head of Midwifery and Deputy Director of Nursing before moving into general management.

Ms Pat Campbell,
Director of Human Resources

Pat has held the position of Director of HR since December 2008; having held previous posts of Personnel Manager and Deputy Director of HR. Pat is a Chartered Fellow of the Chartered Institute of Personnel and Development and has worked in the NHS since 1986, primarily in HR roles.

Ms Karen Dawber,
Chief Nurse

Karen was appointed as Chief Nurse in August 2016. Karen was formerly the Director of Nursing at Warrington and Halton Hospitals NHS Foundation Trust and has nine years' experience as an executive director across three Foundation Trusts.

An experienced nurse and service manager, she started her career as a paediatric nurse at Manchester Children's Hospital before moving into general

management and transformational work. Karen is passionate about patient quality and the impact that well-led and motivated staff have on the care we give to patients. She was named in the inaugural list of the Health Service Journal's lesbian, gay, bisexual and transgender leaders and takes a keen and active interest in the equality and diversity agenda.

Ms Cindy Fedell, Chief Digital and Information Officer

Cindy joined the Foundation Trust in September 2013 as the Director of Informatics. Cindy is also the Trust's Senior Information Risk Owner and both the Chair of the Yorkshire Imaging Collaboration and the Digital Senior Responsible Officer for the West Yorkshire & Humber Partnership. Cindy previously worked in Canada where she was at Mount Sinai Hospital in Toronto, an academic tertiary hospital, and was a member of the Information and Communication Technology Council of Canada's eHealth group. Cindy holds Chief Information Officer and Advanced Leadership certificates from the College of Healthcare Information Management Executives and the University of Toronto respectively, as well as degrees from Ryerson University and Lakehead University in Canada. In addition to her roles in acute care, Cindy worked in the private sector for several years as an Informatics Management Consultant advising hospitals on systems design and implementation.

Dr Bryan Gill, Medical Director

Bryan was appointed to the position of Chief Medical Officer in May 2015 and became the Responsible Officer for the Foundation Trust in July 2015. He is the Foundation Trust's Caldicott Guardian. In his role as Chief Medical Officer, Bryan is the Chair of the Medical Directors' Group for the West Yorkshire Association of Acute Trusts and is the Deputy Chair of the Integrated Care System Clinical Forum. Prior to this he held the position of Medical Director for Quality and Governance at Leeds Teaching Hospitals NHS Trust. Bryan has 15 years' experience at senior medical management level in the Acute Trust sector and has a particular interest and expertise in Quality Improvement, Patient Safety and Medical Workforce. He was a Consultant in Neonatology for 19 years before going into a full-time medical management role in 2013. He is a past President of the British Association of Perinatal Medicine (BAPM) and has previously held national roles of Honorary Secretary of BAPM and Chair and Training Advisor for the Royal College of Paediatrics and Child Health. He was the first Lead Clinician for the Yorkshire Neonatal Network (2003-2008). He is a Fellow of the Royal College of Paediatrics and Child Health.

Mr John Holden, Director of Strategy and Integration

John was appointed in August 2016 as Director of Strategy and Integration, to lead on developing and integrating services which deliver new models of care in the Bradford district and across the wider West Yorkshire region, ensuring the Foundation Trust continues to provide high quality care which meets the needs of the local population. John has spent most of his career in senior roles at the Department of Health and then NHS England, which he helped establish. He is an experienced Director who has shaped strategy at national level and was responsible for leading NHS England's policy on a range of issues, including the Academic Health Science Networks and the review to decide the National provision of Congenital Heart Services. In previous roles John was responsible for NHS quality regulation, Foundation Trust policy, major capital investment programmes, and project management of the comprehensive spending review to secure NHS funds from Treasury. From 1995 to 1996 John was Private Secretary to the Secretary of State for Health. He studied at the Universities of York and California and has an MBA from Manchester Business School.

Mr Matthew Horner, Director of Finance

Matthew joined the Board as Acting Director of Finance in November 2011 and was appointed substantive Director of Finance in August 2012. He has a degree in Accountancy and Finance and is a qualified member of the Chartered Institute of Public Finance and Accountancy. His NHS finance career spans over 27 years and covers a variety of finance roles. He has, for the last 17 years, worked for the Foundation Trust in Bradford, progressing from Finance Manager to Director of Finance.

Dr Trevor Higgins, Non-Executive Director (Deputy Chair)

Trevor was appointed as a Non-Executive Director in May 2012, and became Deputy Chair on 1 November 2013, a role he has retained apart from a 5 month period as acting Chair, from June to October 2016. Trevor was born and educated in the city. He was the Regional Partnership Director for BT and enjoyed a diverse career in over forty years with the company – his roles ranged from call centre management to senior operations management. He has now retired, but in his last role represented all BT's operational divisions. In his previous role, as BT's Regional Business Manager, he managed 1,200 people with responsibility for a budget in excess of £30 million. Trevor is also Chief Executive of Bradford Breakthrough, Chair of the Digital Health Enterprise Zone, Board Member of Bradford Chamber Council and a Lay Member of the University of Bradford Council. Educated to postgraduate level, in July 2011 he was awarded an Honorary Doctorate as Doctor of Bradford University for services to businesses and communities across the region.

Mr Amjad Pervez, Non-Executive Director

Amjad was appointed as a Non-Executive Director in February 2015. He founded Seafresh/ Adams in Bradford over 30 years ago and it is now one of the largest groups of independent specialist catering food service and cash and carry groups in the UK. Amjad has committed a lot of time to education and enterprise in Bradford and the wider West Yorkshire region including establishing Asian Trade Link Yorkshire Limited in 1999, which he chaired until last year. Until recently he was also a Board member of the Leeds City Region Enterprise Partnership. Amjad is currently a Board member with Bradford Matters, Bradford Breakthrough and The National Asian Business Association. He is Chair of the Rainbow Trust through which Rainbow Primary Free School is operated, which opened in 2012.

Ms Selina Ullah, Non-Executive Director (SID and Acting Deputy Chair)

Selina was appointed as a Non-Executive Director in September 2015. She is passionate about people and communities; this has led to her involvement in: national, regional and local government; think tanks; charitable foundations; and non-governmental organisations, working on policy formulation, transformation, service modernisation, regulation and governance. Selina has an in-depth knowledge of engaging diverse communities, in particular 'hard to reach' groups. She has over 25 years of experience of working with charities and the not-for-profit sector and extensive senior management experience in the public sector, working in health service management and on public policy on high profile issues such as community cohesion, diversity, engaging hard to reach groups, mental health and social inclusion, crime and disorder and counter-terrorism. Until June 2011, Selina was Assistant Director – Safer and Stronger Communities at Bradford Council. Selina is an advisor to the Joseph Rowntree Foundation, a Non-Executive Director of a national health regulator, Yorkshire and Humber

Committee member of the Heritage Lottery Fund, Director of Manchester Central Library Development Trust, Chair of the Muslim Women's Council and President of ICLS, an international organisation based in Rome which specialises in intercultural dialogue, participation and leadership. Selina has an extensive career in race relations and is an Advisory Board Member and Trustee of the Ahmed Iqbal Ullah Race Relations Resource Centre and Education Trust based in Manchester Central Library.

Professor Laura Stroud, Non-Executive Director

Laura was appointed as a Non-Executive Director in October 2017. She is Associate Dean (Education) for the School of Medicine, Professor of Public Health and Education Innovation and the Director of the Institute of Health Sciences at the University of Leeds. Laura's expertise is in professional education and supervision. She has significant experience of mentoring and supporting development of individuals and teams and has held a number of roles as an independent chair or expert invitee in the health and not-for-profit sector. She has recently been working on Quality Improvement initiatives in association with the local NHS through her work with the Centre for Innovation in Health Management.

Mr Barrie Senior, Non-Executive Director

Barrie was appointed as a Non-Executive Director and as Chairman of the Audit Committee with effect from 1 December 2017. He was born, educated, trained and qualified as a Chartered Accountant in Bradford. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA). His career to date spans partnership roles with two major accounting firms, finance and corporate development director roles with two significant Yorkshire-based PLCs, as well as non-executive director and audit committee chairman positions. For five years prior to joining the Foundation Trust, Barrie was a non-executive director and chairman of the Audit Committee at Yorkshire Ambulance Service NHS Trust.

Ms Trudy Feaster-Gee, Non-Executive Director

Trudy was appointed as a Non-Executive Director from January 2018. She is a barrister and partner at Walker Morris LLP (Leeds) with some 25 years' experience advising businesses and public sector organisations across a broad range of industries, with a particular emphasis on regulated sectors. Trudy also has experience of advising in-house as well as within enforcement agencies, having worked on secondment at the European Commission, Volkswagen Group UK (as head of legal), the UK's Competition Commission (now part of the Competition and Markets Authority) and at Lloyds Banking Group (as head of external competition engagement).

Mr Jon Prashar, Non-Executive Director

Jon was appointed as a Non-Executive Director from February 2018. Jon Prashar is the Group Head of Diversity and Inclusion at Places for People. He is instrumental in promoting equality and diversity to achieve continual improvement in a changing customer market. With over 30 years of experience of working in the Public, Private and Voluntary sectors, Jon has focussed on designing and delivering best practice. He is therefore particularly adept at designing new operational processes as well as delivering robust communication plans to ensure that employees, service users, contractors and partners promote equality and harness the opportunities created by diversity. Jon has a background in construction, organisational development and training and he has a wealth of experience in building relationships and promoting equality and inclusion. He fully supports the business case for diversity and the benefits that different perspectives bring to deliver creativity and quality outcomes. With a wealth of experience and commitment to public service, Jon is also a Board member of the Housing Diversity Network, a member of Homes England Equality and Diversity Board and

a Board member of Leeds and Yorkshire Housing Association. Jon works passionately to promote a culture of professional accountability. He has a visual impairment and considers himself to be the very lucky owner of a working guide dog.

Mr Andrew McConnell OBE, Associate Non-Executive Director

Andrew was appointed as an Associate Non-Executive Director in September 2018. He obtained a degree in Mathematics at the University of Manchester and went on to qualify as a chartered accountant with a major firm. During 20 years of audit and general practice advisory work he was a partner in a West Yorkshire based regional firm of chartered accountants and in a major global firm when this practice merged.

Andrew has been Director of Finance at the University of Huddersfield since 2001, a role which encompasses strategic and business planning, delivering financial sustainability and value for money, financial management and reporting, risk management and liaising with internal and external audit teams.

Throughout his career Andrew has had a commitment to education, taking governance roles at junior, secondary and FE colleges in the local area. He was formerly chair of the University's Audit Committee and vice-chair of the University Council. He holds several related posts outside the university and is a past chair of the British Universities Finance Directors' Group. He is also currently a board member of the Higher Education Statistics Agency Ltd (and chairs its Audit Committee), Wakefield College (vice-chair) and several other companies.

Andrew was invited to become a Companion of the Chartered Management Institute in 2017. He was awarded an OBE for services to accounting and the community in the 2015 Queen's Birthday Honours list.

Former Directors (Directors who resigned or whose term of office ended during the year)

Professor Bill McCarthy, Chair

Bill was appointed as a Non-Executive Director on 1 November 2015, and was appointed Chair a year later, on 1 November 2016. Bill is Deputy Vice-Chancellor (Operations) and Honorary Professor of Health Policy at the University of Bradford. In previous roles he has acted as the Government's Principal Policy Adviser on health reforms and has served on various national bodies including the NHS Constitution Forum, Civil Service capability review panel and the Health and Local Government Strategy Board. An economist by training, he has held a number of senior public service appointments including Director General in the Department of Health, Chief Executive at City of York Council, Chief Executive of NHS Yorkshire and the Humber, and most recently, National Policy Director, NHS England. On the 31 January 2019, Bill stood down from his position as Chair.

Dr Tanya Claridge, Director of Governance and Corporate Affairs

Tanya was appointed to the post of Director of Governance and Corporate Affairs in April 2018. Originally qualifying as a nurse and health visitor, Tanya has held a number of clinical and managerial roles in both community, commissioning and acute health care organisations during 22 years of NHS service. Awarded a PhD in 2006, Tanya maintains a keen research interest in human factors, psychology and organisational culture. On the 30 September 2018 Tanya stood down from her position as an Executive Director.

Mrs Pauline Vickers, Non-Executive Director Senior Independent Director

Pauline was appointed as a Non-Executive Director in November 2013 and Senior Independent Director (SID) from 1 December 2016. Pauline is currently working for Royal Mail. She brings a wealth of business and leadership experience gained at Board level in a range of commercial, customer and people focused roles across the Royal Mail Group. Educated at Prince Henry's Grammar School, Otley she went on to read Management Science at the University of Manchester Institute of Science and Technology (UMIST), followed by a Postgraduate Diploma in Personnel Training and Development at Leeds Metropolitan University. She is a member of the Institute of Personnel and Development, an accredited coach via Middlesex University and recently completed an Executive Leadership Development Programme at the Oxford Said Business School. Pauline is committed to supporting diversity and is a member of the Diversity Steering Group for Royal Mail and Chairs the London Women's network to support the success of women within the organisation. She is also a Trustee of the Rowland Hill Fund, a charity that supports Royal Mail employees and pensioners in times of need. On the 3 November 2018, Pauline stood down from her position as Non-Executive Director.

Attendance At Meetings Of The Board Of Directors 2017/18

Figure 46: Attendance at meetings of the Board of Directors 2017/18

BOARD MEMBERS	10.5.18	10.5.18	13.9.18	8.11.18	10.1.19	7.3.19	TOTAL
Bill McCarthy	✔	✘	✔	✔	✔		5 of 5
Pat Campbell	✔	✔	✔	✔	✔	✔	6 of 6
Karen Dawber	✔	✔	✔	✔	✔	✔	6 of 6
Cindy Fedell	✔	✔	✔	✔	✔	✔	6 of 6
Bryan Gill	✔	✔	✔	✔	✔	✔	6 of 6
John Holden	✔	✔	✔	✔	✔	✔	6 of 6
Matthew Horner	✔	✔	✔	✔	✔	✔	6 of 6
Clive Kay	✔	✔	✔	✔	✔	✔	6 of 6
Sandra Shannon	✔	✔	✘	✔	✔	✔	5 of 6
Tanya Claridge	✔	✔	✔				3 of 3
Trevor Higgins	✔	✔	✔	✔	✔	✔	6 of 6
Amjad Pervez	✔	✔	✔	✔	✔	✘	5 of 6
Selina Ullah	✔	✔	✔	✔	✔	✔	6 of 6
Pauline Vickers	✔	✔	✔	✔			4 of 4
Laura Stroud	✘	✔	✔	✔	✘	✔	4 of 6
Barrie Senior	✔	✘	✔	✔	✔	✔	5 of 6
Trudy Feaster-Gee	✔	✔	✔	✔	✔	✔	6 of 6
Jon Prashar	✔	✘	✘	✔	✔	✔	4 of 6
Andrew McConnell				✔	✔	✔	3 of 3
✔ = Attended		✘ = Apologies received					Denotes period when not a member of the board

Board of Directors' meetings are also attended by the Trust Secretary. Meetings take place bi-monthly. The Board of Directors met 6 times in 2018/19.

3.5.4

COMMITTEES OF THE BOARD

Finance and Performance Committee

The purpose of the Committee is to provide the Board of Directors with an objective and independent review (including relevant strategic risks and associated assurance) of the management of assets and resources in relation to the achievement of financial targets, business objectives and the financial stability of the Trust, and the effective management of all performance related matters.

Figure 47: Attendance at Meetings of the Finance and Performance Committee 2018/19

MEMBERS	25.4.18	30.5.18	27.6.18	25.7.18	29.8.18	26.9.18	31.10.18	28.11.18	12.12.18	30.1.19	27.2.19	27.3.19	TOTAL
Pauline Vickers (Chair)	✔	✔	✔	✔	✔	✔	✔	✔					8 of 8
Trevor Higgins	✔	✔	✔	✔	✘	✔	✔	✔	✔	✔	✔	✔	11 of 12
Laura Stroud	✔	✔	✘	✔	✔	✔	✔	✔	✔	✔	✔	✔	11 of 12
Trudy Feaster-Gee								✔	✔	✔	✔	✔	5 of 5
Jon Prashar	✔	✔	✘	✔	✔	✔	✔						6 of 7
Andrew McConnell						✔	✔	✔	✘	✔	✔	✔	6 of 7
Matthew Horner	✔	✔	✘	✔	✔	✔	✔	✘	✔	✔	✘	✔	9 of 12
Sandra Shannon	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✘	✔	11 of 12
John Holden								✔	✔	✔	✔	✔	5 of 5
Cindy Fedell	✘	✘	✔	✔	✔	✔	✔	✔	✘	✔	✔	✔	9 of 12
Karen Dawber	✔	✔	✔	✔	✔	✔	✔						7 of 7
✔ = Attended ✘ = Apologies Apologies received				Denotes period when not a member of the Committee									

Committee meetings are also attended by the Trust Secretary, the Deputy Director of Finance and, the Head of Performance. .

Quality and Safety Committee

The purpose of the Quality and Safety Committee is to provide the Board of Directors with an objective and independent review (including relevant strategic risks and associated assurance) of the quality of the care the Trust provides. This remit includes a focus on the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well led, and on also on the effectiveness of quality governance and risk management (including health and safety) systems.

Figure 48: Attendance at Meetings of the Quality and Safety Committee 2018/19

MEMBERS	25.4.18	30.5.18	27.6.18	25.7.18	29.8.18	26.9.18	31.10.18	28.11.18	12.12.18	30.1.19	27.2.19	27.3.19	TOTAL
Laura Stroud (Chair)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12 of 12
Amjad Pervez	✔	✔	✘	✔	✔	✔	✔	✔	✘	✘			7 of 10
Selina Ullah	✔	✔	✔	✔	✔	✔	✔	✔	✘	✔	✘	✘	9 of 12
Jon Prashar	✘	✔	✘	✔	✔	✔	✔	✔	✔	✘	✔	✔	9 of 12
Karen Dawber	✘	✔	✔	✔	✔	✔	✔	✘	✔	✔	✔	✔	10of12
Cindy Fedell	✘	✘	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10 of 12
Bryan Gill	✔	✔	✔	✔	✔	✔	✔	✘	✔	✔	✔	✔	11of 12
Tanya Claridge	✔	✔	✔	✔	✔	✔	✔						7 of 7
✔ = Attended ✘ = Apologies sent			Denotes period when not a member of the Committee										

Committee meetings are also attended by the Trust Secretary

Integrated Governance and Risk Committee

The purpose of the Integrated Governance and Risk Committee is to provide the Board of Directors with Executive oversight and assurance of the strategic risks being mitigated and managed by the organisation

Figure 49: Attendance at Meetings of the Integrated Governance and Risk Committee 2019/20

MEMBERS	24.4.18	23.5.18	20.6.18	17.7.18	23.8.18	19.9.18	17.10.18	22.11.18	7.12.18	17.1.19	13.2.19	20.3.19	TOTAL
Clive Kay (Chair)	✔	✘	✔	✔	✘	✔	✘	✔		✔	✘	✔	7 of 11
Pat Campbell	✔	✔	✘	✔	✔	✘	✔	✔		✔	✘	✘	7 of 11
Karen Dawber	✔	✔	✔	✔	✘	✔	✘	✔		✔	✔	✔	9 of 11
Cindy Fedell	✘	✔	✔	✔	✘	✘	✘	✔		✘	✘	✔	5 of 11
Bryan Gill	✔	✔	✘	✘	✔	✔	✘	✔		✔	✔	✔	8 of 11
John Holden	✔	✔	✘	✔	✘	✔	✔	✔		✔	✔	✔	9 of 11
Matthew Horner	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	11 of 11
Tanya Claridge	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	11 of 11
Sandra Shannon	✔	✔	✔	✔	✔	✘	✔	✔		✘	✔	✔	9 of 11
✔ = Attended			Denotes period when not a member of the Committee										
✘ = Apologies received			Denotes month when no meeting held										

Committee meetings are also attended by the Trust Secretary

Charitable Funds Committee

The purpose of the Committee is to provide the Board of Directors with an objective and independent review of the management of charitable activity within the Trust as set out within its governing document, registered with the Charity Commission. Integrated Governance and Risk Committee.

Figure 50: Attendance at Meetings of the Charitable Funds Committee 2018/19

MEMBERS	12.7.18	8.11.18	7.3.19	TOTAL
Bill McCarthy (Chair)	✔	✔		2 of 2
Trevor Higgins (Chair from 1 February 2019)	✘	✔	✔	2 of 3
Trudy Feaster-Gee	✔	✔	✔	3 of 3
Clive Kay	✔	✔	✔	3 of 3
Karen Dawber	✔	✔	✔	3 of 3
Matthew Horner	✔	✘	✔	2 of 3
John Holden	✔	✔	✔	3 of 3
✔ = Attended ✘ = Apologies received		Denotes period when not a member of the Committee		

Committee meetings are also attended by the Assistant Director of Finance and Charity Fundraiser.

Major Projects Committee

The purpose of the Committee is to provide the Board of Directors with an objective and independent review (including relevant strategic risks and associated assurance) of the management of Major Projects (as defined by the Trust Board of Directors) being planned or implemented within the Trust.

Figure 51: Attendance at Meetings of the Major Projects Committee 2018/19

MEMBERS	25.4.18	27.6.18	29.8.18	31.10.18	12.12.18	27.2.19	TOTAL
Amjad Pervez (Chair)	✔	✘	✔	✔	✔	✘	4 of 6
Trudy Feaster-Gee	✔	✔	✔	✔	✔	✔	6 of 6
Pauline Vickers	✔	✔	✔	✔			4 of 4
Andrew McConnell					✔	✔	2 of 2
Clive Kay	✔	✘	✔				2 of 3
Tanya Claridge	✔	✔	✘	✔	✔	✔	5 of 6
Bryan Gill	✔	✔	✔	✔	✔	✔	6 of 6
Pat Campbell	✔	✔	✔				3 of 3
Cindy Fedell	✘	✔	✔	✔	✔	✔	5 of 6
Matthew Horner	✔	✘	✔	✔	✔	✘	4 of 6
John Holden	✔	✘	✔	✘	✔	✔	4 of 6
Sandra Shannon	✔	✔	✔	✔	✘	✘	4 of 6
✔ = Attended ✘ = Apologies sent		Denotes period when not a member of the Committee					

Partnerships Committee

The purpose of the Committee is to provide detailed scrutiny of the Trust's arrangements for partnerships and collaborative working in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

Figure 52: Attendance at Meetings of the Partnerships Committee 2018/19

MEMBERS	25.5.18	26.7.18	5.10.18	30.11.18	25.1.19	22.3.19	TOTAL
Bill McCarthy (Chair)	✔	✔	✔		✔		4 of 4
Trevor Higgins (Chair)						✔	1 of 1
Amjad Pervez	✔	✘	✔		✔	✔	4 of 5
Trudy Feaster-Gee	✔	✔	✔				3 of 3
Laura Stroud	✔	✔	✘		✔	✔	4 of 5
Clive Kay	✔	✔	✔		✔	✔	5 of 5
John Holden	✔	✔	✔		✔	✔	5 of 5
Bryan Gill	✔	✔	✘		✘	✔	3 of 5
Matthew Horner	✔	✔	✔		✔	✔	5 of 5
✔ = Attended		Denotes period when not a member of the Committee					
✘ = Apologies received		Meeting cancelled					

Committee meetings are also attended by the Trust Secretary

Workforce Committee

The purpose of the Committee is to provide the Board of Directors with an objective and independent review (including relevant strategic risks and associated assurance) of the effectiveness of the workforce management arrangements for the Trust.

Figure 53: Attendance at Meetings of the Workforce Committee 2018/19

MEMBERS	25.5.18	26.7.18	5.10.18	30.11.18	25.1.19	22.3.19	27.3.19	TOTAL
Selina Ullah (Chair)	✔	✔	✔	✔	✔	✘	✘	5 of 7
Laura Stroud						✘		0 of 1
Pauline Vickers	✔	✘	✔	✔				3 of 4
Jon Prashar	✔	✔	✔	✔	✔	✔	✔	7 of 7
Amjad Pervez					✔	✘	✔	2 of 3
Pat Campbell	✔	✔	✔	✔	✔	✔	✔	7 of 7
Sandra Shannon	✔	✔	✘					2 of 3
Bryan Gill	✔	✔	✔	✘	✔	✔	✘	5 of 7
Karen Dawber	✔	✔	✔	✘	✔	✔	✔	6 of 7
✔ = Attended		Denotes period when not a member of the Committee						
✘ = Apologies received		Meeting cancelled						

Audit and Assurance Committee

The purpose of the Committee is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements.

The matters to be considered by the Audit and Assurance Committee are included within the Audit and Assurance Committee Terms of Reference. The Terms of Reference are reviewed annually and approved by the Board of Directors. The Terms of Reference for the Audit and Assurance Committee are published and available on the Trust website.

In year the committee considered and reviewed the following reporting from Internal Audit.

- Internal Audit Annual Report & Head of Internal Audit Opinion
- the Counter Fraud Annual Report
- Local Counter Fraud Specialist Risk Assessment 2018/19
- the Internal Audit Plan for 2018/19
- regular Internal Audit Progress reports
- regular reports concerning follow up of Internal Audit recommendations
- Counter Fraud Progress Reports
- Internal Audit Charter

The Committee considered and reviewed the following reporting from the Trust.

- Accounting Standards 2018/19
- Additional External Audit Fee for 2017/18 Audit
- Annual Governance Statement 2017/18
- Annual Report/Quality Report 2018/19 timetable for production
- Annual Review of Internal Audit and External Audit Performance
- Annual Security Report
- Audit and Assurance Committee Work plan 2018-19
- Audit Committee Annual Self- Assessment
- Board Assurance Framework
- Bradford Hospitals Charity Annual Report and Accounts 2017/18
- Business Continuity Planning (BCP)
- Charitable Funds Accounts
- Clinical Audit Annual Report
- Clinical Audit High Priority Work plan
- CQC Compliance
- CQC Inspection Report and Compliance Actions
- Cyber Security Update
- Data Quality
- Draft Annual Accounts 2017/18
- Draft Annual Report/Quality Report 2017/18
- Effectiveness Reporting and Governance
- Exception Reports
- Final Annual Accounts 2017/18
- High Priority Clinical Audit Plan 2018-19
- Internal Audit Charter
- Internal Audit Report Process
- Losses and Special Payments and Tender Waivers Updates
- Presentation from the new Strategic Head of Procurement
- Proposed Appointment of External Audit to perform non-audit work
- Provider to Provider: Internal Audit Report
- Regulatory Framework Assurance
- Regulatory Requirements
- Review of Audit Committee Terms of Reference
- Review of Board Committees' Terms of Reference
- Referral to Treatment (RTT) and Ambulance Handovers: Progress with remedial actions resulting from the External Audit of the Quality Report 2017/18
- Security Management Standards for Providers
- Self-Certification of the NHS Provider Licence

- Third Party Provider Functions
- Update on remaining issues with EPR
- Way Forward – Governance & Assurance Report

The committee considered and reviewed the following reporting from the External Auditors

- External Audit Report 2017/18
- Charitable Accounts - ISA 260
- Draft letter of Representation 2017/18 (Charitable Accounts)
- Annual Report and Accounts – ISA 260
- Draft letter of Representation 2017/18 (Annual Report and Accounts)
- Quality Report Audit Guidance 2018/19

In-year, the Audit and Assurance Committee considered and approved the following items

- Internal Audit Plan
- Internal Audit Charter
- External Audit Plan
- Foundation Trust Annual Accounts 2017/18.
- Review of arrangements for use of External Auditors for Non-Audit Purposes
- Additional External Audit Fee for 2017/18 Audit
- Audit and Assurance Committee Work plan 2019/2020
- Proposed Appointment of External Audit to perform non-audit work
- Audit Committee Annual Report to Board

The minutes from the meetings of the Audit and Assurance Committee, along with reports from the Chair of the Audit and Assurance Committee, highlighting the key items for discussion, are routinely presented at the public meetings of the Board of Directors and to the Council of Governors. These documents are available on the Trust website.

The committee's membership has been as follows:

- Barrie Senior – Committee Chair
- Trevor Higgins
- Selina Ullah
- Jon Prashar – from 2 February 2019

The Committee met seven times during the year. Attendance at these meetings is detailed in Figure 54: Attendance at Meetings of the Audit and Assurance Committee 2018/19:

Figure 54: Attendance at Meetings of the Audit and Assurance Committee 2018/19

MEMBERS	25.5.18	26.7.18	5.10.18	30.11.18	25.1.19	22.3.19	27.3.19	TOTAL
Barrie Senior	✔	✔	✔	✔	✔	✔	✔	7 of 7
Trevor Higgins	✘	✔	✔	✘	✔	✔		4 of 6
Selina Ullah	✔	✔	✔	✔	✔	✘	✔	6 of 7
Jon Prashar							✔	1 of 1
✔ = Attended ✘ = Appologies received		Denotes period when not a member of the Committee						

Audit and Assurance Committee meetings are also attended by the Director of Finance, an Assistant Director of Finance and the Trust Secretary. The Chief Executive attends at least one meeting per year. Representatives of both Internal and External Audit also attend meetings.

3.5.5

EXTERNAL AUDIT

The external auditor for the Foundation Trust is:

Deloitte LLP
One Trinity Garden
Broad Chare
Newcastle upon Tyne
NE1 2HF

The external auditor was appointed in June 2017 following a procurement exercise led by a working group of the Council of Governors. The appointment was in accordance with the Code of Audit Practice for NHS Foundation Trusts, issued by the National Audit Office on behalf of the Comptroller and Auditor General.

The fee for the year is shown in Figure 55: Remuneration of External Auditors.

Figure 55: Remuneration of External Auditors

Fee (excluding VAT)	2018/19 £000	2016/17 £000
Audit Services – Statutory Audit	48	48
Non Audit Services - Audit-related assurance services	6	6
Non Audit Services – Other Assurance Services	33	32
Total	**87**	**86**

Any proposal for the use of the external auditors to provide non-audit services is reported to the Audit and Assurance Committee. There were two such engagements which were in respect of audit related assurance services (£6,000) and other assurance services (£33,000) (2017/18 £38,000 in total).

3.5.6

INTERNAL AUDIT AND COUNTER FRAUD SERVICE

Internal Audit and Counter Fraud Services are provided by Audit Yorkshire. The Director of Finance sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level.

An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity. This document was updated, reviewed and approved by the Audit and Assurance Committee in August 2018. The Audit and Assurance Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2018/19, and gave formal approval of the Internal Audit Operational Plan in April 2018.

The conclusions as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit and Assurance Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary.

A system is in place whereby all internal audit recommendations are followed-up on a quarterly basis. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Executive Management Team and the Audit and Assurance Committee on a quarterly basis. This has been an area of focus by the Committee during the year and Trust management have worked hard to ensure that the process for responding to Internal Audit recommendations has been improved.

The Counter Fraud Plan was reviewed and approved by the Audit and Assurance Committee and the Local Counter-Fraud Specialist (LCFS) presented regular reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

3.5.7

OTHER DISCLOSURES: TRUST MEMBERSHIP

Membership Constituencies

Bradford Teaching Hospitals NHS Foundation Trust membership is made up of public, patient and staff membership constituencies.

Public Membership Constituency

To be eligible for public membership a person needs to be over the age of 16 years and reside within one of the public constituencies as outlined within the Trust's Constitution. The public membership constituency is divided into six sub-constituencies which are known as Keighley, Shipley, Bradford East, Bradford South, Bradford West and 'Rest of England and Wales'. Keighley, Shipley, Bradford East, Bradford South and Bradford West are comprised of the 30 electoral wards within the Bradford Metropolitan District Council (BMDC) area. Members allocated to the 'Rest of England' sub-constituency are those who live outside the BMDC area and have not received treatment at Bradford Teaching Hospitals NHS Foundation Trust. Public members are automatically registered in one of the sub-constituencies listed in Figure 56: Public Membership Constituencies as determined by their home postcode.

Figure 56: Public Membership Constituencies

Public Membership Constituencies	Wards
Keighley	Craven, Ilkley, Keighley Central, Keighley East, Keighley West, Worth Valley.
Shipley	Baildon, Bingley, Bingley Rural, Shipley, Wharfedale, Windhill and Wrose.
Bradford East	Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, Eccleshill, Idle and Thackley.
Bradford South	Great Horton, Queensbury, Royds, Tong, Wibsey, Wyke.
Bradford West	City, Clayton and Fairweather, Heaton, Manningham, Thornton, Toller, Little Horton.
Rest of England and Wales	Remaining electoral wards that do not form part of the BMDC area.

Patient (Out of Bradford) Membership Constituency

To be eligible for patient membership a person needs to be over the age of 16 years, have received treatment at Bradford Teaching Hospitals NHS Foundation Trust and live outside the Bradford Metropolitan District Council boundary or, where appropriate, they are the carers of such a patient and act on their behalf.

Staff Membership Constituency

To be eligible for staff membership a person needs to be an employee of the Trust who holds a permanent contract of employment or has worked for the Trust for at least 12 months. Contract staff or those holding honorary contracts and who have worked at the Trust for at least 12 months are also eligible for membership.

Number of Members

At the year end the Trust has a total membership of 48,084. Figure 57: Trust Membership provides a breakdown of membership within each of the main membership constituencies and where applicable the sub-membership constituency within each group.

Figure 57: Trust Membership

Public Membership Constituency Breakdown	FT members	% membership	BMDC total population	% of BMDC population
Bradford East	8,733	24	117,930	22
Bradford South	8,417	23	105,214	20
Bradford West	8,837	25	118,979	22
Keighley	2,969	8	98,756	18
Shipley	6,623	18	97,152	18
Rest of England	258	1	0	0
Total Public Membership	**35,837**		**538,031**	
Total Patient (Out of Bradford) Members	**6,380**			

Figure 57 continued: Trust Membership

Staff Membership Constituency breakdown	FT members	Total eligible staff population	Membership as % of total eligible staff population
Allied Health Professionals and Scientists	654	654	100%
Nursing and Midwifery	1,746	1,746	100%
Medical and Dental	752	752	100%
All Other Staff Groups	3,032	3,032	100%
Total Staff Membership	**5,942**	**5,942**	**100%**

Newly employed staff members are automatically opted into membership of the Trust unless they advise that they do not wish to be a member. Employees who are ineligible for staff membership due to the nature of their contracts are eligible to become public or patient members as long as they meet the qualifying criteria for those membership constituencies.

Membership Recruitment, Engagement and Development 2018/19

At the beginning of April 2018, total overall membership stood at 48,192. During the year, membership has declined overall by 108 members. Membership trends across the sector have been reviewed in comparison to that of the Trust and the general trend is that membership levels are falling (for those Foundation Trusts with sizeable memberships).

As the Trust has a high level of membership (compared to other Foundation Trusts) no active recruitment campaigns have been undertaken, however people were provided with opportunities to register as new members in tandem with general public engagement activities and via the Trust's on-line membership joining form. The profile of the membership continues to be monitored with regard to representation. The Trust is able to report that from a socio-economic perspective the membership remains, on the whole, fairly representative of the communities served. The number of members within the 16-22 age group is under-represented, and the number of members within the 60-75 age group is over-represented.

In March 2019 the Board of Directors approved the Membership Plan 2019/20. The Plan covers

- key Membership and Public Events planned for 2019/2020
- membership and Public Communications
- opportunities for Membership and Public Involvement
- establishment of a 'task and finish group' to develop a Membership involvement and Communications Plan 2020 to 2022 comprising representatives from the Council of Governors, a Non-Executive Director and Executive Director.

The Membership Involvement and Communications Plan for 2020 to 2022 will be presented to the Council of Governors for formal Consultation in October 2019 and presented to the Board of Directors for approval in January 2020 with a view to implementing the plan from April 2020.

Annual Members Meeting / Open Event featuring key developments

The Annual Members Meeting (AMM) was combined with the Annual General Meeting (AGM) and took place on 5 July 2018 the anniversary of the NHS. As well as invitations to the AMM/AGM, Foundation Trust Members and the public were invited to a special presentation focussed on research and development delivered by Professor John Wright, Director of the Bradford Institute for Health Research. The Chair and the Governors were pleased to note that approximately 150 people were in attendance, similar to that experienced in the previous year.

Members and the public have also been;

- involved in 'patient and public engagement' activities across the Trust including Patient-Led Assessments of the Care Environment (PLACE)
- signposted to other health related activities and events both at our Trust and across the district
- encouraged to register as Volunteers

Membership Communications

General and targeted emails have been used as the main means of direct communications with members. 'Focus on' the new membership magazine was launched in June 2018 and received a favourable response. Further issues along with regularity of reporting are being considered as part of the new membership plan.

The Trust continues to encourage people to join online and sign up for electronic communications.

Contact procedures for members who wish to communicate with Governors

If members have specific issues they wish to raise they are able to contact individual Governors, the Chair, or the Council of Governors as a whole via a dedicated helpline telephone number which is 01274 364794 or via the following email and postal addresses:

General membership: members@bthft.nhs.uk

Governors: governors@bthft.nhs.uk

The Trust Membership Office
Trust Headquarters,
Chestnut House
Bradford Royal Infirmary
Duckworth Lane
Bradford BD9 6RJ

Papers and agendas for Council of Governor meetings are published on the Trust's website in advance of the meetings taking place.

Members are advised of these processes through the membership welcome pack, general membership communications, and the agenda for each Council of Governors meeting and via the Foundation Trust's dedicated membership website pages.

3.6 NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

NHS Improvement has placed the Trust in segment 2 which maintains the rating achieved in 2017/18.

This category is for providers who have been offered targeted support because there are concerns in relation to one or more of the themes.

This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Capital service capacity has reduced from a 1 in 2017/18 to a 3 in 2018/19 as a result of a reduction in depreciation charges.

Figure 58: Single Oversight Framework: BTHFT finance and use resources scoring

Area	Metric	2018/19	2017/18
Financial sustainability	Capital service capacity	3	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	2
Overall Scoring		**1**	**1**

3.7 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Bradford Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Bradford Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bradford Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

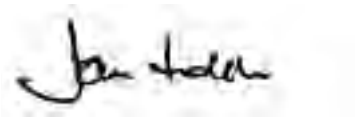
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy, and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed



John Holden

Acting Chief Executive

24 May 2019

3.8 ANNUAL GOVERNANCE STATEMENT

3.8.1

INTRODUCTION

Under the NHS Act (2006) all NHS entities are required to prepare an annual governance statement. The statement considers internal control and report on any significant issues that have arisen during the financial year, including information and quality governance. The Chief Executive owns and signs the document which forms part of the Annual Report.

3.8.2

SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

3.8.3

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Bradford Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Bradford Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3.8.4

CAPACITY TO HANDLE RISK

The Trust is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of its governance framework and system of internal control. We recognise that healthcare provision, and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, risk activities and will therefore involve a degree of risk. These risks are present on a day-to-day basis throughout the Trust. We take action to manage risk to a level which is tolerable. We acknowledge that risk can rarely be totally eradicated and a level of managed residual risk will be accepted.

Risk management is therefore an intrinsic part of the way we conduct business and its effectiveness is monitored by both our performance management and assurance systems.

As Chief Executive, I am the Accounting Officer for the Trust. I have overall responsibility for ensuring effective risk management arrangements are in place. I am supported by the Director of Governance and Corporate Affairs, who is the lead Director for risk management and fulfils the role of Trust Secretary. The Director of Governance and Corporate Affairs develops and manages the corporate approach to the management of risk, including the Risk Management Strategy and the use of the Board Assurance Framework (BAF). I routinely use the BAF, the Trust's risk register, internal audit and the local counter fraud service to ensure proper arrangements are in place for the discharge of our statutory functions, as well as to detect and to act upon any risks and to ensure that the Trust is able to discharge its statutory functions in a legally compliant manner.

As Chief Executive, I have delegated some key responsibilities to other Executive Directors as shown at Figure 59. In addition, for selected roles there is an identified Non-Executive Director sponsor.

Figure 59: Executive Director: Key Responsibilities

Role	Executive Director Lead	Non-Executive Director sponsor
Accountable Officer	Chief Executive	
Caldicott Guardian	Chief Medical Officer	
Senior Information Risk Owner	Chief Digital and Information Officer	
Fundamental Standards of Quality and Safety (CQC)	Chief Executive	
Controlled Drugs	Chief Medical Officer	
Allegations against professionals	Director of Human Resources	
Doctors in Difficulty	Chief Medical Officer	
Responsible Officer	Chief Medical Officer	
Equality and Diversity	Director of Human Resources	•
Learning from deaths	Chief Medical Officer	
End of Life	Chief Nurse	•
Fire Safety	Chief Operating Officer	•
Health and Safety	Chief Executive	•
Emergency Planning	Chief Operating Officer	
Infection Prevention and Control	Chief Nurse	•
Patient Safety	Chief Medical Officer Chief Nurse	•
Freedom to Speak Up	Chief Nurse	•
Digitisation	Chief Digital and Information Officer	•

The Directors of the Trust, individually and collectively, also have responsibility for providing assurance in relation to the risks associated with the Trust's strategic objectives and regulatory compliance to the Board of Directors.

I am accountable to the Chairperson of the Trust for my performance and to NHS Improvement (NHSI) for the performance of the Trust.

All Executive Directors report to me and the Executive Team is held to account for its performance through regular one to one meetings with me, individual annual performance reviews and through challenge from the Non-Executive Directors.

The Non-Executive Directors are accountable to the Chairperson. They are expected to hold the Executive Directors to account and to use their skills and experience to make sure that the interests of patients, staff and the Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

The Trust provides a comprehensive mandatory training programme, which includes governance and risk management awareness and training. During 2018/19 training was delivered centrally and within individual Divisions /Specialties. Training can be classroom-based with internal or external trainers, web-based or 'in situ'; this sort of training often being developed following identification of potential risk in the way that care is being delivered through learning from incidents or risk assessments. The Trust also has a clear commitment to individual personal development, and through all these mechanisms staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The governance and risk management training programme is reviewed annually by the Director of Governance and Corporate Affairs to ensure that it remains responsive to the needs of staff. There is regular reinforcement of the requirements of the Mandatory Training Policy, and the duty of staff to complete training deemed mandatory for their role is a key element of the annual appraisal process. Monitoring and escalation arrangements are in place to ensure that the Trust can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

We have continued with our focus on developing awareness and skills in relation to high quality and focused risk assessments and business continuity planning, amongst both clinical and non-clinical staff. A Risk Management and Compliance Development Group are supporting this work and a central repository for all risk assessment documentation has been implemented.

The NHS has a key role in responding to large scale emergencies and major incidents and throughout 2018/19 the Emergency Planning Team has worked to ensure that the Trust is adequately prepared for any such events. We have in place plans that are substantially compliant with the requirements of the NHS England Emergency Planning Resilience and Response Core Standards (2015) and associated guidance. The Trust will be able to demonstrate full compliance during Quarter 1 2019/20, demonstrating the significant progress we have made with emergency preparedness, including business continuity arrangements.

The Trust's Board of Directors recognises that it has a legal duty, to ensure, as far as is reasonably practicable, the health, safety and welfare of all patients, employees, contractors and members of the public who access the Trust's services or use the Trust's premises. Compliance with the Health and Safety legislative framework, under which the Trust operates, is reflected in current Trust policies. The Policies provide an overarching framework for the management of risk across all areas of the Trust and are applicable to both clinical and non-clinical risk management. The Trust has a Health and Safety Committee, which reports to the Quality Committee and ensures that it has all other Health and Safety related statutory Committees in place.

The Trust was inspected by the CQC in February 2018 and in relation to the 'well led' domain received an overall rating of 'good'. In addition the Trust continues to monitor and assure the effectiveness of actions being taken to address the findings of external well led reviews undertaken in 2016 and 2017.

The effectiveness of our implementation of our Risk Management Strategy was audited by Audit Yorkshire during 2018/19, who found there was significant assurance relating to the processes we have in place.

3.8.5

THE RISK AND CONTROL FRAMEWORK

Our strategic approach to risk management

We are committed to establishing an organisational philosophy that ensures risk management is aligned to strategic objectives, clinical strategy, business plans and operational management systems.

We recognise that the specific function of risk management is to identify and manage risks that threaten our ability to meet our strategic objectives. We are clear, therefore, that understanding and responding to risk, both clinical and non-clinical, is vital in making the Trust a safe and effective healthcare organisation.

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

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

The Trust's Risk Management Strategy 2017-2020 was approved by the Board of Directors in November 2017. The strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives, are identified, evaluated, monitored, and managed appropriately. It defines how risks are linked to one or more of the Trust's strategic or operational objectives, and clearly defines the risk management structures, risk tolerance, accountabilities, and responsibilities throughout the Trust.

In order to effectively deliver the objectives of the risk management strategy we have ensured that the following are in place:

- an articulated and demonstrated Board and Senior Management commitment to risk management
- a clearly articulated organisational risk appetite described and ratified on at least an annual basis by the Board of Directors. (see Figure 60: Our Risk Appetite)
- an effective Trust Governance and Quality framework to ensure the strategy remains effective in the application of risk management
- employee participation, consultation and accountability in risk management processes
- effective systems of control to ensure compliance with regulatory standards are routinely assured
- effective systems to ensure that risks identified from major projects are incorporated into operational risk assessment and mitigation strategies
- application of this strategy across the organisation, including clinical divisions and corporate departments
- effective application of Equality, Quality, Cost and Privacy Impact Assessments across the governance and business of the Trust
- effective mechanisms for incidents to be immediately reported categorised by their potential impact and consequences and investigated to determine system failures in an open and fair manner
- system design with a focus on the reduction of the likelihood of human error occurring
- formal and effective mechanisms to measure the effectiveness of risk management strategies and infection control strategies, plans and processes against NHS standards
- preventative risk management processes applied to the management of facilities, amenities and equipment
- risk Management principles and processes applied to contract management especially when acquiring, expanding or outsourcing services
- safe systems of work and practice in place for the protection and safety of patients, visitors and staff
- plans for emergency preparedness, emergency response, business continuity and contingency

Our risk management strategy directly influences and supports the following:

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

Figure 60: Our risk appetite

The Board of Directors has a defined risk appetite statement, which is aligned to the strategic objectives of the organisation, determining the amount of risk which is desired (opportunistic related to delivery of the strategic objectives) and tolerated (usually related to operational risk).

The risk appetite is reviewed at least annually by the Board of Directors through a series of development sessions, but also in an iterative way by the relevant Board Committees. At a meeting of the Trust's Board of Directors on the 8th November 2018 the Trust's strategic objectives were used, alongside the principal risks managed by the organisation, as a framework to support the reaffirmation of the Trust's risk appetite.

The Board of Directors recognised 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 was dependent upon the delivery of our strategic objectives. It also recognised that the "Requires Improvement" rating applied to the Trust by the CQC in 2018 also has a strong influence on the risk appetite of the organisation.

It also recognised that the overall 'cautious' risk appetite in terms of risks associated with the delivery of a number of our strategic objectives may be seen as being at odds with our ambition. We believe that this is because a balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective, and without exception, there is a minimal appetite in relation to any risks to patient safety, staff safety or regulatory compliance. This minimal risk appetite for risks associated with compliance with Fundamental Standards of Quality and Safety therefore underpins, and influences the overall risk appetite for a number of strategic objectives.

Risk identification, assessment, management and escalation

We routinely identify risks from a range of internal and external sources, including workplace risk assessments, analysis of incidents, complaints, claims, external safety alerts, the 'Freedom to Speak Up' initiative, through ProgRESS (our Programmed Reviews of Effectiveness, Safety and Sensitivity-assuring our compliance with the Fundamental Standards of Quality and Safety) and assessments of compliance with other standards, targets and indicators.

There is an expectation that risk assessment is a key feature of all normal management processes. All areas of the Trust have an ongoing programme of risk assessments, which inform the Trust's risk registers. Risks are evaluated using the Trust risk matrix which contributes to decision making in the context of the Trust's risk appetite and risk tolerance. The Trust rates these risks on a scale from 1-25, where 25 is the highest risk. Risks are appropriately graded and included on the Foundation Trust's Risk Register.

Figure 61: Risk escalation framework

Risk identified and assessed	An initial discussion takes place with a line manager (and the Divisional/ Specialty Governance Lead for assistance if required) and then be assessed, graded and added to the risk register as appropriate
Ward/specialty / corporate service level	Monthly review of risks is undertaken at ward/specialty/corporate service level. Where the ward specialty or department feel unable to manage the risk this should be formally escalated to the Divisional Governance Lead for consideration at next meeting
Care Group / Corporate Department Level	Monthly review of risks escalated formally from ward/specialty/corporate service and all risk scored at 9 or greater to be reviewed at divisional level. Where the Division/Department feels unable to manage or address the risk themselves this should be escalated formally to the Strategic Risk Register.
Strategic level	The Integrated Governance and Risk Committee reviews all risks newly escalated, considering whether to accept them onto the corporate risk register. Risks accepted are identified with an executive lead.
	All risks on the corporate risk register scoring greater than 12 are reviewed monthly at the Integrated Governance and Risk Committee., and managed within the principal risk structure of the register to enable alignment to the Board Assurance Framework
Committee Level	Board committees will review the principal risks and their component risks assigned to them and consider their impact on the Board Assurance Framework and how they should be reflected
Board Level	The Board reviews a high level register of Trust wide risks graded at 15 or greater at each meeting as required by the Integrated Governance and Risk Committee. The Board reviews its strategic risks (12 or above) via the BAF, receiving assurances from the Board Committees and undertaking a review of all BAF risks at each meeting.

The Trust uses a single electronic Risk Management System - Datix - which links all key risk elements (including incident reporting, complaints, and claims and inquest management). All of these elements are used to inform the Foundation Trust's Risk Register, which is also held on Datix. During 2018/19, following an extensive review in 2017/18 a revised approach to recording incidents across the Trust was implemented. The Trust also introduced the Datix Care Quality Commission (CQC) module during 2017/18, and will be using this module proactively to support the assurance associated with risks in relation to our compliance with the CQC Fundamental Standards of Quality and Safety

The Trust identifies and manages risk at service, organisational and strategic levels. Service level (Divisional/Directorate/Specialty/Ward) risks are risks that have been assessed in relation to their likelihood and consequence and it is considered that they can be effectively managed and mitigated at Divisional/ Directorate/Specialty or ward level. Organisational risks are risks that apply to the organisation as a whole, and cannot be managed at Divisional Level, these are reflected on the Strategic Risk Register along with risks which relate to the achievement of our Strategic Objectives. The Risk Escalation Framework is described in Figure 60: Risk escalation framework.

Risk Profile

As the Trust moved into 2019/20, a suite of principal risks was used to structure the Strategic Risk Register. These risks are presented in a matrix, shown in Figure 62: Quarter 4, Month 3 2018/19 Principal risk matrix together with their overall proposed risk rating. Principal risks have a number of component risks and an assessment of their impact on the overall principal risk score is made on a monthly basis by the lead executive director.

Figure 62: Quarter 4, Month 3 2018/19 Principal risk matrix

		Proposed Overall Risk Rating					
	Principal Risk	**Initial**	**Residual**	**Target**	**Current**	**Direction**	**Risk appetite**
1	Failure to maintain the quality of patient services	16	8	4	12	↔	Minimal
2	Failure to recruit and retain an effective and engaged workforce	15	6	4	12	↔	Cautious / open
3	Failure to maintain operational performance	20	6	6	16	↔	Cautious
4	Failure to maintain financial sustainability	16	10	10	16	↔	Cautious
5	Failure to deliver the required transformation of services	12	8	8	8	↔	Open
6	Failure to achieve sustainable contracts with commissioners	12	6	6	12	↓	Cautious
7	Failure to deliver the benefits of strategic partnerships	12	9	9	12	↔	Seek
8	Failure to maintain a safe environment for staff patients and visitors	12	8	6	8	↔	Cautious
9	Failure to meet regulatory expectations and comply with laws, regulations and standards	12	6	4	12	↔	Minimal
10	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	12	8	6	8	new	Open

The Strategic Risk Register currently (Quarter 4, Month 3 2018/19) has one risk that is rated 20 or above; this is a current, in-year risk but will require ongoing management into the future. The risk is described below; mitigating actions have been developed and are recorded on the Strategic Risk Register, along with the details of the action plan lead and the date for completion of these actions. The Strategic Risk Register is monitored each month at the Integrated Governance and Risk Committee meeting, and progress is also evaluated in line with the processes detailed elsewhere in this Annual Governance Statement

- Failure to maintain financial stability

Control and Assurance

The Trust has an established assurance framework which provides a number of benefits. It:

- provides confidence in the operational working of the trust
- maximises the use of resources available in terms of audit planning, avoiding duplication of effort
- educates members of staff across all disciplines
- ensures assurances are appropriately gathered, reported and that the governance structure is working as intended
- identifies any potential gaps in assurances relating to key risks and key controls, and ensures that these are understood and accepted, addressed as necessary
- supports the preparation of this Annual Governance Statement and regular governance reports

The assurance associated with the effective management of risk has improved during 2018/19. This can be evidenced through the widespread use of the Trust's Board Assurance Framework which describes the Trust's key strategic objectives, the associated assurance and risks and controls in place, in addition the Board and Board Committees receive regular reports, including an Integrated Dashboard, containing assurance related to key controls for the risks associated with the achievement of the Trust's Strategic Objectives.

Learning

We have an established knowledge management framework to support our learning, embedded within a quality oversight system. This system enables the identification of precursor incidents from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews (our reviews of our compliance with fundamental standards), effectiveness data information from regulators and external partners, staff and patient conversations, risks and a quarterly focus group of the learning and surveillance hub. The system allows the creation, acquisition, dissemination, and implementation of this knowledge across the organisation.

Key outputs from the system are:

- 'bounce back communication' to staff or patients that identify an incident or a risk, in order to keep them informed
- the publication of 'rapid response alerts' to support immediate notification of actual or potential risks to patient safety. These alerts are issued at the discretion of the Quality of Care Panel, which is chaired by an Executive Director, meets weekly and considers current actual and potential risks to quality and patient safety
- the monthly publication of 'Learning Matters' through the Learning and Surveillance Hub, which is a prioritised programme of dissemination of targeted learning from incidents, claims, complaints and inquests
- the quarterly publication of 'Responding and Improving', which is a document that describes serious incidents or complaints, their impact on the patient or staff involved, their root cause, what was done to prevent a re-occurrence and details of how we know that the actions taken have been effective

The Trust-Wide Learning and Surveillance Hub, which was established during 2016/17, is a developing multi-disciplinary group that explores transferable learning and works to identify new ways of dissemination across the organisation.

Public Stakeholder involvement in risk

The Board of Directors actively engages with the Council of Governors and our respective public stakeholders in the reporting of the financial and performance management of the Trust and in the management of risks which impact on them. The Council of Governors is a key mechanism in ensuring that the Trust's public stakeholders are involved in the understanding and contextualisation of risk. The Council meets five times per year and receives reports on performance, quality and safety. The Trust Board of Directors meets in public and all papers are available on the Trust's website. The Trust has recently approved a revised Membership Plan and will be seeking different and novel ways of engaging with our membership about a number of matters, including risk and governance.

During 2018/19 the Trust has worked closely with NHS Improvement, which is responsible for overseeing the performance management, clinical quality, and governance of NHS Trusts. Performance against the national priorities set out in the 'Single Oversight Framework for NHS Providers' is discussed at the regular Provider Oversight Meetings held between the Trust and NHSI covering the themes of quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement quality.

I lead the Trust's Executive Team in developing positive relationships with stakeholder partners including clinical commissioning groups, local authority, other partner organisations across Bradford and across the region in order to support the detection and management of system wide risk and ensure that patients are provided with the highest possible care within the resources available.

The Trust directly participates in the Bradford Health and Well Being Board, Health Scrutiny Committee and Safeguarding Boards and a range of other forums for service planning, performance and contracting.

On a wider footprint, the Trust is a partner organisation within the West Harrogate and Yorkshire Health and Care Partnership (WYHCP) which is an integrated Care System (ICS). The Trust is working with others within health and social care to implement key elements of acute and out of hospital health and social care strategy.

3.8.6

GOVERNANCE

During 2018/19 every Division, and in turn each component specialty, had a Quality and Safety meeting where key individuals come together to discuss quality and safety issues as part of a standard agenda, ensuring the sharing of transferable lessons from incidents, complaints and claims and reviewing the risks being managed at both specialty and divisional level, identifying the effectiveness of controls in place and ensuring appropriate application of the risk escalation framework.

During 2018/19 the Trust took further steps to strengthen the governance of the Committees of its Board of Directors following a formal self-assessment process.

As a result of the self-assessment process and the subsequent revision to the terms of reference of the Committees, the Board of Directors has given formal delegated accountability for assurance in relation to the effective management of risk associated with the delivery of the Trust's strategic objectives to its Committees (see Figure 63: Board and Board Committees diagram).

The Committees with an assuring role in relation to a strategic objective are all chaired by a Non-Executive Director. The Committees each have one or more lead Executive Directors, reflecting their accountability (delegated from the Chief Executive) for specific areas of risk, and take responsibility for the Committee's operational management.

The principal duties of the all the Committee are:

- to receive and review the strategic objectives related to quality allocated to it by the Board of Directors, agreeing the key controls and identifying any areas where routine and additional assurance is required within its work-plan and what type of assurance is required
- to receive and review the Board's Risk Appetite statement at each meeting and apply it to their review of the risks and assurance associated with the Trust's Strategic Objectives
- to receive and scrutinise the Strategic Risks (with a risk score of 12 or more) or any other risks identified or being managed by the Trust allocated

to it by the Board of Directors in the context of the Board Assurance Framework, monitoring progress made in mitigating those risks through the work of the Integrated Governance and Risk Committee, identifying any areas where additional assurance is required

- to report to the Audit and Assurance Committee, as per the memorandum of understanding and provide assurance to the Trust Board on the adequacy of control and mitigation against such risks
- following consideration of the assurances received through the discharge of its operational responsibilities, agree the level of confidence the Committee has in relation to the achievement of the strategic objectives allocated to it and provide the associated rationale for inclusion within the Board Assurance Framework

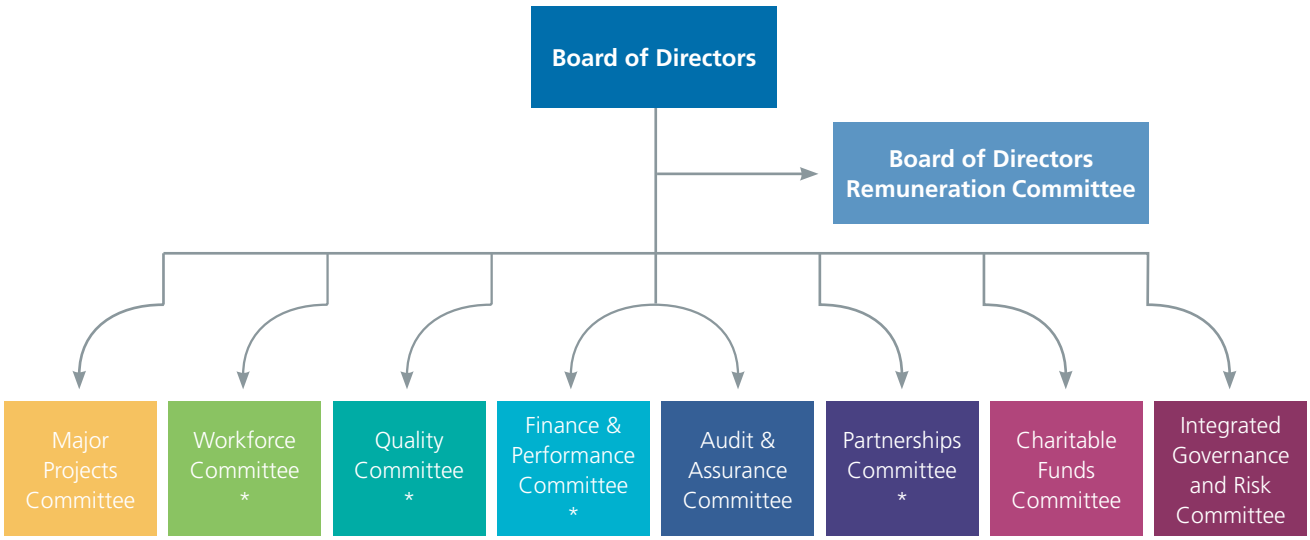
The Integrated Governance and Risk Committee receives monthly reports in relation to significant new and changed risks and those that have not been reviewed; this is because the Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register is an ongoing, dynamic process.

The Strategic Risk Register, together with the Board Assurance Framework, is a monthly agenda item at the Integrated Governance and Risk Committee, and the Chief Executive holds to account the Executive Director Lead for each strategic risk. All the Board Committees receive the section of the Board Assurance Framework related to the Strategic Objective they have an assuring role for each month. The Board Assurance Framework is also an agenda item at each meeting of the Board of Directors, and the Audit and Assurance Committee reviews the Board Assurance Framework process annually.

Oversight and assurance related to the Trust's risk management arrangements (both clinical and non-clinical) are provided by the Audit and Assurance Committee to the Board of Directors.

The approved minutes of these Committees along with Chairs' summaries are included in Board papers which are published on the Trust's website, apart from reports and minutes containing confidential information. All Committees have a programme of work for the year in the form of a work plan, which is aligned to the key controls identified in relation to the risks to achieving the Trust's Strategic Objectives and each Committee maintains an action log that ensures the flow of work from one meeting to the next.

Figure 63: Board and Board Committees



(*) denotes Committees with an assuring role in relation to a strategic objective and are all chaired by a Non-Executive Director.

Quality Governance

The Quality Committee provides the Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the quality of the care the Trust provides. This remit includes a focus on the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well led, and on also on the effectiveness of quality governance and risk management (including health and safety) systems.

The objective of the Committee is to enable the Trust Board to obtain assurance that high standards of care are provided and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- promote safety, high quality patient care across the Trust
- identify, prioritise and manage risk arising from clinical care
- ensure the effective and efficient use of resources through evidence based clinical practice
- ensure that the Trust is aligned to the statutory and regulatory requirements relating to quality and safety
- protect the health, safety and wellbeing of Trust employees
- ensure effective information governance across the Trust's functions

Performance Governance

The Finance and Performance Committee provides the Trust's Board with an objective and independent review (including relevant strategic risks and associated assurance) of the management of assets and resources in relation to the setting and achievement of financial targets, business objectives and the financial stability of the Foundation Trust, and the effective management of all performance related matters.

The objective of the Committee is to enable the Trust Board to obtain assurance that the arrangements for the management and development of finance and performance matters are effective and that appropriate governance structures, processes and controls are in place for the Trust to:

- Promote the effective use of resources (including the effective use of data from the Model Hospital)
- Identify, prioritise and manage risk associated with financial or clinical performance
- Ensure that the Trust is aligned to the statutory and regulatory requirements relating to finance and performance

Workforce Governance

The Trust has a robust approach to workforce planning. Workforce plans and risks are reviewed through the Education and Workforce sub-committee and key issues are escalated to the Workforce Committee and upwards to the Board of Directors as necessary.

The Workforce Committee provides the Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the effectiveness of the workforce management arrangements for the Trust.

The objective of the Committee is to enable the Trust Board to obtain assurance that high standards of workforce management are in place across the organisation and that adequate and appropriate governance structures, processes and controls are in place to:

- protect the health, safety and well-being of Foundation Trust employees
- protect the safety and the effectiveness of care provided through the oversight of short, medium and long term workforce planning (aligned to the NHS I Developing Workforce Safeguards Recommendations), staffing levels, appraisal and training and development.

In discharging their responsibilities the committee will be mindful of the guidance in place on safe staffing and in particular the recommendations contained within NHSI's Developing Workforce Safeguards publication.

Workforce, finance and operational plans are informed through the use of Safe Care, Birthrate Plus and data from ESR and the Allocate roster system. The Trust ensures that we use evidence based tools [where they exist], professional judgement and outcomes in our safe staffing processes and ensures that the National Quality Boards [NQB] guidance is embedded in our processes.

3.8.7

KEY AREAS OF FOCUS WITH SPECIFIC CONTROLS AND ASSURANCE IN PLACE

Care Quality Commission Regulatory Framework

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

During January 2018 the CQC carried out an unannounced inspection of the Trust. The CQC inspected the following core services:

- Maternity
- Urgent and emergency services
- Medicine and care of older people
- Surgery

The Trust was rated as 'required improvement' overall. Surgery and Urgent and Emergency services were rated as 'good', Maternity and Medicine and Care of Older People were rated as 'requires improvement'. We were required to address the following compliance actions to bring two of our services in line with legal requirements

In Medical care services we had to:

- ensure staff complete mandatory training, including safeguarding training, so they have the skills and competence to undertake their roles
- ensure they have a robust system in place to identify policies and guidance approaching their review date

In Maternity services we had to:

- Ensure midwifery staffs are compliant with all aspects of mandatory training
- Ensure daily checks of emergency equipment are undertaken in maternity
- Ensure fridge temperature monitoring is in place in maternity areas and that action is taken when minimum or maximum temperatures are exceeded
- Ensure all staff are engaged and participate in all steps of the World Health Organisation' (WHO) surgical safety checklist, and that this is consistently utilised
- Ensure all polices and guidelines are up to date
- Ensure all staff have undergone an annual appraisal

We initiated a Trust-wide compliance action plan to address the concerns which was completed in December 2018.

During February 2018 the CQC carried out a 'Well led' inspection of the Trust. The Trust received a 'good' overall rating.

Also during February 2018 the Trust was involved in a CQC Area Review which focused on the care and the management of care of people over 65 years old. The report detailed a positive outcome for the Trust and a system wide action plan has been developed and is being implemented.

In September 2018 the Trust received a Fixed Penalty Notice in respect of a breach in our Duty of Candour, which occurred in 2016. We reported the breach ourselves to the CQC in 2016 and as a result undertook a full review of our systems and processes to ensure that a similar breach could not happen again. We complied fully with the CQC's investigation during 2018 and accepted the fine.

During February 2019 the Trust was part of a CQC review of services for looked after children and safeguarding in Bradford. At the time of writing the associated report had not been published.

Management of risks to compliance with the NHS Foundation Trust licence condition 4

Compliance with the Code of Governance is formally reviewed on an annual basis. This was last carried out by the Integrated Governance and Risk Committee in April 2019, and reported to the Board of Directors in May 2019. The review concluded that the Foundation Trust was compliant with all requirements.

A CQC Well Led Review was undertaken in February 2018. The Trust was rated 'good' overall for the 'well-led' domain.

Data Security

The Chief Digital and Information Officer and Senior Information Risk Owner (SIRO) provides a quarterly report to the Board of Directors and ensures that there is an effective information governance infrastructure in place and any information risks are reported. This is an appointment which was required by the NHS to strengthen controls around information risk and security. The Trust also carries out an annual assessment by means of the Data Security & Protection Toolkit.

The Medical Director and Caldicott Guardian works closely with the SIRO, particularly where any identified information risks include patient confidentiality or information sharing issues. The SIRO chairs the Information Governance Sub-Committee which reports monthly to the Quality and Safety Committee which reports to the Board of Directors. The Caldicott Guardian is the Deputy Chair of this Sub-Committee.

The Trust has its IT equipment fully encrypted and has robust cyber security measures to ensure essential safeguarding of our information assets from all threats.

The Trust's Serious Incident Policy includes incidents relating to data loss or breach of confidentiality.

Register of Interests

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS'22 guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations

Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Board has ensured that arrangements are in place to ensure that the Trust complies with the Equality Act 2010. Approved equality objectives are in place and their achievement is closely monitored. An equality analysis is carried out for all new and revised policies. It includes analysis of all nine protected groups and also considers the human rights FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy). Changes are made where there is evidence that protected groups might be disadvantaged by the policy.

Carbon Reduction

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

3.8.8

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

We have a range of tools and an effective governance infrastructure to ensure resources are used economically, efficiently and effectively. This includes monthly finance and performance reports provided to the Finance and Performance Committee supporting the use of a Finance and Performance Dashboard. The Board of Directors used an Integrated Dashboard, alongside detailed reports to support key metrics in general and by exception and the Board Assurance Framework to assure and ensure that the Trust is using resources effectively. The Trust also provides financial information to NHS Improvement on a monthly basis.

During 2018/19 we began integrating the use of the Model Hospital digital tool to compare our productivity and identify opportunities where we can make improvements in the way we use our resources. One of the ways we have done this is to ensure that a specific reference is made to any consideration of or impact on our effective use of resources within every paper received by the Board and Board Committees. We have also established a specific programme board within our Bradford Improvement Programme which considers the data presented within the Model Hospital tool, providing a key forum for the discussion and planning associated with the opportunities identified within the tool.

The resources of the Trust are managed within the framework set by the Standing Financial Instructions, and various guidance documents that are produced within the Trust, which have an emphasis on budgetary control and ensuring that service developments are implemented with appropriate financial controls.

We have a risk based three year audit plan with our internal auditors. We regularly use the audits to evaluate our effective use of resources. The Head of Internal

Our external auditors are required, as part of their annual audit, to satisfy themselves that we have made proper arrangements for securing economy, efficiency and effectiveness in our use of resources and report to the Audit and Assurance Committee by exception, if, in their opinion the Trust has not.

The Trust has complied with cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

To ensure that any cost improvement schemes, developed through the Bradford Improvement Programme, do not impact adversely on the quality of patient care, a Trust approved Quality Impact Assessment process is led by the Chief Medical Officer and the Chief Nurse. This ensures that any schemes identified as having high risks to patient safety have to have controls or mitigation in place before they are commenced, or are not commenced at all. In addition there is a retrospective review of all schemes where the risk was assessed as low, to ensure that there were no unintended adverse outcomes.

3.8.9

INFORMATION GOVERNANCE

During the last financial year, the organisation has had no externally reportable incidents where personal data has been compromised; no high risk information governance incidents have been reported to the Information Commissioner's Office (ICO). A strong emphasis continues to be put on staff awareness around information governance and training to reduce information risk and avoid breaches, including cyber security.

Details of Data Security and Protection Incidents (personal data breaches) are set out in Figure 64 that details all information governance incidents classified at a lower security level.

Figure 64: Other incidents

Summary of Other Personal Data Related Incidents in 2018/19		
Category	**Breach Type (ICO categorisation)**	**Total Number of Incidents in this category**
Confidentiality:		
Unauthorised or accidental disclosure	Data sent by email, fax or post to incorrect recipient	12 incorrect patient detail (letters / systems / ID tags) 3 incorrect email addresses 19 postal incorrect addresses 1 unencrypted identifiable data emailed 6 verbal disclosures
Unauthorised or accidental access		13 unauthorised access 10 papers filed incorrectly 4 using own device
Availability:		
Unauthorised or accidental loss	Loss or theft of paperwork	1 loss
	Data left in insecure location	23 papers in car park / stairwell 2 unemptied confidential waste cupboards 2 papers left on computer
	Other	1 loss of Virtual Desktop (VDI) connection affecting clinics
Integrity:		
Unauthorised or accidental alteration	Principle 7 failure	50 incorrect medical record details, e.g., another patient on record 9 data entered incorrectly 1 missing medical records (not input

NB: Reportable incidents are no longer classed as Level 2 incidents. The Information Governance Incident Reporting Tool guidance was updated in 2018 to take account of the new reporting and assessment criteria.

3.8.10

ANNUAL QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Governance and Leadership

The Director of Governance and Corporate Affairs leads on matters relating to the preparation of the Trust's Annual Quality Report.

The Audit and Assurance Committee, which is chaired by a Non-Executive Director, and the Board of Directors maintain oversight of the Report throughout production, using their wider knowledge of the Trust activities to ensure the Report presents a balanced view.

The Quality Committee, which is also chaired by a Non-Executive Director, ensures an integrated and co-ordinated approach to the management and development of quality and safety at a corporate level in the Trust.

Our Quality Plan

Quality is not simply about achieving a standard, or reaching an end point. It is about learning from what we did yesterday; focusing on what we do today; and striving to make it better tomorrow. It is all the ways we ensure our services are safe, effective, caring, responsive and well-led.

Our Quality Plan 2018/19 marked the start of a year-long engagement process, building on the progress we had already made as a Trust. It describes the things we are doing to understand and improve quality, and how they join up, right across our organisation.

And it makes a promise: that we will continue to adapt and learn from our experience, for the benefit of our patients. The starting point, basis and success criteria for our Quality Plan are our Vision, Mission, Objectives and Values as described in the Trust's Clinical Service Strategy (2017-2022). Our Quality Plan (2018-2019) has been written to support the Trust's Clinical Service Strategy and bring our plans in line with the Care Quality Commission's regulatory framework.

Our Quality Plan provides a 'pen portrait' of our current approach to quality, our approach and objectives for quality improvement and the quality goals and targets that we need to meet over the next year to ensure that we achieve our vision and deliver our strategic objectives.

Our Quality Plan (2018-19) was delivered through the achievement of our current quality goals (see Figure 65: Our Quality Goals). For each goal identified we identified a number of targets. These goals were chosen, in part with direct reference to CQC standards, to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been made. We believe that if we achieve our goals in the priority areas identified, we will achieve our ambition of providing highest quality healthcare. The targets which help us understand delivery of these goals have been developed for this year. The targets are reported through our Integrated Quality Dashboard to enable oversight and assurance from our wards to the Board of Directors. Our goals are set out under each of the five CQC quality domains. The implementation of our Electronic Patient Record in September 2017 has enabled us to begin to capture real time data. This enables us to learn, intervene and make timely changes and drive real improvements to achieve our quality ambition and ensure learning and recognition when our goals have been achieved.

Figure 65: Our Quality Goals

GOAL: To eliminate avoidable harm to patients in our care evidenced through a reduction in the number of avoidable incidents which cause serious harm and for there to be no serious incidents where the root cause is repeated

GOAL: To perform the same as or better than the national average in all standards of all National Clinical Audits that we are eligible to participate in

GOAL: To demonstrate that our patients feel that they are treated with compassion, kindness, dignity and respect through them recommending our Trust to their friends and family. None of our services will perform in the bottom 20% of Trusts in a national survey

GOAL: To meet our access targets

GOAL: To increase the percentage of our people who would recommend our Trust to friends and family as a place to work or a place for treatment and to be in the top 20% of places to work as measured by the NHS staff survey though a year on year improvement in engagement scores

Systems and Processes

The effectiveness of the systems of internal control in relation to data in the Quality Report is subject to review by Internal Audit.

Consultation has been carried out with Governors and members of the Trust to agree the priorities in the Quality Report. Information about the progress against these priorities will be routinely fed back to Governors and members.

Data use and reporting

The maturity of data and information, its use, processes and supporting technology is key to the Trust using information to make decisions; an information-led Trust. High quality data and information is vital to the effective and efficient running of the Trust and leads to improved decision making which in turn results in improved patient care, wellbeing and safety.

Poor data quality can put the Trust at significant risk of losing stakeholder trust, negatively impacting service delivery, incurring financial penalties or inappropriate utilisation of resources amongst others. The Trust has clear processes, controls, and governance in place to managing the quality of data, using best practice and including a master list of key data and information and how it is identified and kept current. In any organisation there are a number of data sets that are important to the successful operation of the business. Should the quality of this data be sub-optimal the business will not properly execute its role. The Trust uses a standard classification system to assist in the process of managing data quality. There are a number of systems and controls in place for each of the data types at various stages in the lifecycle of data and its conversion to information. The responsibility for overarching data quality lies with the Information Governance Sub-Committee. The Information Governance Sub-Committee provides assurance to the Quality Committee of the Board of Directors. The data quality position is presented through a scorecard-type approach using a number of indicators.

With high quality data and information the Trust can support decision-making for patient care, day-to-day and tactical management and strategic planning and decisions. The Trust enables this requirement through a suite of industry-standard tools, including the highly-ranked Cerner Millennium Electronic Patient

Record, a CACI data warehouse, SAP's Business Objectives business intelligence tools, and a variety of presentation tools. The tools allow the Trust to present data and information pertinent to and in a way (visual intelligence) which supports the nature of the decision.

Clinicians and administrative teams using data and information to deliver front line care are supported mainly through the Electronic Patient Record. Day-to-day and tactical management of the Trust's operations are supported by data and information specific to those functions being executed. This could be done through daily reports, dashboards, and through real time software. The Trust utilises ward to board dashboards for key indicators aligned to the Trust's Strategic Objectives. These indicators, reviewed ultimately by Board of Directors' Committees, aggregate into a Board of Directors' Dashboard that provides a holistic, rounded view of the Trust's position against its plans.

3.8.11

REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the Executive Directors and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors and its Committees and plan to address weaknesses and ensure continuous improvement of the system is in place.

In support of this:

- the Head of Internal Audit Opinion on the effectiveness of the system of internal control was presented to the Trust's Audit and Assurance Committee on 21 May 2019. The opinion was that there was Significant assurance and that there is a generally sound system of internal control, designed to meet the organisation's objectives. Internal audits carried out have provided a range of assurance levels, from limited to high assurance: any internal audit reports with Limited Assurance opinions are reviewed by the Integrated Governance and Risk Committee and added to the strategic risk register. For each Internal Audit report where a limited assurance opinion is given, the Executive Director responsible is asked to attend the Audit and Assurance Committee to discuss the action being taken as a result of the audit. For these reports, detailed lists of prioritised recommendations are agreed and the implementation of these recommendations is followed up by Internal Audit and reported to the Audit and Assurance Committee.
- Executive Directors and Non-Executive Directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and each of them has taken the stapes that they ought to have taken to make themselves aware of any information and to establish that the auditors were aware of it.
- Regular reviews of the Trust Board assurance framework and risk registers provide me with assurance of the effectiveness of the controls being used to manage the risks to the organisation in achieving its strategic objectives. Internal auditors have rated the framework as having significant assurance.
- Through the use of an integrated dashboard the Trust Board and its Committee routinely reviews contemporaneous and quality assured data in relation to quality, finance, performance, workforce and strategic partnerships.
- The Audit and Assurance Committee reviews the system of integrated governance, risk management and internal control, across the whole of the organisation's activities - both clinical and non-clinical. The Committee maintains an

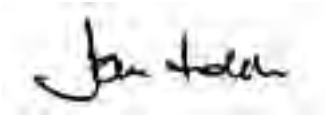
oversight of the Trust's general risk management structures and ensures appropriate information flows to the audit committee in relation to the trust's overall internal control and risk management position. In carrying out this work the Committee primarily utilises the work of Internal Audit, External Audit and other assurance functions, but it is not limited to these audit functions. It also seeks reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

- The CQC undertook a Well Led Inspection of the Trust in February 2018, the Trust was rated as good overall.

No significant internal control issues have been identified. The Trust and its officers are alert to their responsibilities in respect of internal control and have in place organisational arrangements to identify and manage risk.

I also sign in respect of the Accountability report.

Signed



John Holden

Acting Chief Executive
24 May 2019

Bradford Teaching Hospitals
NHS Foundation Trust

Quality Account

2018/19

Together, putting patients first

PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Thank you for taking the time to read our 2018/19 Quality Account. I hope it reflects how immensely proud we are of our achievements during the year.

Our mission is to provide the highest quality healthcare at all times, supported by our vision to be an outstanding provider of healthcare, research and education and a great place to work.

Despite the challenging financial environment we have focused our resources and actions on delivering safe, effective, caring, responsive and well led services for our patients. This is echoed in our Board Risk Appetite Statement, which underpins our approach to managing risk.

In this Quality Account we describe how we have performed as a Trust, in relation to local and national priorities, including the progress we have made with our Quality Priorities for 2018/19. We also describe our Quality Priorities for 2019/20, and will present our progress against these in next year's Quality Account.

In particular, this year, we have further developed our Electronic Patient Record, which we first implemented in September 2017. We have implemented a range of tools, alerts and assessments, which support the effective identification and management of sepsis, the effective implementation of the NEWS2 (National Early Warning Score), the effective assessment of risk of Venous-thromboembolism (VTE), and effective medicines management. Our digital strategy, "*From digital to virtual*", launched during 2018/19, describes our ambitions to use digital technology to support continuous improvement in the quality of care we provide.

"*Embracing Kindness,*" our patient experience strategy, was also launched during 2018/19. It sets clear expectations for the way that our staff interact with our patients. We listen to those who have had a poor experience of care in our services, to learn how we can make improvements, and we are looking forward to implementing the opportunities for improvement in 2019/20 and beyond.

Between January 2018 and February 2018, the Care Quality Commission (CQC) inspected four of our core services: urgent & emergency, maternity, medical & services for older people, and surgery. They also carried out a "well-led" inspection (CQC have identified a strong link between the quality of overall management of a Trust and the quality of its services).

PART 1

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Overall, inspectors rated our Trust as "Requires Improvement," rating us "Good" for being caring and well-led, and "Requires Improvement" for being safe, effective and responsive. We were particularly pleased to receive an overall "Good" rating for the well-led domain, reflecting significant improvements we have made in relation to staff engagement and the core governance of our organisation.

No element of any of our services was "Inadequate" and we did not receive any warning notices. As with our previous inspection, there are examples throughout the CQC's report where inspectors observed good and outstanding practice and compassionate care by our staff. They heard feedback from patients that staff treated them with kindness and provided emotional support to minimise their distress. Overall, we think that the CQC's assessment of the services it inspected was accurate, balanced and fair, and we look forward to the opportunity during 2019/20 for a number of our services which have not been inspected since 2016 to be reviewed, and a fresh assessment made to reflect the many improvements since then.

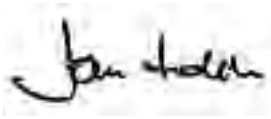
In September 2018 we accepted a fixed penalty fine for a breach in the Duty of Candour in 2016, which we had identified and reported ourselves. We had informed a family that a notifiable incident had been identified, but we did not provide them with a timely written apology, and we regret the additional distress that this caused. When the breach was identified we undertook a review of the systems and processes we had in place to assure our compliance with the regulation, and we have not reported any further breaches in our Duty since then.

In January 2019 Professor Bill McCarthy, our Chairman, left the Trust to be the North West Regional Director for NHS Improvement. We look forward to consolidating his legacy with our new Chairman, Dr Maxwell Mclean, who joined us in May 2019.

At the end of March 2019, Professor Clive Kay, our then Chief Executive, left the Trust to begin a new role at Kings College Hospital, London. I am therefore writing this summary as Acting Chief Executive, and on behalf of the leadership team in place during 2018/19. The year was not without its challenges, and I am proud that despite the pressures we faced, we have continued to receive positive feedback from patients and carers, and we continue to fulfil the requirements of NHS Improvement's Single Oversight Framework.

To the best of my knowledge and belief the Trust has properly discharged its responsibilities for the quality and safety of our care, and the information presented in this Quality Account is accurate.

Signed



John Holden

Acting Chief Executive

24 May 2019

PART 1

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

PART 1.1 BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST ACHIEVEMENTS IN 2018/19

- **New clinic provides on-the-day results:** Our Urology specialists redesigned the way in which patients with blood in urine are clinically reviewed and investigations undertaken. The new one-stop-shop clinic has sped up the process, saving patients from anxious waits for test results.
- **New CT scanner arrives:** We welcomed the arrival of a brand new £700,000 CT scanner in Radiology. The machine strengthens our scanning capabilities by producing higher quality images and being able to perform more complex scans.
- **Working better together:** We put our Trust's values into action across all our wards and departments with the launch of our first Work As One week – which explored how we could all work better together to improve the flow of patients through, and out of, our hospitals.
- **Royal College recognition:** Our Postgraduate Medical Education Team was presented with a plaque by the Royal College of Physicians London – in recognition of our help in running its prestigious medical exams. It marked a rare double for the team as it is already in possession of a similar award from the Royal College of Physicians Edinburgh.
- **Project SEARCH scoops top prize:** Our terrific team of colleagues involved in Project SEARCH scooped a top accolade in the Healthcare People Management Awards for cross-sector working, helping young people with learning disabilities gain vital on-the-job work experience ahead of finding employment.
- **New clinic brings rapid treatment:** Patients with suspected inflammatory disease were able to access rapid assessment and treatment thanks to a new Early Arthritis Clinic launched at St Luke's. The one-stop clinic brings together a range of different healthcare professionals to offer this unique service.
- **Major step forward in stroke care:** One of our stroke patients, became the first in the country to have been admitted to his local hospital, moved to the regional centre (in Leeds) for a new procedure to remove a clot from the brain called mechanical thrombectomy, and then safely transferred back to our care – all within nine hours. Consultant Stroke Physician Stuart Maguire hailed the new pathway a major step forward.
- **NHS celebrates 70th anniversary:** Our celebrations got into full swing thanks to the wonderful children's choir of Girlington Primary School. The pupils, all of whom are deaf or hearing impaired, sang and signed renditions of three songs, including taking us back to the 1940s with the classic Run, Rabbit Run.
- **National award for 'trail blazing' project:** Head Orthoptist, Dr Alison Bruce, was awarded the Council for Allied Health Professions Research (CAHPR) Public Health Research Award for her work exploring the effect of reduced vision on literacy. Alison led the largest-ever study of its kind into the effect of children's sight problems on reading skills.

- **New flagship research centre:** Building work started on a new flagship research centre at Bradford Royal Infirmary which will spearhead improvements to the health and wellbeing of children and elderly people. The £3m Wolfson Centre for Applied Health Research is set to open in 2019.
- **Top prize for student:** Desiree Deighton, a third-year student nurse in our neonatal unit, won a top prize from the Royal College of Nursing for her "Safe Baby" booklet. She developed the guide to support parents when their babies are discharged from the unit and give advice on how to promote safe sleeping.
- **Improving care for women with bladder problems:** A new outpatients' clinic has transformed care for women with bladder problems by offering cystoscopy, a procedure in which a thin viewing tube goes into the bladder, as an outpatient appointment instead of an operation under general anaesthetic.
- **From the airwaves to the internet:** Forty years since its launch, radio station St Luke's Sound went digital. Its DJs and presenters – all volunteers – unveiled its first-ever streaming service, opening it up to listeners all over the world on the internet.
- **Building Europe's first AI hospital command centre:** We announced the launch our very own Command Centre, using unprecedented real-time data from across our hospitals to unblock bottlenecks and improve patient flow – the first Trust in Europe to do so. The Command Centre will transform how care is delivered by reducing unnecessary delays in the patient journey and reducing pressure on staff.
- **National prize for patient safety:** Our Emergency Department team won a national prize for its work on improving the care of deteriorating patients. The King's Fund awarded us its Patient Safety Learning Award, which was received on behalf of the whole department by Consultant in Emergency Medicine, David Robinson.
- **ACE team crowned champions:** Winning in the world's largest healthcare awards was a fitting tribute to the skills of our Children and Young Persons' Ambulatory Care Experience (ACE) Team. It was crowned champion in the Improvement in Emergency and Urgent Care category in the HSJ awards. Launched just a year ago, the service brings care to young patients in the comfort of their own home, and prevents unnecessary admissions to our hospitals.
- **EPR system marks its first birthday:** Hailed as the "most complete go-live" switch-on by our technology partners, Cerner UK, our electronic patient records (EPR) system has transformed the way we work forever and helped to develop a sense of togetherness and common purpose.
- **Women's and Newborn Unit gets a makeover:** The £1.8m transformation of our Women's and Newborn Unit was completed. The building has an attractive new look and is more comfortable and welcoming for our staff and patients – with a raft of energy-efficient measures included too.
- **On the road to surgery:** Children undergoing treatment at Bradford Royal Infirmary (BRI) are now able to drive themselves to the operating theatre thanks to the generous donation of a mini electric car by the Tesla Owners Group.
- **Hospital charity has a big impact on patients:** Bradford Hospitals' Charity – the official NHS charity partner of Bradford Teaching Hospitals NHS Foundation Trust – spent £1.2 million on a number of high profile projects. From hospital equipment to items which improved quality of life, toys for our younger patients to events which supported patients and their families – the charity funded extras which had a big impact on patients and were over and above what the NHS provides.

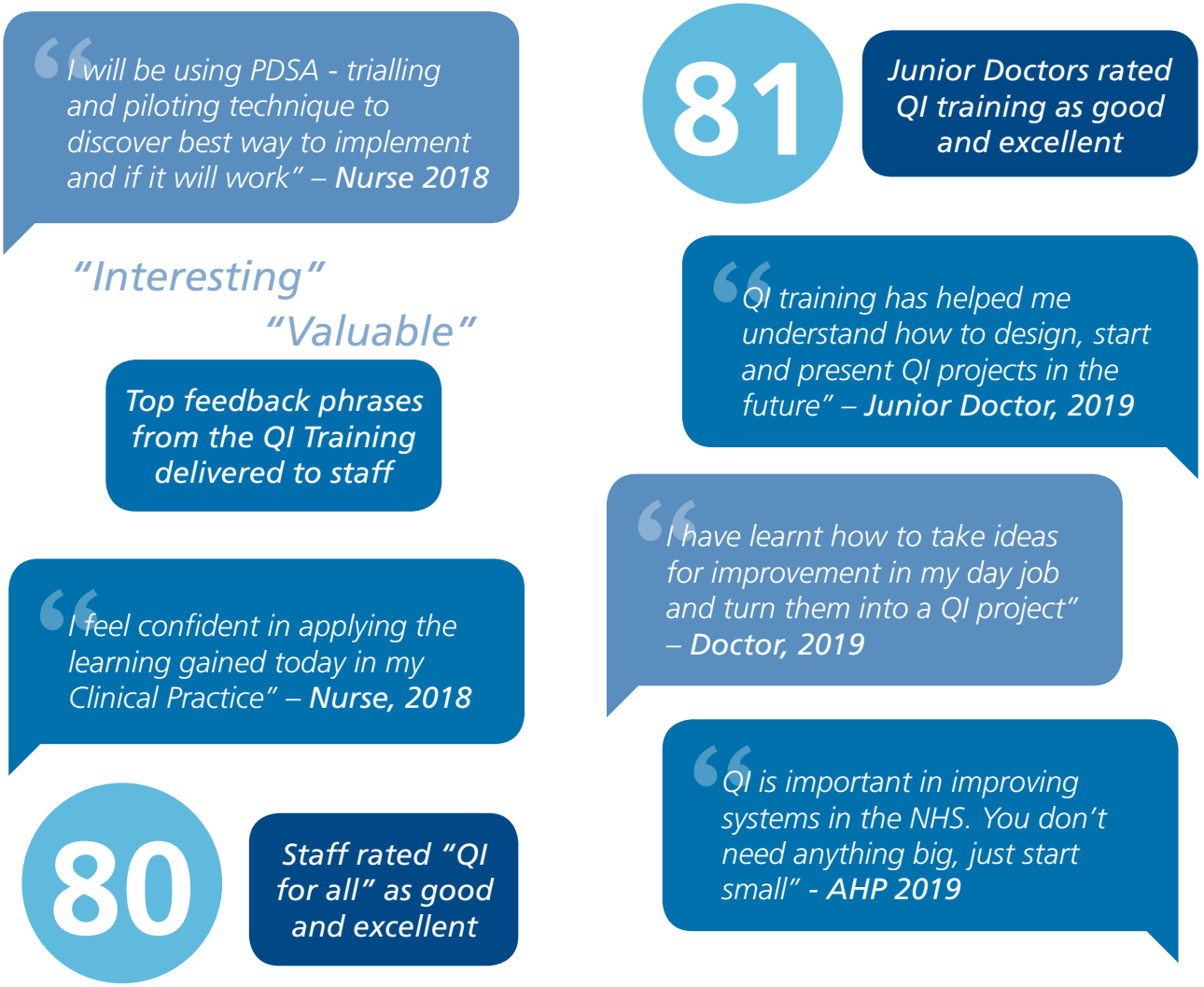
PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PRIORITIES FOR IMPROVEMENT

Significant improvement has been made for improving quality over the last year at the Trust. We want to continue to make sure we provide the best possible healthcare and services to our population which are: Safe, effective, caring, responsive and well-led.

We believe quality improvement (QI) is everyone's business and creating a culture, environment and enthusiasm for ensuring it is part of everyday work is crucial. Staff have embraced Quality Improvement which has been reflected in part 1.1: Trust Achievements 2018/19. Feedback from our staff demonstrates how Quality Improvement is the future for providing the best possible healthcare and services to our population:

Figure 1: Quality Improvement: feedback from staff



Ensuring our staff, services, leadership and culture have Quality Improvement running throughout requires capability and capacity building. We are committed to ensuring we equip our staff with the skills, experience and resources to carry out Quality Improvement as part of daily practice.

Figure 2 demonstrates some of the achievements made last year that help to ensure we provide the best possible healthcare and services.

Figure 2: Quality Improvement Achievements 2018-2019

23% reduction
In the time taken to discharge patients as part of the Pharmacy Technician QI project

Patient's Own Medicine lockers secured as part of medication safety

100%
Of learning disability deaths have been reviewed using the Structured Judgement Review (SJR)

287
Back to basics in care pledges have been made by staff

15%
Reduction in inpatient falls as part of the QI Falls Collaborative

3600+
Patients up and dressed/mobilising as part of the End PJ Paralysis campaign

'Keep me safe Keep me warm' campaign launched to ensure babies are kept at the right temperature.

NEW
24-hour Maternity Assessment Unit opened - direct access area for women to contact/ come to if they are experiencing/suspecting reduced foetal movements.

50+
Staff engaged in the QI Falls collaborative

NEW
Recruitment of the Sepsis Nurse Specialist

292
staff members trained in back to basics over 25

450
Red bags have been issued to over 100 nursing homes as part of improving patient's pathways when they come into hospital

30
PRASE volunteers recruited and trained to deliver the PRASE questionnaire to

Award Winning
RCN award winning "safe baby" book – reducing sudden infant death syndrome

Significant
improvement in the number of patients screened for sepsis

First
The neonatal unit is the first in the UK to receive baby friendly accreditation

50% reduction
In 83% of women in the delay during induction of labour

50
Staff members involved in the "Make A Change Heroes" improvement community

88
One of the lowest Hospital Standardised Mortality Ratio in our region

5
Staff members successful in completing the improvement Science for Leaders training programme

50% reduction
In grade 2 pressure ulcers on the wards involved in the pressure ulcer collaborative

We are part of NHS Quest Improving Theatre Safety Culture Clinical Community

3
Trust wide improvement collaboratives: Falls, safer procedures & Deteriorating patients

59
staff members engaged in Improvement Academy QI Training

11% reduction
In the number of cardiac arrest calls as part of the deteriorating patients programme

80%
of staff rated "QI for all" training as good & excellent

Top 3
For participation factors with NHS Quest

50
improvements shown at our first ever "learning from each other" celebration event

78
Days was the longest period Ward 23 ever achieved without a pressure ulcer

269
Junior Doctors trained/engaged in QI training

Senior Assistant Pharmacy Technician made permanent on Children's ward following a QI project

12
QI training courses on offer as part of the new QI Training plan launched 2018-19

15
departments signed up to improving processes for invasive procedures in non-theatre environments

Quality, Service Improvement and Redesign (QSIR)
accredited organisation with 5 staff members qualifying at QSIR Associates

515
Staff members engaged/trained in QI training

99% & above
Compliance with WHO checklist in theatre areas

2.1.1
RETIRED PRIORITIES FROM 2018/19:

The following is a retired priority for improvement that was submitted as a priority for 2018/19.

1. Priority 1 (effectiveness and safety): Mortality review programme

The mortality review programme was a priority for 2018/19. Whilst we will continue to improve how we learn from deaths, extensive improvement work has been carried out to ensure we have a robust and effective framework for doing this.

The Structured Judgement Review (SJR) method is the Trust's standardised template and approach to undertaking mortality reviews. It is a documentation review that constitutes a subjective in-depth capture of the reviewer's assessment of the quality/standard of care received during the hospital stay; and as such, provides invaluable insight into how we provide care in the Trust.

Emergent learning is gleaned through thematic analysis of all mortality reviews submitted centrally. These are captured in the hospital mortality outcomes report, which provides some of the best indications for learning.

Key achievements leading to the retirement of this priority are:

- the Trust continues to have one of the lowest HSMR (Hospital Standardised Mortality Ratio) in our region, 88, (better than expected). This reflects the high level of care delivered by staff in this Trust
- an established framework for capturing, monitoring and ensuring learning is taking place from deaths is in place with strong oversight and governance.
- a mortality screening tool has been implemented to enable screening of all deaths in the hospital
- delivery of SJR training is on-going to all doctors, consultants, senior nurses and allied health professionals in the Trust
- case selection guidance for use by specialties –this guidance recommends a minimum number of reviews to be completed annually by each specialty. It will be expected to include mandated reviews and a selection of cases of interest/alarms identified with a view to eliciting learning
- generation of local mortality outcomes and statistics reports

The excellent work carried out for Mortality Review will continue to be strengthened to ensure it is sustained.

The remaining identified priorities from 2018-19 will remain as priorities for the Trust in 2019/20.

2.1.2
2019/20 PRIORITIES

We are committed to ensuring we continuously improve our healthcare and services for our local population. We will continue to focus on a broad range of topics for the coming year. Figure 3 details our priorities and how they fit in within the organisation's quality objectives:

Figure 3: 2019/20 Priorities

Priority		National Quality Indicator	Local Quality indicator	Trust's values
Priority 1	Management of the Deteriorating Patient	**Effectiveness and safety**	Safe, effective, caring, responsive, well-led	We care, We value people
Priority 2	Pressure Ulcers	**Effectiveness and safety**	Safe, caring,	We care, We value people
Priority 3	Safer Procedures	**Safety & experience**	Safe, effective, caring,	We care, We value people, We are one team
Priority 4	Patient Experience	**Experience**	Caring, responsive, well-led	We care, We value people
Priority 5	Medication Safety	**Effectiveness and safety**	Safe, caring	We care, We value people
Priority 6	Learning from each other	**Effectiveness**	Effective, well-led	We care, We value people, We are one team

The improvement priorities for inclusion in the Quality Account have been selected following a review of themes and areas of concern arising from a range of sources including:

- consultation with our Trust members
- a review of complaints and Patient Advice Liaison Service (PALS) reports
- a review of serious incident and other incident reports
- a review of national and local patient surveys; and
- a review of our Quality Dashboard indicators (including patient safety data)

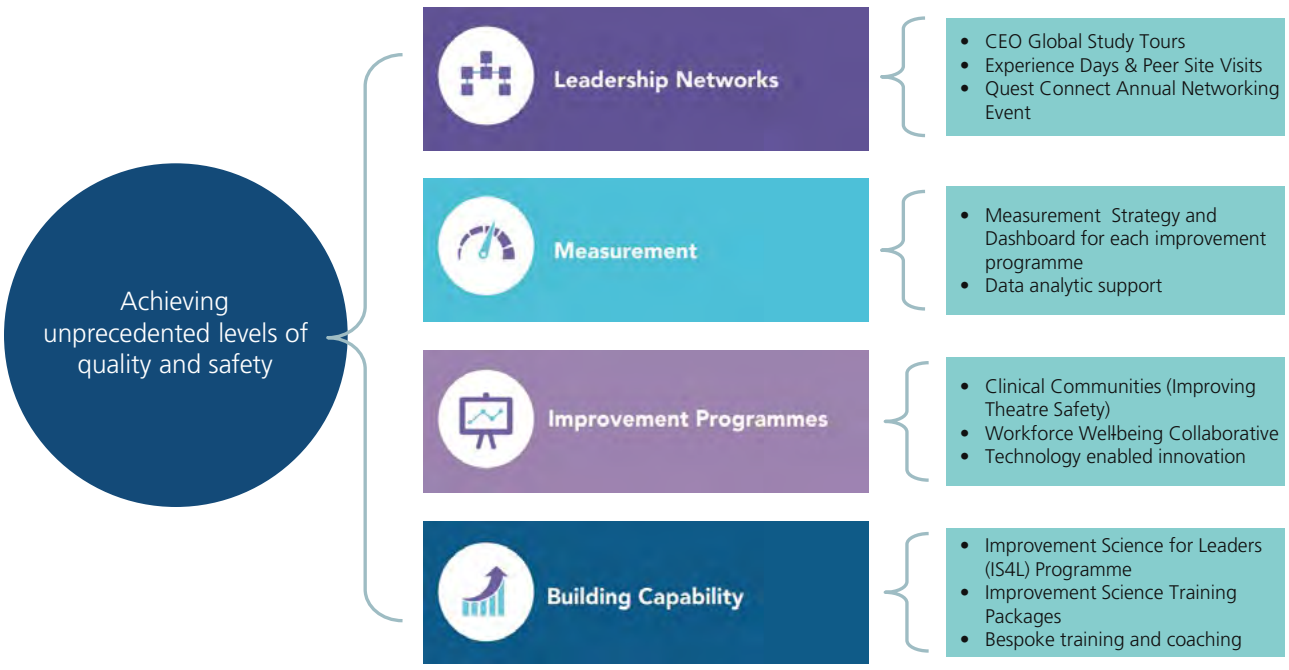
With the recent development and identification of improvement opportunities in medication safety and safer procedures, these are two areas that are identified as a priority for 2019/20. A short summary of each of the areas is provided below. Work to define the patient experience collaborative for 2019/20 is on-going.

The programmes of work will all report to the Trust's Quality Committee.

2.1.3 NHS QUEST

NHS Quest is a national network that focuses on supporting organisations to improve their quality and safety. They provide a range of resources, development sessions, tools and networking days to assist with learning across organisations. As a member of the NHS Quest network, the Trust utilises these resources to assist with developing an optimistic and compassionate culture for workforce, and reliably deliver our priorities and the best possible care.

Figure 4: The work of the Quest national network



Bradford Teaching Hospitals NHS Foundation Trust is one of sixteen NHS Trusts which is working with member trusts to improve the quality of care for our patients.

The NHS Quest Group of NHS Trusts is committed to the triple aim of:

- improving patient safety and reducing harm in patient care
- striving to be best employers in the NHS
- leading the way in technologically enabled innovation

The areas of focus of the NHS Quest network which the Trust is participating in are:

- Improvement Science for Leaders – this learning programme supports leaders within healthcare to develop skills in improvement science and use this to deliver quality improvement projects in their organisation. Our staff are supported by our Quality Improvement team.
- Improving Theatre Safety Culture Clinical Community – This improvement collaborative is enabling member trusts strive to have the safest operating theatres in the country by undertaking an improvement initiative to develop exceptional safety awareness and healthy departmental cultures. Our theatre teams, supported by our Quality Improvement team, are currently actively involved in this initiative and have also hosted a learning workshop on behalf of NHS Quest.

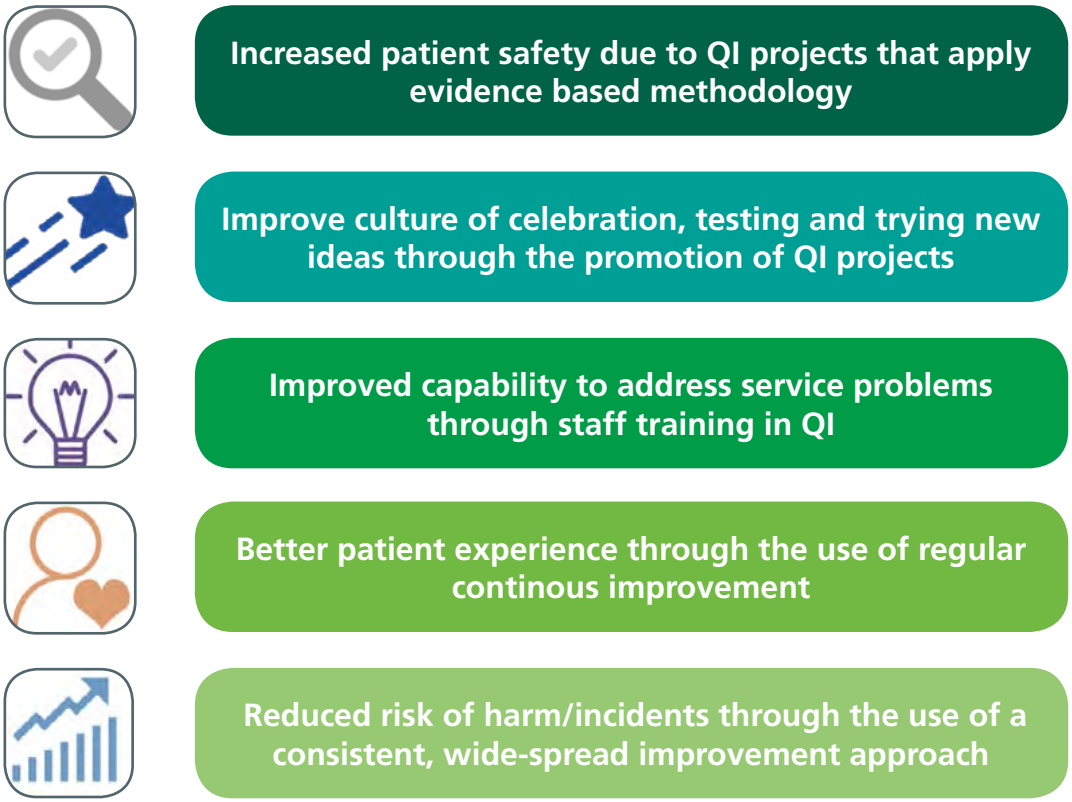
Recent membership participation scores with NHS Quest over the past twelve months highlighted Bradford Teaching Hospitals in the top three for participation factors.

2.1.4 QUALITY IMPROVEMENT CAPABILITY BUILDING

At Bradford Teaching Hospitals NHS Foundation Trust, we aim to provide the highest quality healthcare at all times. We strive for excellence and are committed to learning from and leading best practice to make sure we are delivering quality care.

The aims and objectives for our 2019/20 Quality Improvement Training Plan are:

Figure 5: Objectives for 2019/20 Quality Improvement Plan



Evidence suggests the potential benefit for applying Quality Improvement (QI) techniques consistently and systematically across organisations is significant. NHSI publications 'Building Capacity and Capability for Improvement, Embedding QI skills in NHS providers' and 'Developing People-Improving Care' give recommended national best practice in regards to developing QI capability across the workforce. The State of Care report (CQC 2017) found that almost all the Trusts rated as outstanding had a clear model for Quality Improvement across the trust.

Increasing the capability and knowledge of Quality Improvement for staff is in keeping with the Trust's vision to 'be an outstanding provider of healthcare, research and education' whilst supporting the Trust's strategic objectives of 'providing outstanding care to patients, delivering our financial plan and key performance indicators.'

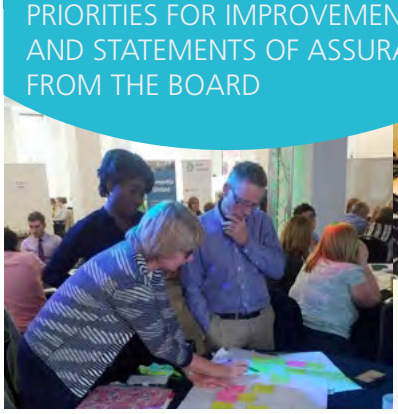
The QI Training Plan for 2019/20 will focus on achieving the aim in the Driver Diagram at Figure 6.

Figure 6: Quality Improvement Training Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Ideas
To have 10% of the workforce actively engaged/involved in QI projects in their workplace with evidence they are applying QI methodology to them by 31st December 2019 across Bradford Teaching Hospitals NHS Foundation Trust	Leadership & Culture	Roles and responsibilities at all levels	Create an accreditation scheme
		Leadership behaviours	Promote 8 QI leadership behaviours
		Improvement coaching	Connect with Organisational Development
		Empowerment and encouragement	OD: Curious questions cards
	Quality Improvement Training & Education	Accessible QI Training	Varied training dates/times/targeted groups
		Different levels of QI Training	Suite of QI Training packages
		Standard tools and templates	QI Training toolkit
		Upskilling the workforce	Train the trainers: e.g. QSIR
	Communication & Engagement	Learning form each other	Learning form each other quarterly events
		QI training central resources area	QI training intranet page
		Regular QI articles/publications	Global emails, let's talk, flyers, awards
		QI Training walk rounds	Visible engagement - direct communication
	Quality improvement Governance & Monitoring	QI training evaluation	QI training evaluation forms
		OVersight on number of QI projects	QI respository of projects
		QI project registration	Standard QI registration form
		QI training reporting	QI Faculty and QI Programme Board

PART 2

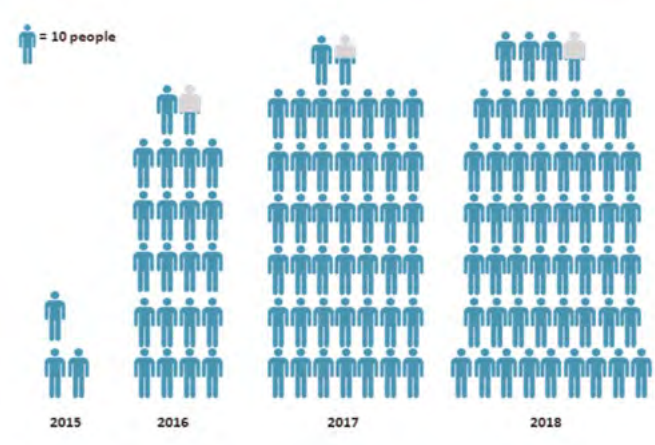
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



We believe leadership behaviour is key to ensuring QI is spread, embedded and sustained across the Organisation and therefore, we will continue to deliver a range of QI workshops, training sessions and learning.

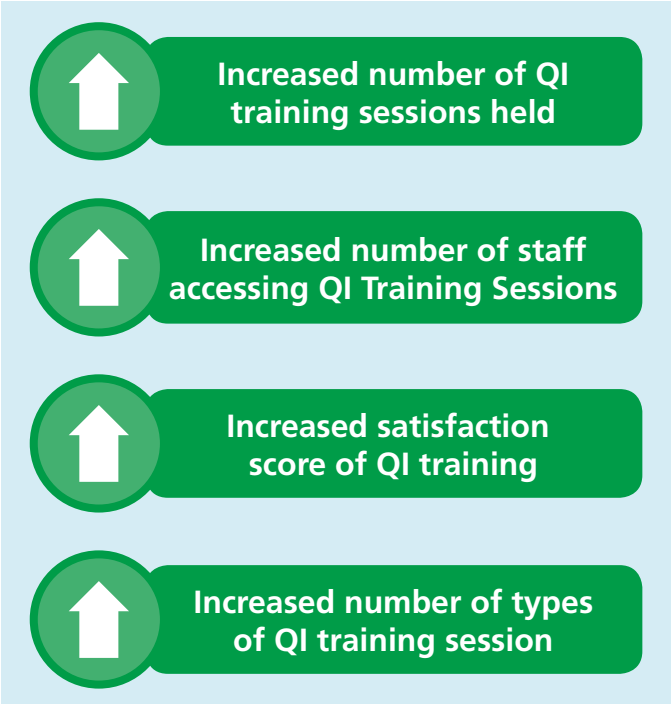
The number of staff accessing QI training in the organisation continues to increase:

Figure 7: Number of staff trained in QI methodology



There is a continuous increase in capability and capacity building indicators which we will continue to strengthen in 2019/20. In comparison with the previous year we have:

Figure 8: increase in QI capability and capacity building indicators



As part of the suite of QI training modules delivered at Bradford Teaching Hospitals, we are now able to offer the nationally recognised Quality, Service Improvement and Redesign (QSIR) programme developed by NHS Improvement. It is aimed at providing staff at all levels a range of tried and tested improvement techniques, tools and skills to design effective and productive services that will lead to sustainable changes that improve the patient experience. We are committed to giving staff the tools they need to carry out their own improvements and we want to empower them to act on their own initiative.

We are also developing our portfolio of targeted QI training for Junior Doctors, New Consultants and Senior Nurses.

2.1.5
PROGRAMME DESCRIPTIONS

Management of the Deteriorating Patient

Aim: To reduce avoidable deterioration on the collaborative wards

Operational definition of *'avoidable deterioration'* is described as –
'deterioration that could have been prevented if there was timely detection'

How Much:
Reduce by 50%

By When:
March 2019

Outcome: In progress, to date: 11% reduction in the number of crash calls among the collaborative wards

Focus
Improving the care of the deteriorating patient continues to be a key focus for 2019/20. We are committed to ensuring patient safety for deteriorating patients is maintained, sustained and spread across the organisation.

Description
Recognition and timely response to the deteriorating patient is a complex, broad and multi-disciplinary care pathway. Improving the effectiveness and timeliness of how we manage and care for sick patients is influenced by a number of contributing factors. These are actively being explored by collaborative staff members who are trialling different approaches that address identified opportunities for improvement relevant to their clinical areas. A wide range of staff groups are involved in the collaboration which involves those sharing experiences, learning from each other, reflecting on tests of change and measuring their improvement journey.

Key achievements
- 16 wards/departments committed to the collaborative and all areas are actively involved in trying to reduce avoidable deterioration
- Development of a change package consisting of 4 key change ideas which address some of the fundamental issues identified as challenges and barriers to providing safe, timely and effective care to patients.
- Between periods Apr to Dec-17 and Apr to Dec-18 achieved a: 11% reduction in the number of crash calls numbers
- 16% reduction in the number of medical emergency calls
- Introduction of a HCA Co-ordinator role to improve communication of staff concerns relating to patients at risk of deteriorating and workload during shift. Post incident reviews are completed following incidents relating to deteriorating patients by the nurse involved; this includes reflection on what went well, not so well, what happened and then sharing these findings at the clinical governance forums
- Training / education around responding to the sick patient
- Trialling the use of the 'Bones skeleton' template to improve structure and documentation of MDT handovers

Next steps
- Roll out the tried and tested interventions that formed part of the change package that is being tested on the collaborative wards
- Establish robust governance at an operational departmental level (to ensure sustainability)
- Continue to engage with wards/departments to focus on continuous improvement for deteriorating patients
- Create data tiles which will be codesigned with staff and displayed to drive measurement for improvement and local ownership
- Training and education about spotting the signs of a deteriorating patient
- Continue to strengthen safety culture practice, leadership and multiprofessional communicatoin around the recognition of the deteriorating patient
- Develop a "quality" real time analytical tile as part of the Command Centre Programme

Pressure Ulcers

Aim: To reduce category 2 pressure ulcers by 50% by November 18

How Much: Reduce by 50%

By When: November 2018 – new aim to be set for spread phase

Outcome: 50% reduction on 2 wards involved in the collaborative – now plan to spread the changes across other wards/departments

Focus

Pressure ulcer prevention remains a key priority for 2019/20 as we work at improving the quality of care we provide by reducing the risk of patients developing a pressure ulcer whilst in hospital. Preventing pressure ulcers is a priority because not only can they cause harm and distress to the patient, they can reduce quality of life, increase the length of stay in hospital and complicate treatment.

Description

Nationally pressure ulcer prevention remains a key priority with working groups examining education, pressure ulcer data collection and audit. We are keen to continue to build on the good work from the national pressure ulcer collaborative and ensure improvement is sustained and consistent across the whole organisation.

The Tissue Viability Nurses, Quality Improvement Team and Wards 23 and 31 participated in the national pressure ulcer collaborative. The ideas that were tested on these 2 wards will be spread to other wards. A positive campaign to help reduce the incidence of pressure ulcers has been spread across the Trust with recognition for wards that have made significant progress.

Key achievements

- Both wards involved in the national collaborative have seen an increase in the days between events. Ward 23 achieved their longest period without a pressure ulcer (78 days)
- A traffic light system has been designed to help reduce pressure damage on the wards
- The wards have reviewed the management of incontinence to ensure a patient-centred approach and the roles and responsibilities of the staff have also been reviewed and expectations are communicated to the team
- A tried and tested "patient repositioning chart" has been created as part of the collaborative
- A 50% reduction in category 2 pressure ulcers has been achieved (comparing pre and post collaborative time periods)
- Delivery of pressure ulcer prevention training by the Tissue Viability Nurses to all newly qualified nurses and midwives, Healthcare Assistants (HCAs), apprentices as well as bespoke sessions as required
- Celebration of good practice and achievement of milestones via monthly pressure ulcer hero nominations and wards
- A robust tried and tested change package ready to be rolled out across the organisation

Next steps

- Spread the learning from the national collaborative project (ended November 2018) to all wards/ departments
- Provide other wards/departments with the opportunity to test their own improvement ideas as well as the interventions proven as part of the national collaborative
- Ensure ward level data is shared on a regular basis for pressure ulcers. Ensure this data is used to reflect and learn what improvement is needed and sustained.
- Continue to raise awareness of pressure ulcer prevention through International Stop Pressure Ulcers day, posters and a staff competition.
- Look into testing out new innovative approaches and equipment that reduce the risk of pressure damage skin e.g. softer nasal cannula that reduce the risk of pressure damage to ears and noses.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Safer Procedures

Aim: To improve the delivery of safe care for patients and reduce the number of incidents for patients who have an invasive procedure in non-theatre areas across the Trust

How Much: Reduce by 20%

By When: By September 2019

Outcome: To be assessed

Focus

This priority will continue for 2019/20. Extensive work has been undertaken in theatres with WHO checklists, working with the Improvement Academy and NHS Quest to embed standards. The focus has now shifted to run a collaborative with wards/departments where invasive procedures happen outside the theatre environment. We will continue to embed the he National Safety Standards for Invasive Procedures (NatSSIPs) guidance that set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice, such as a series of standardised safety checks and education and training.

Description

National safety standards for invasive procedures 2015 set out a definition for ensuring invasive procedures have safety checks in place. This includes having key steps in place to harmonise practice across the organisation which is a consistent approach for the care of patients undergoing invasive procedures in any location.

In July 2018 a safer procedures collaborative was formed to reduce the risk of harm from invasive procedures and increase patient safety. In particular, the focus for the collaborative is in non-theatre areas, which builds on the good work that has already taken place for invasive procedures carried out in theatres.

Several departments/wards are currently undergoing testing to explore how to improve safety culture, reduce the risk of harm and maintain a safety standard for patients.

Key achievements

- "BRADSIPPS" Local standards have been developed in line with the national safety standards for invasive procedures.
- Extensive work in theatres on checklists, briefing and debriefing
- On-going monthly audits show consistent 99% and above compliance with WHO checklist in theatre areas
- New World Health Organisation (WHO) checklists produced in areas outside theatres
- Safer procedure group recently revitalised to review checklists, identify any gaps and provide audit and assurance in all areas
- Quality improvement collaborative using agreed Institute of Healthcare Improvement (IHI) breakthrough collaborative methodology with 15 different departments
- Improvement ideas booklet created with over 16 improvement interventions for non-theatre environments to test
- Learning from incidents and reflecting on culture taking place as part of the collaborative sessions
- Some WHO checklists are been re-designed in collaboration with non-theatre teams and successful PDSA testing taking place

Next steps

- Continue with the monitoring and sustainability of The National Safety Standards for Invasive Procedures (NatSSIPs).
- Continue with the Breakthrough series collaborative (across 15 departments/ward areas) aimed at reducing incidents and harm relating to invasive procedures
- Work closely with our external colleagues through the NHS Quest Theatre Clinical Community to share good practice and aid widespread, sustainable improvements.
- Continue to work on our primary drivers: 1. Culture and teamwork 2. Standardisation of the 5 steps to safer surgery 3. Education and awareness
- Create a best practice change package to share across all areas (following testing within the collaborative)
- Ensure there is a robust governance and framework to continue to ensure WHO checklists are in place for all invasive procedures

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Patient Experience

Aim: In line with the new Patient Experience Strategy, aim to promote kindness across the Organisation

How Much: To be determined

By When: Date to be agreed but will be approximately March 2020

Outcome: To be determined

Focus

Patient experience will be a key priority area for 2019/20. Patient experience is core to everything we do in the NHS. We want to provide the best possible experience for patients, their relatives and carers. Patient experience encompasses a wide range of both clinical and non-clinical aspects of a patient's journey; this means that improving patient experience requires the involvement of every member of staff.

Description

Measuring patient experience is fundamentally about ensuring our patients and the community we serve has a voice. We can listen to that voice directly through complaints, compliments, engagement work and surveys or more indirectly by working in partnership with patient bodies such as Healthwatch and on specific Campaign like the very successful #Hellomynameis.

Bradford Teaching Hospitals NHS Foundation Trust's mission is to provide the highest quality healthcare at all times. We will do this by working together, putting patients first. We believe listening, talking and responding to patients, carers, relatives and local people should be part of our everyday work and that the way we do this should match what we say we believe in – our values.

With the recent publication of the new Patient Experience Strategy (2018-2023) plans are under development to create a Patient Experience Collaborative that will help achieve some of the aims and ambitions outlined in the strategy.

Next steps

- Strengthen leadership and partnership for improving patient experience
- Work collaboratively with external organisations to ensure we have an active voice in the shaping and delivery of healthcare services, such as Healthwatch, national and local organisations and community representatives
- Create a culture of improving experience
- Improve how we ask and capture experiences
- Improve how we listen, understand and act to improve on experiences shared
- Set up a collaborative programme to embed the new patient strategy across the organisation

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Medication Safety

Aim: Introduction of a Senior Pharmacy Assistant working as part of the paediatric team to facilitate good management of medicines

How Much: 1. Reduce the cost associated with medication waste by 20%

2. To decrease the time taken to produce discharge prescriptions for patients on the paediatric ward by 10%

By When: March 2019 then spread phase until March 2020

Outcome: To be assessed

Focus

There are an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant (NHS England 2018). Medication safety is about preventing errors in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines. There are 3 key projects that will be a priority for medication safety during 2019/20.

Description

It is anticipated that the implementation of a medicines optimisation assistant (known as a SATO) on ward 30 will enhance medication safety. The SATO role, previously undertaken by the nurses, will involve ordering of medicines, stock rotation and clinic room management. They will also encourage patients to bring their own drugs into hospital. By introducing a Senior Pharmacy Assistant to undertake medicines specific tasks, it is hoped that nursing time will be freed up to spend more time with patients and thus reduce patient harm

The project also focuses on achieving a more fluid approach to patient flow by identifying patients for discharge in advance and ensuring the medicines are ready in a timely manner.

Key achievements

- Funding Senior Pharmacy Assistants (2x job share) in position and role extended for a further 3 months
- Extremely positive feedback from ward staff who have found this role meant nursing staff had more time to engage in patient related matters
- Data collection in progress. Initial data shows a reduction in time taken to discharge patients by 23%.
- Stock lists have been reviewed and amended, meaning wastage is reduced
- Patient's Own Medicine lockers in situ and discussions starting around this

Next steps

- Assess outcome measures to show if the introduction of a Pharmacy Technician leads to improved medication safety
- Continue with the trial of a Senior Pharmacy Assistant on the children's ward – aim to enable nurses and healthcare workers to focus more of their time on direct patient care.

Medication Safety

Aim: To reduce the number of avoidable omissions of critical medications on SAU and AMU wards

How Much: By 10%

By When: By March 2020

Outcome: To be assessed

Focus

There are an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant (NHS England 2018). Medicines should be administered at the prescribed time and for most this can be considered as plus or minus two hours from the time prescribed on the inpatient prescription. An omitted dose is a failure to administer a dose before the next scheduled dose is due or a failure to prescribe a drug in a timely manner. Omitted medicine remains the highest category of medication errors reported to the NRLS. The UK National Patient Safety Agency has reported that up to 20% of medication errors were omitted doses.

Description

Medication omissions at prescribing, dispensing or administration stages have been identified as a potential for patient harm. Omissions at the dispensing or administration stages may persist, leading to suboptimal treatment, which is why this is a priority area for Bradford Teaching Hospitals NHS Foundation Trust. This project is currently under development with a plan to carry out the Quality Improvement on Surgical Assessment Unit and Acute Medical Unit.

Key achievements

- Project not commenced yet.

Next steps

- Review the culture within the organisation in relation to medicines-related incidents and act on the information received.
- Review processes and procedures to reduce avoidable drug omissions
- Improve the reporting of medicines-related incidents and learning from any incidents that occur in order to increase prevention.
- Understand the reasons behind the omission of medicines, with a view to further work on other wards.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Learning from Each Other

Aim: To increase showcasing, sharing and learning from improvements/good changes

How Much: By 50%

By When: December 2019

Outcome: To be assessed

Focus

This is a new priority for 2019/20. As part of being a continuously learning organisation, we recognise the importance behaviours, culture and values have on Quality Improvement. The concept of "learning from each other" is to help celebrate, recognise and share improvements that are successful.

Learning from what has gone well is crucial to help ensure they spread and are sustained. Recognition of achievements carried out helps improve staff morale and boosts confidence in carrying out improvement.

We want to focus on the best in people, our organization, and the opportunity-rich environment around us. This requires a fundamental shift in the overall perspective to focus on system's strengths, possibilities, and successes.

Description

At Bradford Teaching Hospitals NHS Foundation Trust, the Quality Improvement agenda has a key focus on "learning from each other" which focuses on showcasing, sharing and learning from improvements/good changes carried out throughout the organisation. This links closely to the Appreciative Inquiry model (Cooperrider 1986) which focuses on facilitating positive change in human systems by promoting what is already working rather than promoting problems. It also links to the IHI Joy in Work whitepaper (2018) which highlights how to bring joy, purpose and meaning to the good work that is carried out on a daily basis.

In November 2018 we held our first "learning from each other" event in the main concourse at Bradford Teaching Hospitals NHS Foundation Trust. It was organised in less than 5 weeks and we had over 50 improvement projects, ways of working and innovation showcased from a wide range of staff. It helped shine a spotlight on the great Quality Improvement work that is taking place on a regular basis. It was a forum to share successes and learning – no matter how small or big.

Key achievements

- Over 50 improvement projects showcased at the first learning from each other event
- Highlighted and celebrated improvement work
- Sharing and learning from successes
- Created networks between staff to learn/adapt improvement initiatives

Next steps

- Hold "learning from each other" showcasing events
- Have a "learning from each other" celebration awards event & Increase recognition of achievements through publications, articles and awards
- Create an annual "learning from each other" yearbook
- Increase networking opportunities to learn from things that have gone well and spread them to other areas
- Create a positive culture through acknowledgement of all successes taking place in the organisation
- Capture all the "learning from each other" into a central QI repository to ensure they are shared at a senior level
- Link "learning from each other" into all the QI training we deliver

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

2.2.1
REVIEW OF SERVICES

During 2018/19 Bradford Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 41 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in all 41 of these relevant health services.

The income generated by the relevant health NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant services by the Foundation Trust for 2018/19.

2.2.2
PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

Bradford Teaching Hospitals NHS Foundation Trust is committed to a programme of continuous improvement supporting its provision of safe, high quality patient care. It understands clinical audit as a professionally led, multi-disciplinary exercise, which should be integral to the practice of all clinical teams. The Foundation Trust also believes that clinical audit should not occur in isolation and supports the view that it should be considered both within the context of organisational learning and as a mechanism to provide assurance about the quality of services.

The Foundation Trust has a High Priority Clinical Audit Programme that describes both its involvement in the National Clinical Audit Programme and its management of audits that are prioritised at a local level.

During 2018/19 the following covered NHS services that the Foundation Trust provides:

- 60 National Clinical Audits / Registries
- 3 Mothers and Babies: Reducing Risk through Audits and Confidential

Enquiries across the UK (MBRRACE - UK) studies

- 5 National Confidential Enquiries (NCEPOD) and
- 1 Learning Disability Mortality Review Programme (LeDeR)

During that period, the Foundation Trust participated in 97% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate. The national clinical audits and national confidential enquiries that the Foundation Trust was eligible to participate in during 2018/19 are described as follows:

Figure 9: Participation in the National Clinical Audit Programme 2018/2019.

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
Adult Cardiac Surgery	No	No	Not Applicable
Adult Community Acquired Pneumonia	Yes	Yes	100% (est)
BAUS Urology Audit - Cystectomy	Yes	Yes	On-going
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Yes	On-going
BAUS Urology Audit - Nephrectomy	Yes	Yes	On-going
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	On-going
BAUS Urology Audit – Radical Prostatectomy	Yes	Yes	On-going
Cardiac Rhythm Management (CRM)	Yes	Yes	100%
Case Mix Programme (CMP)	Yes	Yes	50%
Child Health Clinical Outcome Programme: Long-term ventilation in children, young people and young adults (NCEPOD)	Yes	Yes	Not Applicable

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
Elective Surgery (National PROMs Programme)			
• Hernia	Yes	Not Required	Not Applicable
• Hip	Yes	Yes	On-going
• Knee	Yes	Yes	On-going
• Vein	Yes	Not Required	Not Applicable
Falls and Fragility Fractures Audit Programme (FFFAP)			
• National Hip Fracture Database	Yes	Yes	100% (est)
• National Audit of Inpatient Falls	Yes	Yes	100% (est)
• Fracture Liaison Service Database	Yes	Yes	67% (est)
Feverish Children (care in emergency departments)	Yes	Yes	100%
Inflammatory Bowel Disease programme / IBD Registry	Yes	Yes	Not Applicable
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	84%
Major Trauma Audit (TARN)	Yes	Yes	41%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	Not Applicable
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK):			
• Perinatal Mortality Surveillance	Yes	Yes	On-going
• Perinatal morbidity and mortality confidential enquiries	Yes	Yes	On-going
• Maternal Morbidity Surveillance and Mortality Confidential Enquiries	Yes	Yes	On-going
Medical and Surgical Clinical Outcome Review Programme: Pulmonary Embolism (NCEPOD)	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Perioperative Diabetes (NCEPOD)	Yes	Yes	58%
Medical and Surgical Clinical Outcome Review Programme: Cancer Care in Children, Teens and Young Adults (NCEPOD)	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Acute Bowel Obstruction (NCEPOD)	Yes	Yes	38%[1]
Mental Health Clinical Outcome Review Programme	No	No	
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	On-going
National Asthma and COPD Audit Programme (NACAP)			
• Chronic Obstructive Pulmonary Disease	Yes	Yes	On-going
• Adult Asthma	Yes	Yes	On-going
National Audit of Anxiety and Depression	No	No	

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Not Applicable
National Audit of Cardiac Rehabilitation	Yes	Yes	On-going
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Not Applicable
National Audit of Dementia (NAD)	Yes	Yes	100% (est)
National Audit of Intermediate Care (NAIC) • Bed based service user questionnaire • Bed based patient reported experience measure • Home based service user Questionnaire • Home based patient reported experience measure	Yes	Yes	6v5% 86% 14% 91% 56%
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	100%
National Audit of Pulmonary Hypertension	Yes	No	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes	On-going
National Bariatric Surgery Registry (NBSR)	Yes	Yes	On-going
National Bowel Cancer Audit (NBOCA)	Yes	Yes	85%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	84%
National Clinical Audit of Psychosis	No	No	
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	No	
National Comparative Audit of Blood Transfusion Programme: • National Comparative Audit of The Use of Fresh Frozen Plasma, Cryoprecipitate and other Blood Components in Neonates and Children • National Comparative Audit of the Management of Major Haemorrhage • Audit of The Management of Maternal Anaemia	 Yes Yes Yes	 Not Required[2] Yes No	 Not Applicable 100% Not Applicable
National Congenital Heart Disease (CHD)	No	No	
National Diabetes Audit - Adults • Care Processes and Treatment • Insulin Pump • Foot care audit	 Yes Yes Yes	 No No No	 Not Applicable Not Applicable Not Applicable
National Diabetes Audit – Inpatient (NaDIA)	Yes	No	Not Applicable
National Diabetes In-patient Audit (NaDIA) Harms	Yes	Yes	100% (est)
National Pregnancy in Diabetes Audit	Yes	Yes	100% (est)

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	On-going
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100% (est)
National Heart Failure Audit	Yes	Yes	On-going
National Joint Registry (NJR)	Yes	Yes	On-going
National Lung Cancer Audit (NLCA)	Yes	Yes	100% (est)
National Maternity and Perinatal Audit (NMPA)	Yes	Not Required	Not Applicable
National Mortality Case Record Review Programme	Yes	Yes	Not Applicable
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	80%
National Ophthalmology Database	Yes	Yes	98.5%
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100% (est)
National Prostate Cancer Audit	Yes	Yes	On-going
National Vascular Registry	Yes	Yes	On-going
Neurosurgical National Audit Programme	No	No	
Non-Invasive Ventilation - Adults	Yes	Yes	On-going
Paediatric Intensive Care (PICANet)	No	No	
Prescribing Observatory for Mental Health (POMH-UK)	No	No	
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	55% (est)
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	97% (est)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	100%
Seven Day Hospital Services	Yes	Yes	100%
Surgical Site Infection Surveillance Service	Yes	Yes	100% (est)
UK Cystic Fibrosis Registry	Yes	Yes	On-going
Vital Signs in Adults (care in emergency departments)	Yes	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	98%

[1] Submission on-going

[2] No cases eligible for submission

The reports of 53 national clinical audits that were reviewed by the Foundation Trust during 2018/19, and any actions that the Foundation Trust intends to take to improve the quality of healthcare provided, are described in the Figure 10.

Figure 10: Actions taken to improve the Quality of healthcare

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
BAUS Urology Audit - Cystectomy	October 2018	The 2018 data covered the published results of cystectomy for surgery performed between 2015 and 2017. Mortality is higher than the national average for both 30-day mortality rate (2.8% against 1.31%) and 90-day mortality rate (2.8% against 2.21%), assurance has been received from the audit lead that this does not represent a concern, as the patient risk profiles are higher than the national average. As a result further action was not assessed as being necessary.
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	June 2018	The data published covered the period between 1st January 2015 and 31st December 2017. The published findings consider the outcomes for patients considering the type and volume of surgery undertaken. All outcomes were reported as being within range or better than the national average. The Foundation Trust identified some potential concerns regarding data completeness for this audit, specifically relating to Patient Reported Outcome Measures (Pre-op, post-op and follow-up questionnaires).
BAUS Urology Audit - Nephrectomy	August 2018	The audit published covered the period between January 2015 and December 2017. The audit data indicates that the complication rate experienced by patients is slightly above the national average. This finding has been assessed by the Foundation Trust and it was concluded that this outcome reflects the morbidity of patients being managed by the service (24.2% of patients have a recorded WHO performance status of 2, 3 and 4, compared to the national average of 10.4%). Performance in relation to case ascertainment and the audit findings were discussed with the speciality lead. An investigation in to case ascertainment is planned to be undertaken by the audit lead with support from the central Clinical Effectiveness Team.
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	May 2018	The Foundation Trust reviewed the findings and recommendations from the published report The transfusion rate was 0%; this is below the national average of 2.09%. The median length of stay (LOS) was 3 days which is similar to the national average. Mortality rate is reported as being below the national average (0% against 0.4%).

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
BAUS Urology Audit – Radical Prostatectomy	September 2018	The Foundation Trust reviewed the findings from the data published which covered the reporting period 1st January 2015 and 31st December 2017. The complication rate (graded Clavien Dindo III and above) was slightly higher than the national average, this has been considered within specialty discussions.
Case Mix Programme (CMP)	October 2018	The Foundation Trust reviewed the Annual Quality Report. Case ascertainment reported was 50%, this is due to a vacancy within the post of ICNARC Audit Clerk. Whilst the Trust is not an outlier for any outcomes reported in the audit, the findings suggested that the number of high-risk admissions from medical wards and the number of unplanned readmissions within 48 hours were above comparator units. The ICU Unit reviewed all the records where it was identified that patients had been re-admitted and assurance was gained that all patients were appropriately discharged by the unit however later required ICU care again due to their medical condition. High-risk sepsis admissions from wards were one of the highest rates within the region. The Foundation Trust has developed a local service action plan to mitigate the risks identified; in addition the Trust is implementing a Trust-wide Sepsis improvement plan which is being led by the newly appointed Sepsis Specialist Nurse.
Child Health Clinical Outcome Programme: Chronic Neurodisability (NCEPOD)	March 2018	The Foundation Trust has initiated the process of reviewing the report recommendations with the speciality.
Elective Surgery (National PROMs Programme) - Hip	August 18	The provisional report data was published in August 2018. Total hip replacement average health gain is below the national average. The report was discussed within the speciality clinical governance and weekly Arthroplasty meetings by the clinical lead for the service. Reported performance is due to low response rates, this is being addressed by discussion with patients as part of the Enhanced Recovery programme in the Arthroplasty service, with the aim to improve response rates and data quality.
Elective Surgery (National PROMs Programme) - Knee	August 18	The provisional report was data published in August 2018. The knee replacement health gains are generally above the national average. The report has been discussed within the speciality clinical governance and weekly Arthroplasty meetings by the clinical lead for the service. Reported performance is due to low response rates, this is being addressed by discussion with patients as part of the Enhanced Recovery programme in the Arthroplasty service, with the aim to improve response rates and data quality.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Hip Fracture Database (Falls and Fragility Fractures Audit Programme (FFFAP))	September 2018	The Foundation Trust is in the top quartile of the national outcome for 13 standards, the second quartile for 7 standards and the 3rd quartile for 4 standards. Standards that are lower are delirium assessment, this has been discussed at the monthly Hip Fracture Meeting and the audits leads plan to discuss this with junior doctors for improving completion timely. Recording has been amended on the electronic patient record in relation to recording mobilisation the day after surgery, this should improve compliance with this standard.
Fracture Liaison Service Database Falls and Fragility Fractures Audit Programme (FFFAP)	September 2018	The Foundation Trust reviewed the findings from the FFFAP audit. The Trust has made improvements since the Bradford Falls Liaison Service was established during 2017/18. Performance associated with major key performance indicators are being supported by this service.
Fractured Neck of Femur (care in emergency departments)	May 2018	Patients in severe pain receiving analgesia for developmental targets is 0%, although this is on par with the national average, 100% of these patients received analgesia within 60 minutes of arrival which is above the national median of 30%. The audit was discussed in the Trist's Quality and Safety meeting. A local re-audit is planned to take place.
Inflammatory Bowel Disease programme / IBD Registry	September 2018	The findings of this report were based on cumulative data submitted up to September 2018 (91 patients registered with a recorded diagnosis). The Foundation Trust reviewed the recommendations from this report and as a result the Foundation Trust is considering a new method of recruitment to the Registry via invitation letters being sent to eligible patients.
Learning Disability Mortality Review Programme (LeDeR)	March 2018 - Ongoing	The Foundation Trust now participates fully in the local LeDeR programme, following the establishment of an appropriate governance framework. The Foundation Trust has trained members of the risk team to undertake reviews which will commence in May 2019.
Major Trauma Audit (TARN)	August 2018 and November 2018	The audit findings and outcome measures from the validated live dashboard system is reviewed on a regular basis. The case ascertainment and data completeness were variable during 2018/19. Process mapping and gap analysis sessions were carried out in November 2018. Following the gap analysis session, a service level action plan was completed. The compliance around criteria relating to Consultant/STR-3 led trauma teams has since improved. The Foundation Trust continues to network with other Trusts and take part in the regional TARN meetings. The Foundation Trust's Informatics and Business Intelligence Team developed an SQL script to run the data sample which should improve data quality, data completeness and case ascertainment in the future.
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK): Perinatal Mortality Surveillance	June 2018	The Perinatal Surveillance Report (2017 data) from MBRRACE was published in June 2018. The Foundation Trust reviewed the findings and recommendations from this report. The report was discussed with the speciality lead for obstetrics. There is on-going quality improvement work within Maternity Services that will address the findings and recommendations within the report.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK): Maternal Morbidity Surveillance and Mortality Confidential Enquiries	November 2018	The Foundation Trust reviewed the report findings and recommendations. Legitimate concern was raised during this process of review about test tracking of investigations which are managed externally to the Electronic Patient Record. Discussions have been held in the core speciality and divisional governance meetings to ensure these concerns were escalated. In addition, a Training Needs Analysis has been undertaken in response to the findings of the report and the relevant guideline updated. The specialty is assured that more proactive use of risk assessments has improved the overall outcome with regards to this audit.
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Heart Failure: Failure to Function	November 2018	The Foundation Trust has reviewed the recommendations from this National Confidential Enquiry. The overarching purpose of these recommendations is to improve the quality of care provided to people with acute heart failure. The specialty have considered the recommendations and included any identified actions to optimise patient care in their routine governance.
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Peri-operative management of surgical patients with diabetes: Highs and Lows	December 2018	The Foundation Trust has reviewed the recommendations from this National Confidential Enquiry. The overarching purpose of these recommendations is to improve the quality of care provided to patients over the age of 16 who were diabetic and were undergoing a surgical procedure. An action plan has been developed by the division to address the concerns, and any opportunities for change and improvement identified within the service. There is an established whole Trust governance forum to promote and ensure safety of children and young people, the 'Children's and Young People's Board' where improvements have been driven in relation to the surgical care of all children, including those with complex co-morbidities.
Myocardial Ischaemia National Audit Project (MINAP)	November 2018	The MINAP report made six recommendations for Acute Trusts and these relate to the dissemination of findings, exploration and action in relation to variations, maintenance of the quality of care, timely angiography, resource allocation for audit and quality improvement and presentation of findings at board level; these have been fully considered by the relevant specialty. The findings were presented within the Cardiology Speciality Quality and Safety Meeting. A locally developed action plan is being implemented to address areas for improvement, in relation to the number of patients admitted to a specialist ward. In addition the NSTEMI pathway in AED is being reviewed to ensure that there is earlier recognition of NSTEMI cases; the implementation of a daily handheld echo ward round and a confirmatory local audit is planned during 2019/20.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
NACAP - COPD Audit Programme	November 2018	The Foundation Trust reviewed the findings and recommendations from the COPD audit. The audit findings were discussed and presented in the Speciality Respiratory Clinical Governance Meeting. The Foundation Trust was not compliant with the Best Practice Tariff for the second consecutive year. The audit found that the respiratory team reviewed a lower proportion of patients during admission and there was a longer mean time from admission to respiratory review. Spirometry results were not available in a higher proportion of cases than the national average. BTS discharge bundle completion rates were also lower than the national average. There were lower levels of clarity regarding follow-up arrangements, with 48.8% of cases were arrangements were not apparent. In order to address the findings of the audit a business case to increase capacity within the Respiratory service for additional Clinical Nurse Specialist and Consultant time in order to achieve compliance with best practice standards has been developed and subsequently approved. A local service action plan has been developed by the respiratory core group to address all the opportunities for change and improvement identified.
National Audit of Breast Cancer in Older People (NABCOP)	June 2018	The Foundation Trust reviewed the recommendations relating to carer and patient involvement; monitoring length of stay, reviewing the accuracy of audit data and the use of protocols for assessment and treatment. The report was discussed at the Breast Clinical Governance Meeting and it was reported that some of the outcomes of the audit were not reflective of practice, including the proportion of women that have contact with the Breast Care Nurses and the proportion of women receiving triple diagnostic assessment in a single visit. There is on-going work to ensure clinical validation can be completed prior to data submission. Developments with recording for Cancer Services have improved the quality of data that is submitted to the Cancer datasets.
National Audit of Cardiac Rehabilitation	November 2018	The Foundation Trust have achieved the NACR certification for 2018/19, meeting all seven standards, including having evidence of prompt identification of eligible patients, early assessment and demonstration of sustainable health outcomes.
National Audit of Dementia (NAD): Care in General Hospitals 3rd Round (NAD) - Assessment of delirium in hospital spotlight report	August 2018	The Foundation Trust reviewed the audit findings and recommendations of this report. A "Plan on a Page" has been completed, which supports the assessment of risk in relation to the audit outcomes and an action plan has been implemented to ensure that care for patients with dementia is optimised across the Trust. The Trust has a recruited a new Dementia Specialist Nurse. Areas of concern identified within the report relating to obtaining a corroborative history from someone who knows the patients well, undertaking a standardised confusion assessment and a standardised cognitive test. Lower compliance than nationally with physical investigations (FBC, LFT, blood cultures, urinalysis / MSU, chest x-ray). Delirium or acute confusion during initial presentation or within 24 hours of admission recorded on the discharge summary. A spot check of electronic records was undertaken by the Dementia Lead in April 2019 of all patients with a diagnosis of Delirium (n=18). The results from this spot check confirmed that 94% of patients had a corroborative history completed and had all routine investigations completed. 90% of patients discharged in March 2019 had a recorded diagnosis of delirium or dementia (or both) on the GP discharge summary.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Audit of Intermediate Care	November 2018	The Foundation Trust reviewed the audit findings and found that the registered nursing staff vacancy rate (26%) for home based rehabilitation is higher than the England mean (10%). The Trust is engaging in recruitment of nursing staff in order to address this concern.
National Audit of Percutaneous Coronary Interventions (PCI)	November 2018	The audit findings and recommendations of this report have been considered and discussed in the specialty meeting. The report identifies that there were no areas of sub-optimal care identified, and the results demonstrate that in spite of the local population having higher prevalence rates of diabetes and acute work (previous MI & previous CVA) outcomes are comparable to the national average.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	January 2019	This organisational audit report made 12 recommendations including a recommendation relating to workforce. A plan on a page and a recommendations checklist are underway to support with reviewing the findings and recommendations. The percentage of general paediatric workforce with 'expertise in epilepsy' is 5.4%, this is lower than in England & Wales (14.8%). A business case has being approved which will increase the number of Paediatricians with a specialist expertise in epilepsy. In addition adjustments have been made to clinical appointment timings to enable a longer paediatric consultation.
National Bariatric Surgery Registry (NBSR)	July 2018	The Foundation Trust reviewed the findings and recommendations from this report. There are significant concerns relating to data completeness, data quality and case ascertainment with this audit which have been escalated to the Chief Medical Officer. A process mapping exercise and gap analysis is being undertaken to identify areas where these issues can be effectively mitigated. These issues are being directly considered by the Foundation Trust's Clinical Audit and Effectiveness Committee.
National Bowel Cancer Audit (NBOCA)	December 2018	The NBOCA 2018 Report presents data from patients diagnosed with Colorectal Cancer between 1st April 2016 and 31 March 2017(the 2017/18 reporting period), alongside an organisational report detailing services that the Foundation Trust provides. The Trust is reported as being excluded from the risk-adjusted analysis for 90-day mortality and 30-day emergency re-admission rates due to data completeness/data quality issues. A process mapping exercise and gap analysis have been undertaken to identify reasons for this poor case ascertainment and data quality. The outcome of this work is currently under review.
National Cardiac Arrest Audit (NCAA)	May 2018	The Foundation Trust considered and discussed the findings and recommendations of this report in the Divisional Quality Governance meeting, Deteriorating Patient Group and Patient Safety Committee. Data completeness is 100% for all values. Favourable neurological outcomes and survival to discharge are lower than national average, but are within the acceptable limits. Actions being taken to respond to the findings are monitored by the Patient Safety Committee.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Comparative Audit of Blood Transfusion: Audit of Transfusion Associated Circulatory Overload The (TACO)	2018	The Foundation Trust developed a Local Service Action Plan in response to the audit results and recommendations made by the audit provider. The audit results indicate that not all patients for TACO had documentation for risk assessment in their clinical notes. To ensure that a formal pre-transfusion risk assessment for TACO a checklist has been developed by the Transfusion Nurse Specialist and added to the Hospital Transfusion policy. The TACO checklist has been added to the blood component record / prescription record.. There is a plan to implement an appropriate transfusion campaign to re-inforce what is discussed in medical mandatory training.
National Comparative Audit of Blood Transfusion: Re-Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	2018	The Trust development and implemented an action plan in response to the audit results and recommendations. The results of audit were presented at the Haematology Journal Club and the audit results were discussed by the Consultant Haematologist audit lead and Transfusion Lead. Where appropriate the Trust guidelines have been re-iterated to support improved patient care and compliance with best practice.
National Diabetes Audit – Core Audit	March 2018	The Foundation Trust was not able to participate in the 2017/18 audit due data transfer and compatibility problems following a change in pathology provide. . A work stream has been established, involving Informatics, Specialty and Clinical Effectiveness Teams to lead and task the effective collection and input of audit data to enable a more meaningful participation with the national audit.
National Diabetes Audit – Insulin Pump	June 2018	The Insulin Pump audit is part of the National Diabetes Core Audit, is as described above, the Foundation Trust could not participate in this audit due to data transfer issues. The issue is now resolved and the data has been collected for the 2018/19 National Diabetes – Insulin Pump Audit.
National Diabetes Transition Audit	January 2019	The National Diabetes Transition Audit covers the care of children / young people transitioning to adult services and included recommendations that support the transition processes.
National Emergency Laparotomy Audit (NELA)	September 2018	The Foundation Trust reviewed and considered the audit findings and recommendations. The recommendations were discussed at the Clinical Audit and Effectiveness Committee. Key areas considered relate to the assessment by elderly medicine specialist patients >70 years decreased in compliance compared to the previous year but was higher than the national average (28.3% verses national mean of 22.9%). A "Plan on a Page" and local service action plan have been developed and implemented to ensure that any areas of potential sub-optimal care provision have been identified, risk assessed and that there is a plan for improvement in place.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Heart Failure Audit	November 2018	The National Audit of Heart Failure 2017/18 is a continuous, prospective audit that looks at the treatment and management of heart failure patients who have an unscheduled admission to hospital. The audit looks at inpatient care, investigations and treatment and also referral to outpatient services. The Foundation Trust is lower than the national average in a number of standards, including rates of echocardiogram, input from a consultant cardiologist and referral to cardiology and/or cardiac rehabilitation An action plan is in place to address all these issues and it is anticipated that the results for 2018/19 will be significantly improved. Indeed early informal feedback from the 2018/19 audit results is that Bradford has performed significantly better in a number of audit standards and has been approached by the audit provider to share its improvement story.
National Joint Registry (NJR)	September 2018	The Foundation Trust reviewed the audit findings and recommendations. The Foundation Trust was historically reported an outlier for knee revision rates (2003-2017 data). All key performance indicators are currently within the expected rage. During 2018/19 the Foundation Trust was awarded as an NJR Quality Data Provider Certification for commitment to patient safety through National Joint Registry. This was discussed at the Clinical Audit and Effectiveness Committee and congratulated the staff who collect and input the data for NJR.
National Mesothelioma Audit (Spotlight Audit of National Lung Cancer Audit)	June 2018	The results from the spotlight audit were reviewed by the audit lead, data quality issues found are being addressed by the Cancer Services Team. A lower proportion of patients are seen by a clinical nurse specialist, The Trust has completed a local audit and results suggest that a higher percentage of patients are now seen by nurse specialist.
National Mortality Case Record Review Programme	October 2018	The Mortality Review Outcomes Report and Mortality Dashboard provides an overview of the mortality case note reviews completed by doctors and senior nurses in the Foundation Trust on deaths occurring between January 2019 and March 2019. It presents a summary of emerging themes and identifies key learning and areas for improvement such as timeliness of care and delayed treatments monitoring of medications, care of the deteriorating patient. The Foundation Trust holds a bi-monthly Mortality Committee to monitor the SJR reviews outcomes and to assure the lessons are learned across the Trust, these feed into the Quality oversight system and the Quality Improvement programme. The Quality Committee receives a quarterly Learning from Deaths report.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Neonatal Audit Programme (NNAP)	September 2018	The National Neonatal Audit presents results relating to 15 neonatal care indicators for neonates with a final discharge from neonatal care between 1st January 2017 and 31st December 2017. The Foundation Trust reviewed the findings and recommendations from this report. Compliance with many standards was above national average and the Trust received a positive outlier notice (this relates to care that is excellent) for admitted babies born at less than 32 weeks having a first measured temperature 36.5°C to 37.5°C within one hour of birth. Actions identified for improvement relate to the measures of parental involvement and performance associated with follow up and improved communication with the staff team is in place to address this. The Foundation Trust is also improving information to improve the usage of breastmilk to address the higher than national rate of necrotising enterocolitis.
National Oesophago-gastric Cancer (NAOGC)	September 2018	The Foundation Trust reviewed and discussed the findings of this audit and at the Clinical Audit and Effectiveness Committee.
National Ophthalmology Database	August 2018	This is the second prospective report from the National Ophthalmology Database Audit. A total of 2,344 eligible cases were submitted (e 94.5% case ascertainment) from 30 surgeons. Data collected include visual accuracy pre and post operation and change. The report makes several recommendations including supporting improved data collection, use of audit information in revalidation and appraisal, reviewing care pathways to ensure that data is recorded for every operation, and individual surgeons comparing their results against their peers. The Foundation Trust reviewed the recommendations A Plan on a Page has been completed with the audit lead to assess any emergent risk and ensure an improvement plan is in place. A business case been developed to address purchase of new instrumentation. A local audit of cataract surgery is on-going to compare the latest data with the given national findings. A new service will be provided at Westwood park, which will use improved instrumentation.
National Paediatric Diabetes Audit (NPDA)	July 2018	The Foundation Trust disseminated and discussed the audit findings with speciality core groups and divisional quality meetings. The Trust had negative outlier status for two audit measures; HbA1c (measure of diabetes control) and the healthcare check completion rate. Collection of this data was affected by children having separate notes for dietetics, nursing and medical, and the service did not used a shared electronic record. The Trust has now developed a system to improve the capture of information related to procedure performed elsewhere. An action plan has been put in place to address the outlier notifications and the Foundation Trust is no longer an outlier for the health care check – now at 98%, for the high HbA1c measurement there is quality improvement work commencing on the introduction of education to patients and new technology that aim to demonstrate improvements going forward.

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Prostate Cancer Audit	February 2019	The National Prostate Cancer annual report covers the complete care pathway for men diagnosed between 01/04/2016 to 31/03/2017. The Foundation Trust reviewed and discussed the findings and recommendations both within the core specialty and at the Clinical Audit and Effectiveness Committee. The data completeness and data quality were identified as the key issues, overall the standards were better than the national average and the service is recruiting another clinical nurse specialist to further improve the service.
National Vascular Registry	November 2018	The Registry is commissioned by the Healthcare Quality Improvement Partnership and is designed to support quality improvement within NHS hospitals performing vascular surgery by providing information on their performance. This registry collects data for surgery for aortic aneurism, carotid endarterectomy, lower limb angioplasty or stent and lower limb amputation. The review of the audit outcome with the Audit Lead identified some areas for improvement in relation to data quality and data completeness. The Trust is working with the West Yorkshire Association of Acute Trusts (WYAAT) to review and enhance pathways of all relevant conditions to ensure optimal care for our patients and compliance with audit standards.
Pain in Children (care in emergency departments)	June 2018	The foundation Trust reviewed the report and found that there was a lower number of children that had pain assessed and offered analgesia within the recommended timeframes. 50% of children had received analgesia within 60 minutes of arrival / triage compared with nationally. The Trust is in the process of reauditing these measures.
Procedural Sedation in Adults (care in emergency departments)	May 2018	Performance for standards relating to location of procedural sedation and presence of staff are 100% compliant. Areas of where improvements are been made are the implementation of a LocSSIP checklist and also information leaflets regarding procedural sedation will be provided to patients.
Sentinel Stroke National Audit programme (SSNAP)	December 2018	The Sentinel Stroke National Audit Programme published the annual portfolio based on stroke patients admitted to and/or discharged from hospital between April 2017 and March 2018. The Foundation Trust has shown an improvement in the overall SSNAP indicator, which has now moved to a 'B banding' and SSNAP score is 71. The case ascertainment and audit compliance has remained at the highest performance indicator level, A. The findings and a proposed action plan to improve the thrombolysis indicator and stroke unit (patient-centred KI level) are routinely discussed at the Clinical Audit and Effectiveness Committee and the Quality Committee.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	July 2018	The Serious Hazards of Transfusion annual report covers all reportable transfusion related events and near misses. The root cause analysis from each transfusion incident is reported at the Hospital Transfusion Committee. The findings suggested that the near misses are above the average by area and cluster use. The implementation of the 'Group and Save Two-sample Rule' has demonstrated positive results in reducing incidents. Incidents relating to Transfusion are routinely reported to the Quality Committee.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

The reports for 25 local audits and audit programmes were reviewed by the Trust in 2018/19; the key actions that it intends to take to improve the quality of healthcare provided are described in Figure 11, which includes examples of local audits reported in 2018/19.

A more detailed review of the outcomes of the Trust's local audit programme will be published in its Annual Clinical Audit Report later in 2019/20.

Figure 11: Intended actions following review of the recommendations from local audits completed during 2018/19

Title of Audit	Report Produced	Actions
Sepsis CQUIN	Quarterly	The Deteriorating Patient Group continues to work to improve sepsis care within the Foundation Trust and sepsis screening continues to improve. The Nurse Consultant Infection Control and Sepsis Nurse Specialist review reporting weekly, this is disseminated to Head of Departments and Clinical Leads. Sepsis improvement events have been held, including ward visits. Data collection against the CQUIN is continuous and reported to the Deteriorating Patient Group regularly. Appointment of a Sepsis Nurse Specialist has occurred. The Quarterly Sepsis report is presented to Quality Committee.
Seven Day Self-Assessment Toolkit (7DSAT)	March and September	The Seven Day Self-Assessment Tool audit has been discontinued. The last audit was done in March 18 and reported on in June 2018. There will be no further seven day services self-assessments that are commissioned; this will be done via Board Assurance Framework.
Nutrition	Ongoing	Dieticians have worked with the Chief Nurse's Office to rewrite the audit tool to reduce overlap with Ward Accreditation audit. The data collection is ongoing and the audit outcomes are reported to the Improving Nutrition Group where Trust wide actions are agreed and assured,
Fundamental Standards of Quality and Safety (ProgRESS)	Various	The Foundation Trust has an established programme of reviews, ProgRESS (Programmed Review of Effectiveness, Safety and Sensitivity). ProgRESS enables the Trust to identify difficulties, risks, opportunities for improvements and areas of best practice against the CQC Fundamental Standards. Review outcomes are reported to the Patient Safety Sub-Committee. The reviews resulting in no confidence or limited confidence are escalated to the Executive Lead for action through the designated oversight committee. In 2018/19 ProgRESS has been adapted to focus on the moving to good, becoming outstanding and has supported a series of Mock Inspections of the CQC core services.

Title of Audit	Report Produced	Actions
Medicines Safety	Various	Four medicines safety audits were reported on in 18/19. • Medicines practice audit: wards and departments (April 2018) audited forty-five wards and three departments. It was found that in one area the medicine return to pharmacy box was overflowing, it has been re-iterated that these can be reported to the Pharmacy Department. • Medicines practice audit: theatres (April 2018) audited eleven theatres. In general a high level of compliance was shown with audit standards, however there was found to be out-of-date posters within some theatres and in one theatre food items were stored within the medicine cupboard. Actions have been taken to reinforce the importance of storing medications safely and reiterating that no items other than medications should be stored within the medicines cupboards or refrigerator. A medicines management checklist for theatres will be used to audit areas regularly and it has been assurance that all posters / guidelines are up to date. • Storage and Handling of Control Drugs was audited twice (June 2018 and November 2018). 13 actions were recommended from the first audit and 11 recommendations from the second audit. In areas where wards are not manned 24 hours a day and there is no alarm system in place there have been a risk assessment completed and this will be checked in May / June. The audits were presented at the Medicines and Nursing Midwifery Forum.
NHS Safety Thermometer	Ongoing	The Patient Safety Thermometer results are reported at the monthly Patient Safety Sub Committee. Any actions that are required are completed within Care Groups.
Endoscopy Global rating scale (JAG)	Ongoing	GRS data is submitted twice a year. There was a break in submission because of software problems which are now resolved. Data was submitted as required on April 2019.
Physiological and Operative Severity Score for Enumeration of Mortality and Morbidity (POSSUM)	N/A	Data extract from the POSSUM database has been severely limited due to technical problems. In light of this the Trust has downgraded the audit and closed work on this at present.
VTE prophylaxis on the Gynaecology Ward	2018	This audit identified that 65% of patients were up-to-date with their VTE forms however 35% were not, however all patients audited were on the correct VTE. Several recommendations were made in relation to the audit including suggestions to amend the VTE 'pop' up window to appear upon opening a record as well as when a patient record is closed and if the electronic patient record system would be able to alert the ward charge nurse if the VTE form is over 12 hours overdue. A re-audit has also been proposed.
Renal Registry 20th Annual Report	01/07/2018	The Trust plans to review the report findings and will take appropriate action where necessary.

Title of Audit	Report Produced	Actions
Induction of Labour and Monitoring	April 2018	The results of this audit indicate that there is assurance in 70% of cases that the decision to induce was based on clinical guidelines however in the remaining 30% of cases forms were not completed. There was a documented risk discussion in 30% of cases, in the remaining 70% of cases there was not a form completed.
Audit of discharge of 15-17 year olds from adult wards	April 2018	In all cases audited a safeguarding concern was identified however Trust procedure was not followed with a notification to the Children's Safeguarding Team. In only 28% of cases was the documentation felt to be clear about the concern. An action plan has been developed to ensure that Level 2 training is continued to be offered for all adult staff, there is an on-going audit of training figures. There will also be liaison with ward managers and divisional manager to ensure that staff have access to training date and ward staff on adult wards will be targeted to n=ensure that they are aware if Safeguarding training.
Audit of Management of Bruises, Burns and Scalds in non-mobile infants	August 2018	It was found that 21 children had no LCS ID reference and an additional 6 children did have a reference however no contact was recorded following the Emergency Department Visit. Recommendations have been made by the audit authors including improving referral to Paediatric Liaison Nurses and to ensure that all cases are discussed with social care. Improvements have been made and now there is screening of all paediatric attendances to the Emergency Department. The audit findings have also been presented.
Patient involved audit of Inflammatory Bowel Disease (IBD) Transition Service	May 2018	This was a joint Paediatric and Gastroenterology Audit. The audit was presented at the Speciality Governance meeting. Recommendations have been made and there is a plan for ongoing review.
Management of anaemia in children and young people with inflammatory bowel disease	July 2018	The audit findings were presented at the Yorkshire Paediatric Gastroenterology Network in September 2017. The audit found that whilst patients undergo regular blood tests for anaemia treatment is not always initiated in those with milder anaemia, this has resulted in a change of practice from the audit report author. It is suggested that a short cut could be created for the electronic patient record as well.
Palliative Care Team Prescribing Audit 2018	June 2018	The palliative care team saw a total of 20 patients during the audit period and made 81 medication recommendations, slightly lower than in previous years, but they directly prescribed a higher proportion of medications than in previous years. The audit found that syringe drivers were mainly initiated by the team, but delays were noted in the administration. There is a plan for increased education to improve this standard. An action plan has been completed to address all the issues raised in the audit.

Title of Audit	Report Produced	Actions
Paediatric Stabilisation Audit	May 2018	The Paediatric Stabilisation audit recommendations were discussed at the core speciality group and an action plan has been developed and implemented. Following the audit the PAWS (Paediatric Advanced Warning Score) track and trigger tool was modified. Escalation was changed with an ordered response strategy with an emphasis on continuous monitoring until the doctor review and timings set for clinician to attend. Regular scenario on training real time is provided to ward staff, all nurses were also assessed on recognising and responding to the sick child in response to the audit.
Unexplained Extubations in the Neonatal ICU	February 2019	This audit was undertaken to identify potential themes contributing to the incidence of unplanned extubations, identify potential changes that could be made to practice to reduce the risk of unplanned extubations and to put changes into place and re-audit to assess whether changes made have improved the rate of unplanned extubations. A local service action plan was been developed to implement the audit recommendations.
Adult Head Injury re-audit	May 2018	It was found that whilst clinicians do not use the specified EPT Head Injury template for documentation for the majority of cases patients are received promptly and there is through assessment in line with NICE guidance. Areas of lower compliance are in documenting any amnesia post injury and also of any anticoagulant medication taken by the patient. Recommendations made in the report are that clinicians consider using the EPR template and that this would be able to support improvement in formal documentation of GCS, post-injury amnesia and anticoagulation status.
Hepatitis B screening pre-chemotherapy	January 2019	This audit reviewed new haematology regimes on ChemoCare undertaken between May 2017 and July 2017. The Pathology records were examined for HBcAg screening in 3 months prior to regime initiation. The audit recommendations are to increase the awareness of staff and to develop prompts on ChempCare to improve compliance.
Autism Spectrum Disorders (ASD): Diagnosis – Inconclusive or Uncertainty	July 2018	This local audit was aimed to review the current practice of pre-5 ASD diagnostic assessment in case of uncertainty following initial assessment. The audit reviewed cases within 6 months (unless complex cases), and considered social communication, and neurocognitive or disinhibited social engagement. It was recommended that the children should be referred to Joint Assessment Clinic for Communication after 6 months attendance in a nursery settings. A local service action plan has been developed to address this recommendation.
Anaemia in Pregnancy	May 2018	This retrospective audit looked at the management of anaemia in pregnancy. 10% of patients had prophylatic iron and 9% of patients had prophylactic folic acid. Iron and folic acid documentation is an area of low compliance. Recommendations included of improving documentation and to aim for all patients to have a FBC check at 28 and 36 weeks gestation. The audit was presented in Speciality Governance.

Title of Audit	Report Produced	Actions
Small for Gestational Age (SGA) Audit	October 2018	This local audit covered two criteria; babies born as SGA should have risk assessments correctly documented and filled in both at booking and throughout pregnancy and babies born as SGA who were scanned should have had their SGA status identified. Out of 9 missed cases, 3 (33%) were missed due to incorrect antenatal risk assessment. There were 5 risks missed from these cases, these included a previous SGA baby x2, heavy smoker x2 and static growth on SFH. The Trust has made the following recommendations for practice including All women at booking should receive adequate screening for risk factors for the possibility of SGA and for those who are identified as being high risk should be appropriately referred according to the Trust Fetal Growth and Doppler guideline for follow-up. The audit was also presented at the Speciality Group meeting.
Fetal Monitoring Audit	March 2019	This local audit reviewed 28 sets of notes between January – March 2019. There were four standards that were reviewed. The audit found concern with clear documentation of hourly review of the CTG, clear documentation of fresh eyes hourly review on CTG assessment sticker and a maternal pulse oximeter used for a minimum of 20 minutes if a CTG is required or recommended. Two recommendations were made regarding 1) educational standards for CTG's via posters on the Labour Ward and a plan to include these in the next Lessons Learned e-mail and 2) Disseminate the audit results at the Labour Ward handover. The audit was presented at the Speciality Group meeting. There is a plan for a repeat audit.
Management of Preterm Birth	July 2018	The audit found that 2 patients had no booking MSU sent and no patients audited had a MSU in every trimester. Only 2 out of 9 patients received cervical length scanning. Not all patients received Steroids and Magnesium Sulphate. The audit concluded that management of preterm labour is generally well performed however there is variation of management. Recommendations proposed are to improve the standard of care for managing women at risk of preterm births in Antenatal Clinic, consider introducing a preterm clinic or guidance tick box sheet to aim for consistency in management, ensure that all patients identified at risk are offered cervical length scanning and clarify local guidance regarding investigation required and when. The audit was presented at the Speciality Group meeting.

2.2.3

PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

In 2018/19 Bradford Teaching Hospitals NHS Foundation Trust recruited patients to 189 National Institute for Health Research (NIHR) portfolio projects.

There were 11825 patients who received relevant health services, provided or sub-contracted by the Foundation Trust in 2018/19 that were recruited during that period to participate in NIHR portfolio research.

Participation in clinical research demonstrates the Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are aware of the latest treatment possibilities and active participation in research can improve the prospect of successful patient outcomes.

Further information is detailed in this report under section 3.6 Research Activity.

2.2.4
COMMISSIONING FOR QUALITY INNOVATION FRAMEWORK (CQUIN)

The Commissioning for Quality and Innovation payment framework is an incentive scheme which rewards the achievement of quality goals to support improvements in the quality of care for patients. The inclusion of the CQUIN goals within the Quality Account indicates that Bradford Teaching Hospitals NHS Foundation Trust is actively engaged in discussing, agreeing and reviewing local quality improvement priorities with our local Clinical Commissioning Groups (CCGs).

In 2018 the CQUIN scheme announced encompassed a 2-year period between 2017 and 2019. A proportion of the Foundation Trust income in 2017-19 was conditional upon achieving quality improvement and innovation goals agreed between the Foundation Trust and any of its commissioning partners who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the CQUIN goals for 2017-19 are available online at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The Trust's performance against the second year of CQUIN standards can be found in 3.4.2 Local Performance Measures section of this report.

The monetary total for the amount of income in 2018/19 conditional upon achieving quality improvement and innovation goals is estimated as £7.5m and the monetary total for the associated payment in 2017/18 was £6.7m.

2.2.5
CARE QUALITY COMMISSION (CQC) REGISTRATION

Bradford Teaching Hospitals NHS Foundation Trust is required to register with the CQC and its current registration status is 'registered' with no compliance conditions on registration.

The CQC served a fixed penalty notice on the Foundation Trust for failing to meet fundamental standards on the 18 September 2018. A fine of £1250 was paid as an alternative to prosecution. This related to a breach in Duty of Candour which occurred in 2016.

2.2.6
CQC INSPECTION

In 2018 the Foundation Trust's overall rating, following an unannounced inspection of four core services and a Well Led Inspection, was 'Requires Improvement'. The Trust received a "Good" overall rating for the Well Led Domain. The Trust developed and implemented a detailed action plan to address the compliance actions identified in the report, including actions to address the "should" and "could" dos identified by the CQC during the inspections.

We provide regular evidence to the CQC in relation to progress with, and outcomes of, action plans, and have our own internal challenge and assurance process through ProgRESS (Programmed Review of Effectiveness, Safety and Sensitivity), a programme of work within the Foundation Trust in relation to understanding and ensuring compliance with the CQC's Fundamental Standards. This is discussed in more detail in section 3.4.4 The Quality Management System, on the Assurance, Testing and Inspecting Process.

The Foundation Trust participated in an Area Review undertaken by the CQC in February 2018 relating to partnership arrangements in relation to the care and management of people over 65 living in Bradford and Airedale. The report identified areas of good practices and also areas where there were opportunities for change and improvement. The Foundation Trust has participated in the development of system-wide action plan which is currently being implemented.

The Foundation Trust was included in a short notice local health system CQC inspection which focused on safeguarding children and young people. The inspection took place in February 2019, and the report has not yet been published.

2.2.7
NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

Bradford Teaching Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode

Statistics (HES) that are included in the latest published data by the Service. The percentage of records in the published data that included patients' valid NHS Number and General Practitioner Registration Code is displayed in Figure 12. These percentages are equal to or above the national averages.

Figure 12: Percentage of records which included the patient's valid NHS number

Record type	Area	2018/19 (April 2018 to December 2018)	2017/18 (April 2017 to December 2017)	2016/17 (April 2016 to January 2017)	2015/16 (April 2015 to January 2016)	2014/15 (April 2014 to January 2015)	2013/14	2012/13	2011/12
Patients Valid NHS number	Admitted Patient Care	99.6%	99.6%	99.59%	99.00%	99.60%	99.60%	99.60%	99.50%
	Outpatient Care	99.9%	99.9%	99.83%	99.00%	99.40%	99.40%	99.40%	99.80%
	A&E Care	99.8%	98.8%	98.71%	98.00%	98.50%	98.60%	98.40%	98.30%
Patients Valid General Medical Practice Code	Admitted Patient Care	100%	99.0%	99.26%	100%	99.90%	100%	100%	100%
	Outpatient Care	100%	99.2%	99.89%	100%	100%	100%	100%	100%
	A&E Care	100%	98.9%	99.06%	100%	99.09%	100%	100%	100%

2.2.8 DATA SECURITY AND PROTECTION TOOLKIT ASSESSMENT

For 2018/19, the Information Governance Toolkit was replaced by the Data Security and Protection Toolkit.

The data security standards (known as Assertions) which are assessed within the Data Security and Protection Toolkit (DSPT) provide an overall measure of the quality of information governance related systems, standards and processes within an organisation. Bradford Teaching Hospitals NHS Foundation Trust's Data Security and Protection Assessment outcome for 2018/19 is 'Standards Met'. This is confirmed when an organisation evidences all mandatory Assertion items by final submission on 31 March 2019. A sample of the Assessment Evidence is independently assessed by Audit Yorkshire.

2.2.9 PAYMENT BY RESULTS CLINICAL CODING AUDIT

Clinical coding is the process through which the care given to a patient (usually the diagnostic and procedure information) that is recorded in the patient notes is translated into coded data. The accuracy of the coding is an indicator of the accuracy of patient records.

Bradford Teaching Hospitals NHS Foundation Trust was subject to an Information Governance clinical coding audit during 2018/19. The audit consisted of a sample of all specialties selected at random from activity between January and June 2018. The error rates reported in the latest preliminary published audit for that period for diagnoses and treatment clinical coding are shown in Figure 13. These rates have improved significantly in 2018/19.

Note: Clinical Coding results should not be extrapolated further than the actual sample audited; and which services were reviewed within the sample

Figure 13: Clinical Coding Error Rate

Coding Field	% Incorrect 2018/19	% incorrect 2017/18	% incorrect 2016/17	% incorrect 2015/16	% incorrect 2014/15	% incorrect 2013/14	% incorrect 2012/13
Primary Diagnoses Incorrect	5.7%	8.6%	8.17%	5.50%	9.00%	8.00%	10.45%
Secondary Diagnoses Incorrect	6.3%	10.2%	9.2%	4.80%	9.47%	5.90%	11.82%
Primary Procedures Incorrect	4.7%	8.1%	9.09%	9.10%	2.00%	0.70%	6.45%
Secondary Procedures Incorrect	2.1%	7.2%	14.79%	5.60%	8.02%	8.70%	10.50%

The audit was based on the methodology detailed in the current Version 11.0 of the Clinical Coding Audit Methodology set out by NHS Digital Classifications Service undertaken by an approved Clinical Coding Auditor.

2.2.10
DATA QUALITY

The maturity of data and information, its use, processes and supporting technology is key to the Trust using information to make decisions; an information-led Trust. High quality data and information is vital to the effective and efficient running of the Trust and leads to improved decision making which in turn results in improved patient care, wellbeing and safety.

Poor data quality can put the Trust at significant risk of losing stakeholder trust, negatively impacting service delivery, incurring financial penalties or inappropriate utilisation of resources amongst others. The Trust has clear processes, controls, and governance in place to manage the quality of data, using best practice and including a master list of key data and information and how it is identified and kept current. In any organisation there are a number of data sets that are important to the successful operation of the business. Should the quality of this data be sub-optimal the business will not properly execute its role. The Trust uses a standard classification system to assist in the process of managing data quality. There are a number of systems and controls in place for each of the data types at various stages in the lifecycle of data and its conversion to information. The responsibility for overarching data quality lies with the Information Governance Sub-Committee. The Information Governance Sub-Committee provides assurance to the Quality Committee of the Board of Directors. The data quality position is presented through a scorecard-type approach using a number of indicators.

With high quality data and information the Trust can support decision-making for patient care, day-to-day and tactical management and strategic planning and decisions. The Trust enables this requirement through a suite of industry-standard tools, including the highly-ranked Cerner Millennium Electronic Patient Record, a CACI data warehouse, SAP's Business Objectives business intelligence tools, and a variety of presentation tools. The tools allow the Trust to present data and information pertinent to and in a way (visual intelligence) which supports the nature of the decision.

The need of clinicians and administrative teams for data and information in the delivery of front line care is provided mainly directly through the Electronic Patient Record. Day-to-day and tactical management of the Trust's operations are supported by data and information specific to those functions being executed. This could be done through daily reports, dashboards, and through real time software. The Trust utilises 'ward to board' dashboards for key indicators aligned to the Trust's Strategic Objectives. These indicators, reviewed ultimately by Board of Director's Committees, aggregate into a Board of Directors Dashboard that provides a holistic, rounded view of the Trust's position against its plans.

2.2.11
REPORTING AGAINST CORE INDICATORS

The indicators that are relevant to Bradford Teaching Hospitals NHS Foundation Trust for 2018/19 are reported in Appendix A.

In order to provide assurance on the quality of the data the Trust has governance arrangements to review and improve data quality, and has acted upon recommendations of internal and external data quality audits.

All of our data-reporting processes have standard operating procedures which ensure that correct processes are followed. The data is then checked for validity and data quality errors, sometimes using the previous period to ensure it is in line with what is expected, and where this does not occur, is checked by another member of the team to ensure there are no data anomalies.

2.2.12
DUTY OF CANDOUR

The statutory Duty of Candour for the NHS is designed to ensure that providers are open and transparent with people in relation to care and treatment, specifically when things go wrong, and that they provide people with reasonable support, truthful information and an apology.

Healthcare treatment is not risk-free. Patients, families and carers want to know that every effort has been made to put things right, and prevent similar incidents happening again to somebody else. We know that trust in our organisation is directly related to how we respond when things go wrong. Being open is comparatively easy when all is well, but can be far more challenging in cases of actual or possible harm, whether caused by error or when a known and accepted complication occurs during treatment.

The Trust is committed to making this duty a reality for the people who use our services. We want to ensure there is clear, strong organisational support for staff to supplement their professional and ethical responsibility in being open and honest with patients. We understand that the impact and consequences of mistakes or errors made during the course of care or treatment can affect everyone involved and be devastating for individual staff or teams. We aim to ensure there is sustained support for staff in reporting incidents and in being open with their patients. Clinicians already have an ethical Duty of Candour under their professional registration to inform patients about any errors and mistakes related to their care.

The Trust has therefore built on that individual professional duty and has implemented a policy which places an obligation on the organisation, not just individual healthcare professionals, to be open with patients when harm has been caused. The policy describes how the Foundation Trust will meet its statutory and contractual Duty of Candour. The intention is to support a culture of openness, transparency and candour between healthcare professionals and patients and/or their carers when an incident or a prevented incident has occurred and to learn from the error, whatever the level of harm caused.

We routinely monitor our compliance with the statutory and contractual requirements relating to our Duty of Candour using our incident reporting system. We report details of any breaches, their impact and opportunities for change and improvement through our Quality Committee and Finance and Performance Committee, to the Care Quality Commission and our Commissioners. During 2018/19 there have been no reported breaches in Duty of Candour.

In the 2016/17 Quality Report the Trust reported a breach of its Duty of Candour which related to a serious incident. The CQC commenced an investigation into this breach during Quarter three in 2017/18. This investigation was concluded during 2018/19 and the CQC served a fixed penalty notice on the Trust. A fine of £1250 was paid as an alternative to prosecution.

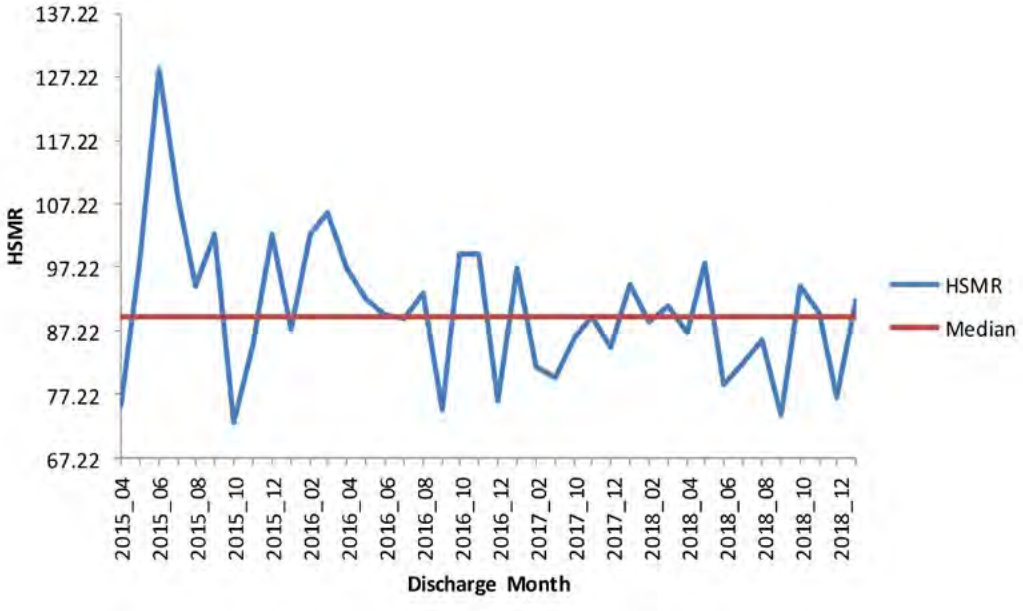
2.2.13
LEARNING FROM DEATHS

The Trust routinely reviews the care of patients that have died whilst in hospital and uses various methodologies and uses various data sources to do this. These processes include:

- Mortality statistics which includes Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). These are nationally benchmarked and reviewed on a monthly basis
- Reports from National audits when published
- Learning from internal investigations, serious incidents and coroners investigations.
- Screening tool used to identify patients requiring case note reviews
- Use of the Structured Judgement Review (SJR) methodology as a standard template for undertaking case note reviews

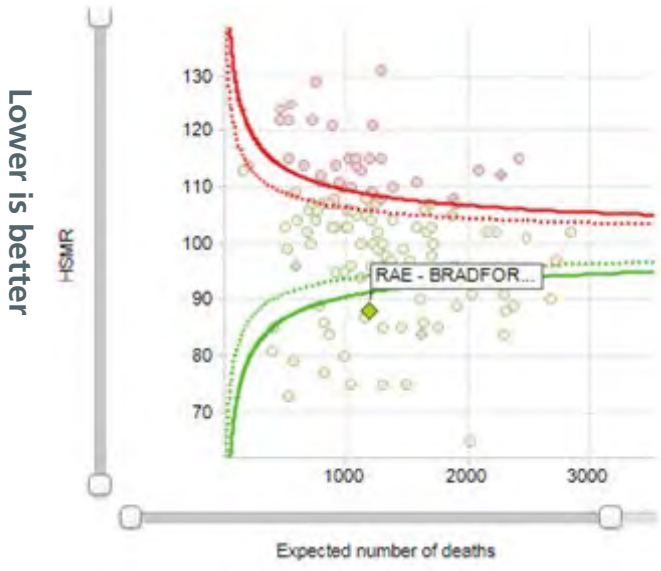
Mortality Statistics

Figure 14: Graph showing monthly HSMR at BTHFT



The Trust continues to have one of the lowest HSMR (Hospital Standardised Mortality Ratio) in our region, 88, which is better than expected. This represents 142 fewer deaths than expected over the 12 month period (February 2018—March 2019). This reflects the high level of care delivered by staff in this Trust.

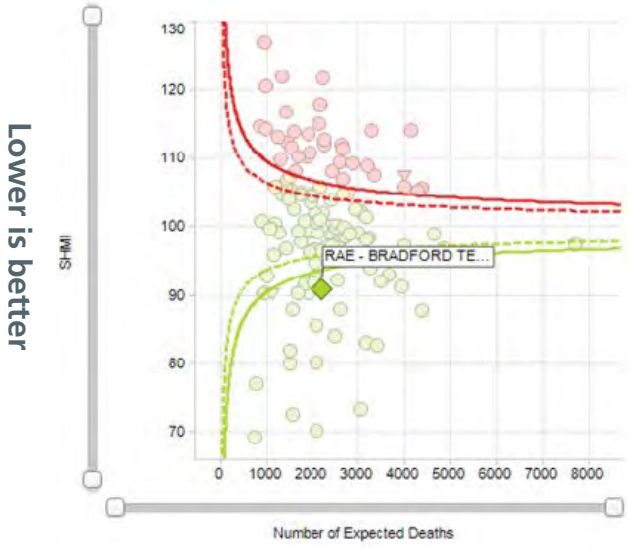
Figure 15: HSMR –National Funnel Pot



HSMR for most recent 12 months is 88 (better than expected)

The Trust's most recent data for the Summary Hospital-level Mortality Indicator (SHMI) places the Trust in the "as expected" category with an outcome of 93.

Figure 16: SHMI –National Funnel Pot



SHMI for most recent 22 months is 91 (better than expected)

As part of the national guidance on learning from deaths, a quarterly report outlining the mortality statistics and learning identified from mortality case note reviews is compiled by the central mortality team and reported quarterly at the Quality Committee. This includes information on reviews of the care provided to those with learning disabilities and severe mental health needs.

Statements of assurance in line with Learning from death reporting

Figure 17: The number of patients who have died during April 2018 to March 2019, including a quarterly breakdown of the annual figure.

Period	Quarter	Number of deaths
April – June 18	Q1	325
July - September 18	Q2	268
October - December 18	Q3	323
January - March 19	Q4	405
Total		1321

Figure 18: The number of deaths included in Figure 17 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

Period	Apr - Jun 18	July - Sept 18	Oct - Dec 18	Jan - Mar 19	Total
Quarter	Q1	Q2	Q3	Q4	
Number of deaths	325	268	323	405	1321
No. of SJR reviews	48	37	21	37	143
No. of SJR second reviews	1	4	3	1	10
Number of deaths with potential problems in care identified requiring further investigation	1	2	2	1	6

There were 6 deaths representing 0.5% of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient.

Figure 19: Is an estimate of the number of deaths during April 2018 to March 2019, included in Figure 18 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

In relation to each quarter, this consisted of 1 representing 0.3% for the first quarter; 2 representing 0.7% for the second quarter; 2 representing 0.6% for the third quarter; 1 representing 0.2% for the fourth quarter. These numbers have been estimated using the methodology described below:

Methodology used to assess problems in care provided to patients

The SJR method is the Trust's standardised template and approach to undertaking mortality reviews. It is a documentation review which constitutes a subjective in-depth capture of the clinical reviewer's assessment of the quality/standard of care received during their stay in

hospital, providing invaluable insight into how we provide care across the organisation.

Where care has been viewed as excellent and of an exemplary nature relevant staff or team efforts are acknowledged and showcased within the internal mortality reports as part of evidence of exemplary care provided in the organisation. Where overall care has been judged to be inadequate or poor, a second review is initiated. This assesses whether problems in care identified contributed to death. These cases which are very few may lead to an internal investigation. The learning from these reviews are collated centrally at an organisational level to generate themes which are shared with appropriate specialties.

The SJR reviews provide some of the best indications to where overall care has been very good and areas where we could do better.

Problems in care identified are dealt with through our internal investigation systems which include serious incident investigations or referral to the Coronial services. For cases that go on for further trust wide investigations, the learning is managed through risk management governance processes in place. Following a reported patient death on datix where there is an assessment completed (via the daily risk safety huddle) that describes suspected omissions in care, a SJR or Clinical review is requested to ascertain level of harm and outcomes for the patient.

This information is subsequently discussed at the incident performance management group and either an internal investigation will be reported or a referral to the Quality of Care panel for consideration to declare a serious incident investigation. Learning from these investigations are subsequently fed back to the hospital staff using the established processes.

Figure 20: A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in Figure 19.

- *Timeliness of care - Delays in healthcare make outcomes poorer*
- *Communication - Poor communication leads to delays and poor care*
- *Infections – It is easy to spread infection. All staff are to be vigilant*
- *Reports - A requested investigation must be read and acted upon*
- *Diagnostic bias - Just because a patient has one diagnosis does not mean they cannot have 2 or more problems.*
- *Make sure NEWS observations are done and appropriately acted on at all times.*
- *When transferring or receiving patients to new areas, make sure a risk assessment of the transfer has been considered, a quality handover is completed and that this is documented.*
- *Ensure appropriate communication with bereaved relatives including outcomes of discussions are documented.*
- *Investigation requests must be followed up and acted on in a timely way*
- *It is important to identify early on that the patient has a learning disability and establish what their typical level of functioning is - Remember 'Walk, Talk, Feed, Read'.*
- *Routine consideration of the involvement of relevant learning disability & mental health services is beneficial so that they are aware of the patient' current condition and also for the ward team to gain an understanding of the patient's usual capacity e.g. Waddiloves (Bradford learning disability health support team) are an excellent resource and can be contacted for support and background information.*

Figure 21: A description of the actions which the provider has taken in April 2018 to March 2019, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see Figure 20).

- *Delivery of the deteriorating patient collaborative improvement programme*
- *Ongoing improvement work around early detection, screening and treatment of patients with suspicion of sepsis, medicines safety, falls and pressure sores, 7 day working*
- *Junior doctor induction and training regards communication, handovers and treatment of deteriorating patients*
- *Simulation Training*
- *Improvement of facilities for stroke patients*
- *Improvement of facilities for fractured neck of femur patients*
- *Publication of internal rapid response alerts covering topics such a safe patient transfers, restraining patients and monitoring vital signs*
- *Timely response and actions to NPSA alerts*
- *Learning Disability training and awareness events*

Figure 22: The number of case record reviews or investigations finished in April 2018 to March 2019 which related to deaths during the previous reporting period but were not included in Figure 18 in the relevant document for that previous reporting period.

There were 62 case record reviews and 2 investigations completed after March 2018 which related to deaths which took place before the start of the reporting period.

Figure 23: An estimate of the number of deaths included in Figure 22 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

There were 2 deaths representing 0.14% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the methodology described in Figure 19.

Figure 24: A revised estimate of the number of deaths during the previous reporting period stated in Figure 19 of the relevant document for that previous reporting period, taking account of the deaths referred to in Figure 23.

There were 2 deaths representing 0.14% of the patient deaths during 2017-2918 that are judged to be more likely than not to have been due to problems in the care provided to the patient.

Figure 23 is reporting the same number and percentage as Figure 24 because numbers due to problems in care have only been reflected in reports for the 2018-2019 reporting period onwards.

PART 3: INFORMATION ON THE QUALITY OF HEALTH SERVICES

3.1 KEEPING PATIENTS SAFE

3.1.1
PATIENT SAFETY PROGRAMMES

In addition to the Quality Improvement initiatives that will take place over the coming year, the Trust is committed to delivering key patient safety programmes that focus on the safety of our patients and staff. These programmes are described in Figure 32 – 42.

Quality and Safety Leadership Walk-round Programme

Aim: To increase the visibility of the senior executive team with frontline staff and patients

How Much: By 100%

By When: March 2020

Outcome: To be assessed

Focus
Leadership Walk rounds were initially developed by the Institute for Healthcare Improvement (IHI) as an improvement tool to connect senior leaders with their frontline staff, to help build a culture of safety within the organisation. The walk rounds increase Executive visibility and oversight of the operations of the hospital at different times in the day.

Description
The current format of the walk rounds enables an informal reflective engagement meeting intended to allow more meaningful conversations between the Executive Team, staff and patients. Leadership walk rounds routinely take place throughout the organisation across the Bradford Royal Infirmary, St Luke's Hospital and the Community Hospitals. This approach has allowed for in-depth, rich conversations between the leadership team and frontline teams.

Clinical teams share their stories and experiences of the innovative work practices developed as well passion and pride in their areas of work. This has increased staff engagement and developed a culture of open communication where the safety of patients is seen as a priority of the organisation.

Conversations are noted and organised into themes. Responsibility for any immediate actions identified is confirmed at the visit which may be led by the Executive Director, ward level management or appropriate divisional lead.

Key achievements

- Collaborative working between Multi-professional teams (internal and external) is now common practice
- There are some great examples of a positive safety culture, with safety huddles taking place across more clinical areas
- Key themes from the walk rounds are about excellent patient care, collaborative working, patient safety and positive patient/staff feedback
- Patients are approached as part of walk rounds to gain feedback on their experiences
- Continued positive feedback from staff relating to the style walk-round visit format which is more informal, reflective and conversational

The Learning Hub

Aim: To develop and facilitate a multi-disciplinary forum that translates data from our surveillance mechanisms into opportunities to learn

By When: Established – meeting monthly

Outcome: To be assessed

Focus

The Learning Hub (was the learning and Surveillance Hub) is a key part of our quality oversight system. We have developed a virtual network of partners who work across the Foundation Trust. The Hub brings together all Divisions and Corporate Departments and their respective information and intelligence, gathered through performance monitoring and regulatory activities and our day to day work. The group works to collectively consider and review this information, with members working together to safeguard the quality of care that people receive through identifying learning and ensuring translation into practice.

Description

In 2017/18 the Hub developed the use of 'Learning Matters' which identifies learning from incidents and produces a regular publication that describes high impact learning from incidents that have taken place in the Foundation Trust. In 2018/19 the Hub tailored and expanded the use of alerts to ensure the learning from incidents is easily recognisable and themed based on the cause or impact of the incident(s). The Hub now produces Learning Matters, EPR matters, Caring Matters, People Matters, Medicine Matters and Checking Matters.

The Hub has also embedded a quarterly learning newsletter 'Responding and Improving', which describes how the Foundation Trust has responded to serious incidents, and how we know that the actions undertaken have been effective, thus reducing the likelihood of similar incidents.

Key achievements

- Identification and agreement of learning strategies and information sharing mechanisms across the Foundation Trust
- Development of testing methodologies ensuring learning and information is received and utilised by the intended audience
- Tailored and expanded the use of the Learning Matters alerts to ensure the learning from incidents are easily recognisable and themed based on the cause or impact of the incident(s)
- Embedded Responding and Improving, a quarterly publication which describes the response and its effectiveness to serious incidents in the Foundation Trust
- Held a second victim workshop focused on being involved in a patient safety incident as either a witness or a reviewer
- Developed a learning strategy to ensure the Trust is learning from external organisations and considering 'could it happen here?'
- Annual work plan established with theme based learning each month

National maternity and neonatal health safety collaborative

Aim: 1. Reduce the number of women experiencing delays during the induction of labour care pathway in our antenatal ward
2. Reduce the number of babies admitted to the neonatal unit due to avoidable hypoglycaemia and hypothermia
3. Work with expectant mothers to understand the reasons why there is a delay in accessing the maternity services when they experience decreased foetal movements

How Much:1. Reduce by 50%
2. Reduce by 5%
3. 95% contact within 12 hours

By When: 1. March 2020
2. March 2020
3. March 2020

Outcome: 1. On target
2. On target
3. On target

Focus

The Maternal and Neonatal Health Safety Collaborative is a three-year programme, launched in February 2017. The collaborative is led by NHS Improvement and covers all maternity and neonatal services across England

Description

The aims of this programme are to:

- Support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience to all women, babies and families across maternity care settings in England
- Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system.
- Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

Each Trust involved in the collaborative is responsible for developing a set of local improvement objectives based around: human dimensions; systems and processes; clinical excellence and person centeredness.

Key achievements

- Analysed data from 80 sets of case notes to ensure the change has been sustained showed 83% of women experienced a 50% reduction in the delay during induction of labour pathway; and 39% of women are experiencing a 50% reduction today compared to the baseline. The original target is achieved when excluding the times Labour Ward was in escalation. Next steps are to create a separate induction suite / 2-person staff team in May 2019 and measure progress using the same methodology
- Now cohort women in a 4 bedded bay, previously they had next available bed anywhere in a large ward area
- Assessing continuity of carer as a factor in enhancing timeliness of assessments and Prostin dose intervals
- Started a weekly case discussion for all babies admitted to Neonatal Unit at term to learn from the reasons for admission to understand what processes can be put in place to reduce avoidable admissions
- 'Keep me safe Keep me warm' campaign launched to ensure babies are kept at the right temperature
- Secured 1 year supply of MAMA wallets (a plastic wallet for carry notes and maternity information in) that are aimed to help women detect the signs of reduced foetal movement
- A new 24-hour Maternity Assessment Unit opened which will be the direct access area for women to contact/come to if they are experiencing/suspecting reduced foetal movements
- A patient focus group is being set up with vulnerable women in the community to understand how we can increase the recognition and timely response to reduce foetal movement
- Bespoke Quality Improvement training was provided to Maternity staff to help develop their knowledge and skills for carrying out improvements as part of this collaborative
- Implemented a daily MDT safety huddle based on Labour Ward

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Reducing Inpatient Falls Collaborative

Aim: To reduce the number of inpatient falls

How Much: By 15%

By When: September 2018 (then to reassess for the spread phase)

Outcome: 15% achieved

Focus

We wanted to try to reduce the number of inpatient falls happing at Bradford Hospitals. A fall can be devastating, the human cost of falling includes, distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality.

Falling also affects the family members and carers of people who fall and has an impact on quality of life, health and social care costs. Using the estimated falls rate per 100 bed days, a provider with 800 beds will have approximately 1,500 falls at a cost of £3.9 million. (The estimate in 2007 was £92,000).

Description

Our aim was to reduce inpatient falls by 15% by September 2018. Our approach was to use a collaborative method with 12 of our wards. We empowered, educated and gave them space to work together to think of ways to reduce falls. We held a series of collaborative working sessions where the wards came together to work on achieving the aim.

All the wards involved tried and tested different improvement ideas and along the way, they tweaked them if they didn't work. They carried out PDSA (plan do study act) cycles until eventually, we had the best possible versions of the things that were tested. We then created a change package with all the great interventions gathered, with some credit to East Lancashire Hospitals who shared some of their improvement ideas with us.

One of the key changes was the falling leaves system – an amber leaf is placed on the patient's bed board if they are at risk of a fall, and a red leaf is placed if they have had a fall. This is a great simple visual reminder. The focus is to now roll out the change package across the Hospital to spread and sustain the improvements across the whole organisation.

Key achievements

- 15% reduction in inpatient falls across the pilot wards (12 wards)
- A robust tried and tested change package with interventions proven to reduce falls
- A buddy system set up to help wards learn from each other and implement falls interventions
- A successful 12 month falls collaborative
- Improved staff skills and knowledge for reducing falls and using improvement methodology
- Improved patient safety, care and experience for patients
- Better identification of patients wo are at risk of a fall

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Red Bag Pathway

Aim: To improve the experience and pathway for care home residents when they need to go in to hospital

By When:
June 2019

Outcome:
To be assessed

Focus

The aim of the Red Bag Pathway is to improve the experience for care home residents when they need to go into hospital by helping to streamline and speed up transfers between hospital, ambulance and care home settings.

The distinctive red bag contains all the patient information staff require to understand their health and social care needs, why they have been sent to the hospital and details of their current medication. In addition to this, the red bag will contain personal items to make their stay more comfortable, such as day/ night clothes, dentures, spectacles and hearing aids. Each year we have approximately 2300 A&E presentations and 1800 Emergency hospital admissions of care home residents.

Nationally one in seven people aged 85 or over are living permanently in a care home. The evidence suggests that many of these people often experience unnecessary, unplanned and avoidable admissions to hospital.

Description

We worked with our clinical commissioning group (CCG) colleagues, who had discussions with our colleagues from care homes, Yorkshire Ambulance Service, hospitals and communities to find out if the Red Bag Transfer Pathway could work for us.

We helped scope out best practice from other organisations and had workshops where a wide range of staff came together to design what key documentation will go in the red bags. We then tested this for 2 months with 6 care homes to see if it worked in practice. We analysed the findings, made some final changes and launched the red bag pathway through several launch events, roadshows and promotions at the local Hospitals.

Key achievements

- Over 100 residential and nursing homes have joined the Pathway and over 450 Red Bags have been issued.
- At Bradford NHS, we have seen an increase in the red bag through our A&E.
- Staff have also fed back how it has improved communication with care homes
- Care homes have reported how the use has improved patient experience
- Reduced delays for some patients as the Hospital staff knew what to expect when the patient first arrived- this was through the 6 key standard documents in the red bag

Enhanced Care

Aim: To achieve a statistically significant reduction in the total hours for enhanced care without increased recorded incidents and calls for security

By When: June 2019

Outcome: To be assessed

Focus

There are many reasons for wanting improving the quality, experience and cost of for patients who receive enhanced care. Enhanced care is for vulnerable patients who might be at risk of harm or due to psychological needs; so they need someone to stay with them at specified times.

Description

We want to:

- Engage more with those who receive enhanced care to improve their experience and keep them stimulated
- Engage more with family and carers to build a partnership with them and recognise their rights as care givers
- Create a standard process for determining which patients need enhanced care and assessing this requirement every 24 hours. Currently, practice varies across the organisation.
- Strengthen how we communicate to family and carers especially in terms of understanding how the patient is in their home setting, what they likes/dislikes are and what information might be useful to us.
- Over recent months, the cost of bank and agency staff for enhanced care has rapidly increased across many organisations. By focusing on providing high quality services and improving experience, this should naturally have a positive effect on cost saving.

Key achievements

- 3 pilot ward testing how to improve enhanced care processes, procedures and experiences
- A bespoke training course set up for staff to help improve skills/knowledge of enhanced care
- Involvement of the new Dementia Nurse on how to deliver enhanced care for dementia patients
- Promoting and signing up for John's Campaign
- Reviewing visiting times for families/carers/visitors
- Approval to set up central enhanced care team to review requests for extra staff to provide enhanced care

Quality Improvement for Surgical Teams (QIST)

Aim: To improve patient outcomes after hip and knee replacement surgery in Bradford Teaching Hospitals NHS Foundation Trust

By When: By September 2020

Outcome: On target – to date since starting project, 0 infections.

Focus

QIST provides orthopaedic teams the opportunity to share best practice as part of a national collaborative project. The project aims to reduce infections from MSSA for patients having hip and knee replacement surgery.

Description

The purpose of the Quality Improvement in Surgical Teams Collaborative is to improve the quality of care delivered to patients requiring joint replacement surgery. This is by introducing two complimentary care-bundles, for mild anaemia and MSSA into routine clinical practice. It will focus on the 'scale up' of these two surgical care bundles which have already been tested by Northumbria Healthcare NHS Foundation Trust. They have shown to improve care and outcomes for patients with mild anaemia and to reduce MSSA infection rates. Our Trust is currently participating in this national collaborative and has recently been commended for its contributions to this ambitious improvement initiative to date.

Key achievements

- HSJ Awards 2018 –Acute Sector Innovation category- Highly commended
- Deliver of pre-operative assessment clinical (POAC) training around the Meticillin sensitive Staphylococcus aureus (MSSA) screening protocol
- Redesign relevant patient information document leaflets
- Development of a database to collect measurement for improvement data
- Creation of MSSA and Anaemia screening protocols

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Improving outcomes of patients undergoing Emergency Laparotomy surgery

Aim: Improve outcomes in patients undergoing Emergency Laparotomy surgery in Bradford Teaching Hospitals NHS Foundation Trust

By When: By September 2019

Outcome: Reduction in mortality rate to 11.8%

Focus

The Trust is currently participating in the Emergency Laparotomy Collaborative (ELC) which is a two-year quality improvement project aimed at improving standards of care and outcomes for patients undergoing emergency laparotomy. The hospital also participates and contributes data to the National Emergency Laparotomy Audit (NELA).

Description

The ELC has grown from the successful Emergency Laparotomy Pathway Quality Improvement Care bundle project (ELPQuiC) which was carried out three years ago in four hospitals in the South of England. It is anticipated that we 'hold the gains' gathered through collaborative learning among our peers in the region.

Being part of the collaborative has provided the team the opportunity to share some of the work they have done and also explore and trial different mechanisms for enabling care standards to become part of daily routine. The team are focussing on learning from structured judgement mortality reviews, improving consultant-led input, and improving quality of care which is reflected in the 9 care standards captured as part of the NELA database.

Key achievements

- Reduced mortality rates across the emergency laparotomy patient cohort
- Improved consultant-led care
- Implementation of an emergency laparotomy pathway care bundle
- Engagement of multiple specialties involved in care of this patient group – Emergency Medicine, Radiology, Anaesthesia, Critical care, General Surgery.
- Achieved consistently 100% case ascertainment on the NELA National database
- Improved preoperative risk scoring to guide perioperative Care

SEPSIS Awareness Week

Sepsis

Aim: To achieve a 50 % increase in the recognition and screening of patients with suspicion of sepsis in Bradford Teaching Hospitals.

By When:
March 2019

Outcome: In progress, however to date a 57% increase has been achieved

Focus

Sepsis is the body's overwhelming and life-threatening response to infection. Sepsis can lead to tissue damage, organ failure and death. It is extremely important for health care providers to be well-versed in the signs and symptoms of sepsis in order to treat patients as early and effectively as possible.

Description

We have developed a number of initiatives to improve performance in the recognition and treatment of sepsis. Following EPR implementation and 'switch-on' of the sepsis alert, the Trust is now in a position to extract sepsis data directly from EPR. As a result a reporting suite has been developed to initiate conversations with clinicians in their areas around improving the recognition and response to patients suspected or diagnosed to have sepsis.

The trust has also recently successfully recruited to its first ever Sepsis Nurse Specialist role who is integral to raising the profile of sepsis in the organisation and supporting clinical teams.

Key achievements

- Increased awareness in all departments on the need for early recognition for sepsis
- Education being delivered to individual wards and departments to ensure increased awareness
- Discussions with each division to understand the barriers to completing screening tool aiming for changes and updates to EPR as appropriate
- Sepsis reports indicate a significant improvement in the number of patients screened for sepsis when compared against data submitted in Q3 and Q4 2017/18.
- There has also been a significant improvement in the giving of intravenous (IV) antibiotics within 1 hour of diagnosis.
- Recruitment of the Sepsis Nurse Specialist Collaborative project with Performance team to identify reporting systems and processes from EPR data extract to support CQUIN reporting.
- The new performance report which captures sepsis screening compliance from EPR

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Back to Basics

Aim: To raise the awareness and use of the basic principles of care given to patients

By When: March 2020

Outcome: To be assessed

Focus

The back to basics campaign was launched in 2017 and the purpose was to promote the basics in care.

The Back to Basics campaign is about:

- Putting our patients first
- Sharing the learning
- Making things more relevant
- Real patient stories
- Doing things differently
- Recognising everyone has a contribution
- Remembering what everyone is here for

Description

Monthly back to basic sessions are held with a focus on a particular topic. It is open to all staff to come along and learn more about that topic area. There is a mixture of interactive activities, role play, quizzes and scenarios.

Staffs are given the space to reflect on the basics in care they deliver/their department deliver and think of ways it could be improved or simply take a learning message away to share back in their department.

Providing care to patients with multiple conditions, requirements and treatment management is complex.

There are lots of national and local guidelines to follow, many procedures to adhere to and every patient is different.

Creating a foundation and basic principles can ensure we have a consistent approach to the care given to our patients as well as explore ways to enhance it.

Key achievements

- Over a 12 month period we assessed the evaluation feedback given from staff who attended the back to basics sessions. The top 3 feedback comments were:
- It is interesting
- Valuable
- Thought provoking
- Well structured, engaging and relevant information is shared at the sessions that can practically be taken back to our wards/departments to use
- Over 292 staff trained through the back to basics sessions

End PJ Paralysis

Focus

#EndPJParalysis is a global social movement embraced by nurses, therapists and medical colleagues, to get patients up, dressed and moving.

Having patients in their day clothes while in hospital, rather than in pyjamas (PJs) or gowns, enhances dignity, autonomy and, in many instances, shortens their length of stay. For patients over the age of 80, a week in bed can lead to 10 years of muscle ageing, 1.5 kg of muscle loss, and may lead to increased dependency and demotivation. Getting patients up and moving has been shown to reduce the risk of falls, improve patient experience and reduce length of stay by up to 1.5 days.

Description

Since the start of 2018 we have been working across wards, departments and services to promote encouraging patients to get up, dressed and moving about. This could be through simple things like going to the dining area on the ward to have their lunch.

We also encourage patients to bring their day clothes into Hospital rather than be in their PJs because psychologically, this helps them on their path to recovery. We have been raising the awareness by getting staff to pledge to encourage patients to get up, dressed and moving.

Making the most of valuable patient time is particularly important – as figures show nearly half of people aged over 85 die within one year of a hospital admission.

A patient wearing their own clothes in hospital enhances their dignity, safety and retains their sense of identity. Encouraging patients to get dressed everyday boosts recovery and makes the most of precious time so it can be better spent with loved ones.

Key achievements

- Over 2000 patients up and dressed
- Over 1600 patients encouraged to mobilise
- "Stop gowning around" campaign which aims to encourage staff to assess if patients need to still be in a hospital gown
- We created our own End PJ Paralysis song and movement with lots of different staff coming together to promote the message
- We also found that going back to the basics and promoting independence can have a positive impact on our patients

3.1.2 LEARNING FROM INCIDENTS AND NEVER EVENTS

Learning from incidents

The Trust recognises that many incidents occur because organisations have ignored the warning signs of precursor incidents or have failed to learn from the lessons of the past. We recognise that most learning in any organisation is incidental rather than formal and any system should not replace that, but serve to strengthen it. As a result we have embedded our approach to this 'formal' learning within our Quality Oversight System.

Our Quality Oversight System is designed to ensure that we adopt a systematic approach to learning from incidents. The approach is applied across the Trust to ensure that the key elements of the system are embedded in our governance and assurance structures.

Figure 25: The Quality Oversight System

Surveillance: Information is drawn from safety huddles occurring throughout the Trust and a daily review of all the incidents, coronial referrals and complaints from the previous day into a daily 'risk huddle' where specific incidents and contemporaneous themes and trends are identified and associated action or escalation planned.

Understanding: Every week the Quality of Care Panel (chaired by an Executive Director) meets to discuss and agree the actions associated with any outputs from the Quality Oversight System that are significant. These include incidents that meet the criteria for the declaration of a serious incident, significant themes and trends, or, where concerns are identified that learning following a serious incident is not as effective as it should be. In addition, the Incident Performance Management Group, with representation from all clinical divisions, met weekly during 2018/19 to support the understanding of less serious incidents, themes, or trends, and support appropriate action or escalation.

Managing: The management of incidents, ensuring high quality and timely investigations to maximise the opportunities for high impact learning happens predominantly through the Incident Performance Management Group, the Complaints Management

Group , the Inquest and Claims Management Group and Divisional Quality meetings. These groups are all responsible for supporting the Quality Oversight System and ensuring that issues requiring escalation are managed appropriately and opportunities for learning, change and improvement are provided to the Learning Hub.

Learning: the Learning Hub, members have a key role in relation to the identification of learning and testing of dissemination of learning methodology. Learning Huddles occur in specialties and this learning is shared for Trust-wide contextualisation at the Learning and Surveillance Hub. In addition all Serious Incident reports are distributed for consideration of the actual and potential learning for operational divisions, through the divisional quality systems.

The Quality Committee receives a quarterly report that describes a range of 'precursor incidents' (generated from national audit outcomes, incidents, complaints, ProgRESS reviews etc.), the associated learning and how that learning has been managed and assured across the Trust.

Never Events

Some incidents that occur are serious, largely preventable patient safety incidents that should not occur if the preventative measures have been implemented by healthcare providers. These are defined nationally and called Never Events. It is important to recognise that Never Events hold a high potential for severe harm or death.

The Trust has reported three Never Events in the period 1 April 2018 - 31 March 2019. Two incidents occurred within the Maternity service and related to retained vaginal swabs following perineal repair.

The Trust is committed to learning lessons from all incidents and we take the learning from Never Events extremely seriously. The key lessons learned from the Never Events described above, where there was a failure of the processes designed to ensure the safe management of interventional procedures were as follows:

- the adoption of Local Safety Standards for Invasive Procedures (LocSSIPs) throughout the department / including a review of current procedures
- the participation of the service in the Trust wide safer procedures collaborative
- the introduction of a period of preceptorship midwives (practical training for a student or novice under the supervision of a preceptor) during rotation throughout the departments
- the procurement and introduction of delivery packs to commensurate with requirements
- the development of new swab, needle and instrument check list in maternal notes
- a review of compliance with the procedure checklist on transfer of patients onto wards
- the implementation of a training plan and competency process for midwives inducted / rotating back into the labour ward in perineal repair
- the introduction of visual aids to be used as aide memoirs (i.e. white boards)
- the assurance that all staff are able to identify and articulate the risk associated with the use of non-radio opaque swabs, and can identify when it is not appropriate to use them

One further incident occurred when the wrong tooth was extracted in a patient undergoing multiple extractions. The key lessons learned from this Never Event, where there was again a failure of the processes designed to ensure the safe management of interventional procedures were as follows:

- LocSIPPs are included in the training package for all dental surgical staff, and reinforced with all staff as a reminder
- if at any time there is an interruption in the procedure, the LocSIPPs individual patient pathway incorporating the three R's: Reposition, Recheck, Reaffirm with the assistant is followed
- ensure all members of the team have the confidence to speak up and challenge if they feel there is potential for error

A clear theme across all the Never Events reported during 2018/19 was identified in relation to the handover between clinicians mid-procedure (for appropriate reasons) but without a pause and a recheck of safety processes. This learning has been used to enhance the safety of all interventional procedures in the work of our safer procedures collaborative.

3.1.3
SAFEGUARDING CHILDREN

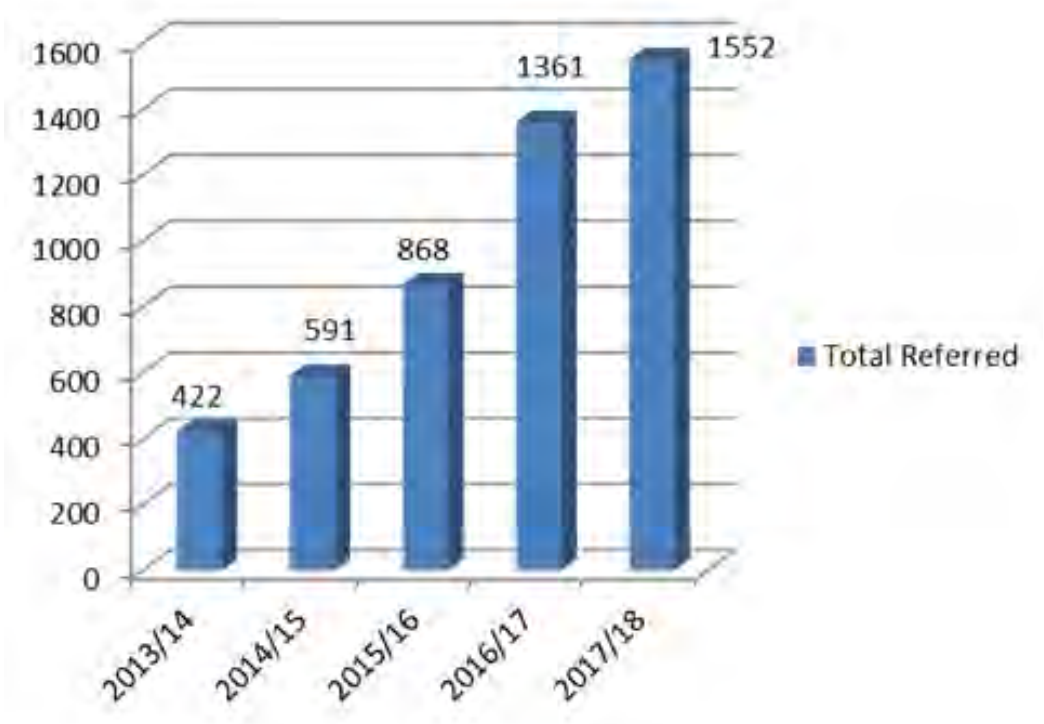
The Trust's framework for safeguarding children is based on the Working Together to Safeguard Children (2018) national guidance, which promotes interagency working to safeguard children. The Trust executive lead for safeguarding is the Chief Nurse, and the Deputy Chief Nurse represents the Trust on the Bradford Safeguarding Children Board (BSCB). The BSCB has a number of subgroups, which are attended by the Named Nurses and Named Doctor, as well as the Safeguarding Children's Specialist Nurse Practitioners, ensuring that Trust staff work closely with other relevant agencies across Bradford to safeguard children.

As detailed in Section 11 of the Children Act, the BSCB and the Clinical Commissioning Groups (CCG) require assurance from the Trust that all service users (patients) are safeguarded and their wellbeing is promoted. The Trust provides evidence of this on a regular basis via an online portal, which holds information that shows how we comply with the requirements of Section 11 (known locally as the Section 11 audit).

Safeguarding children remains a high priority in the Trust. There is a robust policy in place that provides a framework that should be followed by all Trust staff, encouraging professional challenge of practice where appropriate. Best practice is reinforced in training, and through staff support and supervision. There is clear guidance with agreed processes for staff to follow to ensure that they recognise, respond to and report vulnerability of children at risk of abuse or harm.

The activity related to safeguarding is collated on an ongoing basis and the number of referrals to the safeguarding children team is increasing year on year. Figure 26 shows the number of referrals by year from 2013-14 up to 2018-19.

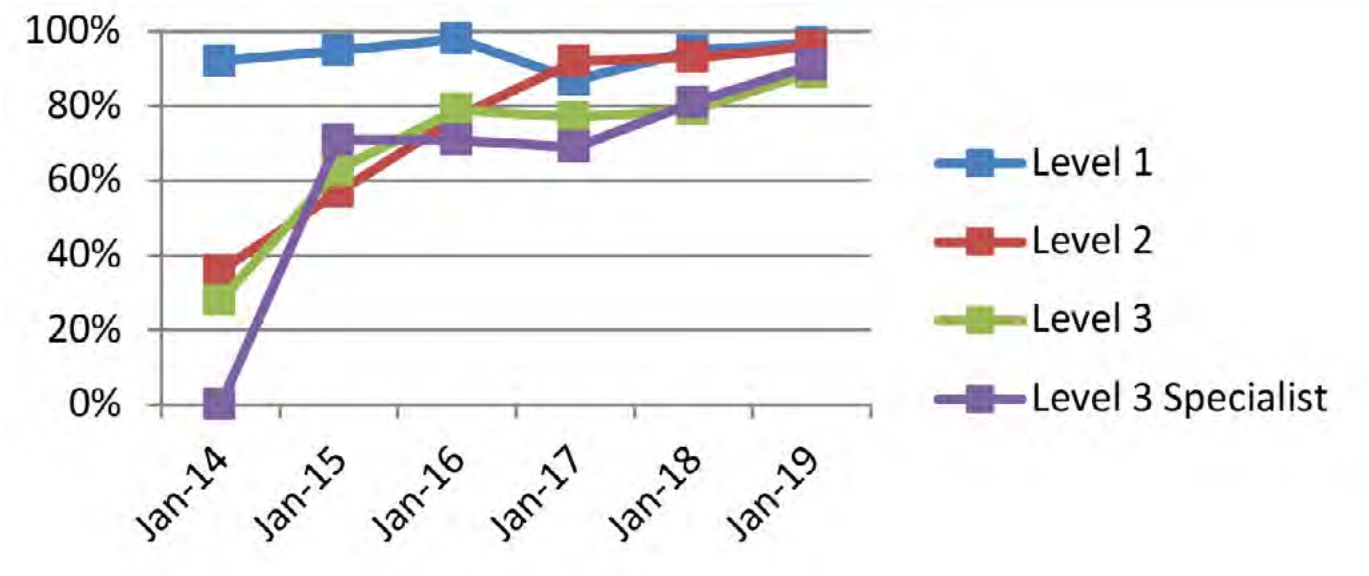
Figure 26: Total number of notifications/referrals to the safeguarding children team



Training for all staff in relation to the Safeguarding of Children is mandatory, based on their roles and responsibilities, in line with national guidance. Compliance with training is closely monitored.

Figure 27 demonstrates the increase in training compliance highlighting that this is currently at the highest level since safeguarding children training became mandatory in the Trust.

Figure 27: Safeguarding Children Mandatory Training Compliance 1st January 2014 – 2019



The Trust has been working closely with NHS Digital to introduce CP- IS (Child Protection - Information System), an additional system to protect children attending for unplanned (emergency or urgent) care. CP- IS is a national system that connects Children's Social Care IT systems with those used by the NHS. CP- IS gives health professionals the ability to see whether a child is subject to a child protection plan (CPP), where a pregnant mother's unborn child is subject to a CPP or whether the child is a Looked After Child. CP- IS has been successfully implemented into the Emergency Department, Children's Clinical Decisions Area and Maternity services. This is particularly helpful for children attending the Trust from outside Bradford, to ensure that staff are aware of any protection measures that are already in place.

The Trust is committed to listening to the voice of the child and is working with multiagency partners on how to ensure that staff can identify and record the child's views. The Trust recognises how important involving children in decisions that affect them is and how this can have a positive impact on the child's care whilst attending the Trust and enable effective safeguarding.

A key emerging theme within child safeguarding nationally is contextual safeguarding, which predominantly affects adolescent children. Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighborhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts and young people's experiences of extra-familial abuse can undermine parent-child relationships.

The Trust is dedicated to safeguarding this group of young people by raising staff awareness of the complex issues that may affect them and how this may present in the Trust. Due to this, the theme for all training for 2019 is focusing on this issue, and additional activity with this age group is taking place by monitoring daily attendance or admissions and taking action where required to ensure they are safeguarded and their wellbeing is considered.

3.1.4
SAFEGUARDING ADULTS

The Trust has continued to undertake work to improve the services it provides with respect to safeguarding adults. This has been both internally within the Trust and externally by working with partner agencies across the District.

There has been a continuous programme of training relating to safeguarding adults. All staff have now been assigned their appropriate level of training on the electronic staff record (ESR) and the Safeguarding team work closely with the Education Department to ensure all staff understand their training requirements and that there are sufficient training sessions provided to meet demand.

The Safeguarding Adults team works closely with the Safeguarding Children team. Each attends the others' safeguarding meetings as well as the Integrated Safeguarding Committee meeting, which is chaired by the Deputy Chief Nurse, and has a role in overseeing the standard of safeguarding across the Trust. The teams work closely together to identify and support adults and children who are experiencing domestic abuse, with targeted work in the Accident and Emergency Department in particular. The Prevent agenda (the Government's Counter Terrorism Strategy) has also required close working to ensure all staff across the Trust have received training appropriate to their role to ensure compliance with NHS England requirements. .

Responsibility for raising awareness of the needs of patients with Learning Disabilities now sits with the Safeguarding Adults team. Work has been undertaken with the learning disabilities team from Bradford District Care NHS Foundation Trust (BDCFT) to raise awareness amongst staff and ensure information and support is available to staff and patients. Honorary contracts have been given to the Learning Disability Matrons from BDCFT to ensure expert support and information is received in a timely manner to ensure appropriate care delivery.

The Chief Nurse is the Vice Chair of the Bradford Safeguarding Adults Board and Chair of the city-wide Safeguarding Delivery Group.

Work with Partners

The Safeguarding Adults team has continued to attend the district-wide Safeguarding Adults Board and its sub groups; the Domestic and Sexual Violence Strategy Board and the Multi Agency Risk Assessment Conference (MARAC). Other district-wide meetings are attended as necessary such as those on the West Yorkshire Human Trafficking and Anti-Slavery Network (WYHTASN) and Prevent, with established links for receiving information and updates.

The Team participates in Domestic Homicide Reviews (DHRs), not only within the Bradford District, but from any area which requests information about victims or perpetrators who have been treated at the Trust. The Trust is legally obliged to participate in any DHR where the Trust has been involved in the care of either the victim or the perpetrator, within a relevant period of time. The Safeguarding Adults team receives the notification when a DHR is required, and is responsible for coordinating the response, monitoring progress and collating information as required. The Trust provides a panel member to sit on the DHR panel, and an author to conduct an Independent Management Report (IMR). The IMR identifies the Trust's involvement and makes an assessment of whether there were indications of domestic abuse apparent, whether support or advice was provided accordingly, or whether there were any actions that could have been taken that might have prevented it from occurring. During 2018/19 the Trust has provided information as requested for DHRs, and worked with partners to review previous action plans related to previous DHRs.

The Named Nurse for safeguarding adults is the chair of the Safeguarding Adults Review (SAR) subgroup of the district wide Safeguarding Adults Board (SAB). This process is similar to the DHR process and requires the Trust to provide information as requested to identify learning.

The Team works closely with the hospital social work team to make enquiries on behalf of the Local Authority (Bradford Metropolitan District Council) when there is a concern that abuse has occurred. This often involves joint visits and ensures that care needs are identified and safety plans are considered, both for whilst the person is in hospital, and also on discharge.

Training is delivered externally by members of the Safeguarding Adults team, in collaboration with partners across Bradford, to assist in the awareness raising and understanding of the West Yorkshire, North Yorkshire and York's multi-agency Safeguarding Adults procedures. This allows for greater understanding of the various agencies' roles within the safeguarding process. It facilitates effective links being made across agencies.

The Safeguarding Adults team participated in Bradford's Safeguarding Week, which took place in June 2018. Training was provided for staff in the Trust as well as those across the Bradford health economy.

Progress and Outcomes

There has been a continued increase in the number of referrals to the Safeguarding Adults team from staff across the Trust, seeking advice and support on a range of safeguarding issues, with noticeable increases in contacts in relation to Mental Health concerns and Human Trafficking. Referrals to the Local Authority relating to concerns of abuse are relatively low in comparison to the total number of contacts. This is due to the implementation of the Making Safeguarding Personal agenda and the involvement of the patient from the outset.

There has been on-going work to embed the routine questioning of staff about domestic abuse, as part of the return to work interview following sickness, following changes made to the Trust's attendance management policy. The policy aims to support staff to disclose domestic violence following periods of sickness, not only to enable them to be signposted to sources of support, but also to make the question routine so that staff in turn feel able to ask patients. The Safeguarding Adults team have supported managers who may have had a disclosure and will support staff experiencing domestic abuse as requested.

The Safeguarding Adults team worked closely with the EPR team and their counterparts in Calderdale to develop further some of the processes in EPR to ensure information that is not currently compatible with EPR, such as national documentation in relation to the Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act (MHA), is accurately reflected in the patient's record. The team ensure accuracy and compliance with legislation.

Future Work

Over the coming year we will see:

- on-going participation and involvement with district-wide work across all networks to ensure staff have access to consistent advice and current practice guidance
- staff continuing to attend multi-agency meetings and assist with the delivery of multi-agency training
- a programme of clinical audits. Any areas of need identified from these will be used to adapt training as necessary
- further development of the processes within the Trust to support people with a learning disability, in conjunction with Bradford District Care Foundation Trust, with specific focus on reviewing the current policies to ensure they achieve a smooth transition for patients with a learning disability from community to hospital and back to community
- development of pathways for accessing support in relation to Mental Health services for patients and the implementation of the NCEPOD guidance 'Treat as One', to ensure a patient's mental illness is recognised and treated concurrently with any physical condition
- review of domestic abuse work within the Trust, with focus on ensuring staff knowledge of recognising signs, responding to disclosures, the child behind the adult and referral to support services
- we are planning to hold a multi-agency event in early summer to look at the 'Treat as One' agenda and how we can take this forward.

3.1.5
SAFE NURSE STAFFING LEVELS

Nurse Staffing Levels

National guidance from the Chief Nursing Officer for England, the National Quality Board and the Care Quality Commission requires all hospitals to agree safe staffing levels for each ward and department, and to publish, on a monthly basis, details of the actual number of nursing and midwifery staff who worked compared to the number of staff planned. This information is uploaded to a central data base (Unify) and is reported to the Board of Directors by ward, following which it is made available on the Trust's website. As part of the information collected, Trusts are also required to provide information about the number of patients occupying beds at midnight, collated over a month. This information along with the actual number of staff available enables the calculation of the total number care hours per patient day.

We take the care of our patients very seriously and have established a number of robust mechanisms to ensure that our wards are safely staffed. This includes taking a census of the number of staff present along with the acuity and dependency of patients on the ward at the time of the census. This information is collected using Safecare a module that forms part of our electronic rostering system. Staffing figures are displayed in each area for each shift, to ensure transparency for our patients and visitors.

Daily meetings of matrons and heads of nursing take place to review the staffing levels (known as staffing huddles), against the information collected in SafeCare about the acuity and dependency of patients, so that decisions about how best to maintain safe staffing levels can be made with all the relevant information required.

During December 2018, we reviewed the nurse and midwifery staffing establishments on all our wards and departments and a report of the results was presented to the Board of Directors in March 2019. This strategic nursing and midwifery staffing review was conducted in accordance with the National Quality Board Safe, Sustainable and Productive Staffing Summary (SSPS). The SSPS document describes that the key to high quality care for all is our ability to deliver services that are sustainable and well led. For nurse staffing, this means continuing our focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles set out in the SSPS document:

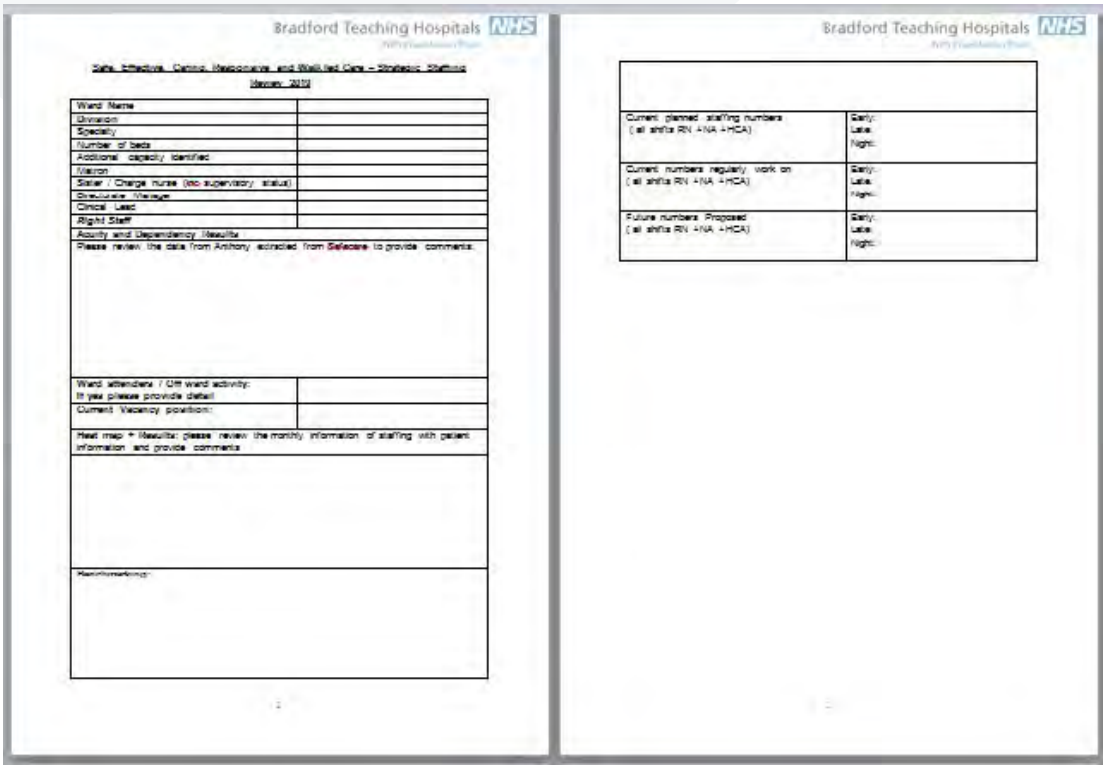
- right care
- minimising avoidable harm
- maximising the value of available resource

The review also ensured that there is effective management and mitigation of current and future nursing/midwifery care delivery risks.

The review utilised the data from the SafeCare system, to look back at the extent to which the planned and actual staffing levels were in line with actual acuity and dependency of patients in a given area over a period in the preceding months. This was compared with other information about nursing indicators such as falls, pressure ulcers and other harms, and took account of the professional judgement of the relevant Senior Sister or Charge Nurse, Matron, and Head of Nursing, together with the Chief Nurse and Deputy Chief Nurse.

An example of the template used to collate this information for each ward and department is shown in Figure 28.

Figure 28: Strategic staffing review template



Actions taken by the Foundation Trust to improve nurse recruitment and retention

The Trust has a comprehensive recruitment and retention plan that is implemented and overseen by the Recruitment and Retention Steering Group. This group is chaired by the Deputy Chief Nurse. The overarching objectives are identified in Figure 29.

Figure 29: Recruitment and Retention Plan objectives

Aim	Objective Ref		Expected Outcome	Assurance Mechanism	Review date
Ensuring continued safe and effective delivery of care and quality withing the current constraints of nursng vacancy, national recruitment and retention difficulties and developing a junior workforce.	1	To improve/ maintain retention rates	Retention rates remain within the national average and improve to the 25th percentile of all Trusts.	Monthly Workforce and staffing papers with analysis of data Model Hospital comparative data	Quarterly – Next Review January 2019
	2	To recruit vacancies	Aim for 95% of all vacancies filled	Monthly Workforce and staffing papers with analysis of data Model Hospital comparative data	Bi-monthly review at workforce committee –Next due January 2019

There are a number of detailed actions supporting the delivery of these overarching objectives; an update on areas of achievement in 2018-19 toward delivering this plan are detailed in the retention section on page 212.

Recruitment

Nursing Associates

The Trust is one of the six regional partnership sites participating in the Health Education England (HEE) Pilot to recruit and train Band 4 Nursing Associate posts to bridge the gap between Health Care Assistants holding the Care Certificate and Registered Nurses. The roles are supported by a two year foundation degree programme, with the aim of introducing an improved career pathway within the nursing workforce and allowing registered nursing staff to focus on the more advanced elements of their roles.

The Trust appointed fifteen Trainee Nursing Associates, who started their employment with us at the end of January 2017. These trainees are based within our Elderly Care, Stroke, Vascular, and Paediatric wards, as well as our Maternity Theatres. A clinical tutor was appointed to support both the trainees in getting to grips with their role within the Trust, as well as our ward teams in understanding how the new role fits into the workforce.

The first cohort of Trainee Nursing Associates has just completed the second year of the foundation degree at the University of Bradford. The successful Trainees are currently in the process of completing their registration with the Nursing and Midwifery Council (NMC), after which they become registered Nursing Associates. Celebration events have been held in conjunction with other partners in the pilot. As part of the programme, the Trust has participated in an annual seminar designed specifically for our Trainee Nursing Associates, which was an opportunity to network with other Trainees from across the partnership as well as hear from local and national speakers on topics relevant to them, as a key part of our workforce.

Figure 30: Certificate of attendance showing all the partner organisation logos involved with the Trust in the West Yorkshire Nursing Associate Pilot programme.

The Trust has established a twice yearly recruitment of Trainee Nursing Associates, which from the second year of the pilot became an apprenticeship route. The University of Bradford continues to be a key partner with the Trust, as the education provider for our January cohort. We are delighted to have been joined in 2018, by the University of Bolton who are supporting our April cohort. This has strengthened the growth of the workforce on the in-patient ward areas.

The introduction of Nursing Associates into several of our ward establishments was a recommendation in the strategic nursing and midwifery staffing review submitted to the Board of Directors in March 2018, and takes account of the National Quality Board improvement resource for the deployment of nursing associates in secondary care.

Return to Practice Course

The Trust continues to support nurses wanting to return to practice, and working in conjunction with the University of Bradford, offers training posts to support nurses who have lapsed NMC registration. This gives them the opportunity to refresh their skills in a clinical area whilst undertaking their required Return to Practice Module, and being paid as a trainee. Previously these staff had to self-fund this process. Numbers are small, but never the less, this is considered an important element of our recruitment strategy.

Overseas Nurse Update

Small numbers of overseas nurses arrived during 2018, as the last of our overseas recruits from our previous recruitment campaign have completed the necessary language and knowledge testing process prior to arrival in the UK. On arrival in the UK, they were supported to work as a Health Care Assistant whilst undertaking the necessary Objective Structured Clinical Examination (OSCE) as required by the NMC. We are proud to report that all of the 2018 recruits passed their OSCE examination first time, following an intensive learning and support programme provided by our Education Department.

Newly Qualified Nurses

Plans are in place for attracting nurses to the Trust who are due to qualify in 2019 with the Trust attending the University of Bradford Careers event in November 2018. Between September 2018 and January 2019 the Trust was delighted to employ a total of hundred newly qualified adult and paediatric nurses and newly qualified midwives.

The Facebook campaign that ran for 2018 has proved extremely successful in advertising and promoting vacancies across the Trust, signposting people to open days that have been held in each of the departments. The Trust continues to use this methodology, with a number of open days to support recruitment in a range of specialty areas, as well as Trust wide open days, the next of which is planned for June 2019.

Figure 31: Facebook campaign supported the new branding and imagery of the Trust

The new initiative that newly qualified nurses should be paid at band 4 pending receipt of their PIN and have their first year's NMC membership funded by the Trust, has made a positive difference in the number of new nurses and midwives attracted and retained.

The Education Department has worked closely with the University of Bradford to offer final placements to student nurses in the area of their choosing, to given them the chance to experience a placement in a ward or department they would like to work in when they qualify. Students will also be interviewed for a post in this last placement to give them an opportunity to secure their chosen area.

The paediatric wards were successful in recruiting a number of newly qualified child nurses in 2018, and in order to ensure they all received the level of support and guidance they would need to make the transition to registered nurse, Practice Educator, Laura Deery produced a bespoke education and competency package for them.

Figure 32: Shows a newly qualified paediatric nurse with the practice educator holding her support profile that has been used to develop her competencies during preceptorship.

New Recruitment Brochure

During 2018, the Trust has produced a recruitment brochure for all areas of employment across the Trust, and the Chief Nurse Team have worked closely with HR colleagues to produce a specific pull-out for nurses and midwives, to supplement this. The supplement sets out the range of opportunities available within the trust and includes a large number of staff profiles, to help bring to life the positive messages about working in the Trust.

Figure 33: The nurse recruitment brochure pull out.

Mitigation

The number of nurse vacancies continues to be managed through use of existing rota cover, agreed over-establishment recruitment in some areas, the use of the Nurse Bank, additional hours and agency usage where required. Matrons review staffing on a daily basis to ensure that ward areas are safe. The strategic staffing reviews have focused on all members of the ward team in order to support patient care, with new roles such as the Nursing Associate, Senior Support Worker and Advanced Clinical Practitioners all being utilised to ensure that teams are able to provide a range of skills to meet the needs of our patients.

The Chief Nurse report provides further detail on nurse staffing levels in line with national requirements.

Retention

There has been significant progress in the retention work plan throughout 2018-19, with many of the actions, such as the development of leadership programmes for particular bands of nurses, (staff nurse, sister / charge nurse and senior sister / charge nurse) fully established and now business as usual. The transfer register for Band 5 nurses remains in place, and this has recently been opened up to Band 2 Health Care Assistants.

Strong links have been made with health education providers (universities and colleges), Health Education England, and Airedale NHS Foundation Trust to progress the development of new roles.

Any emerging national guidance / innovation in relation to recruitment and retention are reviewed in the Nursing and Midwifery Recruitment Steering Group and any new actions added to the action plan as appropriate.

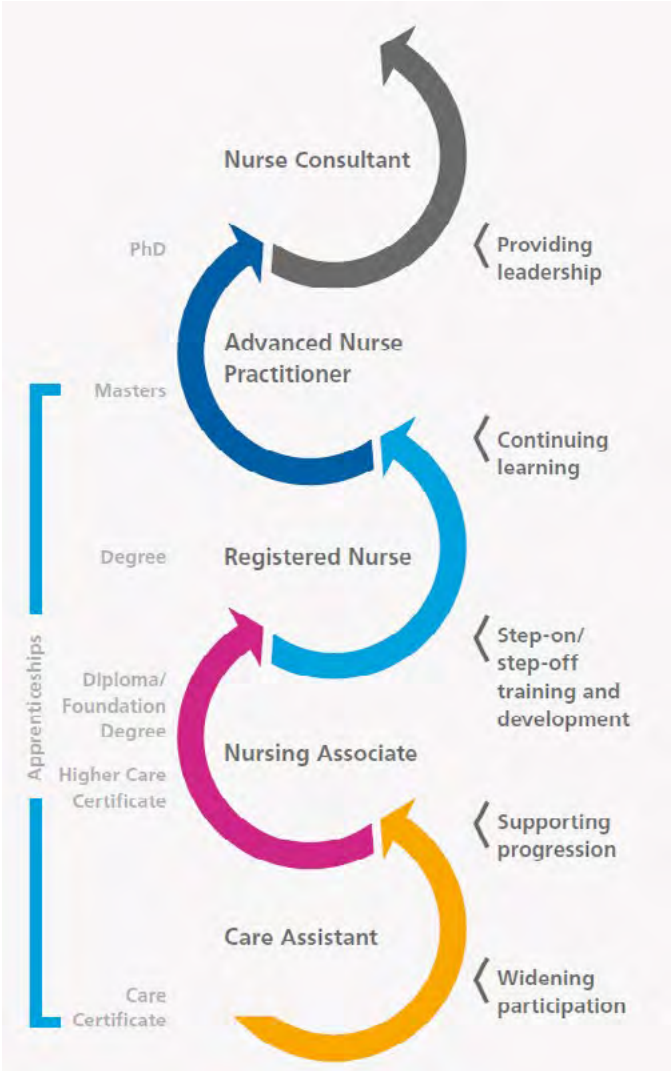
During 2018 there has been a reduction in all areas of band 5 vacancy across the trust for nurse and midwives and review of the data from the Model Hospital Portal (a national benchmarking tool created by NHS Improvement) for retention rates and vacancy position for nursing and midwifery staff shows Bradford Teaching Hospitals NHS Foundation Trust are almost 2% above the national median in the latest data (taken from August 2018), with a Trust Value: 89.3% and a National Median: 87.6%

Figure 34: Senior Sister who has completed the Band 7 leadership programme

Significant work has taken place to develop more opportunities for new roles, e.g. Advanced Clinical Practitioners, to support the wards and departments. The Advancing Practice group continues to review and support applications for advancing practice in all areas of the Trust to support the development of new ways of working, thus creating the opportunity for career development and enhancing skills of the existing workforce to support the quality of care received for patients.

The Trust continues to work closely with education providers to enable training development to support the development of the existing workforce in Bradford in line with the approach shown in Figure 35. Plans involve pre-nursing associate training, post-nursing associate and pre-registered nurse training and development, including support throughout apprenticeship to progress. Furthermore, the Trust is working with the University of Bolton, to establish a new intake of pre-registration nursing students, which will result in Bradford having an outturn of registered nurses twice a year, rather than the current once a year in September.

Figure 35: Nursing workforce development, Health Education England.



3.1.6 MEDICAL STAFFING

Post-Foundation Fellows

A 2016 review of recruitment to trainee rotation gaps (with the emphasis on moving to generic-type appointments rather than individual specialty-specific posts) led to the first cohort of Post-Foundation Fellows joining the Trust in August 2016. These junior doctors had just completed their foundation training, and many were unsure of their future career path in light of the new junior doctor contract negotiations. Whilst they were utilised across specialties to cover gaps in training rotations and long-standing non-training posts, the Fellows were also offered the opportunity to 'try out' other specialties of their choosing during the daytime (they cover rota gaps out of hours), granted up to three months unpaid leave (in agreed blocks), and given study leave time to complete post graduate certificates in education.

The second cohort of Fellows commenced August 2017 with a number assisting the clinical education team as part of their personalised rotations. The third cohort in August 2018 included three Post Core Fellows. These individuals had completed two years Core Medical Training and were seeking additional support to complete exams or to bridge the gap between core training and higher specialty training.

A review of the programme has shown that undertaking such a scheme allows junior doctors to confirm their future specialty choices. There have been a number of Fellows who have gone on to secure places on HEE training rotations having 'tried out' the specialty beforehand.

Medical Training Initiative

The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of twenty four months, so that they can benefit from training and development in NHS services before returning to their home countries. It has been in place with the Academy of Royal Colleges for a number of years. However over the past two years the number of MTI doctors recruited to the Trust has increased considerably. MTI doctors work for a period of six months on core trainee rotas, at which point they join registrar level rotas (subject to competence assessment). There are currently several MTI doctors in the Trust working in Anaesthetics.

Physician associates

Nationally, the development of Physician Associates forms part of the NHS transformation agenda and is aimed at supporting the need for the NHS to work differently in order to continue providing outstanding care to patients. The role of the Physician Associate is an innovative new health care professional who works to the medical model with the attitudes, skills and knowledge base to deliver holistic care under defined levels of supervision.

Seven posts were recruited to for surgical specialties and commenced August / September 2018. A further five posts are being appointed to for acute medicine at present.

The roles will be mentored by a designated Consultant and will work alongside a highly trained team of junior doctors and nurses. They will work collaboratively with all members of the multidisciplinary team contributing to the delivery of care in a range of settings including inpatient wards, outpatient clinics and community clinics.

3.1.7

2018/19 ANNUAL REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

The 2016 junior doctor contract includes a requirement for there to be a Guardian of Safe Working Hours who will submit an annual report to the Board to provide assurance that doctors and dentists in training are working safe rotas and that working hours are compliant with terms and conditions.

High level data

Number of doctors/dentists in training:	358
Number of doctors/dentists in training on 2016 contract:	357
Number of GP trainees (BTHFT lead employer arrangement)	41

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. The exception reporting process is a crucial part of the junior doctors' 2016 contract as it allows contemporaneous reporting of issues, feeding in to the trust and HEE's quality processes, with potential to drive improvement.

There were three hundred and nineteen exception reports submitted for the period 1 April 18 – 31 March 19. The majority related to additional hours worked. Fifteen highlighted educational concerns, submitted by junior doctors in ophthalmology, obstetrics and gynaecology, general medicine, elderly medicine, general surgery and paediatrics.

In total, eight hundred and fourteen additional hours were worked by junior doctors. Additional hours may be recognized with a supplementary payment, time-off-in-lieu or no action.

Figure 36 shows the hours-related exception reports.

Figure 36: Exception reports (hours/rest) by speciality and training grade 1 April 18 – 31 March 19.

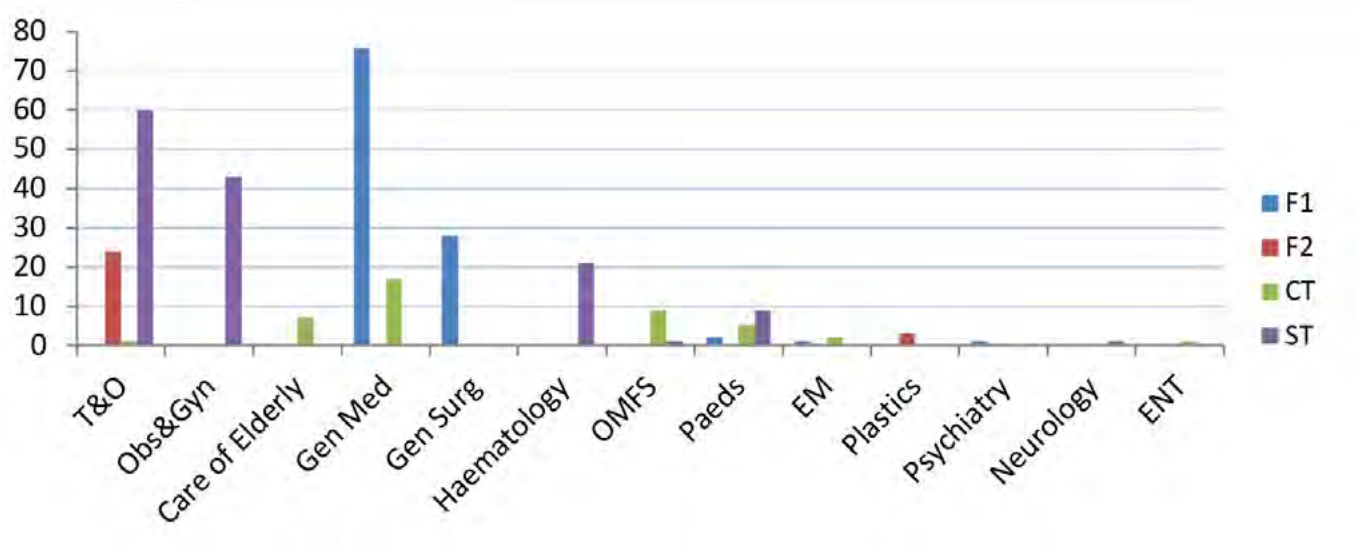


Figure 37 shows the top 5 reporting specialties and the trend in reporting rates.

Figure 37: Number of exception reports by top 5 specialities 1 April 18 – 31 March 19.

April 18 – March 19	
General medicine	94
Trauma & Orthopaedics	85
Obstetrics & Gynaecology	44
General surgery	28
Haematology	21

Vacancies

A gap on a rota results from the post not being filled or from long term sickness. This puts additional pressure on those junior doctors working the rotas. The number of gaps varied over the year between twenty one and twenty four across several specialties. Many were filled by the trust with doctors not in training.

Fines

The Guardian of Safe Working Hours can apply fines if breaches of working hours and rest periods occur. Examples of potential breaches are exceeding the 48-hour average working week, exceeding seventy two hours of work in seven consecutive days, lack of eleven hours rest between shifts, or missed breaks. Fine monies, via the Junior Doctor Forum, are spent on initiatives to enhance the working lives of trainees, in addition to paying locum rates to the affected junior doctors. No fines were levied in 2018-19.

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Qualitative Information

The Junior Doctor Forum meets quarterly and provides an opportunity for junior doctor representatives to bring concerns from their colleagues for discussion. Of note, positive feedback has been received about quality of training and supervision in paediatrics and plastic surgery. A working group has been set up to look at Trust implementation of the BMA's Fatigue & Facilities Charter, in an effort to enhance junior doctor's working lives.

The Trust is actively embracing alternative workforce options, with the appointment of physician associates. This has potential for easing pressure on the junior doctor workforce.

The trust is now lead employer for GP trainees with exception reporting from primary care now falling within the remit of our Guardian of Safe Working Hours.

Summary

The nature of exception reports was similar this year to 2017-18, although numbers were down slightly. The majority of consultant supervisors respond to exception reports appropriately and in a timely manner. Significant efforts have been made by the medical HR department that has led to closure of longstanding overdue reports.

Obstetrics and gynaecology began the year as a high exception reporting specialty. However, due to altered shift times and changes to service delivery, the reporting rate has fallen significantly over the year. Working closely with the education department, new initiatives continue to drive improvement in this high-pressured specialty.

Areas identified in this year's exception reports have an active work programme to reduce the hours of work.

3.2 FOCUS ON THE EXPERIENCE OF PATIENTS AND THE PUBLIC

Patient Experience remains at the heart of our core values within the Trust. Putting patients at the forefront of everything we do remains a high priority and we recognise that this can only be achieved by continuing to engage with patients and develop new ways of working to improve how they, their friends and family experience our care.

Work carried out within the Trust in relation to Patient Experience is over-seen by our Patients First Sub-Committee. This group meets monthly and provides assurance to our Board of Directors via the Quality Committee that we are striving to provide the highest quality of healthcare at all times. As well as providing assurance to the Board, we recognise the need for dissemination throughout the organisation to all areas to ensure patients, friends and family are at the forefront of what we do. During 2018, we have benefited from two excellent Patient and Public Voice Representatives, who are members of the Patient First Committee, increasing our accountability and transparency and furthering our ethos of co-working.

Patient Experience Strategy

Our mission is to provide the highest quality healthcare at all times and over the last year we have been looking closely at what makes a good patient experience. We have spoken to staff, patients and their families and carers and have used a blended approach to gather as much information as possible from a range of resources.

We set out with no pre-conceived ideas other than a willingness to listen, engage and put what we were told into practice. Our findings were simple and can be summarised into one word- kindness.

People told us what mattered most to them was that they were treated kindly, and this has led to the development of the Patient Experience Strategy: Embracing Kindness.

People told us what mattered most to them was that they were treated kindly, and this has led to the development of the Patient Experience Strategy: Embracing Kindness.

The Patient Experience five year Strategy was launched within the Trust during 2018, and extensive work has been carried out to embed this work and promote the five core principles that underpin the strategy. These are:

- Be kind and treat others as we would want our loved ones to be treated
- Introduce ourselves by our first name and explain what we do #hellomynameis
- Make eye contact, use open body language and smile
- Value patients time, if something is delayed we will explain and give realistic timescales
- Ensure that we will always communicate with patients in an honest way, easy to understand and kind

3.2.1 PATIENT STORIES

Patient stories bring the experience of patients, and sometimes of their families or others who care for them, into the spotlight and are a rich and valuable source of learning for improvement. These continue to be of high importance to the Trust and our Board of Directors meetings commence with a Patient Story presentation.

A variety of clinical and non-clinical areas have been the focus of the Patient Stories at Board. We continue to seek out stories from a wide range of patients to maximise our exposure and learning. These stories both celebrate excellent care and highlight areas for improvement.

Patient Stories can:

- identify problems, issues, risks, causes and potential solutions as well as highlight good practice.
- actively provoke debate about change and improvement; hence they can have transformative power.
- enrich and extend our knowledge, understanding, and empathy and open up a different way of knowing and understanding patient experience.
- connect organisational processes, systems and protocols with humanity, values and ethical practice and have a potential positive impact on thinking/decisions.

Patient stories come from a variety of sources including patient feedback mechanisms, personal contact with people in community organisations and events, in addition to staff suggestions. During 2018, we have proactively sought out stories and experiences from some seldom-heard groups including physically and cognitively disabled patients, profoundly deaf and BAME patients. This has enriched the diversity of our learning.

Staff members working in areas related to the patient story are invited to our Board meetings; this enables an active discussion regarding learning and feedback for the area concerned. When it is appropriate, a formal action plan can be requested by the Board of Directors to take forward any necessary learning and improvements which may be identified from a story. On other occasions more informal discussions to share good practice or embed positive changes are more appropriate. Participants have told us that taking part in patient stories has been important for them, both as an opportunity to share the good care they have received and to help us to improve.

During 2018/19 we have worked with the University of Bradford's Working Academy to produce films for our suite of Patient Stories. These are a valuable learning resource for individual staff and teams and they enable stories to reach a wider audience and provide continuous learning.

3.2.2
PATIENT AND PUBLIC INVOLVEMENT (PPI)

We aim to continually develop a range of effective way of involving patients, patient representatives and the wider community at all levels and in all aspects of our work. At this time of change and challenge for the NHS, enabling dialogue with the communities we serve and harnessing their expertise by experience is paramount.

All departments and services within the organisation are responsible for making sure that they think about and plan adequately for patient and public involvement in their services. Support and advice to

do this has been provided as required by the patient and public involvement lead. Examples of work carried out within the Trust during 2018/19 are presented in Figure 38.

Figure 38: Examples of collaborative work with patient and public representation involvement during 2018/19.

Department/Service	Action
Estates/Chief Nurse Office	Implementation of AccessAble. Full survey of site taken place and website now live to provide our service users with very specific details about our buildings and access points. This is available to view at: https://www.accessable.co.uk/
Maternity	Participation in the Maternity Voice Partnership. Antenatal project around "flow" through their services. Involving the Trust Transformation Team and service users to improve quality of service.
Estates	On-going development with Patient-Led Assessments of the Care Environment (PLACE). New monetary powers have enabled patients to be consulted about new equipment e.g. handrails.
Informatics	A listening event was held in June 2018, involving a patient representative group to consult on the new informatics strategy. In particular this demonstrated support for the patient portal (Your EPR), which is now an integral part of our strategy.
Cancer Services	Co-production with cancer patients of enhanced communication standards and bespoke training for staff to improve the experience for patients with cancer.
End of Life Care	Facilitating patient input and providing advice on content and design of the Bereavement Survey.
Paediatric	Survey work carried out with children who have been cared for on adult wards has been carried out to capture their experience and collate suggested improvements.
Estates	Innovation for signage for disabled parking has been improved and the number and proximity of disabled parking spaces providing access to the site has seen development.
Stroke services	Patient feedback regarding service reconfiguration

New standards and frameworks for patient and public involvement have recently been published which will be reviewed and applied appropriately to our approach to involvement.

Initial pilot efforts this year to improve the diversity of people involved with us, sometimes in partnership with other local organisations, have been fruitful, particularly in relation to young adults, disabled people and people from BAME communities. We plan to build on this through increased community outreach. Examples during 2018/19 include inviting local community members via a local Housing Association who support refugees to be part of our work stream and act as ambassadors from their own communities.

We have continued to develop productive collaborative work with other local organisations including, Bradford Metropolitan District Council, Healthwatch, Bradford University, the Alzheimer's Society, and the Stroke Association. This is in addition to working with local schools and colleges.

Membership and diversity of the Involvement Register has continued to grow, enabling us to meet the needs of services who want to be involved and fostering people with specific experience and expertise. Sustained involvement of patient representatives in strategic work has increased this year and relationships with community groups and organisations continue to underpin the development of involvement, an example of this is Public Voice Representation which is now part of our Patients First Sub-Committee.

Social media use and engagement has increased, raising the profile of patient and public involvement at the Trust and creating new connections. We have actively embraced and grown our social media presence with a considerable number of patients, staff and departments throughout the Trust choosing this platform of communication. The established @ bthftpatientexperience and @bthft_yourvoice will continue to value feedback via this medium to further develop patient experience.

3.2.3
FRIENDS AND FAMILY TEST (FFT)

We want to continually use near real-time patient feedback to improve patient experience. The Friends and Family Test (FFT) provides an opportunity for people who use NHS services to provide feedback on their experience in real or near real-time. It asks people if they would recommend the services they have used to friends and family if they needed similar care or treatment and offers a range of responses. The Trust combines the core question with brief follow-up questions to provide more detailed insight, sometimes on areas specifically targeted for improvement, for example, linking to the results of the National Patient Surveys or quality initiatives.

Different methodologies are used depending on the context and type of care. The Foundation Trust offers two main routes for patients to provide their views: postcard type forms and using a tablet device whilst in the ward. The option to use a link in a text message to access an online version is also available for patients attending the Emergency Department who have given us permission to use their mobile phone numbers.

Work continues to promote the use of electronic collection, as the main route for inpatient environments, as this has greater potential to support a swift response to any reported issue and track participation levels on a regular basis, so that the level of feedback remains at a useful level.

Figure 39: Friends and Family Test 2018/19 results

	Q1			Q2			Q3			Q4		
Area	Recommend %	Not Recommend %	Response Rate %	Recommend %	Not Recommend %	Response Rate %	Recommend %	Not Recommend %	Response Rate %	Recommend %	Not Recommend %	Response Rate %
Wards	96%	1%	33%	95%	1%	37%	95%	1%	34%	96%	1%	37%
A&E	100%	0%	0%	89%	3%	0%	90%	2%	0%	83%	17%	0%
Maternity	98%	1%	17%	98%	1%	20%	96%	1%	27%	97%	1%	24%
Day Case	98%	1%	14%	98%	0%	11%	96%	1%	11%	98%	1%	19%
Outpatients	97%	2%	-	96%	2%	-	96%	2%	-	96%	2%	-
Trust Total	**97%**	**1%**	**11%**	**95%**	**1%**	**10%**	**95%**	**1%**	**10%**	**96%**	**1%**	**13%**

Friends & Family Response

The Friends and Family Test is now part of the NHS contract for most NHS-funded services in England, including inpatient, day-case, outpatient, community, maternity and paediatric services. The Trust has implemented the Friends and Family Test across all divisions and services in accordance with NHS England requirements.

Please note some patients did not express an opinion which could be categorised as Recommend or Not Recommend.

% Recommend based on number of responses Extremely Likely and Likely

% Not Recommended based on number of responses Unlikely and Extremely Unlikely

Response rate % based on the above categories including: Neither Likely nor Unlikely and Don't Know

Figure 39: Friends and Family Test 2018/19 results (continued)

2018/19 results

Area	Recommend %	Not Recommend %	Response Rate %
Wards	95%	1%	37%
A&E	87%	2%	0%
Maternity	97%	1%	21%
Day Case	98%	1%	13%
Outpatients	96%	2%	-
Trust Total	**96%**	**1%**	**12%**

The overall percentage of patients who would recommend us to family and friends through each quarter (Q1-Q3) remains fairly consistent with around 95% who would recommend. Whilst this is a figure to be proud of, we always look at what we could be doing better.

We recognise that an area for improvement is within the Emergency Department in relation to patient satisfaction and whilst we acknowledge this is an area of great pressure, we need to look at ways to improve during 2019/20. There is currently a strong focus for development within this area of work.

We are proud to report that our maternity results are excellent from the feedback we have received, demonstrating a consistent trend of patient satisfaction.

The Trust is working on ensuring that each ward is displaying up to date FFT data, including "You Said, We Did" information that shows how we are acting on the issues raised. This is valuable for staff, patients and visitors to visualise how we have acted on the feedback provided and should act as further encouragement to participation in future feedback.

3.2.4
CHAPLAINCY AND BEREAVEMENT

The Trust has a strong multi-faith Chaplaincy Team, which consists of two full time and five part time Chaplains, covering Muslim, Free Church/Church of England, Roman Catholic, Hindu and Sikh faiths alongside Jewish and Jehovah's Witnesses. The Chaplaincy team is there to support patient, carers and staff within the organisation. Referrals to Chaplains can be made directly by patients, carers or by the ward staff, via the Chaplaincy office. An on-call service is also provided by the Chaplains on a rotational basis and the department is contactable seven days a week.

The department is also responsible for prayer facilities and has a Chapel and Prayer Room with ablution facilities and a quiet room for all to use, at our two main sites at Bradford Royal Infirmary and St Luke's Hospital. Our Community Hospital sites also provide prayer facilities. A multi-faith room is provided for all, with ablution facilities, at Westbourne Green and a similar dedicated space is available at Westwood Park.

The Chaplaincy department also has approximately 75 volunteers of different faiths and denominations and of no faith, who visit patients on the wards on a daily basis. The department's volunteers make an average of 32,000 contacts every year providing spiritual and religious support to patients and their carers on the wards.

Bereavement services sit within the Patient Experience Team. In March 2017, the Trust introduced a Bereaved Carer Survey. This is given to a family member when a patient dies in any of the hospital wards and provides us with useful feedback on how the Trust supports families at this difficult time. The Trust recognises that this is a difficult time for any family member and families are under no obligation to complete this. To date there has been a steady flow of responses that are reviewed regularly and fed into the End of Life steering group to inform us about any areas for improvement.

3.2.5
NATIONAL PATIENT SURVEYS

We continue to work on strategies to make sure we make best possible use of the data the surveys provide alongside other patient feedback.

Participating in the Care Quality Commission's National Patient Survey programme is a mandatory activity. This year has seen a number of changes in the CQC programme and methodology, such as increasing the minimum sample size for all surveys, increasing the frequency of some surveys, and new publicity requirements to make sure patients are aware they may receive a survey and offer them the opportunity to opt out of this.

These surveys provide an opportunity for patients and, in the case of children, their parents, to provide us with more detailed and comprehensive feedback on their experience with us. The results contribute to assessments of NHS performance and are also used for regulatory activities such as registration, monitoring and on-going compliance.

Each survey page shows England level results and provides access to Foundation Trust-level results, including results of earlier surveys. Because of the methodology CQC uses, care must be taken when interpreting the results, as it does not allow direct comparison between Trusts, although it does provide a sense of how an organisation is performing compared to all other participating organisations.

All National Patient surveys are provided for the Foundation Trust by Patient Perspective, working closely with our staff. Provision is made, at the point when a postal survey questionnaire is received, for patients who do not read English, or need other support to take part. However, it is the patient's choice to access this or not. Achieving a good response rate continues to be a challenge for the Trust.

There are strict limitations on what we are allowed to do to publicise and promote the survey, so as to ensure methodologies remain as standardised as possible across all participating organisations.

An in-depth analysis is provided by Patient Perspective, which is used alongside the CQC analysis to help staff understand the experience of patients and identify areas where improvement or change is needed.

The Trust holds workshops led by Patient Perspective to enable key staff to gain a more in-depth understanding of the findings and identify priority areas for improvement work, to develop and work through action plans.

Inpatient Survey data July 2018

At the time of writing this report, data is not available (expected publication June 2019).

National Maternity Survey 2018 (reported in 2019)

The National Maternity Survey is now an annual survey and was sent to all women who gave birth in February 2018. In Bradford, 414 surveys were posted and there was a 29% response rate which is slightly higher than the 2017 survey. The average Mean rating score, across all questions was 78.7%, which again was slightly higher than in 2017. On 8 of the questions Bradford scored in the top 20% of Trusts nationally. Ten questions showed at least 5% improvement on the 2017 score and the remaining questions showed either less than 5% change in score or a worse score.

In response to the survey results, we have had very good staff engagement and we have identified a number of areas of care for improvement. This includes

- information around postnatal care and how to access follow up and advice regarding contraception following birth
- advice given around the early stages in labour both at the time and in preparation for birth antenatally
- improving support and 1:1 care in labour

Since the 2018 survey, improvements have been put in place to the overall condition and appearance of the building. A fresh new look and 'face lift' with new cladding and windows for the main maternity building have been completed. We have opened the Maternity Assessment Centre (MAC) twenty four hours a day, where women and their partners can not only ring for advice, but attend for assessment, which enhances the maternity care and experience patients receive.

3.2.6 PATIENT-LED ASSESSMENTS OF THE CARE ENVIRONMENT (PLACE)

Patient-Led Assessments of the Care Environment (PLACE) is a voluntary programme of assessments, run by the Department of Health and Social Care, via NHS Digital, which the Trust participates in every year. All providers of NHS funded care are encouraged to be involved in these unannounced assessments which aim to:

- assess what matters to patients/the public
- report what matters to patients/the public
- ensure that the patient/public voice plays a significant role in determining the outcome

Assessments focus on the environment, in which care is provided, with particular emphasis on:

- cleanliness (including hand hygiene)
- general condition, appearance and maintenance of buildings, fixtures and fittings including safety
- access (for disabled patients and other people who use the Trust premises).
- dementia friendly environments
- privacy, dignity and wellbeing
- nutrition and hydration (including choice of food and drink and other elements of the food service assessed at the point of service on wards)

Assessments are undertaken over several months by teams of 'patient assessors' – in effect volunteers representing the perspective of patients and the public - supported by staff facilitators. The Trust asks all potential patient assessors and staff facilitators to attend training together, before taking part in an assessment. Additional staff from a wider range of services represented the team this year, which has brought useful additional experience and perspectives to the process, and eased the workload and logistical challenges for those carrying out the assessments.

Assessments were carried out over a wider range of days and times than ever before, to sample the standards on areas assessed across the week, and to enable people to take part who are not available during normal working hours. All assessing teams include at least two patient assessors and teams must have a minimum ratio of 50% patient assessor representation in each team.

Assessors are recruited from a variety of sources, including Healthwatch, voluntary and community groups, the Foundation Trust membership and Council of Governors, the Foundation Trust Involvement Register, local colleges and university, and through communications with the local press, media and Foundation Trust social media. We have trained a pool of over 50 volunteers to carry out PLACE assessments; this includes an increased proportion of assessors from BAME backgrounds, students, young adults and disabled persons.

The 2018 PLACE results have been analysed nationally, locally and compared to our local cohort of Acute Trusts.

It is pleasing to note that across all of the assessed domains, the Trust has seen a positive trend against the 2017 scores. The most significant improvements have been seen in Dementia, Disability, Privacy, Dignity and Wellbeing and; Condition and Appearance.

In order to ensure that we continue to improve, a robust Action Plan is in generated to ensure any areas where low performance scores have been obtained, actions to improve are identified.

Figure 40 shows, at a glance; the scores obtained for each domain in both 2017 and 2018. This notes the percentage difference column shows an improvement in all domains in 2018.

This demonstrates a fantastic result in terms of the enhancement work completed in our care environments and the ownership shown by wards and departments in maintaining our sites in good order.

3.2.7
COMPLAINTS

This Trust takes all complaints seriously, and through a rigorous process of investigation, we always strive to be open and honest, providing a thorough explanation to complainants, including offering an apology and taking actions to identify a remedy where services do not meet the expected standard.

We have worked hard this year to ensure better alignment of our complaints and risk management processes, to ensure risks to patient safety and incidents of poor patient experience are addressed in a uniform and robust manner. This will also ensure that we continue to learn valuable lessons from patient feedback and those lessons are shared and actioned across all staff and departments. Further information is detailed in section 3.1.2 Learning from Incidents.

Figure 40: Scores obtained for each domain in both 2017 and 2018

Domain	2017 score	2018 score	% improvement
Cleanliness Score %	96%	97%	⬆ 0.9%
Food and Hydration Score %	85%	85%	⬆ 0.4%
Organisational Food Score %	89%	89%	⬆ 0.4%
Ward Food Score %	84%	84%	⬆ 0.1%
Privacy, Dignity and Wellbeing Score %	71%	76%	⬆ 5.0%
Condition, Appearance and Maintenance Score %	85%	90%	⬆ 4.7%
Dementia Score %	63%	76%	⬆ 13.0%
Disability Score %	67%	76%	⬆ 8.7%

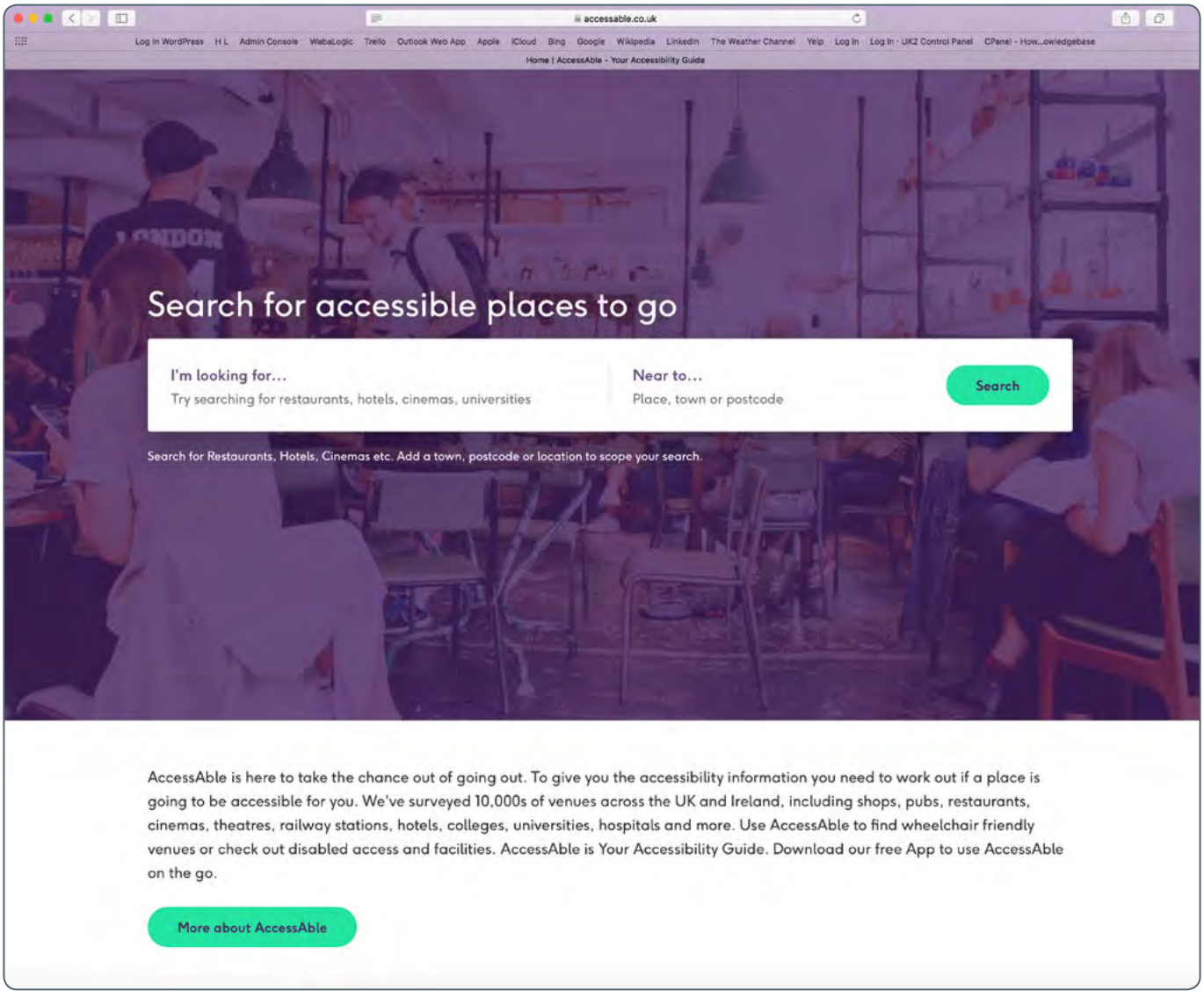
3.2.8
DEVELOPMENTS

AccessAble

In 2017, the Trust was approached by Disabled Go, a charity set up to provide free information to the public (via a website) about the accessibility of a range of public venues, such as restaurants, shops, cinemas, universities and more recently hospitals. The website provides information describing the accessibility features of these venues including parking, ramps, toilet/changing facilities etc. and includes dimensions/ pictures/maps as appropriate.

During 2018 the Trust has been working with this organisation to develop the information for all Trust sites, developing guidance pages. It was originally due to be completed in 2018, but the company itself has gone through a rebranding process which meant the original planned launch was deferred. The company is now called AccessAble, and the information relating to the Trust's facilities is now live, and can be accessed via www.AccessAble.co.uk.

This site is useful to any patient or visitor to the Trust as this provides a comprehensive up to date guide of all areas. An official launch date is currently being arranged for 2019.



3.3 STAFF EXPERIENCE

3.3.1
WE ARE BRADFORD

We are Bradford is about who we are, why we are here and what we're about. It helps staff to make the link between what they do, whatever the role they are in, and our patients. Part of this, bringing our values to life, is really important in shaping our culture and has been the focus for our work during 2018/19. In May 2018 our first 'Work as One' week took place, to bring our values to life as a Trust. The aim was to empower and engage staff through focusing on an operational priority. It encouraged staff to think differently, to be innovative and make changes that will improve the quality of patient care and patient experience. It was a great success and we held five further events throughout the year, including a system-wide week in January 2019.

We are Bradford encompasses all our work around staff engagement, developing our culture and developing our leaders to make sure we deliver the highest quality care for our patients and service users:

We are Bradford

- bringing values to life as teams - workshops launched in May and delivered to teams across the Trust
- embedding our values in our recruitment process (can include link to Nurse recruitment and recruitment materials and/or Trust website)

Work as One

- bringing values to life as a Trust
- working as one big team to develop and embed improvements
- success of first week in May, everyone behind patient flow, with improved patient experience, improved staff experience , improved process and improved collaboration

BRILLIANT BRADFORD
STAFF AWARDS

Brilliant Bradford

- team and employee of the month awards
- Brilliant Bradford annual staff awards
- staff voted online to shortlist for the annual Team and Employee of the year
- We are Bradford page on external website shares staff stories
- newsletter special editions to celebrate 'Work as One' weeks and NHS 70
- nurse Facebook page celebrating winners and sharing staff stories
- 'Let's Talk' Live events shared

Happy, healthy and here

- health and wellbeing initiatives throughout the year
- 12 days of Christmas campaign covering key areas such as mental health, diet, exercise, smoking and flu
- initiatives to improve the health and wellbeing of our staff and reduce sickness absence

Let's Talk

- 'Let's Talk' newsletter, sharing staff stories
- Core briefs to cascade key messages about the Trust to staff
- 'Let's Talk' Live listening events with the Chief Executive
- 'Let's Talk' Together events for Senior Leaders to help shape the direction of our Trust
- increasing our use of social media using Podcasts; Blogs; Facebook and Twitter
- 'Time2talk' campaign to make sure everyone has effective one to one conversations and appraisals
- Annual Staff Survey and regular Staff Friends and Family Test

Our Leaders

- launched Trust Leadership Development programme
- launched Senior Leadership Development programme
- delivered Management Essentials workshops increasing the confidence and capability of our managers
- reviewed and refreshed our Leadership and Management Development framework and intranet hub
- delivered Leadership workshops, accessible to all staff

3.3.2
STAFF SURVEY

Outcomes

Overall the results of the annual NHS Staff Survey are positive and show that we are listening to our staff, working with them to make improvements and making a difference to their experience and how they feel about working here.

Staff feel satisfied with the quality of care they give, feel their role makes a difference, and they are able to do the job to a standard they are pleased with. They feel supported by managers and colleagues; they're clear on responsibilities and feel trusted to do their job. This is the very essence of We are Bradford and shows how important it is to make sure we continue our work to bring our values to life.

More staff are saying they have opportunities to;

- show initiative in their role
- feel able to make suggestions for improvements
- be involved in decisions about changes that affect their work

More are saying their team has;

- a shared set of objectives and meet regularly to discuss how they are doing – things which are demonstrated by effective teams
- a significant positive shift in the number of staff satisfied with recognition of good work and feeling that the organisation values their work

There are improvements across the majority of the areas in last year's Staff Survey action plan. Staff engagement, our priority in 2018, significantly increased again, showing an upwards trend over the last three years from 6.9 in 2016 to 7.2 in 2018. Staff motivation and recommending us as a place to work and receive treatment both show a significant increase in scores. There were positive shifts in the scores for communications between senior management and staff, up from 37.8% to 42.1%; reporting of errors and incidents from 92.9% to 96.0% and a decrease in the percentage of staff experiencing physical violence from staff in the last 12 months.

Overall our scores are above average in nine of the new themed areas; our score for 'Safe environment – Violence' matches the 'best' score of 9.6 benchmarked against other Acute Trusts and we have made significant increases in scores for Quality of Appraisals, Safety Culture, Engagement, Immediate Managers and Safe environment – violence.

Workforce Race Equality Standard (WRES)

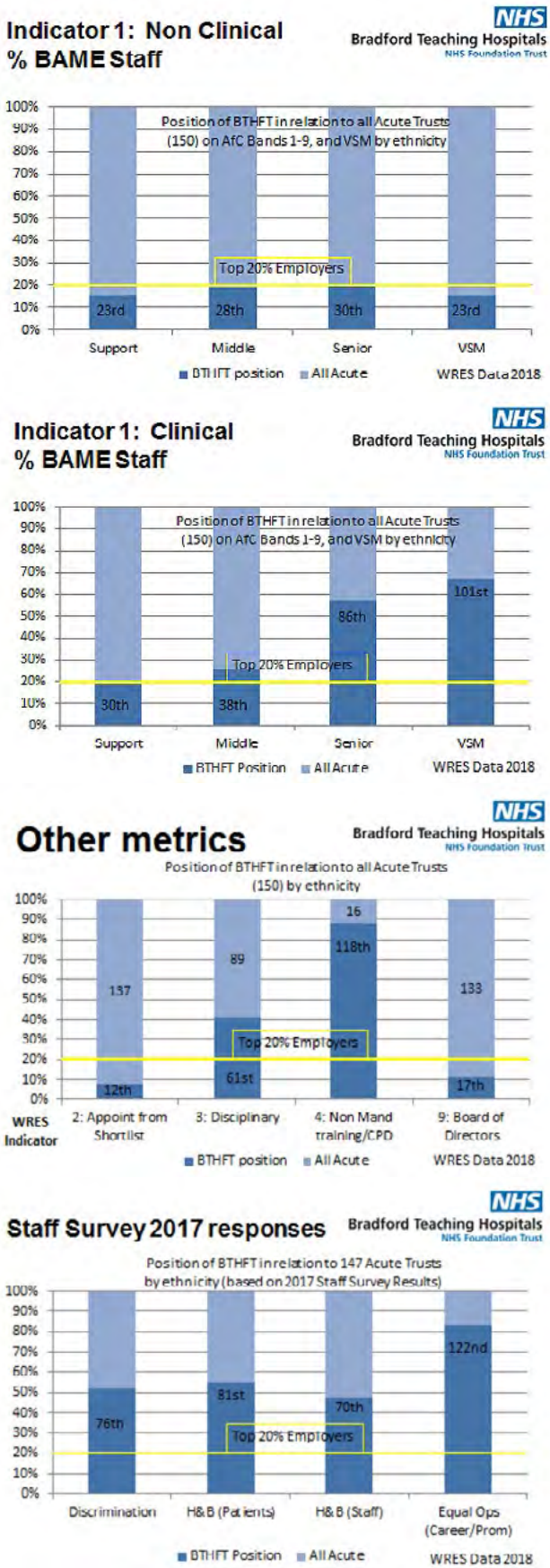
NHS England has agreed a set of Standards against which we have to submit our data in order to comply with the NHS standard contract. The WRES forms the first stage in a process of addressing workforce equality issues. Our WRES data helps form part of the data we scrutinise as part of our Corporate Objective to be in the top 20% of NHS employers.

The nine WRES indicators are:

1. percentage of staff in each of the aggregate AfC Bands 1-9, and VSM by ethnicity (broken down Non Clinical and Clinical)
2. relative likelihood of staff being appointed from shortlisting across all posts
3. relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. relative likelihood of staff accessing non-mandatory training and CPD
5. percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. percentage believing that trust provides equal opportunities for career progression or promotion
8. in the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
9. percentage of Board representation by ethnicity and Executive/Non Executive membership

Four indicators from the 2017 Staff Survey contribute to our WRES data, which we submit annually in July. Our overall WRES response is set out in Figure 41.

Figure 41: Overall WRES response by the Trust



2018/19 and beyond

It is important that we continue to build on the progress we have made during 2018/19 and increasing staff engagement remains our top priority – getting this right should have a positive impact on other areas including patient experience and outcomes; staff motivation; morale and wellbeing.

Although we have made significant improvements in many of the themed areas compared to last year, there is more work to do to improve Equality, diversity and inclusion, Quality of care, Quality of appraisals, Safe Environment – Bullying and harassment and Health and wellbeing and Safety culture. We will be focusing on these areas during 2019/20. We will also be addressing the areas where we are either below average or our scores have decreased since last year. This includes reporting of physical violence and areas around use of patient and service user feedback.

These priorities will be addressed through our Trust Staff Survey action plan and our People Strategy annual plans, with progress monitored throughout the year by the Workforce Committee, Executive Management Team and Board of Directors.

3.3.3
STAFF WHO SPEAK UP (INCLUDING WHISTLEBLOWING)

Freedom to Speak Up (FTSU) is embedded at BTHFT. Staff can raise concerns in a number of ways:

- by emailing a secure email – Speakup.guardian@bthft.nhs.uk
- by down loading BTHFT FTSU free App from the App store (this can be used anonymously)
- by contacting the FTSU Associate Guardians directly by telephone, email or in writing.

The Associate Guardians support the person raising the concern throughout any period of further investigation. At the initial meeting the person raising the concern is informed that they will not suffer any detriment as a result of speaking up, and this is monitored throughout the support. Following any investigation, the FTSU Associate Guardian always ensures that the recommendations are shared with the person who spoke up.

Once the case is closed, the Associate Guardians follow up with the person raising the concern at three months to ask if they would speak up again and also the reason for their answer.

Figure 42: Details the number of concerns raised in 2018/19

Quarter 18/19	No. Of concerns raised
Q1	3
Q2	6
Q3	13
Q4	22

The Trust has also implemented a staff advocacy service which staff can contact directly for confidential, impartial advice, helping them to understand their options and make an informed choice about how to address their situation or concern.

3.4 PERFORMANCE AGAINST NATIONAL AND LOCAL INDICATORS, AND MANAGEMENT OF PERFORMANCE

3.4.1 NATIONAL PERFORMANCE MEASURES

The Trust's performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement is reported in Figure 43. For 2018/19 these are the indicators that are measured by the Single Oversight Framework.

Figure 43: 2018/19 indicators measured by the Single Oversight framework.

Area	Indicator	Current Target	2018/19	2017/18	2016/17	2015/16	0214/15	2013/14	2012/13	2011/12
Access	Total time in A&E: maximum wait time of 4 hours	>=95%	80.07%	83.17%	88.50%	93.50%	95.10%	96.20%	95.70%	95.90%
The foundation Trust has not achieved the 95% threshold for the Emergency Care Standard throughout the financial year which is a position reflected nationally, with the majority of NHS organisations experiencing pressures in achieving this standard. The A&E department saw a high number of attendances in the financial year 2017/2018 with the 3rd highest volumes of the last 8 years. A number of remedial actions have been undertaken with the focus on improving patient flow throughout the hospital. Early planning guidance for 2018/2019 indicates the threshold has been reduced to 90% until September 2018.										
Access	Cancer 2 week wait standard	>=93%	72.73%	80.52%	95.30%	94.80%	95.50%	95.50%	95.10%	94.00%
	Cancer 62 day standard - First Treatment	>=85%	67.06%	76.27%	84.40%	88.70%	86.30%	88.80%	93.30%	83.70%
	Cancer 62 day standard - Screening	>=90%	89.64%	91.83%	92.50%	97.10%	97.00%	97.20%	98.80%	96.20%
In 2017/18 the foundation Trust continued to underachieve against the Cancer 62 day standard. In addition in the second half of the year service demand coupled with clinical capacity gaps have resulted in the Cancer 2 week standard failing the threshold for a number of months and for the financial year as a whole. For the second consecutive year the Foundation Trust has increased the number of patients treated for both indicators but has struggled to accomodate all patients within the threshold.										
Access	Referral to Treatment Waiting Times <18 weeks - Incomplete pathway	>=92%	77.14	82.30%	90.29%	92.60%	96.50%	97.20%	n/a	n/a
The foundation Trust did not achieved the RTT Incomplete threshold in 2017/18. The implementation of the Electronic Patient Record has meant there has been a transition period in reporting performance. The full year position presented represents a combination of performance from the tow systems used. The Foundation Trust has a recovery plan in place to increase access to elective services thereby reducing waiting times for patients and ensuring a better overall patient experience.										
Outcomes	Incidence of *Clostridium Difficile*	<=51	22	17	24	24	32	43	58	88
The foundation Trust has continued to perform well against the threshold set for Clostridium Difficile cases and will report a maximum of 17 cases currently still pending attribution. This reflects the efforts of all staff to incorporate infection control procedures into their normal working practice.										

Key

Green rating indicates that the target was achieved

Red rating indicates that the Foundation Trust failed to meet the target

Reporting against two mandated performance indicators and one locally selected indicator

NHSI Guidance stipulates that the External Auditor should undertake substantive sample testing on two mandated performance indicators and one locally selected indicator. The mandated indicators tested for 2018/19 are:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer

The locally selected indicator is that chosen by the Council of Governors. At their meeting held 11 January 2019 the Council of Governors confirmed that the locally selected indicator would be the 'Summary Hospital-level Mortality Indicator' (SHMI). The Governors noted that this was a nationally defined indicator produced and published quarterly as a National Statistic by NHS Digital.

The SHMI values and bandings for the Trust since July 2014 are presented in Figure 44.

The indicator definition is available in Appendix B.

3.4.2
LOCAL PERFORMANCE MEASURES

In determining the quality indicators for inclusion in the 2018/19 Quality Report we have incorporated Commissioning for Quality and Innovation scheme indicators (CQUIN) to ensure coverage of locally agreed quality and innovation goals as well as nationally defined quality assurance indicators.

The inclusion of the CQUIN goals within the Quality Report indicates that the Trust is actively engaged in discussing, agreeing and reviewing local quality improvement priorities with Bradford City and Bradford Districts Clinical Commissioning Groups.

National CQUIN goals reflect areas where there is widespread need for improvement across the NHS. They aim to encourage local engagement and capability building, but also to share good practice, encourage benchmarking and avoid duplication of effort across the country.

A summary of the goals selected by the Board of Directors in consultation with the lead commissioners and an explanation of their importance is presented in Figure 45.

Figure 44: Summary Hospital-level Mortality Indicator (SHMI) Latest available data (Oct17-Sep18).

Date	SHMI Value	SHMI Banding
Oct17-Sep18	0.909	2 – As Expected
Jul17-Jun18	0.926	2 – As Expected
Jul16-Jun17	0.926	2 – As Expected
Jul15-Jun16	0.978	2 – As Expected
Jul14-Jun15	0.971	2 – As Expected

Figure 45: Goals selected by the Board of Directors in consultation with the lead commissioners

		Quality Domain			
Goal Name	**Description of Goal**	**Safety**	**Effectiveness**	**Patient Experience**	**Innovation**
Staff Health & Wellbeing	Trusts should develop and implement plans to introducing a range of physical activity schemes, improve access to physiotherapy services and introduce a range of mental health initiatives for staff. Trusts are also expected to achieve a step-change in the health of the food offered on their premises in 2018/19 and ensure at least 75% of clinical staff receive influenza immunisation vaccinations.		**Yes**	**Yes**	**Yes**
Reducing impact of serious infections	This CQUIN seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. It also requires that all antibiotic prescriptions for patients diagnosed with sepsis are reviewed after 72 hours if the patient is still in the hospital. Finally, it requires the Trust to reduce antibiotic consumption.	**Yes**			
A&E Mental Health	This CQUIN aims to reduce A&E attendances for patients attending A&E frequently with mental health needs by working with partners to redirect these patients to more appropriate services in the community.		**Yes**	**Yes**	**Yes**
Advice & guidance	This CQUIN seeks to improve GP access to consultant advice prior to referring patients in to secondary care.		**Yes**	**Yes**	**Yes**
Preventing Ill Health - Tobacco & Alcohol	This CQUIN aims to prevent ill-health related to alcohol and tobacco consumption by asking Trusts to screen every patient admitted to hospital in order to identifying patients at risk and providing them with advice and onward referral to the relevant cessation service if necessary.	**Yes**	**Yes**		
Patient Activation	Aims to encourage use of the "patient activation measurement" (PAM) survey instrument, firstly to assess levels of patient skills, knowledge, confidence and competence in self-management for different groups of patients meeting the criteria			**Yes**	**Yes**
Haemoglobinopathy ODNs	This CQUIN incentivises removal of the remaining barriers to achieving an appropriate network of care by enabling lead / specialist centres to provide MDT led annual review of all patients and the associated communications, clinical support, staff training and data entry to demonstrate the clinical outcome benefits of such a model.			**Yes**	**Yes**
QIPP	The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care, at the same time as making efficiency savings.				**Yes**
Dental coding	This CQUIN aims to ensure consistent coding for Oral Surgery and Maxillo- Facial Surgery procedures carried out in an outpatient setting.		**Yes**		

A summary of our 2018/19 performance against the indicators within both the locally-selected and national goals is outlined in Figure 46. Quarter 4 results are currently projected while awaiting feedback from the Commissioners.

Figure 46: 2018/19 CQUIN Achievement

CQUIN	Indicator name	2018/19			
		Q1	Q2	Q3	Q4
Staff Health & Wellbeing	Improvement of health and wellbeing of NHS staff				
	Healthy food for NHS staff, visitors and patients				
	Improving the update of flu vaccinations for frontline clinical staff				
Reducing impact of serious infections	Timely identification of patients with sepsis in the emergency departments and acute inpatient settings				
	Timely treatment of sepsis in the emergency departments and acute inpatient settings				
	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours				
	Reduction in antibiotics consumption per 1,000 admissions				
A&E Mental Health	Improving services for people with mental health needs who present to A&E				
Offering Advice & guidance	Advice & guidance				
Preventing ill health by risky behaviours	Tobacco screening				
	Tobacco brief advice				
	Tobacco referral and medication offer				
	Alcohol screening				
	Alcohol brief advice or referral				
Patient Activation	Ongoing implementation for renal patients				
	Implementation for HIV patients				
Improving Haemoglobinopath Pathways through ODN Network	Participation in ODN				
QIPP	Delivery of a range of QIPP schemes				
Dental coding	Improving inpatient coding for oral and max facial surgery				
Staff Health & Wellbeing	Healthy food for NHS staff, visitors and patients				
	Improving the update of flu vaccinations for frontline clinical staff (Bowel and Breast screening)				

	Achieved
	Partially achieved/Undecided
	Not achieved
	Projected

3.4.3 IMPLEMENTING THE PRIORITY CLINICAL STANDARDS FOR SEVEN DAY HOSPITAL SERVICES

The Trust's Clinical Service Strategy 2017- 2022 describes how we will develop our clinical services consistent with the vision "to be an outstanding provider of healthcare, research and education and a great place to work" in order to meet the health needs of the people of Bradford and West Yorkshire.

The Clinical Services Strategy is set in the context of the NHS Five Year Forward View and its 2017 update, and the West Yorkshire & Harrogate Sustainability & Transformation Plan.

It outlines how we will work with partners to provide new, flexible models of care, tailored to the needs of patients. The vision statement in the Clinical Services Strategy makes a commitment to our patients to meet their needs now and in the future.

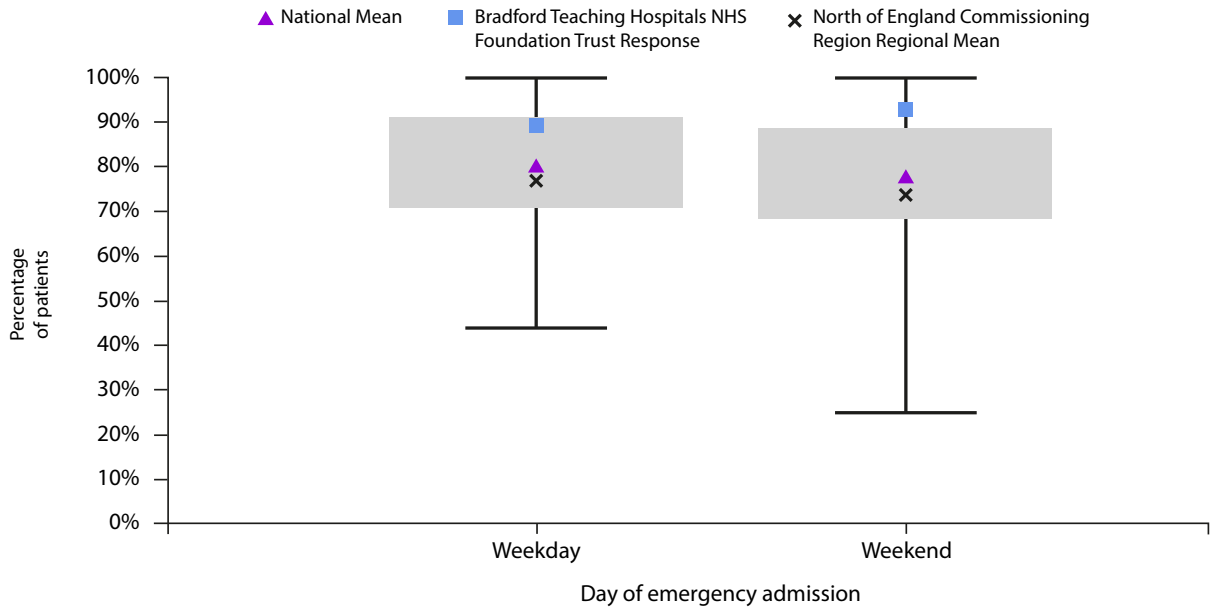
That we will "provide high quality healthcare, 24 hours a day, 7 days a week" – in particular we will focus on seven day services, mortality, the deteriorating patient, surgical safety and the use of digital technology to improve care."

The Seven Day Hospital Services [7DS] Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. The Trust has been a first wave implementer of 7DS, working closely with NHS England, Seven Day Service Improvement Programme [SDSIP] in implementing and reviewing progress from the six monthly surveys undertaken since March 2016. The Trust has also worked with regional and national colleagues to look at new ways of working to improve compliance to the four priority clinical standards. The Trust survey results have shown a continual improvement in compliance with the priority clinical standards, and in the April 2018 the Trust achieved the required 90% compliance for Standard 2 which benchmarked well in terms of National and Regional mean, see Figure 47; however there are still operational challenges to overcome to complete the sustainable transformational changes required to meet all ten agreed 7DS Standards.

From 2018 the six monthly surveys have been replaced by a Board Assurance Framework, NHS England and NHS Improvement have developed a robust board assurance process and single template which enables Trusts to record their assessments of 7DS delivery in each of the four priority standards for both weekdays and weekends as well as allowing a record of progress against the remaining six standards and the network specialised services.

The first formal board assurance submission will be due on the 28/06/2019.

Figure 47: Proportion of patients who received a first consultant review within 14 hours of admission to hospital



As of June 2019 the Trust will be submitting formal bi-annual self- assessments with local evidence that has been Board assured to NHS Improvement, to demonstrate compliance and improvement towards delivery of the ten 7DS standards.

The results from the board-assured assessments will form a 7DS metric in the clinical commissioning group improvements and assessment framework to allow CCGs to assess local delivery of 7DS. The CQC inspection regime will also assess 7DS as part of its judgement on a Trust's effectiveness.

3.4.4 THE QUALITY MANAGEMENT SYSTEM

During 2018/19 the Trust continued the implementation of its Clinical Service Strategy for the next five years. The Clinical Service Strategy was developed to support the development of the Foundation Trust's vision and mission, and was underpinned by its values.

The Clinical Service Strategy directly influenced the identification of the Trust's strategic objectives and as such the design, development, improvement, provision and delivery of its core services. As a result the Trust has worked to ensure that its Quality Management System is aligned to the Clinical Service Strategy, this for instance has led to the implementation of a one year Quality Plan and the Trust's Risk Management Strategy.

The progress of the Foundation Trust in relation to the achievement of the objectives set within the Clinical Service Strategy (and related strategies and plans that support it) is monitored by the Board of Directors, with the oversight of risk and assurance associated with the achievement of key performance indicators being delivered through the Board Assurance Framework.

The Quality Management System ensures, ultimately, that we have a comprehensive approach to identifying, measuring, and controlling and improving our core processes which are designed to support the delivery of our Clinical Service Strategy. This system includes our operational processes, management and review processes and support and assurance processes.

Management and review processes

- a Trust-wide approach to the governance of external data quality submissions has been implemented
- the Quality Oversight System (see section 3.1.2) was reviewed and strengthened
- a full self-assessment of the Board and Board Committees was undertaken and used to strengthen the use of assurance and the Board Assurance Framework throughout the governance infrastructure
- the Trust continues to implement a standardised approach to risk assessment and risk register management and risk escalation
- the Trust continues to implemented a standardised approach to action planning
- the Trust has implemented a consistent programme of Quality Improvement.

Assurance, testing and inspecting

- the Trust's ProgRESS Programme continued to assure and test the compliance with the CQC's Fundamental Standards of Quality and safety.
- the Trust received a rating of 'Good' for the Well Led Domain during 2018/19 following the CQC inspection undertaken during Quarter 4 2017/18
- the Trust received an overall rating of 'requires improvement' following the CQC inspections during Quarter 4 2017/18.
- the Trust participated in a CQC-led area review during 2017/18, the results of which was published during 2018/19
- the Trust commissioned Internal Audit to assure the effective implementation of its Risk Management Strategy and its Board Assurance Framework during 2018/19, resulting in a conclusion that there was significant assurance in relation to the use of both within the Trust's Quality Management System
- the Trust participated in all other statutorily required inspections related to the services which it provides

3.5 EHEALTH ADVANCEMENTS

The Trust is in a privileged position in England with the success of our Electronic Patient Record and state-of-the-art supporting tools. Using the HIMSS EMRAM model, on a scale of 0 to 7, where 7 is everything everywhere is digital, the Trust is currently at a maturity level of 5.036 against an average of 1.5 for other hospitals. The high degree of digitisation, technologically-literate staff, and strong working relationships in our Bradford District and Craven Place provide an enviable position. This position allows us to use our data, tools, and skills for even safer care to our patients, learn and teach, conduct research, and drive innovation for our populations of citizens.

Continuing to develop our digital tools

In particular this past year the Trust has embedded the Electronic Patient Record into clinical use and has seen a number safety benefits. For example VTE Assessments are now consistently over 95%, 89% of discharge summaries are completed online, a decrease has been reported in medication errors and in Grade 3 pressure ulcers. We are now delivering 81% of antibiotics for Sepsis within a fast delivery time. For every patient bed-day the Electronic Patient Record is providing eighteen alerts to clinicians that could potentially avoid harm. The Electronic Patient Record is also contributing to consistent care with 71% of all orders using the standardised protocol.

Further Electronic Patient Record advancements have been made this year with the addition of a direct link into patient images, a Sepsis Alert, updating the early warning score algorithm for deteriorating patients alert, and the new Emergency Care Dataset. Of particular importance in the district is the Health Information Exchange, which came online this year and provides all our GPs and Airedale Hospital clinicians with the ability to see into the Trust's and Calderdale & Huddersfield Hospital's Electronic Patient Record. Going beyond the area, the Trust is home to the Yorkshire Imaging Collaborative whereby the ability for Radiologists to see images from all nine Trusts has been tested and is coming online shortly. This will complement the Trust's active participation in the Yorkshire and Humber Care Record.

With the Electronic Patient Record in place and upgrades to our supporting tools the Trust has been able to advance our digital maturity. This has included growing the Business Intelligence team with the addition of apprentices and skilled people, providing increased opportunity and development for our staff.

The Clinical Coding service has defined a new service development plan which will see their skills and expertise align with the business intelligence aims. The teams have continued to develop the Data Warehouse with automations added for financial processing, and a Neonatal Intensive Care information system feed added in 2018/19. Work is progressing on providing near real time reporting using clinical data with the addition of a facilitating tool.

Keeping our technology current and safe

The Trust completed a number of upgrades this year, ending the year with only a minor number of technology systems that are behind their optimal version. This strong position is complemented by the introduction of a Cyber Security Strategy. The Trust is active in protecting our patients' data and our information systems. The strategy outlines four objectives, whereby the Trust will:

- use a range of technologies to ensure any potential cyber security issues are identified and blocked before any adverse effect on the Trust
- manage cyber security risks by using controls and IT technical user policies to mitigate risk, to ensure the routes to any potential cyber-attacks are mitigated
- continually develop processes and staff to keep the Trust safe
- ensure robust plans to respond to any cyber risks or cyber-attacks

This year the Trust is expected to become one of twelve Trusts in the country to achieve ISO27001 accreditation. This will provide the Trust with assurance that all emails sent to all government bodies are encrypted by default. The accreditation is expected to be in place by the end of May 2019.

Our new Digital Strategy

In recognition of the completion of the previous strategy, in 2018/19 the Digital Strategy was updated. Our new digital strategy aims to see technology and information used intelligently, and along with our partners, to keep our communities well and out of hospital – for example:

- by analysing community-based data from all the providers in near real-time we can coordinate care better and target interventions
- by using artificial intelligence to analyse our data we can assist in determining when patients would do better with other interventions then coming into the hospital
- by using tele-medicine and technology to 'see' patients where they are and help them manage their conditions better outside of hospital with and without our virtual help
- by using home monitoring instead of in-hospital monitoring to keep people at home

This strategy also has the complementary aims of improving the staff working experience through continued development and upgrading of our tools. In 2019/20, the Trust will see the AI-driven Command Centre come on line that will analyse our data, simulate scenarios, and provide prompts for targeted actions. This coming year we are also working to use our Patient Portal to enable patients to fill in assessments prior to coming into hospital and to provide an alternative to in-person visits.

Artist impression of the Wolfson Centre for Applied Health Research

3.6 RESEARCH ACTIVITY

The Trust continues to be the third highest recruiter in the region to National Institute for Health Research (NIHR) portfolio studies ensuring that our patients are able to receive innovative treatments. Up to mid-February 2019, 11825 patients were recruited into NIHR Portfolio adopted studies exceeding the previous year's recruitment levels as well as the Trust target for 2018/19 (6750 patients).

Work on developing the research infrastructure at the Trust continues with the progression of the Wolfson Centre for Applied Health Research. This is a major research venture and collaboration between the Trust and the Universities of Leeds and Bradford. As well as the physical build and its associated design much work is also being undertaken in to the development of the research agenda which builds on and extends the applied health research work undertaken within our Bradford Institute for Health Research. The construction of the Centre is due for completion in May 2019 with occupancy soon after.

The Wolfson Centre for Applied Health Research will focus on two crucial periods of life – healthy childhood and healthy ageing – with an underpinning theme of enhancing quality and safety across the care pathway during those periods.

The Trust continues to conduct a wide range of both clinical and applied health research with most specialties within the Trust being research active. Listed below are some of those areas of work.

Leading centre in Applied Health Research

The three main applied health research teams (Academic Unit of Elderly Care and Rehabilitation, Born in Bradford and Quality and Safety) continue to thrive:

Academic Unit of Elderly Care and Rehabilitation

The Academic Unit of Elderly Care and Rehabilitation research group has developed a programme of multidisciplinary health services research, with current funding over £12million, facilitated by a strong and supportive network of local and national colleague researchers, NHS clinical staff, patients and their families. This includes four large programme grants:

- Developing and evaluating strategies to provide longer term health and social care for stroke survivors and their carers (£1.6m);
- Strategies to reduce sedentary behaviour in patients after stroke and improve outcomes (£3m);
- Personalised care planning to improve quality of life for older people with frailty (£2.7m)
- A NIHR HTA randomised controlled trial to determine the clinical and cost effectiveness of a home-based exercise intervention for older people with frailty (£2m).

Continuing the department's highly successful grants record, we have recently been awarded a new NIHR Programme Development Grant to develop a novel system of care targeting risk factors for five manifestations of frailty to maintain the independence of older people in hospital and post-discharge. The project is scheduled to commence in spring 2019.

Striving to improve outcomes for patients and enhance the health and care system, our research outputs have had an influential impact at both national and international levels. For example, our NIHR funded study exploring the provision of post-stroke therapy led by David Clarke has been used as a case-study by the Royal College of Physicians.

Also cited in the Sentinel Stroke National Audit Programme (SSNAP) report in 2018, the team have showcased the research findings at several national and international conferences, including presentations at the Greater Manchester Stroke Operational Delivery Network and dissemination in Ireland and Australia.

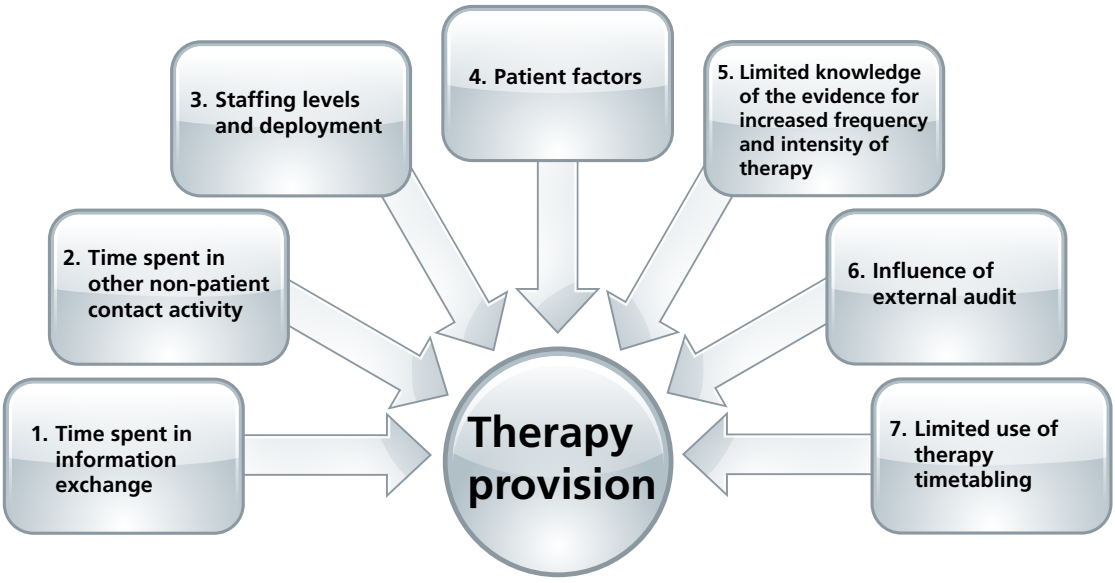
We have also had international success with our Longer-term Unmet Needs after Stroke Questionnaire (LUNS). This has been translated into Dutch and French and is being used widely in service provision and research internationally. The 22 item questionnaire measures the longer-term problems affecting physical, social and mental well-being in the special context of longer-term stroke care. The Dutch team validated LUNS against the Dutch stroke population and concluded that it was feasible, reliable and valid. https://www.strokejournal.org/article/S1052-3057(17)30464-0/pdf

LoTS care
Stroke system of care trial

Our Community Ageing Research Study 75+ (CARE75+) longitudinal cohort study is also progressing at a strong pace with an impressive recruitment figure of over 1200 participants. Recruitment is still on-going in various sites across the nation. The large CARE75+ cohort is collecting an extensive range of health, social and economic outcome data, including on the wider determinants of health, with a particular focus on frailty status and frailty trajectories. CARE75+ uses the 'trial within cohort' design which provides a valuable recruitment platform for other studies to conduct research with older people in varied topics.

December 2018 also saw the retirement of the founder of our Unit, Professor John Young. John's substantial contribution to the local, national and international improvement in care for older people was reflected in the testimonials received from colleagues world-wide.

Figure 48: Factors influencing therapy provision[2]



[2] Clarke DJ, Burton L, Tyson SF, Rodgers H, Drummond A, Palmer R, Hoffman A, Prescott M, Tyrrell P, Brkic L, Grenfell K, Forster A. Why do stroke survivors not receive recommended amounts of active therapy? Findings from the ReAcT study, a mixed-methods case-study evaluation in eight stroke units. Clinical Rehabilitation 2018; 1-14. DOI: 10.1177/0269215518765329

Born in Bradford [BiB]

Established in 2007, the Born in Bradford research programme is one of the largest health research projects in the UK involving over 30,000 Bradfordians. By focusing on key public health priorities for families and conducting cutting edge research it is exploring the reasons why some people fall ill and others stay healthy. This information is being used to develop and evaluate interventions to improve the lives of families.

Over the past five years we have attracted over £20 million in research grants from national and international funders. We host two internationally recognised birth cohort studies - Born in Bradford and Born in Bradford's Better Start, an established programme of applied health research, Connected Yorkshire, and the Better Start Bradford Innovation Hub. Our funders include the National Institute for Health Research, Wellcome Trust, Economic and Social Research Council, Medical Research Council, National Lottery, British Heart Foundation, Kidney Research UK, and Horizon 2020.

We have had a very busy year recruiting thousands of families to our projects. As part of the BiB Growing Up study we have visited over 2500 families, and assessed over 6500 BiB children aged 7-10. We have assessed the cognitive development and wellbeing of over 15,000 Bradford school children in Years 3-5. Our 'Born in Bradford's Better Start' birth cohort has recruited over 2000 pregnant mums living in Little Horton, Bowling and Barkerend and Bradford Moor wards within the city. The results from all of these projects will be used to help shape services within the city to help improve health and wellbeing of Bradford families.

We continue to work closely with our key health, local authority and education partners across the city. Our Sport England Funded Local Delivery Pilot is now in full swing, we are working with local communities to develop and evaluate new and innovative approaches to increasing physical activity amongst children. With support from the Bradford Opportunity area, we have established the new Centre for Applied Education Research (CAER) (www.caerbradford.org) involving partnerships between researchers from Born in Bradford, the Department for Education, Bradford Council, the Educational Endowment Fund (EEF) and the new EEF Research School in Bradford. CAER is currently running two large Randomised Controlled Trials (RCTs) funded by the EEF – Helping Handwriting SHINE https://educationendowmentfoundation.org.uk/projects-and-evaluation/projects/helping-handwriting-shine/

and Glasses in Classes

https://www.leeds.ac.uk/news/article/4370/glasses_trial_sets_sights_on_primary_pupils.

We have also started to work with mosques and madrassas to develop new approaches to tackling obesity based within Islamic Religious Settings, and were delighted to partner with Bradford Council to be one of 13 local authority obesity trailblazer sites which will see us working closely with Public Health England to develop a scalable approach to tackling the obesity crisis.

Based on our learning of working across services in the early years, we have produced toolkits to enable organisations to successfully monitor and evaluate their own services. These have been used widely in Bradford and BiB are now working in partnership with the Early Intervention Foundation in a flagship programme to transform early years services across England.

The Connected Health Cities project (https://www.connectedhealthcities.org/) continues to go from strength to strength on their work with connecting different data sets and identifying pathways through health services. For example, a smaller study within Connected Yorkshire has identified disparate systems used by schools and clinicians which will need improvement to provide better support to local children. Furthermore, working with school nurses has been important in gaining support to use the Unique Pupil Number in child health records, providing an important link to different databases.

Over the past year we have appeared in over 20 local and national television and radio news features including our highly acclaimed yearly Radio 4 broadcast. We have attended over 45 local community events, including taking to the streets in July 2018 for the Bradford Science Festival and we have started planning our 9th Annual Conference which will take place in September. You can find out more about our research, findings and events on our website: www.borninbradford.nhs.uk, Facebook page (BorninBradford) or by following @bibresearch on twitter.

Quality and Safety Research Team

The National Patient Safety Translational Research centre, a collaboration between Bradford Teaching Hospital Foundation Trust and the University of Leeds is now fully established. In 2018 we completed a priority setting exercise, supported by BTHFT. The findings generated from this work were used as the basis of a competitive fund called the Safety Innovation Challenge Fund. In November we hosted an event to introduce this fund to clinical and academic teams around the region. Thirteen applications were submitted in December 2018 and we are planning to shortlist three of these for funding in 2019.

In 2018 the Quality and Safety research group were successful in attracting funding from the Medical Research Council (MRC) of just over £1million to develop and evaluate a technological solution to the problem of misplaced nasogastric tubes. This programme of work, led by Angela Grange, Head of Nursing (Research and Innovation), BTHFT, started on 1st January 2019.

In 2018, the Quality and Safety research group were successful in a bid to THIS Institute, a new Institute set up by the Health Foundation to develop their portfolio of work in Improvement Studies. Our bid, for a PhD student, will focus on identifying and eliminating those practices that are carried out 'In the Name of Safety' but are perceived by healthcare staff to have very little value for safety. For more information please see http://yhpstrc.org/2018/03/02/in-the-name-of-safety/

In 2018, we also completed our NIHR HS&DR project 'Understanding and enhancing the usefulness of patient experience data'. We have written and edited the monograph reporting on this work and have received extremely positive feedback. The toolkit, developed during this project, to support Trusts to engage in patient experience based improvement projects is now available via the Improvement Academy https://improvementacademy.org/tools-and-resources/the-yorkshire-patient-experience-toolkit.html

Clinical Research

Most clinical specialities in the Trust are research active and are taking part in a large number of research projects. The research teams within the clinical areas are extremely motivated to ensure that their patients have the opportunity to take part in research projects thereby being able to receive innovative treatments and the latest advancements in healthcare. Some of their achievements this year include:

Maternal Health Research

The Bradford Reproductive Health and Childbirth Clinical Research team are amongst the most successful; they consistently achieve or surpass performance targets, strengthening their excellent national and international reputation for research delivery.

Since being awarded an NIHR fellowship in 2014 to investigate hypertensive disorders and blood pressure across pregnancy, Dr Diane Farrar has since published papers in several important journals. This includes the Lancet Diabetes and Endocrinology, BMJ and Diabetologia and was recently awarded the title of Visiting Associate Professor at the University of Leeds. Professor Derek Tuffnell is a co-applicant on a NIHR HTA grant to investigate treatments for hyperemesis, has co-authored the recent maternal mortality report and is data monitoring chair for a trial investigating the use of high dose oxytocin to augment labour.

Children's research

We have had another great year full of rewards and challenges. We have continued to increase and diversify our portfolio and recruit more children and families to studies.

We have been able to open two commercial studies this year, one in Paediatrics and one in Neonates, each with a different commercial sponsor. We have opened the Petechiae in Children study on the paediatric wards engaging staff in research and working with a new, enthusiastic Principal Investigator. We have reached and gone beyond our target of 24 for the Neonatal study Baby Oscar, with the study being extended into 2020 we will continue to recruit to this.

We have attended several end of study meetings this year to find out results of the studies we contributed to, several of the trials have now published their work in various journals including ELFIN (Lancet), PREVAIL and SIFT (conference abstracts only to date), and PLANET-2 (NEJM).

We have investigator status in a further two funded neonatal trials, and anticipate shortly opening as a pilot site in a further large multicentre randomised controlled trials with more trial activity in the pipeline.

For the SIFT study – Speed of InFanT feeding trial we were also given an award for being one of the top recruiters to the trial.

Bradford Ophthalmology Research Network (BORN)

The ophthalmology research portfolio has continued to grow in 2018/19 with the opening of two phase two studies, a first for our team. One of these studies – PanOptica, if successful, could revolutionise the way patients are treated for Wet Macular degeneration. Currently patients are injected with drugs into the eye itself within a hospital setting. The PanOptica trial is looking at the possibility of an eye drop which delivers the same treatment, but is self-administered in the comfort of the patient's home. Additionally, BORN have recruited the first European patient to RHINE study. As a result of diabetic eye disease, there is a trial looking at a new treatment for patients with Diabetic Macular Oedema. We continue to lead recruitment in the UK for this trial, and as such have been offered a second trial for the same treatment but in patients with Wet Macular Degeneration which opened in the UK in April 2019.

Digestive Diseases Research

The Gastroenterology and Hepatology Research Department, collectively known as Digestive Diseases, are based at Bradford Royal Infirmary but also work at St. Luke's Hospital. We have a dedicated research team of clinicians, nurses, and our own clinical trials administrator. The main areas we deal with are Inflammatory Bowel Disease, upper and lower gastrointestinal cancers and liver disease such as viral hepatitis, autoimmune liver diseases, alcohol and non-alcoholic liver conditions and pancreatic and biliary disorders.

As a speciality, we work very closely with all the Medical team, Specialist nurses, ward and other health professionals to promote, recruit and deliver the Research Studies.

Our Consultants are Dr Cathryn Preston for Gastroenterology & Dr Sulleman Moreea for Hepatology.

Our aim is to demonstrate how engagement in clinical research leads to improvement in health outcomes and management of patients care and quality of life.

Gastroenterology

2018/19 has been a busy year with the opening of four new studies plus a new commercial study. The purpose of this study is to assess the long-term safety of vedolizumab versus other biologic agents in participants with Ulcerative Colitis (UC) or Crohn's Disease (CD).

Recruitment has been very successful and we are able to follow up our patients working alongside the study protocol offering them extra support. This study will look at the long-term safety of vedolizumab versus other biologic agents in participants with UC or CD. This multi-centre trial will be conducted worldwide. The overall time to participate in this study is seven years. Participants will make visits at every six months to their treating physician.

We continue to recruit all of our willing Inflammatory Bowel Disease (IBD) patients into the IBD bioresource. The IBD Bioresource is a national platform designed to expedite research into Crohn's disease and ulcerative colitis and help develop new and better therapies.

BioResource

The IBD BioResource is funded and supported by these partners

MRC Medical Research Council

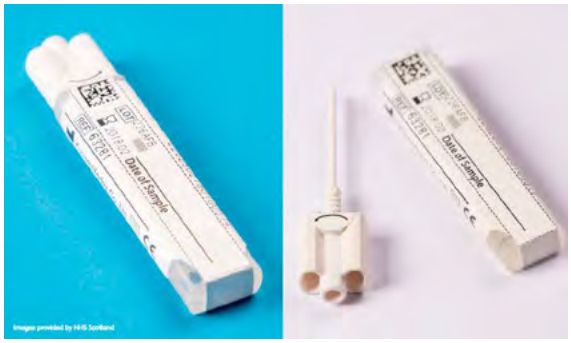
wellcome sanger institute

Open Targets

CROHN'S & COLITIS UK FIGHTING INFLAMMATORY BOWEL DISEASE TOGETHER

NIHR | National Institute for Health Research

We have also been busy with our colleagues in the colorectal department and this year we opened the FIT study. FIT (Faecal Immunochemical Test) is a stool test designed to identify possible signs of bowel disease. It detects minute amounts of blood in faeces (faecal occult blood). Many bowel abnormalities which may develop into cancer over time are more likely to bleed than normal tissue. So, if there is blood in the stool this can indicate the presence of abnormalities in the bowel. Patients with a positive FIT result are referred for further investigation by colonoscopy. If cancer is found early, treatments are more effective. The FIT test is currently only available to research participants referred into the colorectal fast track clinic, as it is still under investigation as a screening tool for high risk symptomatic patients, however the Trust launched FIT for low risk symptomatic patients, with the test being available to GPs from the 7 May.



We also opened up recruitment to the Yorkshire Cancer Research Bowel Cancer improvement Programme (YCR BCIP). There is evidence of variation in the management of bowel cancer and outcomes for patients across Yorkshire and the Humber. This five year study funded by Yorkshire Cancer Research aims to understand the variation and then improve outcomes by addressing these issues. Patients with bowel cancer being treated at Bradford Teaching Hospitals NHS Foundation Trust will be asked to consent to participate in the collection of patient reported outcome measures (PROMS) via patient questionnaires. Patients will also be consented for the use of some of their tissue, which is excess to that required for diagnosis and treatment, to be sent to the research team in Leeds for additional novel biomarker testing.

yorkshire cancer research
Saving Yorkshire Lives

Hepatology

The Hepatology research team recruited three patients to the AbbVie study, a study to ascertain the safety of a combination treatment for Hepatitis C and whether the medication is able to clear HCV from the body. We completed this study in July 2018.

In early 2018 we opened the Nuc-B study with sponsor Imperial College London, this study examines whether if nucleos(t)ide treatment for Hepatitis B is stopped after a few years of treatment/viral suppression some patients may be able to eliminate the virus representing a cure of infection. Participants are followed up by the research team for three years following recruitment. We currently have three participants enrolled in the study and will be continuing to recruit until 31st May 2019.

We are also involved in commercial studies, continuing to recruit to Regenerate, a study regarding non-alcoholic steatohepatitis.

We are recruiting to a study investigating treatment for hereditary haemochromatosis, which opened here in Bradford in May 2018. Sponsored by La Jolla, this a single-blind study assessing the efficacy and safety of a synthetic protein to reduce iron overload in patients with hereditary haemochromatosis.

We successfully recruited 2 patients into the study and recruitment at Bradford Teaching Hospitals NHS Foundation Trust ends May 2019.

The Team - Sarah Tinker, Janet Johnson, Carol Firth, Wendy Cardozo & Sophie Stephenson

Renal Research

Renal patients in Bradford have the opportunity to take part in clinical trials to find new and improved ways to treat, manage and diagnose conditions. The renal research team contribute to a portfolio of commercial and non-commercial projects. The team are proud to have contributed to the PIVOTAL study, which is one of the largest randomised controlled trials to have taken part in the UK dialysis population, exceeding the set recruitment target in this and many other studies.

Rheumatology

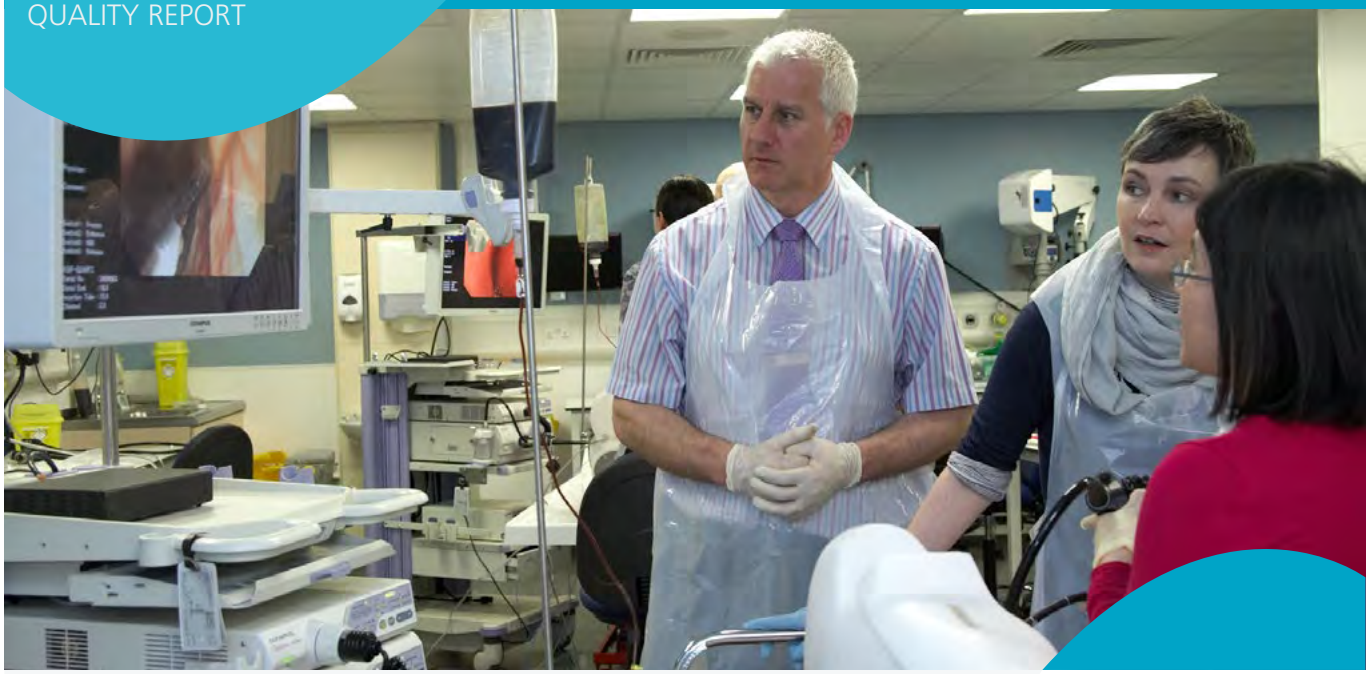
Based at St Luke's Hospital the rheumatology research team continues to grow and now has seven members working across a range of commercial and non-commercial studies. 2018 saw us consolidate our work for the NIHR programme grant into the early detection of psoriatic arthritis and the value of such in terms of outcome. We are one of four centres recruiting nationally. In addition to this we are starting to work more collaboratively with Leeds and so we are now beginning to extend the scope of our research into connective tissue diseases which are particularly prevalent in the Bradford area.

Stroke Research

Research is an integrated part of stroke care. At the recent internal Acute Stroke day a teaching session was delivered by the research team. The overall aim of the session was for staff to understand how they are involved with research by 'delivering evidence based care for stroke survivors at Bradford'.

This session covered an overview of the National (NHS England), Regional (NIHR CRN) and Local (Bradford Teaching Hospitals NHS Foundation Trust) drivers, the plans and strategies, followed by how results are disseminated and how this is transferred to practice.

At the end of the session the care staff could say why research is important and how it is part of their job. Positive reviews and staff discussion about the training day was on face book and twitter.



3.7 SERVICE IMPROVEMENT PROGRAMME

The Bradford Improvement Programme is designed to empower colleagues and engender behaviours that lead to irreversible improvements to patients' experience and outcomes.

The Programme represents a balanced portfolio of actions to address value and efficiency; team performance and colleague wellbeing; safety and reliability of care.

During 2018/19 the Bradford Improvement Programme focused on three key areas:-

- Urgent & Emergency Care Improvement
- Elective Care Improvement
- Better Notes, Better Care

3.7.1 URGENT AND EMERGENCY CARE IMPROVEMENT

The Urgent and Emergency Care Improvement Programme is aimed at better understanding and managing patient flow, predominantly in support of patients attending our Emergency Department and those subsequently admitted on a non-elective basis.

Ambulance Handover Performance

Over winter the ambulance handover process has been supported by a Yorkshire Ambulance Service (YAS) (Hospital Ambulance Liaison Officer (HALO) to help improve the handover of all ambulance conveyed patients. The HALO has ensured that ambulance crews follow the correct process for handover and has ensured that crews are back 'on the road' as soon as practically possible. This has been a great asset to the department.

Work has also been undertaken to look at how the Emergency Department manages the assessment and placement of this group of patients to the most appropriate area within the Emergency Department. Increased staffing in the area and a dedicated porter has meant that a rapid handover can be undertaken, appropriate clinical stabilisation and the patient taken directly to the correct area by the porter. Staff have been involved in embedding the "fit to sit" principle, moving appropriate patients from the trolley into a seating area and encouraging "self-handover" of the patient in main reception.

These activities have contributed towards a reduction of ambulance crews queuing in the assessment area and an improvement in the handover turnaround performance. Year to date the 'ambulance turnaround in less than 15 minutes' is running at 85.25% and breaches over 60 minutes have fallen by 50%.

Streaming

The streaming project aims to ensure that patients are referred to the correct area for assessment and treatment. This project is focused on 3 key areas: initial navigation & streaming, use of same day emergency care and admission avoidance.

A number of pilots have been undertaken to agree the most effective method of streaming patients to the right service within ED or elsewhere within the hospital. The navigation and streaming involves a senior nurse being based in the main access area in the ED department and before registration speaking with the patient to determine the most appropriate setting for their care. Patients arriving with GP letters are directed to the appropriate specialty without having to wait for 'triage'; and patients with minor illnesses or injuries are directed to Green Zone to be seen by a GP or Emergency Department Practitioner. Feedback from patients, nursing staff, and reception staff has been extremely positive and as a result the navigation nurse is now a protected role with effect from the 1 April 2019 between the hours of 10:00 – 22:00 hours.

Work has been undertaken with the Yorkshire Ambulance Service (YAS) around admission avoidance and assurance has been gained that the patients being conveyed are those who will require emergency care. Further work will continue with the support of the Department of Health, Emergency Care Intensive Support Team (ECIST), to look at other primary care service areas and how they can be improved to support admission avoidance.

Green Zone - GP & Minors Unit

The Green Zone has been established to bring together the minor injuries service of the Emergency Department and the Primary Care streaming service which is provided by Bradford Care Alliance, Kensington Street Surgery and Clarendon Medical Centre. The Primary Care Streaming service was launched in November 2017 and its aim is to move suitable patients from the Emergency Department into primary care, where their needs will be best addressed. This is an alternative route for patients with conditions suitable for management by a GP. An area within the Emergency Department footprint has been refurbished to allow the co-location of these two services.

Ten flexible clinical rooms have been developed; a designated reception area and two waiting areas have also been refurbished. Green Zone accommodates approximately 130-140 patients per day including an average of 40 patients being treated through the Primary care Streaming service between the hours of 12.00-00.00, thereby supporting patient flow and waiting times in the Emergency Department.

Blue Zone – Same Day Ambulatory Emergency Care

Work on increasing the use of same day emergency care commenced with a multi-disciplinary workshop in December 2018 where it was agreed that the following pathways were a priority:

- low risk pulmonary embolism
- cellulitis
- low risk Chest Pain
- headaches and acute neurology

All the pathway redesign work has been clinically led with the full involvement of the services.

There are several additional streams being worked on by the senior leadership team to address medical admission avoidance and reduction in the length of stay. These include:

- the development of Consultant Led hot clinics which will enable patients requiring medical assessment to be given an urgent clinic appointment rather than be admitted to hospital.
- nurse led returners' clinics which will enable patients to be discharged from hospital but to return to follow up clinics to continue treatment or follow up care.

Further improvement work is underway to increase the proportion of patients who are referred by their GP or who attend the Emergency Department and require surgical assessment to be assessed and treated on a Surgical Emergency Ambulatory Care pathway, avoiding the need for overnight admission to hospital.

Long Length of Stay (LLOS) Patients

The Trust faces a continuing challenge with ensuring sufficient bed capacity is available to manage acute demand, particularly during the winter months.

In line with the national priority set out by NHS England to reduce the number of patients in hospital with a length of stay greater than 21 days by 24% in 2018/19; the Trust was allocated an improvement target of no more than 55 patients with a length of stay over 21 days by 31 March 2019.

The Trust has increased the focus and monitoring of 'Long Length of Stay' (LLOS) patients which has resulted in improvement to a number of processes including:

- implementing a twice weekly multi-agency ward round to review each patient's plan of care to ensure robust pathway management and effective discharge planning

- increased focus in the multi- agency complex discharge meeting to promote early identification of patients with complex needs or who may require post discharge health or social care support. This is to ensure early planning and effective discharge co-ordination
- implementing a daily long length of stay report identifying patients who are still in hospital at seven, fourteen and twenty one days to enable matrons to maintain oversight of pathway management and take targeted action to prevent unnecessary discharge delay
- a system wide 'Work as One' week was held during the week of 25-29 Jan 2019 to work together with health and social care system partners to identify blockages that prevent us managing patient flow effectively across the whole system and to identify opportunities for new and improved ways of working. This was a real success and demonstrated the positive outcomes which could be achieved through whole system partnership together
- education and training sessions on best practice in the management of LOS commenced for all Clinical staff.

As at 31 March 2019 the number of patients within the Trust with a length of stay greater than 21 days was 70.

Emergency Care Intensive Support Team (ECIST) Whole System Enquiry Visit

The Emergency Care Intensive Support Team was invited by the Trust to undertake a whole system enquiry with system partners to identify areas of opportunity and development to support delivery of the Emergency Care Standard.

The review took place over three days in December 2018 following which a report was received that outlined a number of recommendations of areas for improvement.

ECIST have also supported the Trust in our Emergency Care Improvement Programme including ambulance handover processes, streaming within the emergency department and implementation of the ECIST model for review of stranded patients (patients with a length of stay in excess of twenty one days).

Command Centre

The Command Centre Transformation Programme was established in 2018 to deliver sustainable improvements in how the Trust manages patient flow and makes best use of Trust capacity, infrastructure and staff resources.

The Command Centre will help Bradford transform the delivery and organisation of care in the face of ever-increasing patient numbers. It will help the Trust reduce waiting times, treat more patients, improve their experience, reduce pressure on staff and help identify and mitigate clinical risk.

It will also help to reduce unnecessary time spent in hospital after a patient is medically ready to leave, increase the proportion of patients who arrive and are admitted, transferred or discharged from Accident and Emergency (A&E) within four hours, and help ensure that patients are always treated in the wards best suited to manage their care.

The Command Centre will draw information in real time from a range of source systems including EPR; process that data using advanced algorithms and display new intelligence on custom-built analytic Tiles. These analytic tiles will be displayed across a mosaic of fifty five inch video monitors to form the Command Centre's Wall of Analytics. Analytic Tiles allow more timely and relevant information on patients, beds, diagnostics, and other factors that impact care and throughput, providing a much better understanding of current and predicted operational pressures than is currently available from any one system.

The Tiles are currently under development and will be introduced in a phased way between April and September 2019. The first seven of eight Tiles have now been designed with the first Tile becoming operational in June 2019. An additional Tile will be implemented each month after that until all eight Tiles are operational by March 2020. Each tile has been designed by the staff who will use the data and will be supported by detailed operating procedures and escalation processes. As each tile 'goes live' there will be robust testing of the tile data, procedures and staff training to ensure the whole system is implemented smoothly.

The Command Centre physical space is now open and the clinical site team have relocated to the new working area. It enables appropriate staff to be co-located to work together to manage patient flow across the hospital.

This is an exciting development for the Trust and allows us to be the first healthcare organisation in Europe to develop an AI-powered Command Centre and to use this capability to achieve new levels of operational excellence - meeting the needs of our patients and supporting our staff. Through this programme we will apply the latest digital innovation and proven best practices to optimise patient flow and enable real-time co-ordination of care for each and every patient. This programme is complementary to the EPR implementation (Cerner) and to BTHFT's developments in business intelligence.

3.7.2 ELECTIVE CARE IMPROVEMENT

The objective of this programme is to improve timely access for patients requiring elective treatment by ensuring our operating theatres are safe, effective and efficient.

- **Orthopaedics**

  A key focus of the orthopaedic work stream has been to ensure that patients have optimal, timely access to treatments and in doing so reduce overall waiting times for patients.

  Ward 28 is the elective inpatient ward for Orthopaedics. In previous years attempts to mitigate the effects of 'Winter Pressures' have resulted in the temporary cessation of elective orthopaedic surgery with Ward 28 being used to cope with demand for increased emergency admissions. A decision was taken to 'ring-fence' these beds from April 2018 with no reduction in planned elective surgery.

  Drawing on work initiated as part of the Orthopaedic West Yorkshire Association Acute Trust collaborative, clinicians operate morning and afternoon back-to-back seamless sessions. This entails flexible scheduling of staff around lunch-breaks and prevents the middle of the day down-time as one list finishes and a new list starts, creating additional capacity for an additional arthroplasty case (four cases per list in total).

  Similarly, seamless arthroscopy lists have resulted in there being insufficient patients waiting to continue running the high volume lists. Plans are in place to further communicate the minimal waiting times and improved access for these procedures.

  A Hand Unit model was also trialled successfully with two Consultants sharing capacity across parallel theatres. This team approach resulted in an increase in two patients treated per parallel session and a business case is in development to further develop and sustain this model.

  The above initiatives are expected to deliver an additional 200 surgical cases in orthopaedics by the end of March 2019.

- **Forward Wait Area - Nucleus Theatre**

  Bradford Royal Infirmary has several blocks of operating theatres. The layout of multiple theatre blocks creates inefficiencies in theatre utilisation due to delays in patient transfer between wards and theatres. To address this, the Trust is implementing a new 'forward-wait' area for Urology and Gynaecology patients to reduce delays between theatre cases.

- **Operating Department Practitioner (ODP) Apprenticeships**

  ODPs are key members of the theatre team. There is a recognised national shortage of ODPs. In an attempt to recruit into the persistent vacancies for ODPs ten apprenticeship posts have been created from existing vacancies. All posts have been recruited into and staff commenced work at the Trust in January 2019.

- **Outpatient Improvement Programme**

  The aim of the Outpatient Improvement Programme is to improve the utilisation of our outpatient clinics and to reduce the number of unnecessary outpatient attendances at hospital. Examples of some of the improvement work streams include:

  - *SMS 2-Way Text Messaging, Booking and Clinic Utilisation Tool*

    A new two-way SMS Text confirmation service was introduced in September 2018. This allows patients to let us know they will or will not be attending their outpatient clinic appointment; it also acts as a reminder to attend.

  - *Virtual Clinics*

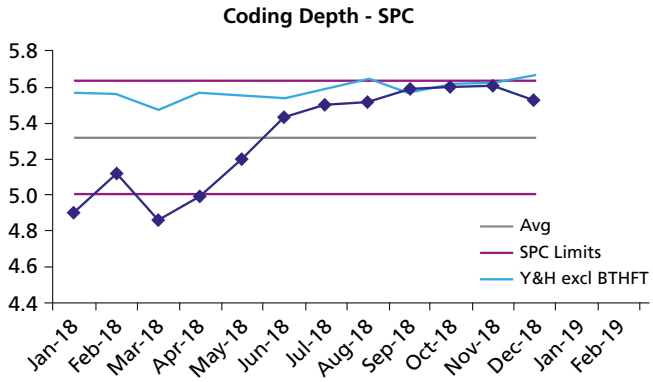
    In December 2018 a trial of virtual clinics was implemented. This involved converting the traditional four hour face to face clinic to a combined 3hr face-to-face Clinic plus a 1hr telephone assessment Clinic. Analysis has shown an aggregate increase of two follow-up appointments per session

BETTER NOTES BETTER CARE

In September 2017 the Trust went live with its new Electronic Patient Record system. Lessons learnt from previous implementations of the same system highlighted a risk to the detail and depth of the clinical coding of patients notes during the immediate post-implementation of such a system. By working as a multidisciplinary team to complete Problems and Diagnoses within Powerchart we are starting to see EPR as an effective tool for communication during handover, on ward rounds and between inpatient and outpatient encounters. As a result since September 2017 we have achieved a progressive increase in the number of diagnoses recorded. This is despite regional and national trends that have seen a decline in the same period.

Thanks to this global effort to improve documentation, by March 2019 the number of secondary diagnoses (sub-diagnoses) recorded per admission had risen by 30% from the 2017 baseline. This improvement has elevated Bradford Teaching Hospitals ranking from 114 of 135 to 61 of 132 acute trusts with respect to depth of coding since 2017.

Figure 49: Coding Depth - SPC



We are now beginning to truly demonstrate the complexity of the patients we are treating. Having a complete picture allows us to channel resources to areas where they are most needed; invest effectively where demands are greatest; and gain credit locally and nationally for the safe, effective and compassionate care we provide.

3.7.3
WORKFORCE IMPROVEMENT

Apprenticeships

In 2018/19 we have recruited 141 apprentices across 17 different apprentice standards at various qualification levels up to degree level. We have recruited an apprenticeship coordinator who has focussed on engagement with staff and managers within the organisation to utilise apprenticeship to meet the learning needs of their existing staff and to recruit new staff in to post.

A review by the Education and Skills Funding Agency (ESFA) has highlighted that of the apprentices we recruited

- 42 apprentices were from a BAME background
- 94 apprentices were from a disadvantaged area
- 19 apprentices had a learning disability or a learning difficulty

This has been highlighted as excellent by the ESFA and we have been invited to be part of a national and local ambassador network for employer diversity champions and we have been asked to share our story.

Agency Staff

As part of improving workforce and reducing reliance on external agency staff, we have an internal nursing and medical bank. This helps with the quality of care as internal staff are more familiar with procedures, processes, culture and care delivery requirements. Review meetings take place with agencies to help ensure where agency staff are used, they are providing the care and services needed. The Trust only uses NHS framework approved agencies that ensure all mandatory training is completed and their agency workers are fully compliant before working shifts.

Attendance Management

Staff health and wellbeing is an important factor in being able to provide high quality care to patients. Development of attendance management training as part of the management development programme was initially launched in 2018 in collaboration with our Organisational Development Team. This training will be revisited in quarter two of 2019/20 following the review of the attendance policy to focus more explicitly on health and well-being support. This fits in with "Our People Strategy" launched in 2017. This focuses on creating a supportive, diverse and engaging environment for our staff. Attendance officers continue to provide direct support to help manage sickness absence and the Occupational Health Manager appointed in 2018 is working closely with HR and Organisational Development to support a calendar of health and well-being events for 2019.

3.7.4
INTEGRATED EDUCATION SERVICE

The Trust's vision is to be "an outstanding provider of healthcare, research and education." The Clinical Services Strategy describes how we will develop our clinical services consistent with this vision, to meet the health needs of the people of Bradford and West Yorkshire. Improved organisational performance, clinical outcomes and patient experience can only be delivered through people. The Board is committed to develop its staff and the next generation of healthcare professionals to deliver the high quality patient care that is the cornerstone of its ambitions and strategic goals.

BTHFT is proud of its Teaching Hospital status and reputation of excellence in provision of clinical placement activity for a whole range of students and trainees from across the healthcare professional groups.

The Education Plan 2019 – 2024, launched in January 2019, sets out how BTHFT will ensure the workforce has the right skills and knowledge to meet the current and future challenges whilst delivering high quality care. It will ensure that the Trust is focussed on developing a flexible workforce that can meet the challenges of the next 5 years, be able to adapt to change and transfer skills into new and different roles as required. The plan targets 2 key groups of staff;

1) BTHFT employees
2) Staff and students undertaking health care professional training.

The objectives within the Education Plan are closely aligned to the HEE Quality Framework to ensure that we are implementing, monitoring and meeting all the quality standards for all learner groups within the healthcare system. The key objectives are:

- to develop a competent, capable, caring and sustainable workforce
- to provide high quality multi-professional training
- to develop excellence in the provision of patient safety training
- to provide high quality learning environments with a culture of lifelong learning
- to support and empower educators, trainers, mentors, supervisors
- to ensure effective governance for all education and maximize the use of resources and funding to support delivery of the plan

An annual implementation plan is being developed and oversight of the implementation will be monitored via the Education and Workforce subcommittee. The structure of the Education Service is that of an integrated service with a Director of Education and Head of Education providing leadership, oversight, quality improvement and quality assurance across postgraduate and undergraduate medical, pre-registration and post-registration non-medical, as well as apprenticeships and staff in bands 1 – 4. A named executive and board member has overall responsibility for the Education Service with additional professional leadership from another board member.

The educational governance arrangements are robust, focused on improving the quality of education and training and are integrated within the overall corporate and clinical governance structures.

We have very good engagement with clinical colleagues, educators and mentors and work closely with them to ensure high quality learning environments for all our students/ trainees. Where we have evidence or feedback to suggest improvement is required action plans are developed in collaboration with the clinical teams to address the issues, with appropriate escalation through the governance structure.

There is a focus on creating a learning culture within the organisation which is clear from the Trust vision and strategy. To support this, appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

Educators receive the support, resources and time to meet their education, training and research responsibilities.

Our top 3 successes as a service are;

- integrated education service with a named executive lead and a clearly defined education plan provides strategic oversight and management of the education service
- excellent student and trainee feedback with high levels of satisfaction reported across all professional groups
- increasing placement capacity and student numbers across the board alongside provision of placements and support to students in new roles such as physicians associates, nursing associate and advanced clinical practitioners

Our 3 Key Challenges

- supporting and managing the totality of the demands on clinical supervisors, mentors and placement areas whilst maintaining the quality of education provision. This includes the additional demands of supporting staff in new roles
- financial constraints and staffing levels within the clinical areas is beginning to impact on trainer/ mentor engagement
- clarification required for new roles and where they will be aligned to within HEE in terms of professional oversight and educational governance

Figure 50: 2018 – Year of Achievement

3.8 KEEPING EVERYONE INFORMED

Our Trust is a special place to work. While we're a large regional centre recognised for clinical excellence, we're also known for our friendly and inclusive culture. People come to work here to care for our patients and progress their careers – and stay because they become part of our 'Brilliant Bradford' family.

We are proud of our people and our culture – which is built on our shared values – we care, we value people, we are one team. Our workforce is the most important asset we have. We understand the importance of communicating with our staff, because an engaged workforce delivers better patient outcomes.

We are significantly improving communications to our people, our patients and the wider public in many different ways, to increase knowledge and awareness of the work of the Trust.

Last year we carried out extensive engagement with our staff, Foundation Trust members, Governors and other stakeholders including local GPs about how we communicate with them – what works well and how we could improve.

This year, as a direct result of their feedback, we have been implementing a new communications strategy which focuses on the way we communicate – how we get the right messages out, at the right time, to the right audience in a format that suits them.

Our staff value our weekly bulletin 'Let's Talk' from the Chief Executive. It keeps them up-to-date with news, views and latest developments across the Trust.

We also use email, the intranet, screensavers, as well as regular walkarounds and Let's Talk Live face-to-face sessions with the Chief Executive and individual directorate briefings.

As a result of staff feedback, we have implemented screen-based information channels across our sites. Displaying key messages and celebrating our monthly staff awards, the screens keep staff and members of the public up to date with our latest achievements.

By engaging effectively with our staff, we believe people will be proud to say they work for Bradford Teaching Hospitals, and recommend it to others as a place to develop their career and to be treated here. We have used our brand new-look website to showcase our world-leading achievements, our excellent reputation for research performance, and the services we provide and the staff who deliver them.

ANNEX 1:
STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

Healthwatch Bradford and District

16 April 2019

Healthwatch Bradford and District welcome the opportunity to comment on Bradford Teaching Hospitals NHS Foundation Trust's Draft Quality report. Healthwatch has an established and positive relationship with the Trust which we will continue to build on in the coming year.

The report sets out a lot of positive action taken in 2018/19 to improve quality at the Trust, and we congratulate staff on these achievements and their on-going commitment to excellent patient care, particularly given the challenging environment facing the NHS locally and nationally.

Healthwatch is supportive of the Trusts priority areas for the coming year and that these are commensurate with the Care Quality Commission recommendations detailed in the 2018 inspection report. Healthwatch additionally believes that the priorities are challenging enough to drive improvement in the future.

Over the past year, Healthwatch Bradford and District has gathered views and experiences of care at the Trust from service users, and their families and carers. People share their experiences both good and bad with Healthwatch Bradford and District and feedback was collected through: outreach sessions at both the Bradford Royal Infirmary and St Luke's Hospital; outreach sessions held with community groups and members of the wider public; patients and carers contacting us directly.

An analysis of the feedback Healthwatch Bradford and District has received over the past year has highlighted:

- Reduction in negative sentiment and more positive sentiment from feedback in 2018 than in 2017.
- Negative feedback was more prevalent amongst the younger and older end of the age spectrum.
- Male and female genders had similar levels of positive sentiment. However females had significantly higher negative sentiment than males.
- Pakistani and White British groups have very similar profiles on sentiment. Other ethnic groupings (treated as a single group in our analysis) exhibited greater negative sentiment.
- St Lukes had slightly higher positive feedback and Bradford Royal Infirmary had the most negative feedback in 2018

In respect to the themes of feedback received by Healthwatch Bradford and District:

- Quality of treatment, Quality of care and Staff attitudes were the three most common and consistent key themes, Quality of care receiving the greatest number of comments in 2018.
- The least well performing theme was that of communication between staff and patients.
- We saw the highest positive sentiment for Service delivery. Quality of care and Quality of treatment scored frequently and well.

Referring to the above reported patient experience of staff to patient communication we recommend that the stated on-going work to define the patient experience collaborative for 2019/20 considers this feedback in its developments.

We are encouraged by the Trusts continued commitment to patient involvement and engagement and welcome the five year Patient Involvement Strategy that will underpin this area of work. We note the statement (page 70) regarding new standards and frameworks for patient and public involvement have recently been published which will be reviewed and applied appropriately to our approach to involvement and we recommend it would be beneficial to state what these are with the inclusion of a timeline for inclusion.

At Healthwatch Bradford and District we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback. We note that the Trust is using various ways to communicate with staff and service users regarding how their feedback is used to make changes and improvements. We therefore welcome the Trusts commitment to ensuring the "you said we did" initiative is embedded across all wards and departments. We particularly welcome the Trusts commitment to the Quality Improvement Capability Building initiative and the Walk-round Leadership programme and look forward to seeing the impact of these in the 2020 quality report.

The Trusts commitment to patient involvement is further evidenced by the PLACE programme and Healthwatch Bradford and District acknowledges the work that has contributed to improvement in PLACE results across all domains.

Healthwatch Bradford and District Bradford and District will continue to listen to people's experiences of care and feeding these back to the Trust. We look forward to working with the Trust to ensure that these experiences remain central to its approach to quality improvement.

Neil Bolton-Heaton
Manager

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Bradford Teaching Hospitals NHS Foundation Trust Quality Report 2018/19

On behalf of NHS Bradford District and Craven CCGs, I welcome the opportunity to feedback to Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) on its Quality Report for 2018/19.

The NHS recently marked its 70th Anniversary; this is a key time to reflect upon achievements across partnerships and look forward to new ways of working, which crucially harnesses the power of people and communities. The Trust has been a key partner in delivering ongoing care and improvements to the population of Bradford District and Craven and has demonstrated a year of progress, driven by a continued commitment to place quality improvement at the very heart of the organisation, from floor to board.

First congratulations on some of the Trust's key achievements during 2018/2019. These include:

- Innovation for Improvement - the Trust launched Europe's first AI command centre, to collect 'real time' data to improve patient flow which will be pivotal in meeting increasing demand for care
- The Project SEARCH team won the top prize in the Healthcare People Management Awards for cross-sector working in recognition of their work helping young people with learning disabilities gain vital on-the-job work experience ahead of finding employment
- The Emergency Department won the King's Fund prize (*Patient Safety Learning award*) for its work on improving the care of deteriorating patients
- The emergence of new clinics to improve the experience of urology and early arthritis patients has been a great success
- The Royal College appreciation of the Postgraduate Medical Education Team in recognition of assistance in running its prestigious medical exams
- The Children and Young Persons' Ambulatory Care Experience won the Improvement in Emergency and Urgent Care category in the HSJ awards for bringing care to young patients in the comfort of their own home preventing unnecessary admissions

I also welcome the news of initiatives which strengthen the way we work as a broader system. These include:

- The system has been working together to improve the way stroke services are delivered across BTHFT and ANHSFT delivering a real improvement in stroke care to our patients (The latest report showed that BTHFT had improved to a grade 'B' for both patient and team centred results). The appointment of system wide posts and single governance and reporting arrangements is positive.
- The first 'Work as One' week was held involving commissioners, Trust colleagues and Local Authority partners to understand how partners can work together better to improve the way our patients move between the hospital and communities.

CCGs working together

NHS Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

- The embedding of the Electronic Patient Record (EPR) continues to improve the ways of working and care delivery and access to real time data across the Trust and I note the arrival of a new CT scanner will strengthen the Trust's ability to perform more complex scans and improve care management.
- The pending opening of the Wolfson Centre for Applied Research, to drive improvements in the health and wellbeing of adults and children will further embed Bradford reputation as a City of Research.

However, the pressures and challenges continue around the achievement of the Emergency Care Standard, urgent care services, recruitment and retention of a skilled workforce, delivery of the 18 week targets and emergency readmissions. This picture is mirrored nationally.

Disappointingly the Trust reported three Never Events during 2018/19 and a CQC fixed penalty notice was also enforced in response to a breach in the Duty of Candour Regulation.

I note that following a CQC inspection earlier in 2018, BTFHT has an overall rating of '*Requires Improvement*' for the services inspected and the Trust was rated as 'Good' in the well-led domain. I understand that the Trust is reporting progress against their CQC improvement action plan and has started planned bi-monthly engagement visits with the CQC to review areas for improvement. The Trust has also implemented an executive committee that reviews CQC actions and highlights areas of good practice and/or areas for improvement.

Bradford is a young city with high levels of deprivation and the Trust's maternity services continue to face a high demand. The Trust continues to make progress against the CQC maternity services improvement action plan and I note the significant amount of work which has already been undertaken by your staff to date. I welcome your proactive approach with the commissioners and regulators to agree a joint approach to quality improvement and surveillance within the service.

The Trust achieved its ambition to implement an effective system mortality review during 2018/19, leading nationally on the Structured Mortality Review process and have plans in place to progress this further.

BTHFT has identified six priority areas for 2019/2020; five of the priority areas are a continuation of the previous year in recognition that there are still more improvements required. These are:

- Management of the deteriorating patient
- Reducing pressure ulcers
- Safer procedures
- Patient experience
- Medication safety

A new priority area for 2019/20 includes:

- Learning from each other by increasing showcasing, sharing and learning from improvements and good changes.

The report includes a review of last year's priorities and I note the improvements the Trust has achieved against these which include:

- The deteriorating patient: a 11% reduction in crash calls and 16% reduction in medical emergency calls
- Pressure ulcers: a 50% reduction of category 2 pressure ulcers on the two focussed wards
- Safer procedures: an improvement in compliance with theatre checklists
- Patient experience: the creation of a patient collaborative in line with the 2018-23 patient experience strategy
- Medication safety: the introduction of pharmacy assistants to facilitate improved medicines management.

Other initiatives include:

- Introduction of a learning hub to promote lessons learned from incidents
- A collaborative for falls prevention resulting in a 15% reduction in the twelve pilot wards.
- Inclusion in the Red Bag Hospital Transfer Pathway to improve the experience for older people in care homes

I would welcome reference to the Trust's community intermediate care services provision in future quality reports as we recognise the importance of the Trust's crucial role in care out of hospital.

I can confirm that the Trust's statements of assurance have been completed demonstrating achievements against essential standards.

BTHFT has committed to working as one system to integrate care locally and is a key member of the Bradford Health Care Partnership Board and actively supports local community partnerships. Demonstrable progress has been made towards utilising the opportunities a shared system will bring involving other partners which includes the work of the acute provider collaboration.

I look forward to continuing to work with you and other partners across the health and social system to ensure that local people will be healthier, happier, and have access to high quality care that are clinically, operationally and financially stable.

I recognise that the workforce remains hugely committed to meeting the needs of the local population in a year of both progress and pressures. I commend the Trust's ongoing commitment to improve the quality and safety of the care that our communities receive.

Finally I confirm that I believe this report to be a fair and accurate representation of BTHFT's achievements and commitments to improve the safety and quality of care of their services.

Helen Hirst

Chief Officer
NHS Airedale, Wharfedale & Craven,
Bradford City & Bradford Districts CCGs

OVERVIEW AND SCRUTINY COMMITTEE

Due to the timing of the local elections this year, the Overview and Scrutiny Committee have opted not to provide comments on the 2018/19 Quality Report.

ANNEX 2:
STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

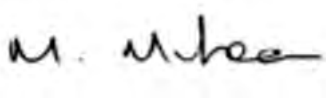
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

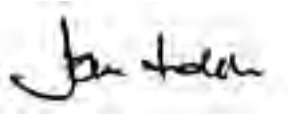
- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from Commissioners dated 23 April 2019
  - feedback from Council of Governors. The draft Quality Report was circulated to Governors but no comments were received
  - feedback from local Healthwatch organisations dated 16 April 2019
  - feedback from Overview and Scrutiny Committee, Bradford Metropolitan District Council dated 23 April 2019 confirming they would not be providing comments
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2018 (Q1), November 2018 (Q2) and February 2019 (Q3)
  - the latest national patient survey
  - the latest national staff survey
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 21 May 2019
  - CQC inspection report dated 15 June 2018
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board



Dr Maxwell Mclean,
Chairman
Date: 24 May 2019



John Holden,
Acting Chief Executive
Date: 24 May 2019

Annex 3: Independent Auditor's Report to the Council of Governors of Bradford Teaching Hospitals NHS Foundation Trust on the Quality Report

Independent auditor's report to the council of governors of Bradford Teaching Hospitals NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Bradford Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Bradford Teaching Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Bradford Teaching Hospitals NHS Foundation Trust as a body, to assist the council of governors in reporting Bradford Teaching Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Bradford Teaching Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in Statement of Directors' Responsibilities for the Quality Account; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from Commissioners, dated 23 April 2019;
- feedback from local Healthwatch organisations, dated 16 April 2019;
- feedback from Overview and Scrutiny Committee, dated 23 April 2019;
- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2018 (Q1), November 2018 (Q2) and February 2019 (Q3);
- the latest national patient survey;
- the latest national staff survey;

Independent auditor's report to the council of governors of Bradford Teaching Hospitals NHS Foundation Trust on the quality report (continued)

- Care Quality Commission inspection report, dated 15 June 2018; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 21 May 2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Bradford Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in Statement of Directors' Responsibilities for the Quality Account; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP

Deloitte LLP
Newcastle
24 May 2019

APPENDIX A: NATIONAL QUALITY INDICATORS

Domain	Preventing people from dying prematurely	
Indicator	SHMI value and banding (Oct 2017 - Sep 2018)	
Latest available reported position	SHMI value = 0.9086	Band 2 As expected
National Average	1	Band 2 As expected
Where Applicable – Best Performer		
South Tyneside NHS Foundation Trust	SHMI Value = 1.2681	Band 1 - Higher than expected
Where Applicable – Worst Performer		
Homerton University Hospital NHS Foundation Trust	SHMI Value = 0.6917	Band 3 - Lower than expected
Trust Statement		
Bradford Teaching NHS Foundation Trust is proud of the high quality care all the staff give to all our patients which is reflected in our low mortality rate. The Foundation Trust has the second lowest mortality rate in the West Yorkshire region and ranks around 20th in having one of the lowest mortality rates nationally. *In line with National Guidance on learning from Deaths, the Foundation Trust has actioned in depth case note reviews using Structured Judgement review methodology. The learning from these reviews including serious incident investigations are used to drive our quality improvement programmes and the training we deliver. Some of the Quality improvement programmes include; recognition of the deteriorating patient, sepsis care, safer invasive procedures and pressure ulcer prevention. We carry out mortality surveillance which involves a complete analysis of our mortality data and also involve the bereaved in the review of care.*		
Currently reported position for 2017/2018	0.926 Band 2 As expected	
Currently reported position for 2016/2017	0.926 Band 2 As expected	
Currently reported position for 2015/2016	0.978 Band 2 As expected	
Currently reported position for 2014/2015	0.971 Band 2 As expected	
Currently reported position for 2013/2014	0.963 Band 2 As expected	
Currently reported position for 2012/2013	0.999 Band 2 As expected	
Currently reported position for 2011/1012	0.953 Band 2 As expected	

Domain	Enhancing quality of life for people with long-term conditions
Indicator	% patients deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period (Oct 2017 - Sep 2018)
Latest available reported position	Combined Rate - 25.1
National Average	33.6
Where Applicable – Best Performer	
Royal Surrey County Hospital NHS Foundation Trust	59.5
Where Applicable – Worst Performer	
The Queen Elizabeth Hospital, Kings' Lynn, NHS Foundation Trust	14.3
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust has an advisory palliative care team available to the wards which sees approximately 60 patients per month. *The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by taking steps to improve the recognition of patients that are in the last years of life, improving the sharing of information between primary and secondary care relating to palliative care patients and implementing the five priorities for the care of the dying.*	
Currently reported position for 2017/2018	Combined Rate - 26.6
Currently reported position for 2016/2017	Combined Rate - 31.6
Currently reported position for 2015/2016	Combined Rate - 22.37
Currently reported position for 2014/2015	Combined Rate - 18.7
Currently reported position for 2013/2014	Combined Rate - 18.7

Domain	Helping people recover from episodes of ill health or following injury
Indicator	Patient reported outcome scores for groin hernia surgery
Latest available reported position	No provisional data available for 2017/18
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust no longer participates in this therefore no information is available.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	0.093 (Not an outlier)
Currently reported position for 2015/2016	0.082 (Not an outlier)
Currently reported position for 2014/2015	0.103 (Not an outlier)
Currently reported position for 2013/2014	0.091 (Not an outlier)
Currently reported position for 2012/2013	0.086 (Not an outlier)
Currently reported position for 2011/1012	0.114 (Not an outlier)

Indicator	Patient reported outcome scores for varicose vein surgery
Latest available reported position	No provisional data available for 2017/18
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust no longer participates in this therefore no information is available.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	0.089 (Not an outlier)
Currently reported position for 2015/2016	0.118 (Not an outlier)
Currently reported position for 2014/2015	0.053 (Not an outlier)
Currently reported position for 2013/2014	0.104 (Not an outlier)
Currently reported position for 2012/2013	0.098 (Not an outlier)
Currently reported position for 2011/1012	0.085 (Not an outlier)

Indicator	Patient reported outcome scores for hip replacement surgery (2017/18 data)
Latest available reported position	0.444 (Not an outlier)
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to safer procedures. *The performance is due to a low response rate, the actions agreed to improve this are that we are now picking this up with patients as part of the Enhanced Recovery programme which is underway in the Arthroplasty service. The aim of which is to improve both response rates and data quality going forward.*	
Currently reported position for 2017/2018	0.444 (Not an outlier)
Currently reported position for 2016/2017	0.442 (Not an outlier)
Currently reported position for 2015/2016	0.445 (Not an outlier)
Currently reported position for 2014/2015	0.439 (Not an outlier)
Currently reported position for 2013/2014	0.416 (Not an outlier)
Currently reported position for 2012/2013	0.39 (Negative)
Currently reported position for 2011/1012	0.371 (Negative)

Indicator	Patient reported outcome scores for Knee replacement surgery (2017/18 data)
Latest available reported position	0.305 (Not an outlier)
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to safer procedures. *The performance is due to a low response rate, the actions agreed to improve this are that we are now picking this up with patients as part of the Enhanced Recovery programme which is underway in the Arthroplasty service. The aim of which is to improve both response rates and data quality going forward.*	
Currently reported position for 2017/2018	0.305 (Not an outlier)
Currently reported position for 2016/2017	0.326 (Not an outlier)
Currently reported position for 2015/2016	0.304 (Not an outlier)
Currently reported position for 2014/2015	0.341 (Not an outlier)
Currently reported position for 2013/2014	0.321 (Not an outlier)
Currently reported position for 2012/2013	0.297 (Not an outlier)
Currently reported position for 2011/1012	0.289 (Not an outlier)

Domain	Helping people to recover from episodes of ill health or following injury
Indicator	28 day readmission rate for patients aged 0 – 15
The data made available to Trusts for reporting has not been updated since last year's Quality Account.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	
Currently reported position for 2015/2016	
Currently reported position for 2014/2015	
Currently reported position for 2013/2014	(2011/12) 8.04%
Currently reported position for 2012/2013	(2010/11) 7.23%
Currently reported position for 2011/1012	(2009/10) 6.94%

Indicator	28 day readmission rate for patients aged 16 or over
The data made available to Trusts for reporting has not been updated since last year's Quality Account.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	
Currently reported position for 2015/2016	
Currently reported position for 2014/2015	
Currently reported position for 2013/2014	(2011/12) 12.38%
Currently reported position for 2012/2013	(2010/11) 11.93%
Currently reported position for 2011/1012	(2009/10) 11.16%

Domain	Ensuring that people have a positive experience of care
Indicator	Responsiveness to inpatients' personal needs: CQC national inpatient survey score (2017/18 data)
Latest available reported position	74.5%
National Average	78.4%
Where Applicable – Best Performer	
The Clatterbridge Cancer Centre NHS Foundation Trust	(88.9%)
Where Applicable – Worst Performer	
Barts Health NHS Trust (71.8%)	(71.8%)
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has continued to focus on a programme of work to improve the patient experience through the Patient First Committee. In November 2018, Bradford Teaching Hospitals NHS Foundation Trust launched a Patient Experience Strategy: Embracing Kindness, which sets out our approach to enable all our staff to improve the care we provide, and help us to deliver our ambition of providing outstanding care for all our patients.	
Currently reported position for 2017/2018	74.5%
Currently reported position for 2016/2017	75.6%
Currently reported position for 2015/2016	73.8%
Currently reported position for 2014/2015	74.5%
Currently reported position for 2013/2014	75.2%
Currently reported position for 2012/2013	71.5%
Currently reported position for 2011/2012	74.2%

Indicator	Percentage of staff who would recommend the provider to friends or family needing care (2018 Staff Survey)
Latest available reported position	67.7%
National Average	70.0%
Where Applicable – Best Performer	
Liverpool Heart and Chest Hospital NHS Foundation Trust	92.4%
Where Applicable – Worst Performer	
Norfolk and Suffolk NHS Foundation Trust	43.2%
Trust Statement	
The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has continued to focus on a programme of work to improve the patient experience through the Patient First Committee. In November 2018, Bradford Teaching Hospitals NHS Foundation Trust launched a Patient Experience Strategy: Embracing Kindness, which sets out our approach to enable all our staff to improve the care we provide, and help us to deliver our ambition of providing outstanding care for all our patients.	
Currently reported position for 2017/2018	67.47%
Currently reported position for 2016/2017	67.5%
Currently reported position for 2015/2016	63.8%
Currently reported position for 2014/2015	66.3%
Currently reported position for 2013/2014	68.0%
Currently reported position for 2012/2013	71.0%
Currently reported position for 2011/2012	67.0%

Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm
Indicator	Rate of patient safety incidents per 1,000 Bed days (Oct 2017 – Mar 2018) *High Reporters Should be shown as better
Latest available reported position	31.34 (Number of incidents occurring 3903)
National Average	Not Given
Where Applicable – Best Performer	
South Tyneside NHS Foundation Trust	(24.19)
Where Applicable – Worst Performer	
Croydon Health Services NHS Trust	(124)
Trust Statement	
Bradford Teaching Hospitals NHS Foundation Trust considers that this data demonstrates that the Trust continues to promote a culture of open and honest reporting and endorses a just culture so that all opportunities for learning are identified. Bradford Teaching Hospitals NHS Foundation Trust has taken actions to improve this outcome, and to improve the experiences of care and quality of its services. A quality oversight system is in place to ensure there are effective processes for managing risks and learning.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	52.42 (Apr17_Sep17 Number of incidents occurring 3963)
Currently reported position for 2015/2016	52.82 (Oct15_Mar16 Number of incidents occurring 4732)
Currently reported position for 2014/2015	57.83 (Apr15_Sep15 Number of incidents occurring 4989)
Currently reported position for 2013/2014	52.34 (Oct14_Mar15 Number of incidents occurring 4924)
Currently reported position for 2012/2013	40.36 (Apr14_Sep14 Number of incidents occurring 3745)
Currently reported position for 2011/2012	No data for rate per 1,000 bed days (Oct13_Mar14 Number of incidents occurring 3598)

Indicator	Rate of patient safety incidents per 1,000 Bed days that resulted in severe harm or death* (Oct 2017 – Mar 2018)* High Reporters Should be shown as better
Latest available reported position	0.1% (count of incidents = 3)
National Average	Not Given
Where Applicable – Best Performer	
Multiple Trusts	(0%)
Where Applicable – Worst Performer	
United Lincolnshire Hospitals NHS Trust	(1.5%)
Trust Statement	
Bradford Teaching Hospitals NHS Foundation Trust considers that this data demonstrates that the Trust continues to promote a culture of open and honest reporting and endorses a just culture so that all opportunities for learning are identified. Bradford Teaching Hospitals NHS Foundation Trust has taken actions to improve this outcome, and to improve the experiences of care and quality of its services. A quality oversight system is in place to ensure there are effective processes for managing risks and learning. All serious incidents are shared within and outside of specialities to ensure wide spread learning. There is also an established Trustwide Learning HUB with monthly presentations and dissemination of alerts, learning and current articles.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	0.00 (count of incidents = 2) (Apr17 - Sep17)
Currently reported position for 2015/2016	0.08 (count of incidents = 4) (Oct15 - Mar16)
Currently reported position for 2014/2015	0.08 (count of incidents = 4) (Apr15_Sep15)
Currently reported position for 2013/2014	0.20 (count of incidents = 10) (Oct14_Mar15)
Currently reported position for 2012/2013	0.21 (count of incidents = 8) (Apr14_Sep14)
Currently reported position for 2011/2012	0.25 (count of incidents = 9) (Oct13_Mar14)

*** A note from the guidance**

The SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, it is inappropriate to rank trusts according to their SHMI. Instead, the SHMI banding can be used to compare mortality outcomes to the national baseline. If two trusts have the same SHMI banding, it cannot be concluded that the trust with the lower SHMI value has better mortality outcomes

APPENDIX B: GLOSSARY OF AUDITED INDICATORS

Indicator	Description	Criteria	Source
Cancer – 62-day wait from GP referral to treatment	This indicator is required to be reported by the Single Oversight Framework: Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Operating standard of 85%.	Data is submitted monthly to NHS England by all providers of NHS-funded, consultant led services, through the Strategic Data Collection Service (SDCS). SDCS is the online tool used by NHS England for the collection and sharing of NHS performance data. NHS commissioners review and sign off the data and NHS England performs central validation checks to ensure good data quality. The definition of the indicators are provided by the NHS Standard Contract 2018/19
Emergency care standard	This indicator is required to be reported by the Single Oversight Framework: Percentage of A&E attendances where the service user was admitted, transferred or discharged within 4 hours of their arrival at an A&E department.	Operating standard of 95%. Reduced to 90% in January 2018 with a trajectory for recovery to 95% in 2018/2019.	
Summary Hospital-level Mortality Indicator' (SHMI)	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation by the trust.	

APPENDIX C: GLOSSARY OF ABBREVIATIONS AND MEDICAL TERMS

List of Abbreviations

AAWG	Audit Appointment Working Group	**DNACPR**	Do Not Attempt Resuscitation
A&E	Accident and Emergency	**DoLS**	Deprivation of Liberty Standards
ACE	Ambulatory Care Experience	**ECDS**	Emergency Care Data Set
AED	Accident and Emergency Department	**ECS**	Emergency Care Standard
AIS	Accessible Information Standard	**eFI**	Electronic Frailty Index
AKI	Acute Kidney Injury	**ELC**	End of Life Companions
AUKUH	Association of UK University Hospitals	**ENT**	Ear, Nose and Throat
BAC	Business Advisory Committee	**EPR**	Electronic Patient Record
BAF	Board Assurance Framework	**ERIC**	Estates Returns Information Collection
BAME	Black, Asian and Minority Ethnic	**ESR**	Electronic Staff Record
BAPM	British Association of Perinatal Medicine	**FFFAP**	Falls and Fragility Fractures Audit Programme
BAT nurses	Brain Attack nurses	**FFT**	Friends and Family Test
BDCFT	Bradford District Care NHS Foundation Trust	**FREDA**	Human Rights principles - Freedom, Respect, Equality, Dignity, Autonomy
BIG	Bradford Innovation Group		
BIHR	Bradford Institute for Health Research	**FRF**	Financial Recovery Fund
BMDC	Bradford Metropolitan District Council	**GP**	General Practitioner
BPA	Bradford Provider Alliance	**HCA**	Healthcare Assistant
BRI	Bradford Royal Infirmary	**HPMA**	Healthcare People Management Association
BSCB	Bradford Safeguarding Children's Board	**HQIP**	The Healthcare Quality Improvement Partnership
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust	**HSE**	Health and Safety Executive
CCG	Clinical Commissioning Group	**HSMR**	Hospital Standardised Mortality Ratio
CIP	Cost Improvement Programme	**HUB**	Health User Bank
COPD	Chronic Obstructive Pulmonary Disease	**IBD**	Inflammatory Bowel Disease
CPAP	Continuous Positive Airway Pressure	**ICNARC**	Intensive Care National Audit
CQC	Care Quality Commission	**ICO**	Information Commissioner's Office
CQUIN	Commissioning for Quality and Innovation	**IHI**	Institute for Healthcare Innovation
CRIS	Clinical Record Interactive Search	**IMR**	Independent Management Report
DCE	Deputy Chief Executive	**ITFF**	Independent Trust Finance Facility
DEC	Display Energy Certificate	**KPI**	Key Performance Indicator
DHR	Domestic Homicide Review	**LeDeR**	National Learning Disabilities Mortality Review
DHSC	Department of Health and Social Care	**LGBT**	Lesbian, Gay, Bi-Sexual and Transgender
DNA	Did Not Attend appointment	**LLP**	Limited Liability Partnerships

List of Abbreviations

MARAC	Multi-Agency Risk Assessment Conference	**PMO**	Programme Management Office
MARS	Mutually Agreed Resignation Scheme	**POMH**	Prescribing Observatory for Mental Health
MBRRACE - UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK	**PPI**	Patient and Public Involvement
MEWS	Maternal Early Warning System	**PRASE**	Patient Reporting and Action for a Safe Environment
MINAP	Myocardial Ischaemia National Audit Project	**ProgRESS**	Programmed Review of Effectiveness, Safety and Sensitivity
MHA	Mental Health Act	**PSF**	Provider Sustainability Funding
MRSA	Methicillin Resistant Staphylococcus Aureus	**QIA**	Quality Impact Assessment
MTI	Medical Training Initiative	**QIPP**	Quality, innovation, Productivity and Prevention
NatSSIPs	National Safety Standards for Invasive Procedures	**PROMS**	Patient Reported Outcome Measures
NCEPOD	National Confidential Enquiry into Patient Outcome and Death	**RAG**	Red, Amber, Green
NHS	National Health Service	**RIDDOR**	Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013
NHSCFA	NHS Counter Fraud Authority	**RTT**	Referral To Treatment
NHSI	NHS Improvement	**SDSIP**	Seven Day Service Improvement Plan
NICE	National Institute for Health and Care Excellence	**SFI**	Standing Financial Instructions
NIHR	National Institute for Health Research	**SHMI**	Summary Hospital-level Mortality Indicator
NIPE	Newborn and Infant Physical Examination	**SID**	Senior Independent Director
NIV	Non-Invasive Ventilation	**SIP**	Safety Improvement Plans
NLCA	National Lung Cancer Audit	**SIRO**	Senior Information Risk Owner
NNAP	National Neonatal Audit Programme	**SJR**	Structured Judgement Review
NPCA	National Prostate Cancer Audit	**SSNAP**	Sentinel Stroke National Audit Programme
NPDA	National Paediatric Diabetes Audit	**STF**	Sustainability and Transformation Funding
NRC	Nominations and Remuneration Committee	**VTE**	Venous Thromboembolism
ODN	Operational Delivery Network	**WHO**	World Health Organisation
PALS	Patient Advice and Liaison Service	**WRAP**	Workshops to raise Awareness of Prevent
PCI	Percutaneous Coronary Interventions	**WRES**	Workforce Race Equality Standard
PCSO	Police Community Support Officers	**WTE**	Whole Time Equivalent
PCT	Primary Care Trust	**WYAAT**	West Yorkshire Association of Acute Trusts
PLACE	Patient-Led Assessment of the Care Environment	**WYHTASN**	West Yorkshire Human Trafficking and Anti-Slavery Network

List of Terms

Anticoagulation	Medicines that reduce the ability of the blood to clot
Cochrane Review	Cochrane Reviews are systematic reviews of primary research in human healthcare and health policy
Computerised tomography (CT) scan	Uses X-rays and a computer to create detailed images of the inside of the body
Deep vein thrombosis (DVT)	A blood clot that develops within a deep vein in the body, usually in the leg
Endoscopy	A procedure where the inside of your body is examined using an instrument called an endoscope
Ischaemic stroke	The most common type of stroke. They occur when a blood clot blocks the flow of blood and oxygen to the brain
Laparotomy	A surgical procedure done by making an incision in the abdomen (tummy) to gain access into the abdominal cavity
Luer connection systems	The standard way of attaching syringes, catheters, needles, IV tubes etc to each other
Nephrectomy	Surgery to remove all or part of the kidney
Operational Delivery Network	Clinical networks which coordinate patient pathways between providers over a wide area to ensure access to specialist resources and expertise.
Parenteral Nutrition	The feeding of a person directly into the blood through an intravenous (IV) catheter (needle in the vein)
Percutaneous Coronary Interventions	A procedure used to widen blocked or narrowed coronary arteries (the main blood vessels supplying the heart)
Percutaneous nephrolithotomy	A minimally-invasive procedure to remove kidney stones via a small incision in the skin
Prostatectomy	Surgery to remove the prostate gland
Pulmonary embolism	A blockage in the pulmonary artery, the blood vessel that carries blood from the heart to the lungs
Subarachnoid haemorrhage	An uncommon type of stroke caused by bleeding on the surface of the brain. It's a very serious condition and can be fatal
Thalassaemia	The name for a group of inherited conditions that affect a substance in the blood called haemoglobin. People with the condition produce either no or too little haemoglobin, which is used by red blood cells to carry oxygen around the body
Venous thromboembolism (VTE)	A condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)

Bradford Teaching Hospitals NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2019

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

CONTENTS

NATIONAL HEALTH SERVICE ACT 2006

DIRECTIONS BY MONITOR IN RESPECT OF NHS FOUNDATION TRUSTS' ACCOUNTS

Monitor, with the approval of the Secretary of State, in exercise of powers conferred on it by paragraphs 24(1A) and 25(1) of Schedule 7 to the National Health Service Act 2006 (the '2006 Act'), hereby gives the following Directions:

1. Application and interpretation

(1) These Directions apply to NHS foundation trusts in England.

(2) In these Directions:

(a) references to "the accounts" and to "the annual accounts" refer to:

for an NHS foundation trust in its first operating period since being authorised as an NHS foundation trust, the accounts of an NHS foundation trust for the period from point of licence until 31 March

for an NHS foundation trust in its second or subsequent operating period following initial authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March

for an NHS foundation trust in its final period of operation and which ceased to exist as an entity during the year, the accounts of an NHS foundation trust for the period from 1 April until the end of the reporting period

(b) "the NHS foundation trust" means the NHS foundation trust in question.

2. Form and content of accounts

(1) The accounts of an NHS foundation trust kept pursuant to paragraph 24(1) of Schedule 7 to the 2006 Act must comply with the requirements of the Department of Health and Social Care Group Accounting Manual in force for the relevant financial year.

3. Annual accounts

(1) The annual accounts submitted under paragraph 25 of Schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.

(2) The annual accounts shall follow the requirements as to form and content set out in chapter 1 of the NHS foundation trust Annual Reporting Manual (FT ARM) in force for the relevant financial year.

(3) The annual accounts shall comply with the accounting requirements of the Department of Health and Social Care Group Accounting Manual as in force for the relevant financial year.

(4) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

4. Annual accounts: Statement of accounting officer's responsibilities

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

5. Annual accounts: Foreword to accounts

(1) The foreword to the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

Signed by the authority of Monitor
Signed:

Name: Ian Dalton (Chief Executive)
Dated: November 2018

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Bradford Teaching Hospitals Foundation Trust (the 'foundation trust'):

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 23.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • *Revenue recognition in respect of Commissioning for Quality and Innovation (CQUIN) income and Provider Sustainability Fund (PSF) income; and* • *Property Valuations.* Within this report, any new key audit matters are identified with ⏫ and any key audit matters which are the same as the prior year identified with ⏩.
Materiality	The materiality that we used for the current year was £8.2m which was determined on the basis of 2% of total operating income.
Scoping	All testing of the foundation trust was performed by the main audit engagement team performed at the foundation trust's head offices in Bradford, led by the audit director.

Significant changes in our approach	In the current year Impairment of the Electronic Patient Record (EPR) system is no longer considered to be a key audit matter following the determination of the impairment upon completion of the project in 2017/18. There is one new key audit matter in the year concerning property valuations.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

In the current year 'Impairment of the Electronic Patient Record (EPR) system' is no longer a key audit matter as this was due to the judgement involved around the foundation trust bringing the asset into use in the prior year and there has been no similar transaction in the current year.

Property Valuations are noted to be a new key audit matter in the current year because the foundation trust has undertaken a full estates revaluation and has implemented a new Modern Equivalent Asset (MEA) design.

Revenue recognition in respect of Commissioning for Quality and Innovation (CQUIN) income and Provider Sustainability Fund (PSF) income	
Key audit matter description	As described in note 1.5, Accounting Policies and note 1.26, Critical Accounting Estimates and Judgements, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: • the judgements taken in evaluating volume-related and Commissioning for Quality and Innovation ("CQUIN") income. Details of the foundation trust's income, including £340m (2017/18: £335m) of Commissioner Requested Services are shown in note 2.9 to the financial statements. NHS debtors are shown in note 10 to the financial statements. The majority of the foundation trust's income comes from Bradford City CCG, Bradford District CCG and NHS England increasing the significance of associated judgements.

How the scope of our audit responded to the key audit matter	We identified managements controls aimed at challenging, validating and agreeing the original target measures and for reviewing progress against the target and undertook a review of the design and implementation of these controls. We have obtained evidence that CQUIN income for the year has been agreed between the foundation trust and the Commissioner and ensured that the income recognised by the foundation trust is in line with that which has been agreed. We have reviewed the controls put in place by management to validate performance against the PSF metrics. We selected a sample of differences between the amounts that the foundation trust reports as receivable from commissioners, and the amounts that commissioners reported that they owed the foundation trust, in the agreement of balances ("mismatch") report. For the samples selected, explanations were sought from management for the variances together with documentary evidence to corroborate those explanations. We have reviewed management's judgements in relation to the recognition of PSF income in year.
Key observations	We consider the revenue recognition to be fairly stated as at 31 March 2019. The judgements arrived at in relation to recognising both CQUIN and PSF income are reasonable.
Property valuation	
Key audit matter description	The foundation trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £144.5m (2017/18: £184.4m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. As detailed in note 1.27, Key sources of estimation uncertainty, and Note 8, Property, plant and equipment, the foundation trust has reassessed a number of valuation assumptions in the current year, including the MEA assumptions used in the valuation. In particular, the change in assumption on the recoverability of VAT decreases the assumed cost of rebuild. The net valuation movement on the foundation trust's estate shown in note 8 is an impairment of £36.6m.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls over property valuations. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the foundation trust's properties. This included the reasonableness of the foundation trust's assumptions on which they based their reduction in the footprint of the site. We have reviewed the disclosures in Note 8, Property, plant and equipment and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.

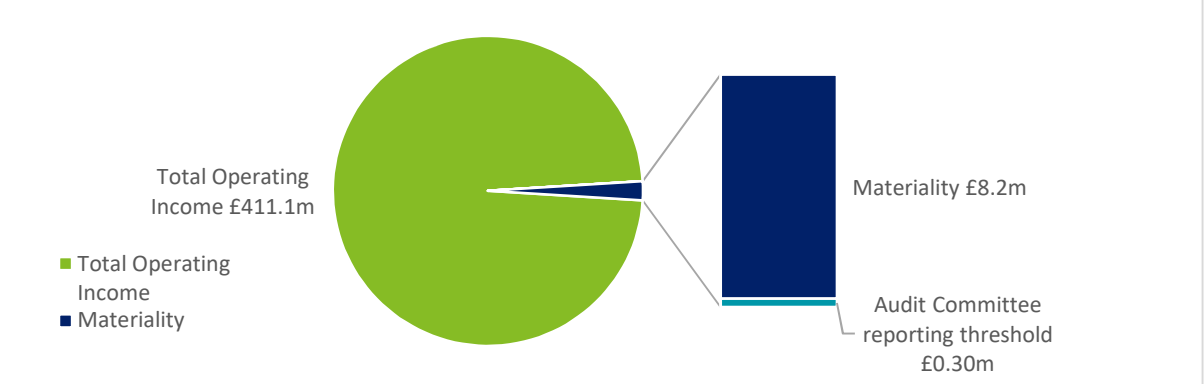
Key observations	We consider the valuation of property assets to be fairly stated as at 31 March 2019.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£8.2m (2017/18: £8.0m)
Basis for determining materiality	2% of Total Operating Income (2017/18: 2% of Total Operating Income)
Rationale for the benchmark applied	Operating Income was chosen as a benchmark as the foundation trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300k (2017/18: £250k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our scope is in line with the Code of Audit Practice issued by the NAO.

Our audit was scoped by obtaining an understanding of the foundation trust and its environment, including internal control, and assessing the risks of material misstatement.

All testing of the foundation trust was performed by the main audit engagement team performed at the foundation trust's administrative offices in Bradford, led by the audit director.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Bradford Teaching Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Hewitson FCA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
Newcastle Upon Tyne, United Kingdom
24 May 2019

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2019 have been prepared by Bradford Teaching Hospitals NHS Foundation Trust (the NHS foundation trust) in accordance with paragraph 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act.

Signed:

Name: John Holden (Acting Chief Executive)
Dated: 24 May 2019

STATEMENT OF COMPREHENSIVE INCOME

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	2.1	346,674	343,269
Other operating income	2.1	64,429	58,367
Operating expenses	3.1	(418,609)	(403,924)
OPERATING DEFICIT		**(7,506)**	**(2,288)**
FINANCE COSTS			
Finance income	5	192	110
Finance expense	6.1	(516)	(582)
Public dividend capital dividends payable	6.2	(4,840)	(4,744)
NET FINANCE COSTS		**(5,164)**	**(5,216)**
Losses on disposals of assets		(6)	(117)
DEFICIT FOR THE YEAR		**(12,676)**	**(7,621)**
Other comprehensive income			
Impairment losses	15	(35,132)	(8,957)
Revaluation gains	15	13,371	29,200
TOTAL COMPREHENSIVE INCOME / (EXPENDITURE) FOR THE YEAR		**(34,437)**	**12,622**

All income and expenses shown relate to continuing operations.

The notes on pages 13 to 54 form part of these accounts.

STATEMENT OF FINANCIAL POSITION

	Note	31 Mar 2019 £000	31 Mar 2018 £000
Non-current assets			
Intangible assets	7.3	11,776	11,257
Property, plant and equipment	8.2	164,315	206,181
Trade and other receivables	10.1	5,978	1,254
Total non-current assets		**182,069**	**218,692**
Current assets			
Inventories	9	7,413	6,588
Trade and other receivables	10.1	27,017	30,453
Cash and cash equivalents	16.1	21,203	25,646
Total current assets		**55,633**	**62,687**
Current liabilities			
Trade and other payables	11	(33,367)	(39,935)
Borrowings	13	(3,138)	(4,052)
Provisions	14.1	(355)	(1,311)
Other liabilities	12	(4,952)	(5,741)
Total current liabilities		**(41,812)**	**(51,039)**
Total assets less current liabilities		**195,890**	**230,340**
Non-current liabilities			
Borrowings	13	(25,792)	(28,844)
Provisions	14.1	(2,953)	(3,070)
Other liabilities	12	(1,819)	0
Total non-current liabilities		**(30,564)**	**(31,914)**
Total assets employed		**165,326**	**198,426**
Financed by taxpayers' equity			
Public Dividend Capital		122,581	121,244
Revaluation reserve	15.1	48,310	75,332
Income and expenditure reserve		(5,565)	1,850
Total taxpayers' equity		**165,326**	**198,426**

These accounts together with notes on pages 13 to 54 were approved by the Board of Directors on 24 May 2019.

Signed:

Name: John Holden (Acting Chief Executive)
Dated: 24 May 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Total £000	Public Dividend Capital £000	Revaluation reserve (see note 15.1) £000	Income and expenditure reserve £000
Taxpayers' equity at 1 April 2018	**198,426**	**121,244**	**75,332**	**1,850**
Deficit for the year	**(12,676)**	0	0	(12,676)
Other transfers between reserves	**0**	0	(5,261)	5,261
Impairments	**(35,132)**	0	(35,132)	0
Revaluations – property, plant and equipment	**13,371**	0	13,371	0
Public dividend capital received	**1,337**	1,337	0	0
Taxpayers' equity at 31 March 2019	**165,326**	**122,581**	**48,310**	**(5,565)**
Taxpayers' equity at 1 April 2017	**185,645**	**121,085**	**55,089**	**9,471**
Deficit for the year	**(7,621)**	0	0	(7,621)
Net impairments	**(8,957)**	0	(8,957)	0
Revaluations – property, plant and equipment	**29,200**	0	29,200	0
Public Dividend Capital received	**159**	159	0	0
Taxpayers' equity at 31 March 2018	**198,426**	**121,244**	**75,332**	**1,850**

STATEMENT OF CASH FLOWS

	2018/19 £000	2017/18 £000
Cash flows from operating activities		
Operating deficit from continuing operations	(7,506)	(2,288)
Non-cash income and expense		
Depreciation and amortisation	9,068	11,124
Impairments and reversals	18,964	14,599
Income recognised in respect of capital donations (cash and non-cash)	(133)	(798)
Increase in trade and other receivables	(779)	(9,783)
Increase in inventories	(825)	(1,918)
Decrease in trade and other payables	(4,683)	(2,791)
Increase/(decrease) in other liabilities	1,030	(1,232)
Decrease in provisions	(1,083)	(4,500)
Net cash generated from operations	**14,053**	**2,413**
Cash flows from investing activities		
Interest received	191	103
Purchase of intangible assets	(1,896)	(9,086)
Purchase of property, plant and equipment and investment property	(8,174)	(9,144)
Sale of property, plant and equipment and investment property	6	23
Receipt of cash donations to purchase capital assets	133	0
Net cash used in investing activities	**(9,740)**	**(18,104)**
Cash flows from financing activities		
Public dividend capital received	1,337	159
Movement in loans from the Department of Health and Social Care	(4,052)	(4,052)
Movement in other loans	0	(38)
Interest paid	(520)	(595)
Public dividend capital dividend paid	(5,521)	(4,503)
Net cash used in financing activities	**(8,756)**	**(9,029)**
Decrease in cash and cash equivalents	(4,443)	(24,720)
Cash and cash equivalents at 1 April	25,646	50,366
Cash and cash equivalents at 31 March	**21,203**	**25,646**

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified, where applicable, to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going Concern

After consideration of the contract position with commissioners, the control total offered by NHSI and forecast cash balances for 2019/20, the Directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.3 Accounting standards that have been issued but have not yet been adopted

The Department of Health & Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2018/19.

These standards are recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2018/19.

- **IFRS 16 Leases** – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- **IFRS 17 Insurance Contracts** – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- **IFRIC 23 Uncertainty over Income Tax Treatments** – Application required for accounting periods beginning on or after 1 January 2019.

At this stage and subject to any interpretation by the FT ARM, we do not envisage a material impact on the Trust's financial statements.

1.4 Interest in other Entities

Joint Venture

Joint Ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint Ventures are accounted for using the equity method.

In 2016/17 the Trust entered into two joint venture limited liability partnerships, each with 50% equity investment, with Airedale NHS Foundation Trust, with losses limited to £1 each. The joint ventures, Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP, have been established to deliver and develop laboratory based pathology services and are not consolidated.

NHS Charitable Funds

The Trust has not consolidated the financial statements with Bradford Hospitals Charity (the Charity), charity registration number 1061753, on the grounds of materiality.

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to trusts, principally the Trustee Act 2000 and the Charities Act 1993, as amended by the Charities Act 2011, the Charities (Accounts and Reports) Regulations 2008 (as modified by section 5 and the Schedule to Order) and the Statement of Recommended Practice (FRS102, effective from 01 January 2015). The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee, which administers the funds on behalf of the Corporate Trustee.

1.5 Income

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Income derived from NHS commissioners in received in the month performance obligations fall due. Reconciliation is carried out with commissioners annually to adjust for any over or under trades against the agreed performance. All other activity is invoiced monthly or quarterly in arrears with credit terms of 30 days.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

Where the Trust enters into contracts for research studies, the contract is reviewed to establish the performance obligations to be met before a consideration can be made. Income is then recognised in line with the obligations being met on a contract by contract basis.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the annual accounts to the extent that employees are permitted to carry forward leave into the following period.

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses, except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- the item has a cost of at least £5,000; or
    - collectively, a number of items have a cost of at least £5,000 and individually have a cost of £250 or more, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
    - have a cost of £250 or more and form part of the initial set up cost of a new building or refurbishment of a ward or unit, where the value is consistent with that of grouped assets.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their

service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been on a single site basis with reprovision of all services on the current Bradford Royal Infirmary site. This meets the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

The valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset basis for specialised operational property and existing use value for non-specialised operational property.

For non-operational properties, including surplus land, the valuations are carried out at open market value. Any new building construction or an enhancement to an existing building or building related expenditure of greater than, or equal to, £1,000,000 will necessitate a formal impairment valuation.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset, when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the SoCI in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated to their residual values over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the SoCI as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. In 2018/19 the impairment is £54,096,000 and in 2017/18 there was an impairment of £23,556,000.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed.

Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets, intended for disposal, are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged.. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sales proceeds (if any) and the carrying amount of the asset and is recognised in the SoCI.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	32	58
Dwellings	44	52
Plant & machinery	5	15
Transport equipment	7	7
Information technology	4	10
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output or, where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

There was no such expenditure requiring capitalisation at the SoFP date. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS foundation trusts disclose the total amount of research and development expenditure charged in the SoCI separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised on a straight line basis over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

The range of useful lives for intangible assets are between 4 and 10 years.

1.10 Government and other grant funded revenue

Government grants are grants from Government bodies other than income from NHS commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the SoCI to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.11 Inventories

All inventories are valued at the lower of cost and net realisable value. The cost of other inventories is measured using the First In First Out (FIFO) method. The cost of pharmacy inventories is measured using weighted average historical cost method. Provision is made where necessary for obsolete, slow moving inventory where it is deemed that the costs incurred may not be recoverable through usage or sale.

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as and subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest

rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets are categorised as 'loans and receivables'. Financial liabilities are classified as 'other financial liabilities'.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated by applying a rolling 3 year average write off percentage against Non-NHS aged debt. The write of percentage for each financial year is based upon the total invoice written off against total invoices raised in the respective financial year. This approach is applied to a number of income streams to capture their different risk profiles.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Finance leases

The NHS foundation trust does not currently hold Finance leases.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.16 Provisions

The Trust recognises a provision:

- where it has a present legal or constructive obligation of uncertain timing or amount;
- for which it is probable that there will be a future outflow of cash or other resources; and
- where a reliable estimate can be made of the amount.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution (formerly NHS Litigation Authority) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed at note 14.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS foundation trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public Dividend Capital

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

Most of the activities of the NHS foundation trust are an exempt VAT supply and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of both intangible assets and property, plant and equipment. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Corporation Tax

The Trust is a Health Service body within the meaning of s519 ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a trust (s519A (3) to (8) ICTA 1988), but, as at 31 March 2019, this power has not been exercised. Accordingly, the NHS foundation trust is not within the scope of corporation tax.

1.21 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the SoFP date:

- monetary items are translated at the spot exchange rate on 31 March 2019;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the SoFP date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.22 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 16.1 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the NHS or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.26 Critical accounting estimates and judgements

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Income estimates

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However, as cash is not received until future periods, when the claims have been settled, an estimate must be made as to the collectability.

Expense accruals

In estimating expenses that have not yet been charged, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Impairment of fixed assets

In accordance with the stated policy on asset valuation, a full asset valuation exercise was undertaken by the Cushman and Wakefield at the prospective valuation date of 1 Apirl 2018. This valuation moved to a single site modern equivalent asset basis and excluded VAT from building replacement costs. A desktop valuation of assets was subsequently carried out on the same basis at the valuation date of 31 March 2019.

Specialised property has been valued at depreciated replacement cost on a modern equivalent asset basis in line with Royal Institute of Chartered Surveyors standards. Land has been valued having regard to the cost of purchasing notional replacement sites in the same locality as the existing sites.

Recoverability of receivables

In accordance with the stated policy on impairment of financial assets, management assess the impairment of receivables and make appropriate adjustments to the existing allowance account for credit losses.

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rates as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

1.27 Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

i. The NHS foundation trust holds a significant asset base and any variation in the useful economic life will have an impact on both the statement of financial position and the in year financial position of the NHS foundation trust. During this financial year the NHS foundation trust amended the useful economic lives of its buildings as a result of a full revaluation of the NHS foundation trust's estate. Depreciation and amortisation charged during the year, including donated assets, was £9,068,000 (2017/18: £11,124,000).

ii. Impairments are recognised where management believe that there is an indication of impairment (through for example, obsolescence). They are recognised where the carrying amount of an asset exceeds its recoverable amount. Significant assets of the Trust are reviewed for impairment as they are brought into operational use. The value of impairments charged to the Statement of Comprehensive Income is disclosed in Note 7 Intangible Assets and Note 8 Property, plant and equipment.

iii. The valuation of the NHS foundation trusts estate is based on reports from a Chartered Surveyor on a five-year rolling basis, supplemented by indices provided by the Surveyor in the intervening period where values change s by 5% or more. The net book value of the NHS foundation trust's land, buildings and dwellings as at 31 March 2019 was £147,292,000 (31 March 2018: £185,920,000).

iv. The NHS foundation trust hold a number of provisions where the actual outcome may vary from the amount recognised in the financial statements. Provisions are based on the most reliable evidence available at the year-end. Details surrounding provisions held at the year-end are included in Note 14 Provisions. Uncertainties and issues arising from provisions and

contingent liabilities are assessed and reported in Note 14 Provisions and Note 18 Contingent liabilities / assets.

v. The NHS foundation Trust has a number of agreements in place to provide services over more than one year (for example, contracts relating to research and development). These are reviewed for profitability at each Statement of Financial Position date, but the assessment of future costs to complete are subject to uncertainty. The revenue recognised in the year reflected management's judgement regarding the outstanding obligations and the associated income values. Income which has been deferred to future periods relating to these contracts at 31 March 2019 amounted to £6,771,000 (31 March 2018 : £5,741,000)

Events which occur after the Statement of Financial Position date can have a material impact on the NHS foundation trust Statement of Financial Position. Where the event should reasonably have been foreseen at the Statement of Financial Position date, the impact has been included in the financial statements. If this is not the case, the impact has been included as a narrative disclosure.

Note 2 Operating income

Note 2.1 Income from patient care (by nature)

	Note	2018/19 £000	2017/18 £000
Income from activities			
Elective income		50,723	46,915
Non elective income		96,621	83,936
First outpatient income		33,131	21,877
Follow Up outpatient income		28,002	22,902
Accident and emergency income		16,217	15,894
High cost drugs income from commissioners		29,901	31,604
Other NHS clinical income	2.2	74,170	100,043
Income from CCG's and NHS England		12,124	11,907
Private patient income		604	768
Agenda for Change pay award central funding		3,800	0
Other clinical income	2.3	1,381	7,423
Total income from activities		**346,674**	**343,269**
Other operating income from contracts with customers:			
Research and development		7,439	13,664
Education and training		17,656	14,957
Provider sustainability fund income (PSF)	2.4	13,908	13,467
Income in respect of employee benefits accounted on a gross basis	2.5	4,097	3,804
Other Contract Income	2.6	16,218	11,177
Other non-contract operating income			
Research and development (non-contract)		4,851	0
Donations/grants of physical assets (non cash) received from other bodies		0	798
Cash donations for the purchase of capital assets received from other bodies		133	0
Charitable and other contributions to expenditure – received from NHS charities		127	500
Total other operating income		**64,429**	**58,367**
Total		**411,103**	**401,636**

2017/18 other clinical income included £14.3m for obstetrics income which is now reported in non-elective (2018/19: £15.2m).

2017/18 other clinical income included £11.7m for direct activity, ward attenders and non-face to face appointments now reported as outpatient income (2018/19: £12.7m).

The Terms of Authorisation set out the mandatory goods and services that the NHS foundation trust is required to provide (commissioner requested services). The majority of the income from activities shown above is derived from the provision of commissioner requested services other than other non-commissioner requested clinical income and private patient income.

Note 2.2 Other NHS clinical income

Other NHS clinical income comprises of income for critical care £15.7m, block funding £12.2m, maternity pathway £10.9m, devices £8.1m, CQUIN income £6.2m, renal £6.1m, diagnostic imaging £4.7m, other various £10.3m. This is in line with the national contract which makes provision for financial neutrality with Commissioners where activity exceeds the contracted casemix.

Note 2.3 Other clinical income

Other clinical income comprises of, in the main, Road Traffic Accident (RTA) income (£1.3m).

Note 2.4 Provider Sustainability Fund (PSF) Income

	2018/19 £000	2017/18 £000
Core	7,225	7,658
Incentive scheme (finance)	483	711
Incentive scheme (bonus)	1,481	1,951
Incentive scheme (general distribution)	4,719	3,147
Total	**13,908**	**13,467**

The provider sustainability fund (formally sustainability and transformation fund) was introduced in July 2016 as part of the NHS financial reset. The changes introduced included the introduction of agreed financial control totals for individual trusts. Provider sustainability funding is paid to trusts should they meet financial and operational targets.

Note 2.5 Income in respect of employee benefits accounted for on a gross basis

Provider to provider income relates to services provided by the Trust to other trusts or commissioners. Income recorded under this heading relates to areas including ear, nose and throat, ophthalmology and plastic surgeons working at Calderdale and Huddersfield NHS Foundation Trust (£0.5m), Airedale NHS Foundation Trust (£0.8m), individual posts and services charged to Leeds Teaching Hospitals (£0.3m), Bradford CCGs (£0.7m), Bradford District Care Trust (£0.3m), other hospitals across Yorkshire (£0.3m) and support to non NHS organisations (£1.2m) including Macmillian Cancer Support and Marie Curie Hospice for doctors, nurses, AHPs and administrative staff.

Note 2.6 Other contract income

Other Income, in the main, includes income associated with services provided to other NHS organisations (£10.7m), pharmacy sales (£2.8m), car parking income (£1.7m) and clinical excellence awards (£0.5m).

Note 2.7 Segmental analysis

The Chief Operating Decision Maker (CODM) is the Board of Directors because it is at this level where overall financial performance is measured and challenged. The Board of Directors primarily considers financial matters at a trust wide level. The Board of Directors is presented with information on clinical divisions but this is not the primary way in which financial matters are considered.

The Trust has applied the aggregation criteria from IFRS 8 operating segments because the clinical divisions provide similar services, have homogenous customers, common production processes and a common regulatory environment. Therefore the Trust believes that there is one segment and have reported under IFRS 8 on this basis.

Note 2.8 Income from patient care (by source)

Income from activities	**Note**	**2018/19 £000**	**2017/18 £000**
NHS England		63,514	69,207
Clinical commissioning groups		276,780	269,579
Department of Health & Social Care		3,800	0
NHS Foundation Trusts		211	854
NHS Trusts		236	314
Local authorities		0	254
NHS other (including Public Health England)		0	120
Non-NHS: private patients		604	768
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)		185	339
Injury cost recovery scheme		1,344	1,833
Non-NHS: Other		0	1
Total income from activities		**346,674**	**343,269**
Of which:			
Related to continuing operations		346,674	343,269
Related to discontinued operations		0	0

Note 2.9 Income from activities arising from commissioner requested services

	2018/19 £000	2017/18 £000
Income for services designated as commissioner requested services	340,889	335,078
Income from services not designated as commissioner requested services	5,785	8,191
Total	**346,674**	**343,269**

Under the terms of its provider license, the Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure.

Note 3 Operating expenses

Note 3.1 Operating expenses

	Note	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies		0	2,635
Purchase of healthcare from non NHS bodies and non-DHSC bodies		448	293
Staff and executive directors costs		251,115	241,098
Non-executive directors		120	154
Supplies and services – clinical (excluding drug costs)		42,203	33,450
Supplies and services – general		15,309	8,396
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		39,549	39,917
Consultancy costs		1,299	967
Establishment		3,048	3,828
Premises – business rates collected by local authorities		1,928	1,837
Premises – other		6,086	10,871
Transport – (business travel only)		437	455
Transport – other (including patient travel)		20	23
Depreciation on property, plant & equipment		6,845	10,287
Amortisation on intangible assets		2,223	837
Impairments net of (reversals)		18,964	14,599
Movement in credit loss allowance: contract receivables / assets		123	0
Movement in credit loss allowance: all other receivables & investments		0	254
Change in provisions discount rate		(58)	46
Audit services – statutory audit		57	58
Other auditor remuneration	3.2	40	39
Internal Audit – non-staff		175	0
Clinical negligence – amounts payable to the NHS Resolution (premium)		12,294	11,496
Legal fees		224	185
Insurance		337	154
Research and Development – staff costs		7,592	7,341
Research and development – non-staff		4,697	4,666
Education and training – staff costs		4,345	2,676
Education and training – non-staff		571	447
Operating lease expenditure (net)		2,159	1,559
Redundancy costs – non-staff		0	108
Car parking and security		10	185
Hospitality		17	58
Other losses and special payments – non-staff		27	77
Other services (e.g. external payroll)		978	1,373
Other		(4,573)	3,555
Total		**418,609**	**403,924**

Other expenditure includes a credit of £4,573,000 as a result of an historic VAT reclaim which the Trust qualifies for following the establishment of a wholly owned subsidiary for Estates and Facilities services.

Depreciation on property, plant and equipment in 2018/19 has been reduced by the adoption of a revised valuation which excludes VAT and is based on a revised modern equivalent asset assumption.

2017/18 £2,635,000 reported as Purchase of healthcare from NHS and DHSC bodies is now classified as Supplies and Services clinical.

2017/18 Premises – other has reduced by £5,000,000 from 2017/18 due to external contracts now reported as Supplies and Services general.

2017/18 £3,555,000 reported as Other is now classified as Supplies and Services – General and Supplies and Services Clinical.

Note 3.2 Other audit remuneration

	2018/19	2017/18
	£000	£000
Audit related assurance services	7	7
Taxation compliance services	0	0
Other assurance Services	33	32
Total	**40**	**39**

Note 3.3 Operating leases

	2018/19	2017/18
	£000	£000
Minimum lease payments	2,159	1,559
Total	**2,159**	**1,559**

Note 3.4 Future minimum lease payments

	2018/19	2017/18
	£000	£000
- not later than one year	3,504	3,024
- later than one year and not later than five years	1,528	1,514
Total	**5,032**	**4,538**

Leases comprise of buildings, medical equipment, motor vehicles and other equipment.

Buildings relates to leases held in Community Health Partnerships Limited for accommodation acquired through Transforming Community Services.

All medical equipment currently held under lease is leased under NHS Purchasing and Supply Agency agreements. These make no provision for any contingent rentals. They are silent on renewal and purchase options and do not comprise escalation clauses. The framework they provide is consistent with an operating lease arrangement.

Motor vehicles and other equipment currently held under lease are leased under agreements specific to the lessor concerned. None of the agreements currently in force make provision for any contingent rentals nor include escalation clauses.

There was no intention from the inception of any of the current leases that any of the leased equipment would be purchased outright either at the end of, or at any time during, the lease terms.

Note 3.5 Limitation on auditor's liability

In accordance with SI 2008 no.489, the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreement) Regulations 2008, the limitation on auditor's liability for the year ended 31 March 2019 is £1,000,000 (31 March 2018 £1,000,000).

	2018/19	2017/18
	£000	£000
Limitation on auditor's liability	1,000	1,000

Note 4 Employee expenses

Note 4.1 Employee expenses

	2018/19	2017/18
	£000	£000
Salaries and wages	209,222	195,564
Social security costs	19,205	18,240
Apprenticeship Levy	1,020	641
Pension cost – defined contribution plans, employer's contributions to NHS Pensions	23,592	22,467
Temporary Staff - Agency / contract staff	10,360	15,185
Total	**263,399**	**252,097**
Included within :		
Costs capitalised as part of assets	347	982

All employer pension contributions in 2018/19 and 2017/18 were paid to the NHS Pensions Agency.

The operating employee expense, excluding costs capitalised as part of assets, of £263,052,000 is reported in table 3.1 Operating expenses as Staff and executive directors costs (£251,115,000), Research and Development – staff costs (£7,592,000) and Education and training – staff costs (£4,345,000).

Salaries and wages include £15,824,000 for internal temporary bank staff (2017/18 £12,653,000).

Included in the above figures are the following balances for executive directors:

	2018/19	2017/18
	£000	£000
Directors' remuneration	1,355	1,284
Employer pension contributions in respect of directors	122	108

Note 4.2 Average number of employees

	2018/19	2017/18
	WTE	WTE
Medical and dental	717	696
Administration and estates	1,837	1,774
Healthcare assistants and other support staff	704	634
Nursing, midwifery and health visiting staff	1,947	1,822
Scientific, therapeutic and technical staff	669	629
Other	3	3
Total	**5,877**	**5,558**
of which		
Number of employees engaged on capital projects	8	8

Note 4.3 Exit package cost band (including any special payment element)

	2018/19	2017/18
	Total number of exit packages by cost band	Total number of exit packages by cost band
<£10,000	0	8
£10,000 - £25,000	1	2
£25,001 - £50,000	0	0
£50,001 - £100,000	1	0
Total	**2**	**10**

Note 4.4 Exit packages: other (non-compulsory) departure payment

	2018/19 Agreements	2018/19 Total value of agreements
	Number	£000
Exit payments following employment tribunals or court orders	1	15
Total	**1**	**15**

	2017/18 Agreements Number	2017/18 Total value of agreements £000
Exit payments following employment tribunals or court orders	1	5
Total	**1**	**5**

Note 4.5 Early retirements due to ill health

	2018/19 £000	2018/19 Number	2017/18 £000	2017/18 Number
Number of early retirements on the grounds of ill-health		4		3
Value of early retirements on the grounds of ill-health	199		134	

Note 4.6 Analysis of termination benefits

	2018/19 £000	2018/19 Number	2017/18 £000	2017/18 Number
Number of cases		0		0
Cost of cases	0		0	

Note 4.7 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Auto-enrolment / NEST Pension Scheme

On 1 April 2013, the NHS foundation trust signed up to an alternative pension scheme, NEST, to comply with the Government's requirement for employers to enrol all their employees into a workplace pension scheme, to help people to save for their retirement.

From April 2013, any employees not in a pension scheme were either enrolled into the NHS Pension Scheme or, where not eligible for the NHS Scheme, into the NEST Scheme. Employees are not entitled to join the NHS Pension Scheme if they:

- are already in receipt of an NHS pension;
- work full time at another trust; or
- are absent from work due to long-term sickness, maternity leave, etc. when the statutory duty to automatically enrol applies.

The NHS foundation trust is required to make contributions to the NEST pension fund for any such employees enrolled, 1% from 1 April 2014, rising to 2% in April 2018 and 3% in April 2019.

Employees are permitted to opt out of the auto-enrolment, from either the NHS Pension Scheme or NEST, if they do not wish to pay into a pension, but they will lose the contribution made by the NHS foundation trust.

In the financial year to 31 March 2019, the NHS foundation trust made contributions totalling £42,000 into the NEST fund (31 March 2018 £17,000).

Note 5 Finance income

	2018/19 £000	2017/18 £000
Interest on bank accounts	111	60
Interest on other investments / financial assets	81	50
Total	**192**	**110**

Interest receivable relates to interest earned with the Government Banking Service and the National Loans Fund.

Note 6 Finance costs and Public Dividend Capital dividend

Note 6.1 Finance costs

Interest payable amounted to £506,000 (2017/18: £579,000). This is interest due on the following loans taken from the DHSC.

Date Total Loan Taken	Duration of Loan	Total Loan Amount (£000)	Remaining Amount to Withdraw (£000)	Amount Repaid (£000)	Balance Outstanding (£000)	Total Interest (£000)
21 January 2009	10 Years	10,000	0	10,000	0	17
20 June 2016	20 Years	20,000	0	3,156	16,844	345
19 September 2016	8 Years	16,000	0	4,000	12,000	143
		46,000	**0**	**17,156**	**28,844**	**505**

The unwinding of discount on provisions amounted to £10,000 (2017/18 £3,000).

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2018/19 or 2017/18.

Note 6.2 Public dividend capital dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. See accounting policy 1.18 for an explanation of how this dividend is calculated.

The amount payable this year is £4,840,000 (2017/18: £4,744,000), which is 3.5% of the year's average relevant net assets of £172,051,000 (2017/18 : £184,533,000) less average daily cleared cash balance £33,787,000 (2017/18: £ 48,970,000) at 3.50%.

Note 6.3 Losses and special payments

NHS Foundation Trusts are required to record cash and other adjustments that arise as a result of losses and special payments. These losses to the Trust will result from the write off of bad debts, compensation paid for lost patient property, or payments made for litigation claims in respect of personal injury. In the year the Trust has had 195 (2017/18: 123) separate losses and special payments, totalling £233,000 (2017/18: £125,000). The bulk of these were in relation to bad debts and ex gratia payments in respect of personal injury.

Losses and special payments are reported on an accruals basis but excluding provisions for future losses. There were no individual cases exceeding £100,000.

Note 7 Intangible assets

Note 7.1 Intangible assets 2018/19

	Total	Software licences	Asset under construction
	£000	£000	£000
Valuation / gross cost at 1 April	**19,600**	19,380	220
Additions – purchased / internally generated	**2,744**	267	2,477
Additions – donation of physical assets (non cash)	**0**	0	0
Reclassifications	**(14)**	320	(334)
Disposals / derecognition	**(4)**	(4)	0
Gross cost at 31 March	**22,326**	**19,963**	**2,363**
Accumulated amortisation at 1 April	**8,343**	**8,343**	**0**
Provided during the year	**2,223**	2,223	0
Reclassifications	**(12)**	(12)	0
Disposals / derecognition	**(4)**	(4)	0
Amortisation at 31 March	**10,550**	**10,550**	**0**
Net book value at 31 March 2019	**11,776**	**9,413**	**2,363**
Net book value at 1 April 2017	**11,257**	**11,037**	**220**

Note 7.2 Intangible assets 2017/18

	Total	Software licences	Asset under construction
	£000	£000	£000
Valuation / gross cost at 1 April	**19,701**	**10,748**	**8,953**
Additions – purchased / internally generated	**9,086**	1,335	7,751
Additions – donation of physical assets (non cash)	**12**	12	0
Reclassifications	**72**	16,556	(16,484)
(Impairment) / revaluations	**(9,271)**	(9,271)	0
Gross cost at 31 March	**19,600**	**19,380**	**220**
Accumulated amortisation at 1 April	**7,419**	**7,419**	**0**
Provided during the year	**837**	837	0
Reclassifications	**87**	87	0
Amortisation at 31 March	**8,343**	**8,343**	**0**
Net book value at 31 March 2018	**11,257**	**11,037**	**220**
Net book value at 1 April 2017	**12,282**	**3,329**	**8,953**

All assets classed as intangible meet the criteria set out in IAS 38 (2) in terms of identifiability, control (power to obtain benefits from the asset), and future economic benefits (such as revenues or reduced future costs). The cost less residual value of an intangible asset with a finite useful life is amortised on a systematic basis over that life, as required by IAS 38 (97).

The electronic patient records system is a material asset within the Trusts intangible assets balance. The closing net book value of the asset was £6,116,000 (2017/18: £7,346,000) which will be amortised over the life of the service contract which expires on 31 January 2025.

Note 8 Property, plant and equipment

Note 8.1 Property, plant and equipment 2018/19

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	**259,447**	**14,003**	**170,519**	**1,540**	**1,079**	**48,990**	**43**	**22,870**	**402**
Additions – purchased	**5,581**	-	3,807	-	332	821	-	621	0
Additions – donations / grants	**133**	0	0	0	0	133	0	0	0
Impairments charged to operating expenses	**(21,390)**	(987)	(20,403)	0	0	0	0	0	0
Impairments charged to revaluation reserve	**(35,132)**	(4,648)	(30,484)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	**2,426**	159	2,122	145	0	0	0	0	0
Reclassifications	**(139)**	135	408	(16)	(1,372)	(109)	(1)	822	(6)
Revaluations	**10,992**	0	9,856	1,136	0	0	0	0	0
Disposals	**(558)**	0	0	0	0	(524)	0	(34)	0
Valuation/Gross cost at 31 March	**221,360**	**8,662**	**135,825**	**2,805**	**39**	**49,311**	**42**	**24,279**	**396**
Accumulated depreciation at 1 April	**53,266**	**0**	**131**	**11**	**0**	**37,031**	**38**	**15,830**	**224**
Provided during the year	**6,845**	0	2,327	52	0	2,442	1	2,011	12
Impairments charged to operating expenses	**0**	0	0	0	0	0	0	0	0
Revaluations	**(2,379)**	0	(2,327)	(52)	0	0	0	0	0
Reclassifications	**(141)**	0	(131)	(11)	0	0	1	0	0
Disposals	**(546)**	0	0	0	0	(512)	0	(34)	0
Accumulated depreciation at 31 March	**57,045**	**0**	**0**	**0**	**0**	**38,961**	**40**	**17,807**	**236**

Revised valuations for land, buildings and dwellings were applied twice in 2018/19 by the independent valuers Cushman and Wakefield.

The first valuation dated 1st April 2018 incorporated the following changes to the basis of valuation:

- A revised Modern Equivalent Asset valuation was applied based on a single site replacement of the Trust's buildings based at the Bradford Royal Infirmary.
- Exclusion of VAT from the valuation due to the in year establishment of an Estates and Facilities subsidiary.

The second valuation dated 31st March 2019 was a desktop valuation based on the assumptions above.

Note 8.2 Property, plant and equipment financing 2018/19

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	**161,628**	8,662	134,124	2,805	39	9,394	2	6,472	130
Donated	**2,687**	0	1,701	0	0	956	0	0	30
Net book value at 31 March	**164,315**	**8,662**	**135,825**	**2,805**	**39**	**10,350**	**2**	**6,472**	**160**

No assets were held under finance leases and hire purchase contracts at the SoFP date (31 March 2017: £ nil).

No depreciation was charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts (31 March 2017: £nil).

There are no restrictions imposed by the donors on the use of donated assets.

Note 8.3 Property, plant and equipment 2017/18

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	**243,855**	**16,095**	**150,865**	**1,972**	**4,725**	**51,476**	**61**	**18,268**	**393**
Additions – purchased	**9,630**	0	2,868	0	3,305	1,679	0	1,778	0
Additions – donations / grants	**786**	0	0	0	0	786	0	0	0
Impairments charged to operating expenses	**(12,211)**	(2,223)	(9,988)	0	0	0	0	0	0
Impairments charged to revaluation reserve	**(8,957)**	0	(8,525)	(432)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**6,718**	0	6,718	0	0	0	0	0	0
Reclassifications	**(72)**	0	4,931	0	(6,951)	(1,099)	0	2,997	50
Revaluations	**23,781**	131	23,650	0	0	0	0	0	0
Disposals	**(4,084)**	0	0	0	0	(3,852)	(18)	(173)	(41)
Valuation/Gross cost at 31 March	**259,446**	**14,003**	**170,519**	**1,540**	**1,079**	**48,990**	**43**	**22,870**	**402**
Accumulated depreciation at 1 April	**52,593**	**0**	**15**	**12**	**0**	**38,433**	**54**	**13,826**	**253**
Provided during the year	**10,287**	0	5,675	37	0	2,458	1	2,105	11
Impairments charged to operating expenses	**(165)**	0	(165)	0	0	0	0	0	0
Revaluations	**(5,419)**	0	(5,381)	(38)	0	0	0	0	0
Reclassifications	**(87)**	0	(13)	0	0	(146)	0	71	1
Disposals	**(3,944)**	0	0	0	0	(3,714)	(17)	(172)	(41)
Accumulated depreciation at 31 March	**53,265**	**0**	**131**	**11**	**0**	**37,031**	**38**	**15,830**	**224**

Note 8.4 Property, plant and equipment financing 2017/18

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - Purchased	**201,716**	14,003	166,991	1,529	1,079	10,931	5	7,040	138
Donated	**4,465**	0	3,397	0	0	1,028	0	0	40
Net book value at 31 March	**206,181**	**14,003**	**170,388**	**1,529**	**1,079**	**11,959**	**5**	**7,040**	**178**

Note 9 Inventories

	31 Mar 19 £000	31 Mar 18 £000
Consumables	4,035	3,329
Drugs	3,300	3,177
Buildings and engineering	78	82
Total	**7,413**	**6,588**

Note 10 Receivables

Note 10.1 Trade receivables and other receivables

	31 Mar 19 £000	31 Mar 18 £000
Current		
Contract receivables*	20,631	0
Contract assets*	724	0
Trade receivables*	0	21,029
Accrued income	0	1,463
Allowance for impaired contract receivables / assets*	(880)	0
Provision for impaired receivables	0	(885)
Prepayments	2,824	3,318
Interest receivable	10	9
PDC dividend receivable	508	0
VAT receivables	1,058	418
Other receivables	2,142	5,101
Total	**27,017**	**30,453**
Non-current		
Contract receivables*	1,405	0
VAT receivables	4,573	0
Other receivables – revenue	0	1254
Total	**5,978**	**1,254**

Of which receivables from NHS and DHSC group bodies

Current	16,456	21,029
Non-current	0	0

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and

contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 10.2 Allowances for credit losses 2018/19

	Contract receivables and contract assets	All other
	£000	£000
Allowances as at 1 April 2018 – brought forward	**0**	**885**
Impact of implementing IFRS 9 & IFRS 15 on 1 April 2018	885	(885)
New allowances arising	164	0
Reversals of allowances	(41)	0
Utilisation of allowances (write offs)	(128)	0
Total	**880**	**0**

Note 10.3 Allowances for credit losses 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All Receivables
	£000
Allowances as at 1 April 2017 – brought forward	**676**
New allowances arising	1,168
Reversals of allowances	(914)
Utilisation of allowances (write offs)	(45)
Total	**885**

Note 11 Trade and other payables

	31 Mar 19 £000	31 Mar 18 £000
Current		
Trade payables	11,123	11,464
Capital payables	1,829	3,441
Other taxes payable	5,606	5,255
PDC dividend payable	0	173
Accrued interest on DHSC loan*	0	100
Other payables	2,259	2,812
Accruals	12,550	16,690
Total	**33,367**	**39,935**
Of which payables from NHS and DHSC group bodies:		
Current	5,419	8,618
Non-current	0	0

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 13. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 12 Other liabilities

	31 Mar 19 £000	31 Mar 18 £000
Current		
Deferred income: contract liabilities	4,952	5,741
Non-current		
Deferred income: contract liabilities	1,819	0

Note 13 Borrowings

Note 13.1 Borrowings

	31 Mar 19 £000	31 Mar 18 £000
Current		
Loans from DHSC (capital loans)	3,138	4,052
Total	**3,138**	**4,052**
Non-current		
Loans from DHSC (capital loans)	25,792	28,844
Total	**25,792**	**28,844**

Note 13.2 Borrowings Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**32,896**	**0**	**0**	**0**	**32,896**
Cash movements:					
Financing cash flows – payments and receipts of principal	(4,052)	0	0	0	(4,052)
Financing cash flows – payments and interest	(520)	0	0	0	(520)
Non-cash movements:					
Impact of implementing IFRS9 on 1 April 2018	100	0	0	0	100
Application of effective interest rate	506	0	0	0	506
Carrying value at 31 March 2019	**28,930**	**0**	**0**	**0**	**28,930**

Note 14 Provisions

Note 14.1 Provisions for liabilities and charges

	Current 31 Mar 19 £000	Current 31 Mar 18 £000	Non-current 31 Mar 19 £000	Non-current 31 Mar 18 £000
Pensions – Injury benefits	125	231	2,310	2,390
Equal pay (including agenda for change)	0	822	0	0
Other	230	258	643	680
Total	**355**	**1,311**	**2,953**	**3,070**

Agenda for Change provisions include provisions for unresolved national and local bandings for several job profiles and unresolved enhancement pay claims.

Continuing care provisions relate to contractual issues for service provision from suppliers and commissioners.

Equal pay claims relate to a provision for claims relating to employment contracts.

Additionally, the other category contains amounts due as a result of third party and employee liability claims. The values are based on information provided by the NHS Resolution, NHS Business Services Authority and NHS Pensions and have previously been reported in legal claims.

As at 31 March 2019 £287,790,000 is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2018: £267,264,000).

Note 14.2 Provisions for liabilities and charges analysis 2018/19

	Total	Pensions – Injury benefits	Equal pay (including agenda for change)	Other
	£000	£000	£000	£000
At 1 April 2018	**4,381**	**2,621**	**822**	**938**
Change in the discount rate	**(58)**	(51)	0	(7)
Arising during the year	**316**	73	0	243
Utilised during the year – cash	**(310)**	(108)	0	(202)
Reversed unused	**(1,031)**	(110)	(822)	(99)
Unwinding of discount rate	**10**	10	0	0
At 31 March 2019	**3,308**	**2,435**	**0**	**873**
Expected timings of cash flows:				
-not later than one year	**355**	125	0	230
-later than one year and not later than five years	**2,953**	2,310	0	643
Total	**3,308**	**2,435**	**0**	**873**

Note 15 Revaluation reserve movement

Note 15.1 Revaluation reserve movement – 2018/19

	Total revaluation reserve £000	Revaluation reserve – intangibles £000	Revaluation reserve – property, plant and equipment £000
Revaluation reserve at 1 April	75,332	74	75,258
Net Impairments	(35,132)	0	(35,132)
Revaluations	13,371	0	13,371
Transfers to other reserves	(5,261)	0	(5,261)
Other reserve movements	0	48	(48)
Revaluation reserve at 31 March	**48,310**	**122**	**48,188**

Note 15.2 Revaluation reserve movement – 2017/18

	Total revaluation reserve £000	Revaluation reserve – intangibles £000	Revaluation reserve – property, plant and equipment £000
Revaluation reserve at 1 April	55,089	74	55,015
Net Impairments	(8,957)	0	(8,957)
Revaluations	29,200	0	29,200
Revaluation reserve at 31 March	**75,332**	**74**	**75,258**

Note 16 Cash and cash equivalents

Note 16.1 Cash and cash equivalents

	2018/19 £000	2017/18 £000
At 1 April	**25,646**	**50,366**
Net change in year	(4,443)	(24,720)
At 31 March	**21,203**	**25,646**
Broken down into:		
Cash at commercial banks and in hand	24	19
Cash with the Government Banking Service	21,179	25,627
Cash and cash equivalents as in SoFP and SoCF	**21,203**	**25,646**

Third party assets held by the NHS foundation trust at 31 March 2019 were £3,000 (31 March 2018: £3,000).

Note 16.2 Pooled budgets

The NHS foundation trust is not party to any pooled budget arrangements in 2018/19 or 2017/18.

Note 17 Contractual capital commitments and events after the reporting period

Note 17.1 Contractual capital commitments

Commitments under capital expenditure contracts at the reporting date were £6,689,000 (31 March 2018: £2,278,000). The Trust has capital commitments for a number of capital strategy schemes such as creating a Command Centre to manage patient flow.

Note 17.2 Other financial commitments

Other financial commitments at the reporting date were £7,751,000 (31 March 2018: £9,051,000). The Trust has financial commitments for the ongoing support and maintenance charges for the electronic patient records system.

Note 17.3 Events after the reporting period

There are no events after the reporting period to disclose.

Note 18 Contingent liabilities / assets

	31 Mar 19 £000	31 Mar 18 £000
Value of contingent liabilities		
NHS Resolution legal claims	87	129
Total	**87**	**129**

At 31 March 2019 the NHS Foundation Trust has £87,000 contingent liability for legal expenses, which is based upon the information provided by NHS Resolution (31 March 2018: £129,000).

Note 19 Related party transactions

Note 19.1 Related party transactions

The NHS foundation trust is a public interest body authorised by NHSI, the Independent Regulator for NHS foundation trusts.

During the year none of the Board members nor members of the key management staff, nor parties related to them, has undertaken any material transactions with the Trust.

The Register of Interests for the Council of Governors for 2018/19 has been compiled in accordance with the requirements of the Constitution of the Trust.

The Trust has also received capital payments from a number of funds held within the Charity, the trustee of which is the Trust. Furthermore, the Trust has levied a management charge on the Charity in respect of the services of its staff. The Charity accounts have not been consolidated into the Trust's accounts (see note 1.4).

Note 19.2 Related party balances

	Income £000	Expenditure £000
Value of transactions with other related parties 2018/19		
Charitable fund	219	0
Non-consolidated joint ventures	628	7,840
Other bodies or persons outside of the whole of government accounting boundary	93	595
Total as at 31 March 2019	**940**	**8,435**
Value of transactions with other related parties 2017/18		
Charitable fund	748	0
Non-consolidated joint ventures	129	7,125
Total as at 31 March 2018	**877**	**7,125**

	Receivables £000	Payables £000
Value of balances with other related parties 2018/19		
Charitable fund	189	0
Non-consolidated joint ventures	282	33
Other bodies or persons outside of the whole of government accounting boundary	0	433
Total as at 31 March 2019	**471**	**466**
Value of balances with other related parties 2017/18		
Charitable fund	649	0
Non-consolidated joint ventures	187	64
Total as at 31 March 2018	**836**	**64**

In line with the DHSC interpretation of IAS 24 related parties the NHS foundation trust only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

Note 20 Transactions with Joint Venture

The Trust has a 50% equity share and voting rights in both Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP, with losses limited to £1 each. Neither Integrated Pathology Solutions, or Integrated Laboratory Solutions hold capital assets. Under the terms of the joint venture agreement, the NHS foundation trust is not liable for any losses in the first two years of trading. In year three (2019/2020) of trading the NHS foundation trust is able to receive a 50% share of any profits made, once they exceed the losses in the first two years.

During 2018/19 the interests in Joint Ventures accounted for using the equity method are:

	Profit / (loss) £000	Gross Assets £000	Net Assets £000
Integrated Laboratory Solutions LLP	138	1,267	(524)
Integrated Pathology Solutions LLP	1	725	(1,152)
Total	**139**	**1,992**	**(1,676)**

The combined profit of £139,000 (2017/18: loss of £2,067,000) therefore means the NHS foundation trust has not reflected any entries in the statement of comprehensive income for 2018/19 as there has been a cumulative loss since establishment of £1,928,000.

Note 21 Private Finance transactions

The NHS foundation trust is not party to any Private Finance Initiatives. There are therefore no on-SoFP or off-SoFP transactions which require disclosure.

Note 22 Financial instruments

IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The NHS foundation trust actively seeks to minimise its financial risks. In line with this policy, the NHS foundation trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS foundation trust in undertaking its activities.

Liquidity risk

The NHS foundation trust's net operating costs are incurred under three year agency purchase contracts with local CCGs, which are financed from resources voted annually by Parliament. The NHS foundation trust receives such contract income in accordance with PbR, which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The NHS foundation trust receives cash each month based on an annually agreed level of contract activity, and there are quarterly corrections made to adjust for the actual income due under PbR.

The NHS foundation trust currently finances the majority of its capital expenditure from internally generated funds and funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the NHS foundation trust can borrow, both from the DHSC Financing Facility and commercially, to finance capital schemes. Financing is drawn down to match the spend profile of the scheme concerned and the NHS foundation trust is not, therefore, exposed to significant liquidity risks in this area.

Interest rate risk

With the exception of cash balances, the NHS foundation trust's financial assets and financial liabilities carry nil or fixed rates of interest.

The NHS foundation trust monitors the risk but does not consider it appropriate to purchase protection against it.

Foreign currency risk

The NHS foundation trust has negligible foreign currency income, expenditure, assets or liabilities.

Credit risk

The NHS foundation trust receives the majority of its income from NHS England, CCGs and statutory bodies and therefore the credit risk is negligible.

The NHS foundation trust's treasury management policy minimises the risk of loss of cash invested by limiting its investments to:

- the Government Banking Service and the National Loans Fund;
- UK registered banks directly regulated by the FSA ; and
- UK registered building societies directly regulated by the FSA.

The policy limits the amounts that can be invested with any one non-government owned institution and the duration of the investment to between £3,000,000 and £12,000,000.

Price risk

The NHS foundation trust is not materially exposed to any price risks through contractual arrangements.

Note 23 Financial assets and liabilities

Note 23.1 Financial assets by category

	31 Mar 19 £000	31 Mar 18 £000
Assets as per SoFP at 31 March		
Trade and other receivables excluding non-financial assets – with NHS and DHSC bodies	15,948	21,029
Trade and other receivables excluding non-financial assets – with other bodies	8,084	4,776
Cash and cash equivalents at bank and in hand	21,203	25,646
Total	**45,235**	**51,451**

Note 23.2 Financial liabilities by category

	31 Mar 19 £000	31 Mar 18 £000
Liabilities as per SoFP at 31 March		
Borrowings excluding finance lease and PFI liabilities	28,930	32,896
Trade and other payables excluding non-financial liabilities – with NHS and DHSC bodies	5,363	8,345
Trade and other payables excluding non-financial liabilities – with other bodies	22,398	26,162
Provisions under contract	0	931
Total	**56,691**	**68,334**

All financial liabilities fall within "other financial liabilities".

Note 23.3 Fair values

For all of the NHS foundation trust's financial assets and financial liabilities, fair value matches carrying value.

Note 23.4 Maturity of financial liabilities

	31 Mar 19 £000	31 Mar 18 £000
In one year or less	30,899	39,490
In more than one year but not more than two years	3,052	3,052
In more than two years but not more than five years	9,156	9,156
In more than five years	13,584	16,636
Total	**56,691**	**68,334**

ACRONYMS

CCG	Clinical Commissioning Group
CQUINS	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
DHSC	Department of Health and Social Care
EU	European Union
FT ARM	NHS Foundation Trust Annual Reporting Manual
FReM	Financial Reporting Manual
FSA	Financial Services Authority
HMRC	Her Majesty's Revenue and Customs
IAS	International Accounting Standards
ICTA	Income and Corporate Taxes Act
IFRIC	International Financial Reporting Interpretations Committee
IFRS	International Financial Reporting Standards
NEST	National Employment Savings Trust
NHS	National Health Service
NHSI	National Health Service Improvement
ONS	Office for National Statistics
PbR	Payment by Results
PDC	Public Dividend Capital
SoCI	Statement of Comprehensive Income
SoCF	Statement of Cash Flows
SoFP	Statement of Financial Position
VAT	Value Added Tax
WTE	Whole Time Equivalents